

WASHTENAW
INTERMEDIATE SCHOOL DISTRICT
FLEXIBLE COMPENSATION
PROGRAM

Benefits At A Glance

Workbook

1/1/2010 – 12/31/2010

New Plan Year

Teamsters - Clerical

MEMORANDUM

FROM: Nancy Crane
Marwil & Associates
DATE: December 7, 2009
SUBJECT: 2010 Annual Enrollment (12 month plan year)

Enclosed is the 2010 Benefits At A Glance Workbook which outlines the complete benefit package available through Washtenaw Intermediate School District. Please take the time to review your workbook to ensure that the benefit package you choose for 1/1/2010 - 12/31/2010 will best meet the needs for you and your family.

Also enclosed is your pre-printed 1/1/2010 - 12/31/2010 Flexible Compensation and Optional Benefit Election and Salary Reduction Agreement.

- Please update your beneficiary information, if left blank your beneficiary information provided on the Short Plan year form will be used.
- Please update your dependent data. Social Security numbers are not required at this time.
- If you are not making any changes to your benefit plan, sign and date at the bottom.
- **If you wish to make any changes, please note the changes on the form, initial each change and sign and date at the bottom of the form.**
- **Return the form and all other required forms.** You will receive a copy back once all changes have been recorded.
- **You MUST select new target for Uninsured Health Care and Dependent Care.** These will only be for full 12 month period and are limited in the amount you can elect, please refer to the Workbook for limits.

All forms should be **returned to Coleen Carter** in Human Resources no later than **December 15th 2009.**

Failure to submit your forms by the due date may result in a lapse in insurance coverage.

Please note the changes you elect will be effective January 1, 2010 through December 31, 2010.

The following changes have been made for the 2010 Plan Year, please review your workbook for details:

Co-Premium levels for 2010

	<u>Single</u>	<u>Two-Person</u>	<u>Family</u>
<u>BCBS CB1</u> <i>Annual:</i>			
Per Pay:	0	0	0
<u>BCN</u> <i>Annual:</i>	54.96	398.64	0
Per Pay:	\$2.29	\$16.61	
<i>(rates are by 24 pays)</i>			

If you should have any questions, please feel free to call our office at 1-877-681-1525.

WASHTENAW INTERMEDIATE SCHOOL DISTRICT FLEXIBLE COMPENSATION MENU
"BENEFITS AT A GLANCE" 1/01/2010 – 12/31/2010 NEW PLAN YEAR
Teamsters - Clerical

