

New Branches School

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To be eligible to participate in the New Branches School's benefit program, you must be an active employee working at least 20 hours per week.

All employees of New Branches School will be eligible for benefits on the first day of the month following 90 days of employment.

Benefits Guide

This guide is designed to:

- Explain your health insurance benefits
- Inform you about your Health Reimbursement Account and Health Savings Account
- Provide you will information about your retirement plan savings options

The choices you make during the new-hire enrollment period or open enrollment period cannot be changed again until next year's open enrollment period, unless you experience a qualified family status change during the year.

Additionally, if you do not enroll for coverage at this time, you must wait until our next annual open enrollment period, unless you experience a qualified family status change. Family status changes can include the birth or adoption of a child, loss of coverage due to a spouse's job change, or divorce, to name a few. If you experience a qualified family status change, you must notify the business office within 30 days of the family status change to make changes to your insurance plan.

There is a great deal of information in this newsletter that will help you in selecting the coverage that best meets your needs, and the needs of employees with families. Please take the time to read this Benefit Guide and save it for future reference during the plan year.

High Deductible Health Plan

New Branches School has adopted a “consumer driven” health insurance model. To continue providing the New Branches staff high quality health care, we have chosen to implement a “high deductible” health plan. In implementing a higher deductible it has been shown that employees have a greater interest in minimizing health care costs, and maximizing your health plan dollars.

To offset the “high deductible”, New Branches School will contribute the full amount of the deductible for 2011 into a Health Savings Account (HSA) on January 1, 2011 for all employees **actively** enrolled in the health plan.

For new employees eligible for the New Branches health plan after January 1, we have implemented a Health Reimbursement Account, (HRA) which will reimburse deductible expenses up to the full amount of the deductible. At year end, you will convert to an HSA, You will find definitions and details about these plans in this Benefits Guide.

Deductible Amounts for 2011

Individual - \$1200 * Family - \$2400

Based on your plan contract, whether it is individual or family, you must meet the entire deductible for that contract before benefits begin, except where indicated in the health plan.

According to the IRS, high deductible health plans (or HDHPs):

- Must have a deductible of no less than \$1,200 for singles or \$2,400 for families (in 2011)
- Must have an out-of-pocket maximum no higher than \$5,950 for singles or \$11,900 for families (in 2011) - most plans set them lower (NBS is \$2000 and \$4000 in-network, \$4000 and \$8000 out-of-network)
- Can use any plan design: HMO, POS, PPO or traditional indemnity plan (the NBS plan is POS A)
- Require a member to meet the deductible before the health plan benefits apply - all medical costs count toward the deductible
- Are allowed to cover preventive care services before the deductible is met
- Deductibles can be fully-funded or self-funded (NBS is fully funded by the school)
- Cover standard services, such as physician services, hospital visits, preventive care, and prescription drugs. (NBS covers prescriptions separately through EHIM and do NOT count towards the deductible).
- Cover all medical services in full for the rest of the year once the member meets the out-of-pocket (OOP) maximum

Priority Health Medical Benefit Summary

**You MUST have a PCP on file to receive Preferred In-Network rates.
In and out-of-network deductibles are treated separately.**

Item	In-Network	Out-Of-Network
Plan Type	Preferred Benefits 100% Plan	Alternative Benefits 70% Plan
Calendar Year Deductible		
Individual	\$1200	\$3000
Family	\$2400	\$6000
Annual Out-of-Pocket Maximums		
Individual	\$2000	\$4000
Family	\$4000	\$8000
Lifetime Maximum benefit	not applicable	\$1,000,000
Physician Office Services		* Reasonable and Customary
Preventative Care Services (see the PH Preventative Care Guide)	100% coverage—NO deductible	70% of R/C* after deductible
Routine Pre and Post Natal Care	100% coverage—NO deductible	70% of R/C* after deductible
Office or Specialist Visit	100% after deductible	70% of R/C* after deductible
Allergy Injections and Serums	100%	70% of R/C* after deductible
Allergy Testing	100% after deductible	70% of R/C* after deductible
Hospital Services		
Inpatient, Outpatient and Surgery Non-emergency inpatient stays must be approved in advance, initiated by your PCP, or Specialist.	100% after deductible	70% of R/C* after deductible Pre-approval required or 20% penalty
Certain Surgeries, Treatments and Skin Disorders	See the full plan summary for details	See the full plan summary for details
Emergency room visits/services (co-payment waived admitted)	\$50 co-payment, 100% after deductible	\$50 co-payment 70% of R/C* after deductible
Outpatient Services Diagnostic Lab & X-Ray Chemotherapy, Radiation Therapy Hemodialysis	100% after deductible	70% of R/C* after deductible

