The Dako Group
2015 Benefits and Enrollment Guide

September 1, 2015 to August 31, 2016

STERLING
INSURANCE GROUP

Health | Dental | Vision | Life | Disability

2015 Benefits Summary Guide Overview

The Dako Group offers eligible employees a variety of benefits that can provide you and your family with health care coverage and financial protection, tailored to best fit your needs. Our benefits program is an important part of your overall compensation and with the assistance of Sterling Insurance Group, we are regularly assessing the quality and cost of the benefits to ensure we offer the most competitive package possible. Changes and relevant new information are highlighted below, however, we encourage you to review this guide in its entirety.

Contents

Open Enrollment: Enrollment is available in August for a September 1st effective date. This is the only opportunity you will have this year to make changes to your benefit elections. During this period you may add, drop, or modify coverage. You will be locked into the plan selections for one year unless there is a qualifying event (marriage, divorce, birth, adoption or change in custody of a child, death of a dependent, change in employment status). All changes must be made within 30 days of the event or you will need to wait until the next open enrollment period.

- **Healthcare: ASR Health Benefits**
- **Prescription Drugs: EHIM**
- **Mail Order Drugs: Walgreens**
- **Dental: Delta Dental**
- **Vision: VSP**
- **Supplemental Term Life/AD&D: MetLife**
- **Voluntary Short Term Disability: MetLife**
- **Voluntary Long Term Disability: MetLife**

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 17 for more details.

This booklet is intended for illustrative and information purposes only. The plan documents, insurance certificates and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern. The The Dako Group reserves the right to change or terminate at any time, in whole or in part, the employee benefit package, with respect to all or any class of employees, former employees and retirees.

Eligibility Overview

The Dako Group is pleased to offer its employees an excellent benefits program. These health and welfare benefits are designed to protect you and your family while you are an active employee.

- Medical - Coverage is offered to employees who work at least 30 hours per week. Coverage begins 1st of the month following 60 days from your date of full-time employment. You may cover your unmarried children up to age 26 regardless of student status. Coverage continues to the end of the year in which they turn 26.
- Vision - Coverage is offered to employees who work at least 30 hours per week. Coverage begins first of the month following 60 days from your date of full-time employment. You may cover your unmarried children to the end of the year in which they turn 26.
- Dental - Coverage is offered to employees who work at least 30 hours per week. Coverage begins first of the month following 60 days from your date of full-time employment. You may cover your unmarried children to the end of the year in which they turn 26.
- Supplemental Term Life - Coverage is offered to employees who work at least 30 hours per week. Coverage begins first of the month following 60 days from your date of full-time employment. If your employment ends from your Employer, you may elect portable coverage. You may cover your unmarried children up to age 19, and 24 if a full-time student.
- Voluntary STD - Coverage is offered to employees who work at least 30 hours per week. Coverage begins first of the month following 60 days from your date of full-time employment.
- Voluntary LTD - Coverage is offered to employees who work at least 30 hours per week. Coverage begins first of the month following 60 days from your date of full-time employment.
- It is your responsibility to provide Barbara Micakovic with proof of your dependents' eligibility, in the form of: (a) marriage license, (b) Court order specifying your responsibility to provide "group health care coverage" to your dependent children, (c) copy of birth certificate or (d) class schedule if dependent is between the ages of 19-26.

New employees have up to 30 days after their eligibility to enroll. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period.

Annual Elections: It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual open enrollment period. Exceptions will be made for changes in family status during the year, allowing you to make a mid-year benefit change. A family status change includes:

- Marriage
- Divorce
- Birth or adoption
- Death of a dependent
- Change in your spouse's employment or
- Loss of coverage by a spouse

If you have a family status change, you must change your benefit elections within 30 days of the qualifying event, or you will need to wait until the next annual open enrollment period.

COBRA Continuation Coverage: When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

Healthcare Benefits Overview

Healthcare benefits are one of the most important and necessary parts of your benefit package. The following is a summary of your benefits offered through ASR Health Benefits. For a more detailed explanation of benefits, please refer to your certificate of coverage. You may access a list of participating providers through the carriers website located on page 26 of this guide.

	Premier PPO Plan		Value PPO Plan		HSA PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Plan Year)						
Individual / Family	$500 / $1,000	$750 / $1,500	$1,000 / $2,000	$1,500 / $3,000	$3,000 / $6,000	$6,000 / $12,000
Coinsurance	90%	70%	80%	60%	80%	60%
Annual Coinsurance Maximum (applies to coinsurance but does not apply towards deductible, flat dollar copays, or prescription drugs)						
Individual / Family	$500 / $1,000	$2,500 / $5,000	$1,500 / $3,000	$3,500 / $7,000	N/A	
Annual Out-of-Pocket Maximum (applies to deductible, co-pays, coinsurance and prescription drugs)						
Individual / Family	$6,350 / $12,700	$12,700 / $25,400	$6,350 / $12,700	$12,700 / $25,400	$6,000 / $12,000	$15,000 / $30,000
Office Visit	$40 copay	70% after deductible	$30 copay	60% after deductible	80%	60%
Specialist Visit	$60 copay	70% after deductible	$60 copay	60% after deductible	80%	60%
Emergency Room	$200 copay, then deductible & coinsurance	$200 copay, then deductible & coinsurance	$200 copay, then deductible & coinsurance	$200 copay, then deductible & coinsurance	80%	60%
Chiropractic (20 visits per calendar year)	$40 copay and coinsurance	70% after deductible	$30 copay and coinsurance	60% after deductible	80%	60%
Urgent Care	$75 copay	70% after deductible	$75 copay	60% after deductible	80%	60%
Prescription Drugs - 30 day supply	$10 / $30 / $50	No Coverage	$10 / $30 / $60	No Coverage	$10 / $35 / $50 after deductible	No Coverage
Mail Order Prescription Drugs - 90 day supply	$20 / $60 / $100	No Coverage	$20 / $60 / $120	No Coverage	$20 / $70 / $100 after deductible	No Coverage

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Provider Search Instructions

IMPORTANT: If you are a Michigan resident, please begin your search with Physicians Care & HAP and continue with Cigna/ MultiPlan if the provider does not participate with Physicians Care & HAP. If you are a non-Michigan resident, please begin your search with Cigna/MultiPlan.