BENEFIT	OPTION I	OPTION II	OPTION III																																				
Medical Insurance	<p>BCBSM Community Blue PPO</p> <table style="margin-left: 40px;"> <tr> <td></td> <td style="text-align: center;">In <u>Network</u></td> <td style="text-align: center;">Out of <u>Network</u></td> </tr> <tr> <td>Individual</td> <td style="text-align: center;">\$0</td> <td style="text-align: center;">\$250</td> </tr> <tr> <td>Family</td> <td style="text-align: center;">\$0</td> <td style="text-align: center;">\$500</td> </tr> <tr> <td>Coinsurance</td> <td style="text-align: center;">None</td> <td style="text-align: center;">80/20</td> </tr> <tr> <td>Coins. Out of Pocket</td> <td style="text-align: center;">N/A</td> <td style="text-align: center;">\$2000 Indv. \$4000 Family</td> </tr> <tr> <td colspan="3"><u>Fixed dollar copays</u></td> </tr> <tr> <td>Office visits</td> <td style="text-align: center;">\$10</td> <td></td> </tr> <tr> <td>Copay/Ded applies</td> <td></td> <td></td> </tr> <tr> <td>Hospital, emergency</td> <td style="text-align: center;">\$50</td> <td style="text-align: center;">\$50</td> </tr> <tr> <td>Rx copay</td> <td colspan="2" style="text-align: center;">\$10.00 generic/\$60.00 brand/ 50% copay for lifestyle drugs</td> </tr> <tr> <td>Preventative Services</td> <td></td> <td></td> </tr> <tr> <td>Maximum:</td> <td style="text-align: center;">\$500</td> <td style="text-align: center;">Not Covered</td> </tr> </table>		In <u>Network</u>	Out of <u>Network</u>	Individual	\$0	\$250	Family	\$0	\$500	Coinsurance	None	80/20	Coins. Out of Pocket	N/A	\$2000 Indv. \$4000 Family	<u>Fixed dollar copays</u>			Office visits	\$10		Copay/Ded applies			Hospital, emergency	\$50	\$50	Rx copay	\$10.00 generic/\$60.00 brand/ 50% copay for lifestyle drugs		Preventative Services			Maximum:	\$500	Not Covered	<p>HMO's</p> <p>Blue Care Network</p> <p>Rx copay \$15.00 generic \$50.00 brand</p> <p>50% copay for lifestyle drugs</p> <p>May require a co-premium</p>	<p>Opt Out</p> <p>\$3,500 Cash Rebate</p> <p>(must provide proof of insurance elsewhere)</p>
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Vision Insurance	Combined – vision exam, with frames/lenses or contact lenses \$390 ANNUALLY																																						
Long Term Disability Insurance	<p>66⅔% to \$6,000 90 day elimination</p>	<p>Employee Can Purchase 70% to \$6,000 90 day elimination</p>																																					
Term Life/AD&D Insurance	<table style="margin-left: 40px;"> <tr> <td>If annual salary:</td> <td></td> </tr> <tr> <td>less than \$10,000</td> <td style="text-align: center;">\$15,000</td> </tr> <tr> <td>\$10,000 to \$15,000</td> <td style="text-align: center;">20,000</td> </tr> <tr> <td>\$15,000 to \$20,000</td> <td style="text-align: center;">25,000</td> </tr> <tr> <td>\$20,000 and over</td> <td style="text-align: center;">30,000</td> </tr> </table>	If annual salary:		less than \$10,000	\$15,000	\$10,000 to \$15,000	20,000	\$15,000 to \$20,000	25,000	\$20,000 and over	30,000	<p>Employee Can Purchase An Additional 1 times Employer Provided</p>	<p>Employee Can Purchase An Additional 2 times Employer Provided</p>																										
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Dependent Care Reimbursement	Available																																						
Uninsured Health Care Reimbursement	Available																																						

THE TABLE SHOULD BE READ ACROSS, NOT VERTICALLY. SELECT ONE OPTION FOR EACH BENEFIT CATEGORY

Table of Contents

Introduction.....	1 - 2
Liability Worksheet.....	3
Term Life Insurance	4
Accidental Death & Dismemberment.....	4
Long-Term Disability.....	5
Dental Insurance.....	6
Vision Care Program	7
Medical Insurance (At A Glance).....	8
Medical Insurance Descriptions	
(Option I BCBSM Community Blue PPO)	9 - 11
(Option II HMO Blue Care Network)	12 - 13
(Option III No Medical Coverage).....	14
The Women’s Health and Cancer Rights Act 1998.....	14
Prescription Drug Program (with Option I BCBSM Community Blue PPO).....	15
Employee Reimbursement Account	
General Information	16 - 17
Uninsured Health Care Expenses	18
Estimating Health Care Expenses	19
Dependent Care Expenses	20
Employee Reimbursement Account vs. Dependent Care Tax Credit.....	21
How to Avoid Potential Disadvantages	22
Making Your Selections	23

Introduction

It is inconceivable to think that a single person, a family with children and a couple approaching retirement would all want the same benefits. That is why the Administration and Employee representatives of W.I.S.D. gathered together to create the **Washtenaw Intermediate School District Flexible Compensation Plan**.

Flexible Compensation is based on the concept that you are the best judge of your benefit needs. Therefore, the Employer provides you with essential coverage at no cost to you, then gives you the option of either electing additional coverage, less coverage or opting out of coverage altogether. Should you decide to take less comprehensive coverage or no coverage at all, you will receive a designated amount of cash. **That cash can either be reinvested elsewhere in the menu or added to your earnings and received over your normal pay schedule.**

Flexible Compensation also provides you with an array of benefit alternatives previously unavailable and gives you the opportunity to pay for those benefits before the government takes out any taxes. By shifting current out-of-pocket expenses and paying them through the Flexible Compensation Plan pretax, you not only take care of your necessary responsibilities, but you give yourself a **pay raise** at the same time. In turn, your pay raise can be used to enhance Employer provided benefits or purchase other benefits that were previously unaffordable. (See example on next page.)

The opportunity to choose is accompanied by the responsibility of understanding your choices. This workbook is intended to provide extensive information about Flexible Compensation and the options that are available to you. **This booklet is not a contract**, individual certificates for each applicable coverage prevail and will be issued at a later date.