Priority Health Medical Benefit Summary

Item	In-Network	Out-Of-Network
Other Medical Services		
Skilled Nursing & Hospice	100 % after deductible, max. 45 days per year	70% of R/C* after deductible, max. 45 days per year
Home Health Care	100 % after deductible	70% of R/C* after deductible
Physical, Occupational, Cognitive, Speech and Audiology Therapy (including Spinal Manipulation)	100 % after deductible, max. 30 visits per (combined for all therapies listed)	50 % of R/C after deductible, max. 30 visits per (combined for all therapies listed)
Cardiac Rehabilitation and Pulmonary Rehabilitation	100 % after deductible, max. 30 visits per (combined for all therapies listed)	50 % of R/C after deductible, max. 30 visits per (combined for all therapies listed)
Urgent Care Facility	100 % after deductible	70% after deductible
Durable Medical Equipment, Prosthetic and Orthotics	50 % after deductible	50 % of R/C after deductible
Ambulance (Land and Air)	\$50 co-pay, 100 % after deductible	\$50 co-pay, 100 % after deductible
Family Planning and Infertility Services	See the full plan summary for details	Not Covered
Mental Health, Chemical and Alcohol Dependency		
Note: All mental health and substance abuse treatment must be pre-approved by calling the Behavioral Health department at 616-464-8500 or 1-800-673-8043, Treatment may be covered as deemed clinically necessary.		
Inpatient Services	100% after deductible, maximum 20 days per year	70% of R/C after deductible, maximum 20 days per year
Mental Health Outpatient & Office Therapy Sessions	100% after deductible, maximum 20 days per year	70% of R/C after deductible, maximum 20 days per year
Chemical and Alcohol Dependency Outpatient and Office Therapy Sessions	80% after deductible, up to the minimum annual benefit determined by the State of Michigan.	80% after deductible, up to the minimum annual benefit determined by the State of Michigan
Pharmacy Services		
Prescriptions	Covered under EHIM	Covered under EHIM

Prescriptions - EHIM

Employee Health Insurance Management (EHIM) is a pharmacy benefit management company which negotiates pharmaceutical costs, providing you with the same high quality medications, at more cost effective pricing.

For your convenience, the EHIM help desk has a representative available 24 hours a day, 7 days a week, 365 days a year. The toll free number is 1-800-311-3446. You can also find this number on the back of your EHIM prescription drug card for easy reference.

Summary of Co-payments:

\$10.00	Copayment on any Generic Prescription
\$40.00	Copayment on any Single Source Brand Prescription (Brand Name Drugs that have no Generic Available)
\$40.00	Copayment on any Multi-Source Brand Prescription (Brand Name Drugs that are dispensed when a generic is available). The <i>physician</i> will indicate "DAW" or "Dispense As Written" on the prescription.
\$40.00	Copayment plus the difference in cost between the brand & generic on any Multi-Source Brand Prescription (Brand Name Drugs that are dispensed when a generic is available) The <i>patient</i> indicates the brand to be dispensed.
50%	Copayment on any medication on the Non-Preferred List and Designer Drug List
2x	Copayment on medications filled in extended quantities (i.e. 90 day supplies). Generic drugs can be filled thru Retail or Mail. Brand name drugs can only be filled thru Mail.

Annual Plan Maximums (per plan year October 1 thru September 30)

Amount covered by the plan not to exceed \$5,000 per member, per plan year (plan year runs 10/1 – 9/30). Once the annual maximum has been met, a 100% copay will be assessed for the remainder of the plan year.

Annual Plan Maximum per Contract Type:

- \$5,000 per single contract
- \$10,000 per two person contract
- \$15,000 per family contract

Quantity Limitations

Certain medications under your program may be subject to quantity limits. These limits are not intended to deny benefits, but rather to help protect our members. Medications that are subject to quantity limits are to help insure these medications are not utilized inappropriately or recommended maximum dosages are not exceeded. EHIM's Quantity Limitations are based on FDA-approved dosing recommendations, pharmaceutical guidelines and have been reviewed and approved by our licensed, clinical staff. See Employee Handbook for specific medications and limitations.

Vision - the Guardian

Visit any doctor with your full-feature plan, but *SAVE* by visiting any of the 34,000 locations accepting VSP, the nation's largest network. No claims submissions for in-network services and supplies. Check to see if your doctor is in VSP's network by using the *Find a Doctor* resource at www.guardianlife.com, or call 1-800-627-4200.

Vision Care Services	In-network - YOU pay	Out-of-Network
Routine Exam	\$10 co-pay, then \$0	Amount over \$46
Materials	\$25 co-pay, then \$0 up to your allowance*	
Standard Plastic Lenses (per pair)		
Single Vision	\$0	Amount over \$47
Bifocal	\$0	Amount over \$66
Trifocal	\$0	Amount over \$85
Lenticular	\$0	Amount over \$125
Frames*	80% of amount over \$120 allowance	Amount over \$47 allowance
Additional frames/lenses	20% off retail	No discounts
Contact Lenses (one pair of glasses or contact lenses per year)		
Elective lenses*	Amount over \$120 allowance	Amount over \$120 allowance
Medically Necessary	\$0	Amount over \$210
Evaluation and Fitting	15% off Usual & Customary Rates	No discounts
Cosmetic Extras	Avg. 20-30% off retail price	No discounts
Laser Vision Correction	Up to 25% off retail price or 5% off promotional price	No discounts

Service Frequency - You are eligible for:

- Eye exam, once every 12 months.
- Lenses (for glasses or contact lenses), once every 12 months.
- Frames, once every 12 months
- Network discounts for cosmetic extras, glasses, and contact lens professional service, limitless within 12 months of exam.