Physicians Care & HAP (Michigan)

Step 1: Visit www.asrhealthbenefits.com
Step 2: See Figure 1
Step 3: Click **Physicians Care & HAP**
Step 4: Enter search criteria

Figure 1

Cigna/MultiPlan (Nationwide)

Step 1: Visit www.asrhealthbenefits.com
Step 2: See Figure 1
Step 3: Click **Physicians Care & HAP**
Step 4: See Figure 2
Step 5: Click **Cigna**
Step 6: Click **Find a Doctor**
Step 7: Click **IF YOUR INSURANCE PLAN IS OFFERED THROUGH WORK OR SCHOOL**
Step 8: Locate **SELECT A PLAN,** click **PICK**, and choose **PPO Choice Fund, PPO**
Step 9: Click **DOCTORS** or **HOSPITAL, PHARMACY OR FACILITY**
Step 10: Enter your **SEARCH LOCATION** and the provider you are **LOOKING FOR**
Continue to Step 11 only if your provider does not participate with Cigna.

Step 11: Return to www.asrhealthbenefits.com
Step 12: See Figure 2
Step 13: Click **MultiPlan**
Step 14: Click **Search for a Doctor or Facility**
Step 15: Choose logo (Back of Card)
Step 16: Choose a provider type
Step 17: Enter search criteria

Figure 2

If you are unable to locate your physician on our website, please contact ASR at (888)-262-6401.

Pre-Certification Requirements

You are required to obtain a Pre-Certification prior to any hospital admission or certain outpatient procedures, or within 48 hours after obtaining services listed below by calling (800) 638-0573. Services requiring pre-certification include the following:

1. Inpatient Hospital Confinements
2. Home and Outpatient Rehabilitative Therapy
3. Rental and Purchase of Durable Medical Equipment
4. Home Health Care
5. Purchase of Custom-Made Orthotic or Prosthetic Appliances
6. Oncology Treatment

Auto Insurance Coordination

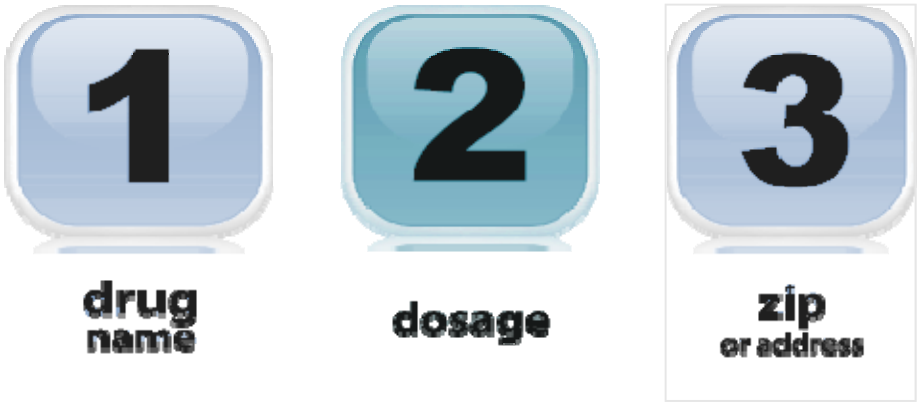
Please note since The Dako Group medical plan is self-funded the medical plan will pay secondary in an auto related accident not primary. Additionally, if a covered person is injured in an motor cycle accident that does not involve a motor vehicle, this plan will exclude coverage for the first $50,000 in eligible charges or, if greater, the amount of health benefits payable by the motorcycle insurance policy.

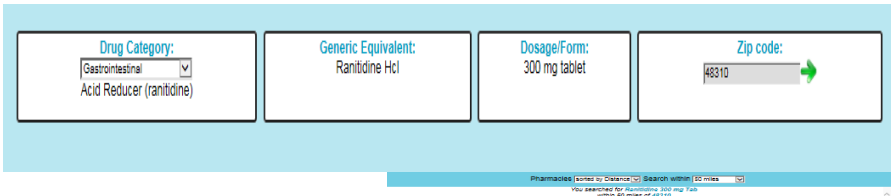
Script Navigator Online Tool Overview

The ultimate pharmacy search engine for discounted generic drug programs available at pharmacies throughout the USA.

Simply go to www.medtipster.com and click on “Enter Medtipster” and begin saving money.

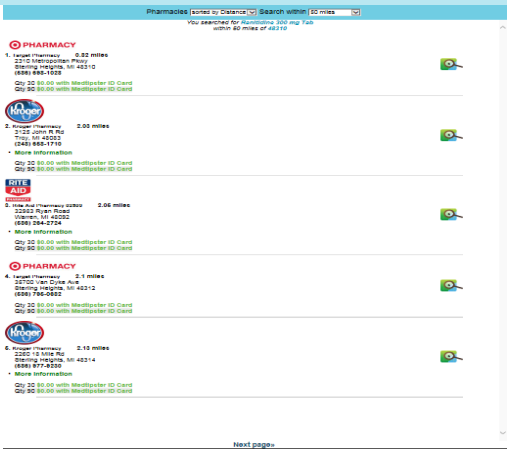
It’s as easy as





Enter the name, dosage, and your zip code to find the best deal for your generic prescription…

You can also find a therapeutic alternative search at a specific pharmacy or sufficient a pharmacy.