In addition, you will find worksheets to help determine your benefit needs. It is essential that you complete the worksheets prior to your individual enrollment since these are intended to assist you in making the proper benefit selections. Enrollment elections can only be held **once** each year, so make sure that you are prepared.

PLAN OVERVIEW

Washtenaw Intermediate School District's Flexible Compensation Program is made up of two components: The Employer provided benefits and Employee Options.

The Employer provided coverage - benefit levels provided by W.I.S.D.

Washtenaw Intermediate School District pays the full cost of providing these benefits.

- Medical Coverage for you and your eligible dependents
- Dental Coverage for you and your eligible dependents
- Vision Coverage for you and your eligible dependents
- Long-Term Disability Income
- Term Life/Accidental Death and Dismemberment Insurance

Employee Options - allows you to modify the Employer provided benefits, as you wish.

Included among your Employee Options are a number of different alternatives:

- An HMO Plan which may require a co-premium
- No Medical Coverage in exchange for cash (you must prove insurance elsewhere to elect this option)
- Less Comprehensive Dental Coverage in exchange for cash
- No Dental Coverage in exchange for cash
- Additional Long Term Disability Insurance
- Additional Term Life and Accidental Death and Dismemberment Insurance
- An Employee Reimbursement Account for Uninsured Health Care and/or Dependent Care Expenses

In addition to what is being offered through the Flexible Compensation menu, you will also receive the opportunity to participate in other benefit programs through payroll deduction. Those programs include:

- A 403 (b) tax deferred investment program

It is up to **you** to decide which of these employee options you would like.

ADMINISTRATOR

Marwil & Associates LLC is a Michigan-based corporation, which specializes in the design, implementation and administration of pensions and employee benefits. Marwil & Associates administers the Flexible Compensation Program. Representatives will be available to answer any questions that you may have either prior to or during enrollment. They will also be responsible for handling the plan on an ongoing basis. For assistance call: 1-877-681-1525.

The following example (assuming Single taxpayer) illustrates how the payment of after-tax expenses on a pretax basis creates a pay raise for the employee.

	<u>With Account</u>	<u>With out Account</u>
Annual Gross Salary	24,000	24,000
Dependent Care	1,800	0
Health Care Expenses	<u>700</u>	<u>0</u>
Taxable Income	21,500	24,000
Federal Tax (18.5% blended)	3,978	4,440
FICA (7.65%)	1,645	1,836
State Tax (3.9%)	<u>839</u>	<u>936</u>
(Total taxes = 30.05%)		
After-Tax Income	15,038	16,788
After-Tax Dependent Care	0	1,800
After-Tax Health Care	<u>0</u>	<u>700</u>
Spendable Income	\$15,038	\$14,288
NET PAY RAISE		<u>750.00</u>

NOTE: *A portion of your pay raise should be used to address the possible disadvantage of pretax funding. (See the section entitled "How to Avoid Potential Disadvantages.")*

Liability Worksheet

Before you can decide which benefits to choose, it is necessary to evaluate your own personal financial responsibilities. Fill in the blanks below as accurately as possible. Once you have completed this section, you will be able to determine your benefit needs.

MONTHLY EXPENSES	MONTHLY PAYMENT	OUTSTANDING LIABILITY
Mortgages/Rent	\$ _____	\$ _____

NOTE: If your homeowners insurance and taxes are included with your mortgage payment, then include them here and skip those items as annual expenses.

Second Mortgage	\$ _____	\$ _____
Car Payment	\$ _____	\$ _____
Car Expense (gas/repairs)	\$ _____	\$ _____
Utilities: Electric \$ _____ + Gas \$ _____ + Phone \$ _____ + Water/Sewage \$ _____ + Cable \$ _____		
+ Other \$ _____ =	\$ _____	
Food/Sundries	\$ _____	
Installment Loans	\$ _____	\$ _____
Credit Cards	\$ _____	\$ _____
Entertainment (theater, movie, sporting events, restaurants)	\$ _____	
Miscellaneous (special occasions, money for children, etc.)	\$ _____	
Monthly Total:	\$ _____	
	x12	
Annual (monthly) Subtotal:	\$ _____ *	

* NOTE: Carry this number to the bottom marked Annual (monthly) Subtotal.