This is only a summary of your vision services and benefits under the plan. Your certificate of benefits will show exactly what is covered and excluded. See the Business Office for your certificate, or go to the NBS Public server, to Benefits, then Lincoln Dental Contract.

Dental Benefits - Lincoln Financial Group

The Lincoln Financial Group Dental Plan offers traditional dental care, where you are free to choose any dentist and do not need a referral to see a specialist. Covered expenses will not exceed the policy's usual and customary allowances, which means you may be billed for the difference not covered by insurance.

Lincoln also offers *DentalConnect*, a list of participating dentists who have agreed to accept Lincoln's payments with NO balanced billing. This listing can be found on the Lincoln website at: www.JPFIC.com. Select the "Click Here if you are the Employee/Insured" and follow the prompts. Click the "My Benefits" tab, under the Coverages section, then click on the Lincoln Dental Connect hyperlink to get a list of dentists in your area.

If you have any questions or would like assistance accessing the Lincoln *DentalConnect* health center web site, please call 1-800 423-2765 and select option one.

Preventative	Basic	Major	Orthodontics
100%	80%	50%	50%
<ul style="list-style-type: none"> • Routine Examinations • X-Rays • Teeth Cleanings (prophylaxis) • Fluoride treatments for children • Space maintainers for children 	<ul style="list-style-type: none"> • Fillings • Root Canal Therapy • Periodontal Surgery and Periodontal Maintenance Procedures • Sealants • Consultations • Extractions & most oral surgeries • Emergency relief of dental pain • General anesthesia • I.V. sedation • Prefabricated stainless steel & resin crowns • Repair of bridgework & dentures 	<ul style="list-style-type: none"> • Crowns & Bridges • Dentures 	<ul style="list-style-type: none"> • Orthodontic Exams • Orthodontic X-rays • Orthodontic Extractions • Orthodontic Study models • Orthodontic Appliances
Calendar-Year Deductible (excludes orthodontia)	Waived for Preventative Services	Individual - \$50 Family - \$150	
Annual Maximum	\$1000 (excludes orthodontia)		
Lifetime Orthodontia	A lifetime maximum of \$1000. <u>There is a one-year waiting period for this benefit.</u> A dependent, under age 18, must not be "banded" prior to eligibility.		

This summary is not intended as a complete description of your insurance coverage. See the full plan for details.

2011 Contributions

Health insurance benefits are provided on a calendar year basis, January 1 through December 31.

Premiums are calculated based on either Group I or Group II, the number of pay periods worked throughout the year, either 26, 22 or 21 pay periods, and the number of hours worked. Based on your written enrollment application, health insurance premiums will be deducted from your paycheck bi-weekly.

Premiums may increase or decrease from time to time, and changes will be automatically adjusted in payroll. You will be given written notice of these changes in advance. To change or stop a health insurance deduction, you will need to provide written notice to the Business Office.

The following **Bi-Weekly** contributions are required for coverage for each group.

(To understand these calculations, multiply the bi-weekly rate x the number of pays and divide by 12 months to get the NBS monthly cost.)

Group I - 2011 Insurance Premium Rates

Assumes 26 pays and 10% contribution at full-time, then pro-rated based on hours (not include add. 10%)	TOTAL	35-40 hrs/ wk	30-35 hrs/wk	25-30 hrs/ wk	20-25 hrs/ wk
Medical, Dental and Vision	\$	Your \$	Your \$	Your \$	Your \$
Family	922	42.53	53.16	106.33	159.49
Double	758	34.96	43.70	87.40	131.11
Single	336	15.48	19.36	38.71	58.07

Group II - 2011 Insurance Premium Rates

Assumes 21 pays and 5% contribution at full-time, then pro-rated based on hours (not include add. 5%)	TOTAL	35-40 hrs/ wk	30-35 hrs/wk	25-30 hrs/ wk	20-25 hrs/ wk
Medical, Dental and Vision	\$	Your \$	Your \$	Your \$	Your \$
Family	922	26.33	65.82	131.64	197.46
Double	758	21.64	54.11	108.21	162.32
Single	336	9.59	23.96	47.93	71.89

Premium Conversion

To help minimize your employee contribution for your medical plan, New Branches School will continue to offer an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows you to pay for your medical, dental and vision coverage on a pre-tax (before taxes) basis. As a result, your net take home pay will be higher than if contributions were deducted on a post-tax (after tax) basis.