Today, pharmacies all across the U.S. have implemented **$4 generic drugs programs**. The question many people ask themselves is, "which pharmacy has my prescription on their **$4 generic drugs program**?" Medtipster.com was designed to answer that question, without sending users through a multiple step process to obtain the answer. **Cheap prescription drugs** are available for more than 70% of written prescriptions. **Generic drugs** are distributed as the bioequivalent to the brand name, and today are more commonly distributed to consumers when and where available. Talk to your doctor if you have specific questions about your prescription and the alternative of a generic equivalent.

Finding the **cheapest prescriptions** is as easy as 1-2-3 with Medtipster.com's proprietary technology. You will never again have to wonder which pharmacy's generic program has your prescription drug. Have your healthcare and afford it, too.

Other search types include…

- Flu Shots
- Immunizations
- Health Screenings

ask PharmaSueAnn™ LIVE
pharmasueann™

The world of healthcare is both confusing and expensive. The Dako Group Script Navigator provides access to pharmasueann. She posts a blog designed to clear things up. To tell it to you straight. To help you navigate through the morass with a little savvy and a lot less stress. From time to time, perhaps even to evoke a smile.

You will get some very concrete advice. Discover steps you can take to avoid the Medicare donut hole. Get tips for managing your care in the hospital. Learn about the background on some of the issues in drug trials.
Healthcare is complicated. Every little bit of knowledge helps!

PharmaSueAnn is here to serve you.

Dental Benefits Overview

Dental coverage is provided by Delta Dental. You may access a list of participating providers through the carriers website located on page 26 of this guide.

	Delta Dental Premier PPO Dental Plan		
	PPO Network	**Premier Network**	**Non Network**
Deductible (Calendar Year) Individual / Family	$50 / $150		
Class 1—Preventative Services: Oral Exams, X-Rays, Cleaning, Sealants	100% Coverage *(deductible waived)*		
Class 2—Basic Services: Fillings, Crown Repair, Periodontal Services, Simple Extractions, Root Canals	80% after deductible		
Class 3—Major Services: Endodontic Services, Crowns, Dentures, Bridges, Implants	50% after deductible		
Class 4—Orthodontics (up to age 19)	50% after deductible		
Maximum Benefit: Annual Maximum - Class 1, 2, & 3	$1,500		
Lifetime Maximum - Class 4	$1,000		

	Delta Dental Standard PPO Dental Plan		
	PPO Network	**Premier Network**	**Non Network**
Deductible (Calendar Year) Individual / Family	None		
Class 1—Preventative Services: Oral Exams, X-Rays, Cleaning, Sealants	100%		
Class 2—Basic Services: Fillings, Crown Repair, Periodontal Services, Simple Extractions, Root Canals	80%		
Class 3—Major Services: Endodontic Services, Crowns, Dentures, Bridges, Implants	50%		
Class 4—Orthodontics (up to age 19)	50%		
Maximum Benefit: Annual Maximum - Class 1, 2, & 3	$1,000		
Lifetime Maximum - Class 4	$1,000		

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Vision Benefits Overview

Vision coverage is provided by VSP. You must be enrolled in health insurance to be eligible for vision coverage. You may access a list of participating providers through the carrier website located on page 26 of this guide.

	VSP Vision Plan	
	In-Network	**Out-of-Network**
Eye Exams *Covered Once Every 12 Months*	$10 copay (applies to first service provided, exam or materials)	Reimbursement up to $45
Lenses (Standard Plastic Lenses) *Covered Once Every 12 Months*	$10 copay	Reimbursement up to approved amount
Frames *Covered Once Every 12 Months*	$130 allowance	Reimbursement up to $70
Contact Lenses (in lieu of glasses) *Covered Once Every 12 Months*	$130 allowance	Reimbursement up to $105

With Exclusive Member Extras, saving never looked so good. VSP provides exclusive special offers and rebates from VSP and leading industry brands that total more than $2,500.

PREMIER PROGRAM

Look for this symbol in find a Doctor or doctor locations offering even more great savings.

Glasses & Sunglasses Offers

Contact Lens Offers

LASIK Offers

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Supplemental Term Life Insurance

Employees have the opportunity to elect **Supplemental Life Insurance** provided by MetLife. This will provide an additional Life Insurance benefit for yourself, your spouse and/or your dependent child(ren). Contributions for these premiums are 100% employee paid. *If you waive supplemental life coverage when you are initially eligible you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date.* Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results. It is important to keep your beneficiary information updated.

	Supplemental Life and AD&D Coverage
Employee Life Insurance	$10,000 increments to a maximum of $100,000
Guarantee Issue Amounts	$100,000
Spouse Life Insurance	$5,000 increments to a maximum of $50,000; not to exceed 50% of Employees Life Insurance Benefit
Guarantee Issue Amounts	$25,000
Dependent Child(ren) Life Insurance	Child from age 15 days to 6 months old $100; Child 6 months old or older Option $1,000, $2,000, $4,000, $5,000 or $10,000; not to exceed the spouse's benefit amount
Guarantee Issue Amounts	$10,000
Benefit Reduction Schedule	35% at age 65, additional 50% at age 70 and an additional 32% at age 75

If your employment ends from your Employer, you may elect portable coverage directly with MetLife.

Supplemental Term Life Rate Table

Supplemental Life/AD&D Employee & Spouse	
Rate per $1,000	
Age Band	
0-29	$0.08
30-34	$0.08
35-39	$0.15
40-44	$0.22
45-49	$0.37
50-54	$0.58
55-59	$0.94
60-64	$1.55
65-69	$2.24
70+	$4.32

Voluntary Life/AD&D Child
Rate Per $1,000
Age 0-19 or 24 if student
$0.291

For Example: Jane Doe is 35 yrs old and makes $14.00 an hour ($14,00 x 2080 hours = $29,120 annual / $560 weekly) To calculate Jane's Voluntary Life Insurance premium we take her benefit amount (i.e. $50,000) divide it by $1,000 and multiply it by her age. So for Jane Doe's $50,000 life policy we divide it by $1,000 to get 50 and then multiply that by $0.15 = $7.50 per month or $1.88 per check.