ANNUAL EXPENSES	ANNUAL PAYMENT	
Taxes (primary residence, secondary residence, other property).....	\$ _____	
Vacation(s)	\$ _____	
Insurance(s) Life \$ _____ + Auto \$ _____ + Health \$ _____ Homeowners \$ _____ + Cancer \$ _____ + Disability \$ _____ + Other \$ _____ =	\$ _____	
Miscellaneous (tuition, political and/or religious donations)	\$ _____	
Annual Subtotal	\$ _____	
Annual (monthly) Subtotal +	\$ _____ *	TOTAL OUTSTANDING LIABILITIES
TOTAL YEARLY EXPENSES	\$ _____	\$ _____

Term Life Insurance

Term Life insurance provides a source of funds to assist you in meeting financial responsibilities in the event of your death. It may be used to ensure the repayment of a loan or mortgage for yourself or your family. It can cover your children's college tuition or provide a source of income for your dependents.

EMPLOYER PROVIDED

The following schedule lists the breakdown of your Employer Provided Term Life insurance benefit.

If your annual salary is:	less than \$10,000	\$15,000
	\$10,000 to \$15,000	20,000
	\$15,000 to \$20,000	25,000
	\$20,000 and over	30,000

All levels of coverage will reduce to 65% of the original amount at age 70, 45% at age 75 and 30% at age 80. **Term Life coverage will cease at retirement or termination.** Coverage is effective 30 days from the date of full time hire.

EMPLOYEE BUY UP OPTIONS

OPTION II

**Additional 1 x Employer
Provided Amount**

OPTION III

**Additional 2 x Employer
Provided Amount**

If you elect to purchase additional Term Life Insurance you may be required to provide evidence of insurability. The cost to elect this coverage is shown on the attached rate sheet. **The maximum allowable amount of coverage (Employer Provided + Optional) is \$90,000.** The first \$50,000 of coverage can be paid with pretax dollars. With amounts in excess of \$50,000, the Internal Revenue Service requires taxation on a portion of your premium.

Accidental Death and Dismemberment

Accidental Death and Dismemberment (AD&D) insurance pays an additional death benefit above any Employer Provided or Optional Term Life insurance coverage in the event of your death or dismemberment that results from an accident.

EMPLOYER PROVIDED

Same as Term Life insurance section

EMPLOYEE OPTIONS

Same as Term Life insurance section

To determine the amount of life insurance that you need, take the numbers on the previous page and fill in the blanks below. The amount shown on the third line will tell you how much life insurance that you should have.

Annual expenses..... \$ _____
Outstanding liabilities..... +\$ _____
Amount of life insurance needed..... = \$ _____

Long-Term Disability

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable certificates and riders.

Long-Term Disability (LTD) benefits provide income if you are unable to work for a prolonged period due to illness or injury.

Disability benefits are available if you are disabled from your own occupation for 2 years and from any occupation (taking into consideration education and experience) until retirement.

LTD benefits are coordinated with other benefits such as Social Security, Worker's Compensation, and the MPSERS Pension.

Once approved, the LTD benefit coordinates with your Short Term Disability benefits. The LTD will begin after 90 days of disability. The LTD benefit is payable while you are proven disabled from performing your own occupation, and can continue for up to 2 years. Thereafter, it can be continued until retirement age if you are deemed disabled from any occupation. The carrier has the right to request information of substantiation at any time. Please refer to your LTD plan Summary Plan Description for full plan details.

EMPLOYER PROVIDED - OPTION I 66b% Percent of Monthly Salary up to Maximum Monthly Benefit of \$6,000

The payments, which begin after the receipt of any wage continuation benefits available, replace **66b%** of your base monthly salary. The minimum benefit is the greater of **\$100** or **10%** of your gross income. The maximum benefit is **\$6,000** per month. Coverage is effective 90 days following your date of hire.

EMPLOYEE BUY UP OPTION - OPTION II 70% Percent of Monthly Salary up to Maximum Monthly Benefit of \$6,000

If you wish to protect more of your income, you may elect to purchase additional Long-Term Disability coverage. This increases the percentage of your monthly income that would be replaced in the event of a disability. Deductions for this benefit will be on a **pre-tax basis**.

LONG-TERM DISABILITY WORKSHEET

In order to determine your disability income needs, follow steps 1-3.