Contributions taken on a pre-tax basis are not subject to federal or state income taxes or FICA taxes. The amount of savings depends on your individual contribution and tax bracket.

Additional Benefits

Basic Life—Lincoln Financial Group

Basic Life insurance is an extremely important benefit. It offers financial security for your dependents should you die. All eligible employees are eligible for a \$10,000 benefit. This benefit is provided at no cost to you.

Voluntary Life/AD&D—Lincoln Financial Group

Newly hired employees have the opportunity to purchase life insurance up to 5 times your annual earnings rounded to the nearest \$1,000, up to a maximum of \$100,000. This benefit is not medically underwritten, and you are guaranteed issue. Spouses are eligible for 50% of the employee amount of insurance, up to \$50,000. All children in the household ages 6 months—18 are eligible for \$10,000 of coverage, for a low monthly cost of \$2.00. The premiums for this insurance are based on age, and are employee paid.

Short Term Disability—Lincoln Financial Group

The Short Term Disability (or Weekly Income Benefit) insurance is a valuable benefit designed to replace a portion of your income when you are unable to work because of a non-work related injury or illness.

This benefit provides all employees with a benefit equal to 60% of weekly earnings to a maximum of \$500 per week. Benefits begin on the 8th day of an injury/accident or illness. Benefits continue up to a maximum of 12 weeks, based on your particular injury or illness. Maternity leaves are covered under Short Term Disability. This benefit is provided at no cost to you.

Long Term Disability—Lincoln Financial Group

A disability of a lengthy duration can devastate the financial and emotional status of an individual or family. To help protect you from the effects of the income loss that results from a serious disability, NBS provides all full time employees with coverage equal to 66.70% of monthly earnings to a maximum of \$5,000 per month. Benefits begin after a 90-day period of disability and continue up to 2 years. This benefit is provided at no cost to you.

MPSERS and Annuity Retirement Accounts

New Branches School has chosen to participate in the State retirement program. Currently the school makes a contribution of approximately 17% of your paycheck to the MPSERS program, each and every payroll. A portion of this goes directly to your pension, part to your future health insurance, and the remainder to subsidize the health insurance of current retirees.

Family Coverage

New Branches will provide insurance coverage for families providing that the employee's spouse /partner or family is not eligible for health insurance coverage at his/her place of employment. Please see the Spousal/Partner Exclusion form for clarification.

Partners will be considered dependents as defined by the rules set forth in the health insurance plan. This may include an affidavit, proof of residency, or other documentation. Partners meeting this definition will be eligible for other benefits as specified in the Employee Handbook.

Medical Opt-out credit

Each school year, if you opt out of the medical insurance coverage, you may be eligible to receive a buy-out from New Branches School. To be eligible for the opt-out credit, you must waive coverage and must be able to provide proof of other coverage (a copy of the front and back of your medical card is sufficient). An annual credit of \$1,500 will be paid to you pro-rated per paycheck.

Health Reimbursement and Health Savings Arrangement

If you enroll into the Priority Health Medical Plan, New Branches School will assist you by funding your deductible, through an HRA or HSA arrangement. For the 2011 plan year, the deductible is \$1200 for single coverage and \$2400 for family coverage. The HSA deposit will be made in full on January 1 in 2011. You must be an active employee to receive these funds, employees on COBRA will not be eligible for the annual contribution from New Branches School. More information is available on the following pages.

Health Reimbursement Accounts

Health Reimbursement Accounts

If you are a new employee and you enroll into the Priority Health Plan, you will be eligible for the Health Reimbursement Plan (HRA) through the plan year-end. This HRA plan is designed to assist you in covering medical costs that are applied to your deductible. If you have single coverage, \$1200 will be available to meet your deductible expenses. If you have family coverage, \$2400 will be available to you . You can get an HRA Claim Form from the business office, or on the NBS server, under Public, in the Benefits folder.

HRA's are IRS-sanctioned arrangements that allow an employer to reimburse for medical expenses paid out of pocket by participating employees. HRAs reimburse expenses which are not covered by the company's insurance plan, such as deductibles. These arrangements are described in IRS Section 105.

Medical Claims Processing Procedures:

This procedure is for health insurance deductibles only, NOT vision, dental or prescription. This procedure should be used for any mid-year enrollments through the end of the calendar year.

Prescriptions

Use your EHIM prescription card. The pharmacy will use your card to determine the cost of your prescription, apply any discounts, and you will be responsible for your co-pay, generally \$10 or \$40.