Voluntary Short Term Disability Overview

Voluntary Short Term Disability Insurance is provided by MetLife. Short Term Disability Insurance provides income protection in the event you become disabled and are unable to work due to sickness or injury.

	Short Term Disability Coverage
Benefit Amount	60% of Base Weekly Earnings
Maximum Weekly Benefit	$1,000
Elimination Period	7th day for Accident/Illness
Maximum Benefit Period	Up to 26 weeks

Definition of disability: Insured is unable to earn more than 80% of their pre-disability earnings at their own occupation due to your injury or sickness.

Voluntary Short Term Disability Rates	
Age Range	**Rate**
0-39	$0.385
40-44	$0.468
45-49	$0.606
50-54	$0.771
55-59	$0.936
60-64	$1.102
65+	$1.322

For Example: Jane Doe is 35 yrs old and makes $14.00 an hour ($14,00 x 2080 hours = $29,120 annual / $560 weekly)

Jane's Voluntary Short Term Disability (STD) benefits is 60% of $560 (her weekly pay) = $336

STD is paid in $50 increments - so Jane's STD benefit would be $300 per week.

To calculate the premium you take the benefit amount $300 divide it by 10 = $30

$30 x Jane's Age Rate which is $0.385 = $11.55 per month or $2.89 per check (out of 4 checks per month)

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Long Term Disability Overview

Long Term Disability Insurance is provided by MetLife. Long Term Disability Insurance provides income protection in the event you become disabled and are unable to work for an extended period of time.

	Long Term Disability Coverage
Benefit Amount	60% of Base Monthly Earnings
Maximum Monthly Benefit	$10,000
Elimination Period	180 days
Maximum Benefit Period	Up to 24 weeks

Definition of disability: Insured is unable to earn more than 80% of their pre-disability earnings at their own occupation for any employer in their local economy, and after such period is unable to earn more than 80% of their pre-disability earnings from any employer in their local economy at any gainful occupation for which they are reasonable qualified taking account their training, prior education and experience.

Voluntary Long Term Disability Rates	
Age Range	**Rate**
0-34	$0.15
35-39	$0.19
40-44	$0.46
45-49	$0.60
50-54	$0.83
55-59	$1.07
60-64	$0.86
65-99	$0.77

For Example: Jane Doe is 35 yrs old and makes $14.00 an hour ($14.00 x 2080 hours = $29,120 annual / $2,427 monthly)

Jane's Voluntary Long Term Disability (LTD) benefit is based on her covered payroll which is $29,120 / $2,427 monthly

To calculate the premium you take the monthly payroll of $2,427 multiply it by her age rate of $0.19 = $461.13.

Take $461.13 divide by $100 = $4.61 per month or $1.15 per check (out of 4 checks per month)

Will Preparation Services

Will Preparation Services are provided by Hyatt Legal Plans, Inc. at no cost to you if you're enrolled in MetLife Supplemental Life insurance. This includes preparation of living wills, power of attorney, and access to network of 13,000 participating attorneys.

MetLife Estate Resolution Services

MetLife Estate Resolution Services are provided by Hyatt Legal Plans, Inc. at no cost to you if you're enrolled in MetLife Supplemental Life insurance. This includes face to face consultation, preparation, representation, correspondence and tax filings, and coverage for attorney fees. Beneficiaries can also use this benefits to consult an attorney to discuss general questions about the probate process.

Travel Assistance Services

Travel Assistance is provided by AXA Assistance USA, Inc. at no cost to you if you're enrolled in MetLife Accidental Death and Dismemberment coverage. This services offers you and your dependents medical, travel, legal, financial, and concierge services 24 hours a day 365 days a year while travelling 100 miles or more from home whether internationally or domestically. Medical assistance includes physician referrals, hospital admission validation, evacuation and repatriation, prescription transfer, transportation to join patient, and return of mortal remains.

Insurance Definitions

ANNUAL MAXIMUM COST: The most you will pay for approved benefits in a benefit year. Also referred to as the annual "out-of-pocket" maximum.

ANNUAL MAXIMUM BENEFIT: The most your plan will pay for approved benefits in a benefit year.

CARRIER: The insurance company (i.e. Delta Dental, VSP).

CLAIM: A bill submitted to your carrier for payment.

COPAY: The amount you pay for a benefit (i.e. prescriptions/office visits - $6, $40, $60).

COINSURANCE: The percentage of costs you pay for a covered service (i.e. 10%, 20% or 30%).

COORDINATION OF BENEFITS: Your insurance combined with another (spouse) insurance company.

DEDUCTIBLE: The amount you pay first before your insurance company pays for your services.

EFFECTIVE 9/01/2015: The day and month your benefits are activated.

EOB (Explanation of Benefits): Information you receive explaining how your claim was processed.

HMO (Health Maintenance Organization): A network where you choose one participating doctor.

IN-NETWORK: A group (network) of Doctors, labs, or hospitals that 'participate' with network carriers, and agree to accept the payment offered by the insurance carrier.

MAIL ORDER DRUGS: Prescription drugs are received through the mail.

MAINTENANCE DRUGS: Prescription drugs that must be taken regularly (i.e. insulin, high blood pressure).

OUT-OF-NETWORK: Doctors, labs or hospitals that do not 'participate' with some insurance carriers.

PCP (Primary Care Physician): A network doctor that you choose 'participates' in a network plan.

PPO (Preferred Provider Organization: A network plan of doctors, labs and hospitals.

PROVIDER: The doctor, lab or hospital (i.e. participating providers in HMO, POS or PPO plans).

REIMBURSEMENT: The amount returned to you after a claim form has been submitted for payment.

TRADITIONAL: You can usually choose any doctor, lab or hospital for service.

