

Notice of Privacy Practices

You are receiving this Privacy Notice because you enrolled in one of the Valassis sponsored health plans identified below (The Plans). Effective April 14, 2003, the law requires the Plans to put in place reasonable measures that protect the privacy of the individually identifiable health information that your Plans transmit or maintain. This health information is considered protected health information. Throughout this notice, "protected health information" is abbreviated as "PHI". The law also requires your Plans to give you this notice of its legal duties and privacy practices related to your protected health information. This notice is for informational purposes – you are not required to take any action as a result of this notice.

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

This Notice applies to all group health plans maintained by Valassis.

If you have any questions about this notice, or, to exercise any of the rights described in this notice, please contact the Privacy Officer listed at the end of this notice.

The plans reserve the right to change their privacy practices and to apply the new practices to all PHI that The Plans maintain. If the Plans make a material change to the privacy practices, The Plans will provide you a revised notice within sixty (60) days of that material change.

A. RIGHTS OF THE PLANS TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION.

The Plans are permitted by law to use and/or disclose your PHI in certain ways. These are described below with examples of permitted uses. This notice does not list every permitted use or disclosure The Plans may make. However, all the ways The Plans are permitted to use or disclose PHI will fall within one of the categories listed below:

1. Treatment – to provide you with treatment and to coordinate or manage your health care, although it is more likely health care provider would receive your PHI from another health care provider than from The Plans. For Example, if your Primary Care Physician (PCP) or your treating medical provider refers you to a specialist for treatment, The Plans can disclose your PHI so the specialist to whom you have been referred can become familiar with your medical condition, prior diagnosis and treatment, and prognosis.
2. Payment – for any reason related to payment for your medical treatment and/or services including, but not limited to, making determinations of eligibility or coverage, and to certain other persons or companies that perform services related to payment. For Example, The Plans may inform your doctor of your eligibility for medical coverage.
3. Health Care Operations – to support The Plan's operations and to certain other persons or companies that perform services related to The Plans' health care operations. For Example, it may use your PHI to conduct quality assessment and improvement activities, to obtain reinsurance for health care claims, or to refer you to a disease management program.
4. Treatment Alternatives – to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For Example, The Plans may use your PHI to contact you regarding participation in an asthma management program.
5. Business Associates of the Health Plans – The plans may disclose PHI to a Business Associate (BA) of The Plans, if a valid Business Associate Agreement is in place between the Business Associate and The Plans. A Business Associate is an entity that performs a function on behalf of The Plans and that uses PHI in doing so, or provides services to The Plans such as legal, actuarial, accounting, consulting or administrative services. Examples of Business Associates include The Plans' Third-Party Administrator (TPA) and broker.
6. Where Required by Law or Requested as Part of a Regulatory or Legal Proceeding - The Plans may disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For examples, The Plans may disclose medical information to a subpoena, or as necessary to comply with Worker's Compensation laws.
7. For Public Health Activities or to avert a Serious Threat to Health or Safety – The Plans may disclose PHI to public health authorities for purposes such as, preventing or controlling diseases, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration on products and reactions to medications; and reporting disease or infection exposure.
8. For Law Enforcement or Specific Government Functions – The Plans may disclose PHI to law Enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with your written authorization or that of your legal representative, and you may revoke such authorization as provided by section 164.508(b)(5) of the Privacy Rule. Any disclosures that were made when your Authorization was in effect will not be taken back.

B. OBLIGATIONS OF THE HEALTH PLANS TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The Plans are required to use and/or disclose your PHI:

1. To you when you exercise your right of access and/or right to an accounting (see Section “C” below), and
2. To the Secretary of the U.S. Department of Health and Human Services for an investigation and/or a determination of The Plans’ compliance with federal privacy law.

C. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

1. Right of Access – You have the right to inspect and copy your PHI that The Plans maintain, as provided by section 164.524 of the Privacy Regulations. To exercise this right, you must submit your request in writing to the contact listed at the end of this notice. The Plans may charge a reasonable fee for producing and mailing copies and in certain cases, may deny the request.
2. Right to Amend – You have the right to request that The Plans amend your PHI that you feel is incorrect, as provided by section 164.526 of the Privacy Regulations. Your request must be in writing and must include the reason for the request. The Plans may deny your request for an amendment but must respond to you in either case.
3. Right to an Accounting of Disclosures – You have the right to receive an accounting of disclosures of your PHI made by The Plans, as provided by section 164.528 of the Privacy regulations. However, this list of disclosures will not include disclosures mad (i) to carry out treatment, payment and/or health care operations, or (ii) for national security, law enforcement, or to corrections personnel or (iii) with your authorization, or (iv) to you, or (v) prior to April 14, 2003. You must submit your request for a list in writing to the contact listed at the end of this notice. Please note the time period for which you want an accounting, and the format in which you wish to receive it (e.g., paper or electronically). Note that The Plans will not account for disclosures made more than six years prior to your request, or for disclosures made before HIPAA became effective for The Plans (April 14, 2003). The Plans will provide one accounting of disclosures free of charge once every twelve months.
4. Right to Request Restrictions – You have the right to request restrictions on certain uses and Disclosures of PHI, as provided by section 164.522(a) of the Privacy regulations (although The Plans are not required to agree to a requested restriction). To do so, you must submit a written request to the contact listed at the end of this notice.
5. Right to Request Confidential Communications – You have the right to request that you receive communications of your PHI from The Plans by alternative means or at alternative locations, as provided by section 164.522(b) of the Privacy regulations. You must submit your request in writing to the contact listed at the end of this notice.
6. Right to a Paper Copy of This Notice – You have the right to receive a paper copy of this notice upon request to The Plans, even if you have previously agreed to receive this notice electronically. You may also obtain a copy of this notice at www.valassisbenefits.com.

D. GRIEVANCE PROCEDURES

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated, you may file a complaint with The Plans or with the Secretary of the U.S. Department of Health and Human Services (“DHDS”). To file a complaint with The Plan, contact: Vice President, Human Resources, 19975 Victor Parkway, Livonia, MI 48152, (734) 591-3000. To file a complaint with DHDS, mail your complaint to: Secretary of the U.S. Department Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. You must submit all complaints in writing. The Health Plan will not retaliate against you for filing a complaint.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT MEMBER NOTICE

The following information is provided to inform the member of certain provisions contained in the Group Health Plan and related procedures that may be utilized by the member in accordance with Federal Law.

Pre-existing Conditions Exclusion Provision:

This is to advise you that pre-existing conditions exclusion period may apply to you if a pre-existing conditions exclusion provision is included in the Group Health Plan that you are or become cover under. If your plan contains a pre-existing conditions exclusion, such exclusion may be waived for you if you have prior Creditable Coverage.

Creditable Coverage:

Creditable coverage includes coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance), Medicare, Medicaid, military-sponsored health care (CHAMPUS), a program of the Indian Health Services, a State health benefit risk pool, the FEHBP, a public health plan as defined in the regulations, and any health benefit plan under section 5 c of the Peach Corps Act. Not included as a Creditable Coverage is any coverage that is exempt from the law (e.g. dental only coverage or dental coverage that is provided in a separate policy or even in the same policy as medical, is separately elected and results in additional premium).

If you had prior creditable coverage within the 90 days immediately before the date you enrolled under this plan then the pre-existing conditions exclusion in your plan, if any, will be waived. The determination of the 90 days period will not include any waiting period that may be imposed by your employer before you are eligible for coverage.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than 90 days gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion (to a maximum period of 12 months).

If you have any questions regarding the determination of whether or not a pre-existing conditions exclusion applies to you, please call the Member Service telephone number on your ID card.

Providing Proof of Creditable Coverage

Generally, you will have received a **Certification of Prior Group Health Plan Coverage** from your prior medical plan as proof of your prior coverage. You should retain that Certification until you submit a medical claim. When a claim for treatment of a potential pre-existing condition is received, the claim office will request from you the **Certification of Prior Group Health Plan Coverage**, which will be used to determine if you have Creditable Coverage at that time.

You Must Give Notice of Some Qualifying Events

For the 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 your local Human Resources representative or the Corporate Benefits Department, Valassis Communications, Inc., 19975 Victor Parkway, Livonia, MI 48152.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both) your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for the employee's spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability of extension of 18-month period of continuation coverage

If you or anyone in your family covered under The Plan is determined by the Social Security Administration to be disabled and you notify The Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. You must notify Ceridian of the disability determination within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to The Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under The Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under The Plan had the first qualifying event not occurred.

If you Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

Keep your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should keep a copy of any notices you send to the Plan Administrator for your records.

Plan Contact Information

Valassis Communications, Inc.
Corporate Benefits Department
19975 Victor Parkway
Livonia, MI 48152