Medical Bills

- DO NOT PAY your medical provider at the time of service. (Non-participating physicians may require payment).
- Present your Priority Health card to your medical provider. Your medical provider will submit the claim to Priority Health. (For non-participating physicians, **you** will have to submit your bill to Priority Health).
- WAIT to pay until you receive your Explanation of Benefits (EoB) from Priority Health which will include the discounted amount you owes. (If your physician is non-participating, you will not receive the Priority Health discount).
- When you receive your EoB from Priority Health, you can submit a claim to BASIC.
- Submit your EoB along with a BASIC HRA Claim form. BASIC will reimburse you the amount applied to your deductible.
- When the medical provider bill arrives, pay the bill with the funds reimbursed to you from BASIC.

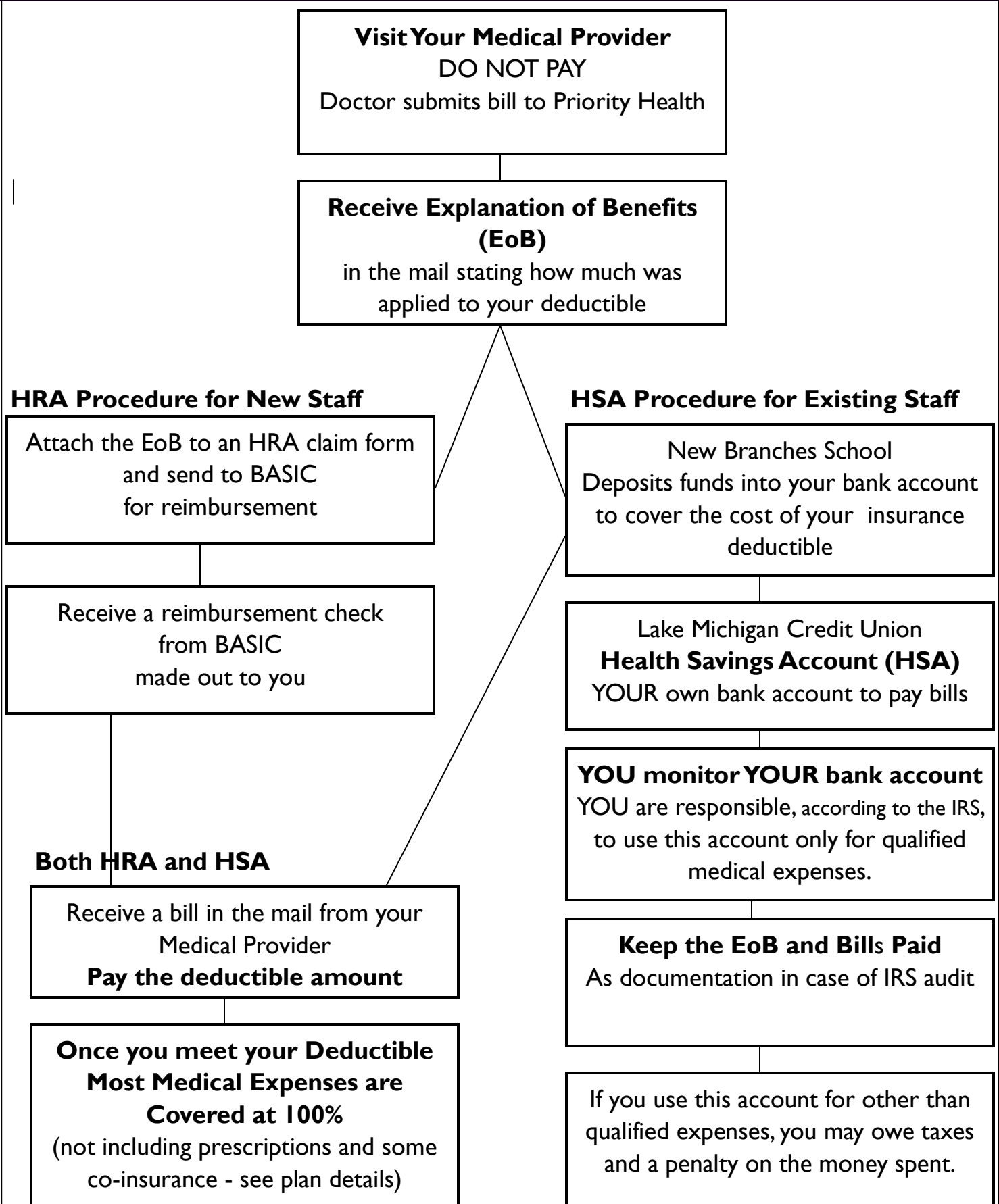
Following the end of the plan year, or termination of employment, you will have 90 days to submit claims for reimbursement.

Contacting BASIC

For questions about your HRA claims, contact HRA claim administration at BASIC by calling 1-800-444-1922 (x1) or setseghra@basicflex.com.

For questions about your Priority Health EoB, call Priority Health customer service at 1-800-446-5674. Press option 2, enter your PH contract number found on your insurance card, then option 3 for the HSA department.