VOLUNTARY: You agree to pay for the insurance coverage offered through your employer.

Important Disclosure Notices

NOTE TO ALL EMPLOYEES:
Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with all of the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

The Dako Group
Barbara Micakovic
2966 Industrial Row Drive
Troy, MI 48084

THIS DOCUMENT IS FOR INFORMATION PURPOSES ONLY
This communication is intended for illustrative and information purposes only. The plan documents, insurance certificates, and policies will serve as the governing documents to determine plan eligibility, benefits, and payments.

LIMITATIONS AND EXCLUSIONS
Insurance and benefit plans always contain exclusions and limitations. Please see benefit booklets and/or contracts for complete details of coverage and eligibility.

ALL RIGHTS RESERVED
The Dako Group reserves the right to amend, modify, or terminate its insurance and benefit plans at any time, including during treatment.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS
If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below.
(a.) If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within **30 days** of the loss of that coverage. Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.
However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.
(b.) You are eligible to enroll yourself and your Eligible Dependent in the Medical Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.
(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:
(1.) Your or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or
(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.
(d.) You are eligible to enroll yourself and your Eligible Dependents in the Plan during an Open Enrollment Period. Your enrollment will become effective on the 1st day of the Plan Year following the Open Enrollment Period.
(e.) You may enroll in the Plan an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.
(f.) You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances permitted under the applicable Benefits Guide (and subject to the Cafeteria Plan rules outlined in Section 125 of the Internal Revenue Code).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; within 30 days of receipt of this notice for a dependent under the age of 26; or within the deadline established by the Plan Administrator for Open Enrollment Period).

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

The Dako Group
Barbara Micakovic
2966 Industrial Row Drive
Troy, MI 48084
(248) 655-0100

NOTICE REGARDING PRE-EXISTING CONDITIONS
The The Dako Group Group Health Plan (the "Plan") does not impose a pre-existing condition limitation as detailed in the Benefit Guide issued by the insurance carrier. Please review the Benefits Guide carefully (you can obtain another copy of it by contacting the Plan Administrator). The following provides an overview of the pre-existing condition limitation that is allowed under the Health Insurance Portability and Accountability Act (HIPAA) as well as protections provided under the Patient Protection and Affordable Care Act of 2010 (PPACA). If the Plan does not impose a pre-existing condition limitation, much of this information does not apply to you; however, this information is provided to make you aware of this important legislation.
The Plan complies with the changes set forth in the PPACA of 2010 and does not impose pre-existing condition exclusions with respect to eligible dependent children who are under 19 years of age. In accordance with PPACA, this change was effective as of the first day of the Plan Year beginning on or after September 23, 2010; and will apply to all other covered individuals on the first day of the Plan Year beginning on or after January 1, 2014.
Pre-existing condition exclusion means that if you have a medical condition before enrolling in the medical program, you might have to wait a certain period of time before the medical program

Important Disclosure Notices

will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month look-back period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a new hire waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the medical program or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. **To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should promptly give the Plan Administrator a copy of any certificate of creditable coverage (HIPAA Certificates) you have**. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or insurer. There are also other ways that you can show that you have creditable coverage. Please contact the Plan Administrator if you need help demonstrating creditable coverage.

Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan Administrator (with the assistance of the prior plan administrator or insurer) to determine its authenticity. Submission of a fraudulent HIPAA Certificate would be considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment, and may result in a loss of coverage under this Plan and other employment disciplinary action.

HOW TO REQUEST A CERTIFICATION OF CREDITABLE COVERAGE FROM THIS PLAN:

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card. If you are unable to obtain the certificate of coverage through the carrier, or have other questions regarding Pre-existing Conditions, please contact the Plan Administrator for assistance at the address or phone number below.

The Dako Group
Barbara Micakovic
2966 Industrial Row Drive
Troy, MI 48084
(248) 655-0100

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan

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or insurance issuer to prescribe a length of stay not in excess of the above periods.

MEDICARE NOTICE

You must notify The Dako Group when you or your dependents become Medicare eligible. The Dako Group is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Non-Creditable Coverage Notice.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

The Dako Group
Barbara Micakovic
2966 Industrial Row Drive
Troy, MI 48084
(248) 655-0100

NOTICE REGARDING PATIENT PROTECTION RIGHTS

The The Dako Group Plan does not a require members to designate a Primary Care Physician. The following paragraphs outline certain protections under the PPACA and only apply when the Plan requires the designation of a Primary Care Physician.

One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. 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 or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

The Dako Group
Barbara Micakovic
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IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by Medicare, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Dako Group and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about Medicare's prescription drug coverage. (Your Plan is Creditable if Covered Under ASR Premier or Value Plan.)

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The Dako Group has determined that the prescription drug coverage offered by their carrier's Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

(Your Plan is not Creditable if Covered Under ASR HSA PPO Plan.)

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Important Disclosure Notices

The Dako Group has determined that the prescription drug coverage offered by your company plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you only have prescription drug coverage from the company plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

You can keep your current coverage for the The Dako Group Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully—it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact your HR Representative. You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your company changes. You also may request a copy of this notice at any time.

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

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

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

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

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

The Dako Group
Barbara Micakovic
2966 Industrial Row Drive
Troy, MI 48084
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Important Disclosure Notices

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – Medicaid
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
Website: http://www.azahcccs.gov/applicants
Phone (Outside Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602.417.5437

COLORADO – Medicaid and CHIP
Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084

Important Disclosure Notices

STATES OFFERING PREMIUM PAYMENT ASSISTANCE PROGRAMS , continued

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-800-383-4278

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH– Medicaid
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA– Medicaid and CHIP
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

WASHINGTON – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

Important Disclosure Notices

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your hours of employment are reduced, or
Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your spouse dies;
Your spouse's hours of employment are reduced;
Your spouse's employment ends for any reason other than his or her gross misconduct;
Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

The parent-employee dies;
The parent-employee's hours of employment are reduced;
The parent-employee's employment ends for any reason other than his or her gross misconduct;
The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
The parents become divorced or legally separated; or
The child stops being eligible for coverage under the Plan as a "dependent child."