HRA and HSA Flow Chart



Health Savings Accounts - IRS Guidelines

A health savings account (HSA), is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a High Deductible Health Plan (HDHP). The funds contributed to the account are not subject to federal income tax at the time of deposit. Unlike a flexible spending account (FSA), funds roll over and accumulate year over year if not spent. HSAs are owned by the individual, which differentiates them from the company-owned Health Reimbursement Arrangement (HRA) that is an alternate tax-deductible source of funds paired with HDHPs. Funds may be used to pay for qualified medical expenses at any time without federal tax liability. Withdrawals for non-medical expenses are treated very similarly to those in an IRA in that they may provide tax advantages if taken after retirement age, and they incur penalties if taken earlier. These accounts are a component of consumer driven health care. Contributions from an employer or employee may be made on a pre-tax basis through an employer. All deposits to an HSA become the property of the policyholder, regardless of the source of the deposit. Funds deposited but not withdrawn each year will carry over into the next year.

HSA Bank Account

According to the IRS, HSA bank accounts:

- Limit annual contributions to \$3,050 for singles and \$6,150 for families (in 2011).
- Allow people aged 55 and older to contribute an additional \$1,000 per year (in 2011) to "catch up" on their contributions.
- Are tax-exempt - no income tax, FICA or FUTA withholding/payments apply to contributions an employee makes directly through an employer's health plan.
- Can be used to pay for all medical, vision, dental or prescription costs; long-term care premiums; COBRA; health care for those drawing unemployment; Medicare premiums (but not Medigap); any health insurance for those 65 and over (per Section 213(d)).
- Cover expenses incurred by and accept contributions from an employee, spouse and dependents. Must charge a 10% penalty for invalid expenses and include the amount on the employee's gross income, making it subject to taxes. The 10% penalty ends when you are 65, disabled or deceased.

Making Deposits to your HSA Bank Account

The funds deposited by NBS are designed to reimburse you for deductible expenses, however these funds can be used for any "qualified medical expenses", see the list on the following page. You may choose to contribute additional funds through a pre-tax payroll deduction to pay for qualified medical expenses. Payroll deductions can be a one-time deduction, or an on-going deduction, and can be started at anytime. You must be an active employee to receive these funds, employees on COBRA will not be eligible for the annual contribution from New Branches School. See the Business Office for assistance.

HSA Qualified Expenses

Employees can use the money in their health savings account to pay for qualified health care expenses, such as:

- Deductibles determined by the health plan
- Copayments and Coinsurance for medical expenses and drugs
- Doctor and hospital visits, including surgeries
- Chiropractor and podiatrist expenses
- Prescription drugs
- Birth control and sterilization
- X-rays and lab tests
- Vaccinations and immunizations
- Vision expenses such as glasses or contact lenses
- Dental and orthodontia expenses
- Hearing expenses
- Long-term care
- Treatment for alcoholism and drug abuse
- Smoking cessation therapy
- Wheelchairs, artificial limbs
- COBRA and Medicare premiums (and, if you are unemployed, other types of health insurance premiums)
- SEE BELOW regarding Over-the-Counter (OTC) medicines

Items Not Considered Qualified Expenses:

- Cosmetic surgery, plastic surgery
- Funeral expenses
- Health club dues
- Tooth whitening (cosmetic), medically related tooth whitening is eligible.
- MANY OVER THE COUNTER medicines which used to be qualifying expenses, now require a prescription.

Read more about what expenses qualify for tax-free reimbursement through an HSA refer to the IRS website at: http://www.irs.gov/publications/p969/ar02.html#en_US_2010_publink1000204020

*Must be related to a current medical condition or injury, and not just to general health.

HSA Tax Information

It is recommended that you keep receipts for all expenses paid with funds from your HSA bank account. These funds are subject to taxes unless they are used for qualified medical expenses under your high deductible health plan. It is your responsibility to be able to provide receipts should you ever be audited by the IRS.

Money contributed by you and/or your employer to this account (up to the legal limit) is exempt from taxes.

Completing your Tax Return

- You should receive a statement from your bank regarding your HSA account.
- On your tax return you will need to note the amount of your deductible, \$1200 or \$2400 depending on whether you have individual or double/family coverage.
- You will need to note how much has been contributed to your account including the employer and employee contribution. This should be on your statement from the bank.

As a note, you are *allowed* to personally contribute up to a combined employee/employer maximum of \$3050 for an individual, and \$6150 for double/family insurance in 2011. If you made contributions to your HSA after tax (by making a deposit into this account), you can take an “above-the-line” deduction on your taxes. In the future, if you are interested in making additional contributions to your HSA just let us know, and we can do this pre-tax through payroll deduction for you (eliminating this adjustment next year on your taxes). This is great if you have medical or dental expenses that are not “deductibles”, for example prescription co-pays or orthodontics.

- You will need to note how much you took out for medical expenses, this should be on the statement from the bank. You should be keeping all your receipts for anything you pay for from this account. If you were audited by the IRS you would need this documentation, or you would be required to pay taxes on this money.
- Lastly, if you took money out for non-medical expenses, you will need to pay taxes on this distribution. Only non-medical expenses are subject to taxes.

See the Business Office for assistance.

Change in Status and Special Enrollment

Making Changes to Your Elections

The enrollment elections you make are for the entire plan year October 1 through September 30. Your benefit elections cannot be changed *unless* you have a qualifying "Change in Status" event.

Change in Status events for all Benefit Programs are any of the following events:

- You or your Eligible Dependent become eligible or ineligible for coverage on account of a change in:
 - Legal marital status (for example; marriage, divorce, legal separation, annulment)*;
 - Number of dependents (for example; birth, death, adoption, placement for adoption);
 - You or your Eligible Dependent's employment status (for example; termination or start of new employment, taking or returning from an extended unpaid leave of absence
 - You or your Eligible Dependent's job status (for example; part-time to full-time, or union to non-union, or vice versa);
 - Residence or work site (i.e., network no longer available where you live/work); or
 - An Eligible Dependent's status (for example, a dependent becomes eligible or ineligible for benefits under the Plan)**.
- A change in coverage due to an election made by your spouse or dependent during an open enrollment period under the spouse's or dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan.
- A change in the availability of benefit options or coverage (addition or removal) under the Plan's Benefit Programs.
- A significant increase or decrease in the cost of coverage during the Plan Year.

Additional Change in Status Events for the Medical, Dental and Vision Benefit Programs:

In addition to the Change Events listed above, you may change your benefit elections for the Medical, Dental and Vision Benefit Programs if:

- You or your Eligible Dependent becomes eligible for COBRA Continuation Coverage or extended coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
- A judgment, decree, or order, resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your child under this Plan;
- You or your Eligible Dependent becomes enrolled or loses coverage under Part A or Part B of Medicare or Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
- For the Medical Benefit Program only, you or your Eligible Dependents are eligible for a Special Enrollment Period.

*You must provide proof of a change in your legal marital status to the Business Office.

**You must provide proof of a change in an Eligible Dependent's status to the Business Office.

Consistency Rule

Your election changes must be consistent with the Change in Status Event that affects your coverage under the Benefit Program. For example:

- If one of your Eligible Dependents no longer qualifies as an Eligible Dependent, you could cancel coverage for that dependent, but you could not cancel coverage for your other Eligible Dependents; or
- If you have single coverage and you marry, you may elect two person (only if your spouse does not have insurance available with their employer). or family coverage whichever applies.

Some of the Change Events may allow you the option of either adding or removing coverage. For example, your spouse changing an election under his or her employer's plan may allow you to add or remove coverage under this Plan, so long as your choice is consistent with your spouse's election.

You must report any status change to the Business Office within **30 days** of the date of the event. Otherwise, you will be required to wait until the next open enrollment to enroll them.

It is your responsibility to notify the Business Office within **30 days** if you have a dependent that is no longer eligible (i.e., a child who reaches age 19 and is not dependent upon you as IRS defined, or you become divorced). Those dependents may have continuation rights for medical coverage under the federal law known as COBRA. If you do not notify the Business Office within the required time frame, those dependents could be left with no insurance coverage under our plan.

Women's Health and Cancer Rights Act of 1998

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and physical complications for all stages of a mastectomy, including lymph edemas (swelling associated with the removal of the lymph nodes).

The group health plan must determine the coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Newborn and Mother's Health Protection Act

This 1998 Federal law states: "Group plans and health insurers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth".

The law provides that neither you nor your newborn baby may be sent home less than 48 hours following a natural childbirth. If you have a Caesarean section, you may remain at the hospital for 96 hours. A longer stay is based on medical necessity, which is determined by your physician. However, the law does not prohibit either of you from going home in less than 48 hours, or 96 hours following a Caesarean section, provided that you or your physician agree that it is safe to do so.

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it.

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. New Branches School has determined that the prescription drug coverage offered by the New Branches School Prescription 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. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

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 New Branches School coverage will be affected. For those individuals who elect Part D coverage, coverage under the New Branches School current prescription plan will end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your current New Branches School coverage, be aware that you and your dependents will be able to get this coverage back as long as you meet your employer's requirements.

Medicare Part D Certificate of Creditable Coverage

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with New Branches School 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 November to join.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 20, 2009

Name of Sender: Kristin Clark

Company: New Branches School

Address: 256 Alger St. SE

Grand Rapids, MI 49507

Phone Number: 616-243-6221

Your Retirement Plan

As a member of Michigan's Public School Employees Retirement System, you are eligible for one of the best public pensions around. To get you started in learning about your retirement plan, some of the basics are summarized from the ORS online website. We encourage you to educate yourself further about this plan through the www.michigan.gov/ORSschools website, or by calling 1-800-381-5111.