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When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;

The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Barbara Micakovic.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Important Disclosure Notices

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

The Dako Group Plan
Barbara Micakovic
2966 Industrial Row Drive
Troy, MI 48084
(248) 655-0100

Important Disclosure Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Barbara Micakovic.

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

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

Important Disclosure Notices

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name: Dako Resources, Inc. dba The Dako Group	4. Employer Identification Number (EIN) 38-3322128	
5. Employer address 2966 Industrial Row Drive	6. Employer phone number (248) 655-0100	
7. City Troy	8. State MI	9. ZIP Code 48084
10. Who can we contact about employee health coverage at this job? Barbara Micakovic		
11. Phone number (if different from above)	12. Email address bmicakovic@dakogroup.com	

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

- All full-time eligible employees.

With respect to dependents:

- We do offer coverage. Eligible dependents are:
  - Legally married spouse as defined by the State
  - Dependent child(ren) as defined by the IRS

- This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Contact Information

Benefit Consultant

General Claims and Benefit Information

Customer Service Hotline: In order to help you with your benefit questions, claim issues, and general inquiries, you and your dependents may contact Sterling Insurance Group. Sterling Insurance Group is a one-source helpline for all of your benefit questions. Please call the toll-free number listed below and speak to a customer service specialist who knows your benefit plan and can help with any questions.

Toll Free: (844) 599-9500

www.sterlingagency.com

Healthcare	ASR Health Benefits	Group Number 1073	(800) 968-2449	www.asrhealthbenefits.com (PPO Networks Michigan) - HAP AHL PPO & Physicians Care (PPO Networks Nationwide) Cigna & MultiPlan
Prescription Drug	EHIM	Group Number 1073	(800) 311-3446	www.ehimrx.com
Mail Order	Walgreens	Group Number 1073	(800) 345-1985	www.walgreens.com/mailservice
Dental	Delta Dental		(800) 524-0149	www.deltadentalmi.com
Vision	VSP		(800) 877-7195	www.vsp.com
Supplemental Life and AD&D	MetLife	Group Number 5999447	(800) 858-6506	www.metlife.com
Voluntary Short Term Disability	MetLife	Group Number 5999447	(800) 858-6506	www.metlife.com
Long Term Disability	MetLife	Group Number 5999447	(800) 858-6506	www.metlife.com
Medical Pre-Certification Requirement	ASR Health Benefits	Group Number 1073	(800) 638-0573	www.asrhealthbenefits.com
Will Preparation Services	Hyatt Legal Plans, Inc.	Group Number 5999447	(800) 821-6400	
Estate Resolution Services	Hyatt Legal Plans, Inc.	Group Number 5999447	(800) 821-6400	
Travel Assistance	AXA Assistance USA, Inc.	Group Number 5999447		http://webcorp.axa-assistance.com

When contacting any of the companies above it is important to have the Insurance card or I.D. number (s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, i.e. Explanation of Benefits, denial letter, receipts, etc.

Summary of Benefits Coverage

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.asrhealthbenefits.com** or by calling **616-957-1751** or **1-800-968-2449**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** per covered person and **$1,000** per family for services rendered by in-network **providers**, and **$750** per covered person and **$1,500** per family for services rendered by out-of-network **providers**. The overall **deductible** does not apply to most in-network physician exam fees, chiropractic x-rays, in-network routine preventive care services, routine immunizations administered in a pharmacy or at the Department of Community Health, or prescription drugs. **Copayments**, **coinsurance**, penalties, charges that exceed the plan's usual and customary fee allowance or are in excess of stated maximums, premiums, balance-billed charges (unless balance billing is prohibited), and health care this plan doesn't cover don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. This plan's **deductible** starts over on September 1st. See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services that this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. The **out-of-pocket limits** for **coinsurance** only are **$500** per covered person and **$1,000** per family for services rendered by in-network **providers**, and **$2,500** per covered person and **$5,000** per family for services rendered by out-of-network **providers**. These figures do not include the **deductible** or any **copayments**. The total **out-of-pocket limits** are **$6,350** per covered person and **$12,700** per family for services rendered by in-network **providers**, and **$12,700** per covered person and **$25,400** per family for services rendered by out-of-network **providers**. These figures include the **deductibles** and the **coinsurance** **out-of-pocket limits** shown above as well as prescription drug **copayments** and all **copayments** charged by in-network **providers**.	The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	**Deductibles** and **copayments** are not included in the **out–of–pocket limits** applicable to only **coinsurance** (but would be included in the total **out–of–pocket limits** as specified above). In general, **out–of–pocket limits** do not include penalties, charges that exceed the plan's usual and customary fee allowance or are in excess of stated maximums, premiums, balance-billed charges (unless balance billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes. For more information, visit the website or call one of the phone numbers shown at the bottom of page 1.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays for different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	30% coinsurance	--none--
	Specialist visit	$60 copay/visit	30% coinsurance	--none--
	Other practitioner office visit	$40 copay/visit and 10% coinsurance for chiropractic services	30% coinsurance	Coverage is limited to 20 chiropractic visits annually.
	Preventive care/screening/ immunization	No charge	No charge for routine immunizations administered in a pharmacy or at the Department of Community Health; otherwise 30% coinsurance	--none--
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	--none--
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.asrhealthbenefits.com**.	Generic drugs	$10 copay/prescription (retail) or $20 copay/prescription (mail order)		Covers up to a 30-day supply (retail) or up to a 90-day supply (mail order). Specific criteria may have to be met in order for some brand-name medications to be covered.
	Formulary brand drugs	$30 copay/prescription (retail) or $60 copay/prescription (mail order)		
	Non-Formulary brand drugs	$50 copay/prescription (retail) or $100 copay/prescription (mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	--none--
	Physician/surgeon fees	10% coinsurance	30% coinsurance	--none--
If you need immediate medical attention	Emergency room services	$200 copay/visit and 10% coinsurance	$200 copay/visit and 10% coinsurance for certain services; otherwise 30% coinsurance	Copay may be waived if admitted inpatient.
	Emergency medical transportation	No charge after deductible	10% coinsurance	--none--
	Urgent care	$75 copay/visit	30% coinsurance	--none--