Contributing to the Plan

The date you began work as a public school employee determines whether you have the MIP or Basic retirement plan. All information in this summary pertains ONLY to the MIP plan, BASIC information can be found online. The retirement system is funded by contributions from you and New Branches School, and by the investment earnings on these contributions. Contributions to your pension begin with your first paycheck. The contributions you make are based on your earnings, the more you earn, the higher the contribution. Currently contributions rates are 3% of the first \$5000 of your earnings, then 3.6% after \$5000, and increase up to 4.3% once you earn over \$15,000. In addition, the school contributes to the Pension Plan, and the rates are adjusted annually. See the tables below:

2009-2010

Pension Normal Cost	3.98%
Pension Unfunded Accrued Liability:	6.15%
Pension Total:	10.13%
Health Benefits (Cash Basis):	6.81%
Total:	16.94%

2010-2011

Pension Normal Cost	3.74%
Pension Unfunded Accrued Liability:	8.42%
Pension Total:	12.16%
Health Benefits (Cash Basis):	7.25%
Total:	19.41%

Personal contributions fund your pension plan. You *cannot* borrow or take a lump sum - unless you leave the system and forfeit your pension rights. These contributions are not refundable to you or your employer.

The Pension Formula

Your annual benefit is based on a formula that multiplies your *final average compensation* (FAC) by a pension factor of 1.5 percent times your *years of service*. Dividing the annual benefit by 12 will tell you how much your monthly benefit will be if you elect the *straight life* option. You can also choose a *survivor* option or an *equated* plan for your pension payments. Details about these options can be found at www.michigan.gov/ORSschools.

The Pension Formula

$$\text{FAC} \times 1.5\% \times \text{YOS}$$

Final Average Compensation **Pension Factor** **Years of Service**

Qualifying for Your Pension

As a MIP member, you will qualify for full retirement under any of the following provisions:

- **MIP 46 with 30.** You qualify for full retirement at any age with at least 30 years of service. However, if you have purchased universal buy-in service credit, you must be at least age 46. At least 15 years of service credit must have been earned through the Michigan Public School Employees Retirement System.
- **MIP 60 with 10.** You are eligible for your pension at age 60 with at least 10 years of service credit.
- **MIP 60 with 5.** If you are age 60 and you have at least 5 years of service credit, you qualify for a pension if you have creditable service earned in each of the five school fiscal years immediately before your retirement effective date and you terminated your public school service immediately before your retirement effective date. A school fiscal year runs from July 1 through June 30.

Your Annual Member Statement

Each year all active (working) members receive a Member Statement. While the primary purpose of the statement is to help you plan for your retirement, it also gives you an update on your account balance and account activity through June 30, the end of the fiscal year.

Review this statement carefully for accuracy. Please verify that your beneficiary is correct and up to date. It is also suggested that you save your statements with your other important papers for future reference.

Benefit Resources:

There are a lot of resources available online at the Office of Retirement Services at www.michigan.gov/ORSschools including:

- Benefit Estimator
- A Retirement Plan Handbook
- Pre-retirement Seminar information
- *Connection* retirees newsletter
- Retiree Health Insurance rates and plan summaries
- Service Credit Information
- And much more...

Important Resources, Numbers, Websites

Benefit Resources:

- Kristin Clark, HR Advisor, New Branches School (616) 243-6221
kclark2623@yahoo.com
- Mark Redfield, Insurance Agent and Financial Planner (616) 447-1600 (ext 10)
Mark.Redfield@nationalplanning.com
- Priority Health, Customer Service (800) 446-5674, Option 2, ID#, Option 3 for HSA Dept.
www.customer.service@priorityhealth.com
- EHIM, 24 hour Hotline (800) 311-3446
- Lincoln Financial Group, Customer Service (800) 423-2765
for *DentalConnect* a network of participating dentists, or STD or LTD information: www.JPFIC.com
- The Guardian, Customer Service (800) 627-4200 Monday - Friday 7:00 am-5:30 pm CTS
To check your benefits, or for a list of VSP providers in your area: www.GuardianAnytime.com
- MSPERS www.michigan.gov/orsSchools
on-line resources, videos and retirement booklets
- TIAA-CREFF (800) 842-2733 or www.tiaa-creff.org
- State of Michigan Prescription Drug Price Finder <http://www.michigandrugprices.com/>

Other Useful Resources:

- New Branches School website www.newbranches.org
- Central Michigan Charter Schools Office www.thecenterforcharterschools.org
- Michigan Association Public School Administrators www.MAPSA.org
- Kent Intermediate School District www.kentisd.org
- AESOP – substitute online system www.aesoponline.com
- Office of Retirement Services www.michigan.gov/ORSschools

This Benefits Guide is meant to serve as a summary of the New Branches School benefit plan designs and associated contributions. The Summary Plan Description (SPD) for each benefit plan contains the full plan information and should be your ultimate reference for plan related detail. If a discrepancy exists between this benefits overview and the SPD, the SPD will take precedence. SPD's can be found on the General server, under the Benefits folder, or hard copies will be provided upon request.