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	$500 penalty if not certified.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay/office visit and 10% coinsurance for other services	30% coinsurance	--none--
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	$500 penalty if not certified.
	Substance use disorder outpatient services	$40 copay/office visit and 10% coinsurance for other services	30% coinsurance	--none--
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	$500 penalty if not certified.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	--none--
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	--none--
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Certification is required.
	Rehabilitation services	$40 copay/visit	30% coinsurance	Certification is required.
	Habilitation services	$40 copay/visit	30% coinsurance	Certification is required.
	Skilled nursing care	10% coinsurance	30% coinsurance	--none--
	Durable medical equipment	10% coinsurance	30% coinsurance	Certification is required.
	Hospice service	10% coinsurance	30% coinsurance	--none--
If your child needs dental or eye care	Eye exam	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine eye care under the medical plan, except as required by Health Care Reform.
	Glasses	Not covered	Not covered	No coverage for glasses under the medical plan.
	Dental check-up	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine dental care under the medical plan, except as required by Health Care Reform.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (except to the extent required to be covered by Health Care Reform) • Glasses	• Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Routine eye care (except to the extent required to be covered by Health Care Reform) • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care up to 20 chiropractic visits allowed annually	• Private-duty nursing	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 616-957-1751 or 1-800-968-2449. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact ASR Health Benefits at 616-957-1751 or 1-800-968-2449 or visit them at www.asrhealthbenefits.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or visit their website at www.dol.gov/ebsa/healthreform. Additionally, a Consumer Assistance Program may be able to help you file your appeal. Visit http://www.healthcare.gov/law/features/rights/consumer-assistance-program/index.html to see if your state has a Consumer Assistance Program that may be able to help you file your appeal.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 616-957-1751 o 1-800-968-2449.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,370
- **Patient pays** $1,170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$20
Coinsurance	$500
Limits or exclusions	$150
Total	**$1,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,920
- **Patient pays** $1,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$900
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,480**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **616-957-1751 or 1-800-968-2449** or visit **www.asrhealthbenefits.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at the website above or by calling the phone numbers above to request a copy.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.asrhealthbenefits.com** or by calling **616-957-1751** or **1-800-968-2449**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** per covered person and **$2,000** per family for services rendered by in-network **providers**, and **$1,500** per covered person and **$3,000** per family for services rendered by out-of-network **providers**. The overall **deductible** does not apply to most in-network physician exam fees, chiropractic x-rays, in-network routine preventive care services, routine immunizations administered in a pharmacy or at the Department of Community Health, or prescription drugs. **Copayments**, **coinsurance**, penalties, charges that exceed the plan's usual and customary fee allowance or are in excess of stated maximums, premiums, balance-billed charges (unless balance billing is prohibited), and health care this plan doesn't cover don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. This plan's **deductible** starts over on September 1st. See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services that this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. The **out-of-pocket limits** for **coinsurance** only are **$1,500** per covered person and **$3,000** per family for services rendered by in-network **providers**, and **$3,500** per covered person and **$7,000** per family for services rendered by out-of-network **providers**. These figures do not include the **deductible** or any **copayments**. The total **out-of-pocket limits** are **$6,350** per covered person and **$12,700** per family for services rendered by in-network **providers**, and **$12,700** per covered person and **$25,400** per family for services rendered by out-of-network **providers**. These figures include the **deductibles** and the **coinsurance** **out-of-pocket limits** shown above as well as prescription drug **copayments** and all **copayments** charged by in-network **providers**.	The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	**Deductibles** and **copayments** are not included in the **out–of–pocket limits** applicable to only **coinsurance** (but would be included in the total **out–of–pocket limits** as specified above). In general, **out–of–pocket limits** do not include penalties, charges that exceed the plan's usual and customary fee allowance or are in excess of stated maximums, premiums, balance-billed charges (unless balance billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes. For more information, visit the website or call one of the phone numbers shown at the bottom of page 1.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays for different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	40% coinsurance	--none--
	Specialist visit	$60 copay/visit	40% coinsurance	--none--
	Other practitioner office visit	$30 copay/visit and 20% coinsurance for chiropractic services	40% coinsurance	Coverage is limited to 20 chiropractic visits annually.
	Preventive care/screening/ immunization	No charge	No charge for routine immunizations administered in a pharmacy or at the Department of Community Health; otherwise 40% coinsurance	--none--
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	--none--
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.asrhealthbenefits.com**.	Generic drugs	$10 copay/prescription (retail) or $20 copay/prescription (mail order)		Covers up to a 30-day supply (retail) or up to a 90-day supply (mail order). Specific criteria may have to be met in order for some brand-name medications to be covered.
	Formulary brand drugs	$30 copay/prescription (retail) or $60 copay/prescription (mail order)		
	Non-Formulary brand drugs	$60 copay/prescription (retail) or $120 copay/prescription (mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	--none--
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--none--
If you need immediate medical attention	Emergency room services	$200 copay/visit and 20% coinsurance	$200 copay/visit and 20% coinsurance for certain services; otherwise 40% coinsurance	Copay may be waived if admitted inpatient.
	Emergency medical transportation	No charge after deductible	20% coinsurance	--none--
	Urgent care	$75 copay/visit	40% coinsurance	--none--

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$500 penalty if not certified.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/office visit and 20% coinsurance for other services	40% coinsurance	--none--
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	$500 penalty if not certified.
	Substance use disorder outpatient services	$30 copay/office visit and 20% coinsurance for other services	40% coinsurance	--none--
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	$500 penalty if not certified.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	--none--
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	--none--
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Certification is required.
	Rehabilitation services	$30 copay/visit	40% coinsurance	Certification is required.
	Habilitation services	$30 copay/visit	40% coinsurance	Certification is required.
	Skilled nursing care	20% coinsurance	40% coinsurance	--none--
	Durable medical equipment	20% coinsurance	40% coinsurance	Certification is required.
	Hospice service	20% coinsurance	40% coinsurance	--none--
If your child needs dental or eye care	Eye exam	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine eye care under the medical plan, except as required by Health Care Reform.
	Glasses	Not covered	Not covered	No coverage for glasses under the medical plan.
	Dental check-up	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine dental care under the medical plan, except as required by Health Care Reform.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (except to the extent required to be covered by Health Care Reform) • Glasses	• Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Routine eye care (except to the extent required to be covered by Health Care Reform) • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care up to 20 chiropractic visits allowed annually.	• Private-duty nursing	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 616-957-1751 or 1-800-968-2449. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact ASR Health Benefits at 616-957-1751 or 1-800-968-2449 or visit them at www.asrhealthbenefits.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or visit their website at www.dol.gov/ebsa/healthreform. Additionally, a Consumer Assistance Program may be able to help you file your appeal. Visit http://www.healthcare.gov/law/features/rights/consumer-assistance-program/index.html to see if your state has a Consumer Assistance Program that may be able to help you file your appeal.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 616-957-1751 o 1-800-968-2449.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,120
- **Patient pays** $2,420

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$1,250
Limits or exclusions	$150
Total	**$2,420**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,950
- **Patient pays** $1,450

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$530
Copays	$840
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,450**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **616-957-1751 or 1-800-968-2449** or visit **www.asrhealthbenefits.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at the website above or by calling the phone numbers above to request a copy.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.asrhealthbenefits.com** or by calling **616-957-1751** or **1-800-968-2449**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** for single coverage and **$6,000** for family coverage for services rendered by in-network **providers**, and **$6,000** for single coverage and **$12,000** for family coverage for services rendered by out-of-network **providers**. The overall **deductible** does not apply to in-network routine preventive care services or routine immunizations administered in a pharmacy or at the Department of Community Health. **Copayments**, **coinsurance**, penalties, charges that exceed the plan's usual and customary fee allowance or are in excess of stated maximums, premiums, balance-billed charges (unless balance billing is prohibited), and health care this plan doesn't cover don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. This plan's **deductible** starts over on September 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services that this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,000** for single coverage and **$12,000** for family coverage for services rendered by in-network **providers**, and **$15,000** for single coverage and **$30,000** for family coverage for services rendered by out-of-network **providers**.	The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties, charges that exceed the plan's usual and customary fee allowance or are in excess of stated maximums, premiums, balance-billed charges (unless balance billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at the website above or by calling the phone numbers above to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For more information, visit the website or call one of the phone numbers shown at the bottom of page 1.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays for different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	--none--
	Specialist visit	20% coinsurance	40% coinsurance	--none--
	Other practitioner office visit	20% coinsurance	40% coinsurance	Coverage is limited to 20 chiropractic visits annually.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic, cont.	Preventive care/screening/ immunization	No charge	No charge for routine immunizations administered in a pharmacy or at the Department of Community Health; otherwise 40% coinsurance	--none--
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	--none--
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.asrhealthbenefits.com**.	Generic drugs	$10 copay/prescription (retail) or $20 copay/prescription (mail order)		Covers up to a 30-day supply (retail) or up to a 90-day supply (mail order). Specific criteria may have to be met in order for some brand-name medications to be covered.
	Formulary brand drugs	$35 copay/prescription (retail) or $70 copay/prescription (mail order)		
	Non-Formulary brand drugs	$50 copay/prescription (retail) or $100 copay/prescription (mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	--none--
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--none--
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance for certain services; otherwise 40% coinsurance	--none--
	Emergency medical transportation	20% coinsurance	20% coinsurance	--none--
	Urgent care	20% coinsurance	40% coinsurance	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$500 penalty if not certified.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	--none--
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	$500 penalty if not certified.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	--none--

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs, cont.	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	$500 penalty if not certified.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	--none--
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	--none--
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Certification is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Certification is required.
	Habilitation services	20% coinsurance	40% coinsurance	Certification is required.
	Skilled nursing care	20% coinsurance	40% coinsurance	--none--
	Durable medical equipment	20% coinsurance	40% coinsurance	Certification is required.
	Hospice service	20% coinsurance	40% coinsurance	--none--
If your child needs dental or eye care	Eye exam	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine eye care under the medical plan, except as required by Health Care Reform.
	Glasses	Not covered	Not covered	No coverage for glasses under the medical plan.
	Dental check-up	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine dental care under the medical plan, except as required by Health Care Reform.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (except to the extent required to be covered by Health Care Reform)
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (except to the extent required to be covered by Health Care Reform)
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- Weight loss programs

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,520
- **Patient pays** $4,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Copays	$20
Coinsurance	$850
Limits or exclusions	$150
Total	**$4,020**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,920
- **Patient pays** $3,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,000
Copays	$330
Coinsurance	$70
Limits or exclusions	$80
Total	**$3,480**

Note: The amounts that may be reimbursed under the Health Savings Account have not been included in these examples. If you are eligible for reimbursement under the Health Savings Account, your costs may be lower. Also, these examples include the deductible amount applicable to a sample patient enrolled with single coverage and do not reflect the deductible applicable to a patient enrolled with family coverage.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
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- There are no other medical expenses for any member covered under this plan.
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Does the Coverage Example predict my own care needs?

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