Step 1	\$ _____ X (Monthly base salary)	66b% (Option I Benefit)	=	\$ _____ (Gross monthly disability payment)
Step 2	\$ _____ -- (Gross monthly disability payment)	\$ _____ (66b% Monthly Tax Liability) (Fed. + state + local taxes) (Listed on paystub)	=	\$ _____ (Net monthly disability payment)
Step 3	\$ _____ -- (Net monthly disability payment)	\$ _____ (Total Monthly expense) (Listed on the Liability worksheet)	=	\$ _____ X

If X is a positive number, then you already have enough disability coverage.

If X is a negative number, then you should consider purchasing additional coverage unless you have additional income from other sources to cover the deficit.

Dental Insurance

The schedule below provides a comparison and explanation of all dental options available. Each employee must elect one option only. Should you elect a coverage with a cash rebate, that rebate will be returned in equal installments over the annual pay schedule. You may spend your rebated dollars on other coverage elsewhere in the menu. Dependent coverage is available with either dental option at no additional cost.

	<u>Option I</u>	<u>Option II</u>	<u>Option III</u>
Deductible Up front payment by employee	0	0	-
Coinsurance Basic Services: Visits, examinations, x-ray, pathology, oral surgery, anesthesia, periodontics, endodontics, amalgam and synthetic restorations, and space maintainers are covered at this percentage of reasonable charges.	95%	50%	-
Major Services: Inlays, crowns and prosthodontics are covered at this percentage of reasonable charges.	95%	50%	-
Orthodontic Services are covered at this percentage of reasonable charges.	50%	50%	-
Annual Maximum Each member is entitled to maximum benefits of this amount every contract year.	\$1400	\$1200	-
Orthodontic Lifetime Each member has a lifetime maximum of this amount available for orthodontic services.	\$1200	\$1000	-
Cash Rebate	0	\$75	\$150

Coverage becomes effective the first of the month following your date of hire.

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable certificates and riders.

Vision Care Program

Vision problems rank third behind heart attacks and arthritis in the United States in limiting worker productivity. With this realization and the growing need for preventive and maintenance types of health coverage, your vision care program has been developed and specially designed to assist in the purchase of corrective lenses and eyeglass frames.

The following covered services are payable subject to the applicable benefit maximums:

Combined: vision exam, with frames/lenses or contact lenses \$390.00

The above benefits are payable once during the annual benefit determination period.

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable certificates and riders.

Medical Insurance - At A Glance

The schedule below provides a "comparison-at-a-glance" of all medical options. Detailed explanations of coverage are outlined on the following pages. Please refer to the detailed explanations before making your selection. Each employee must elect one option only. Should you elect a coverage with a cash rebate, that rebate will be returned in equal installments over the annual pay schedule. You may spend your rebated dollars on other coverage elsewhere in the menu. Employees who wish to opt out of coverage must provide proof of insurance elsewhere, during enrollment.

BENEFIT	OPTION I	OPTION II *	OPTION III
CARRIER:	BCBSM Community Blue Plan	HMO: Blue Care Network	No Coverage
COVERAGE DESCRIPTION:	(Page 9 - 11)	(Page 12- 13)	(Page 14)
DEDUCTIBLE:	Out of Network only \$250 Individual \$500 Family	Refer to page 12 - 13 No out of network benefits, unless certain situations apply.	-
COPAYMENT:	<u>In Network</u> Office visit \$10 Emergency Room \$50 \$50	<u>Out of Network</u> Deductible and Emergency Room	Varies (Page 12 - 13)
MAXIMUM OUT - OF POCKET:	<u>In Network</u> Not Applicable	<u>Out of Network</u> \$2000 Individual \$4000 Family	Varies (Page 12 - 13)
DRUG PLAN:	Yes (Page 15)	Yes (HMO pg 12 - 13)	-
CASH REBATE:	None	None	\$3,500

* May require a co-premium.

Preferred Provider Organizations (Option I)

BCBSM COMMUNITY BLUE PPO

Community Blue PPO is an alternative health care plan that combines the plan design of an HMO with the flexibility of a traditional plan.

In-Network, most benefits are covered with a \$10 copay or payable at the applicable coinsurance level indicated below of the reasonable and customary charges, after your deductible has been satisfied. Other covered services from network providers, such as mammography, pre-natal and post-natal care by a physician, and voluntary sterilization, do not require deductibles or copayments. Members can use non-network providers for these services, but they're required to pay the deductibles and copayments

There are **no** claim forms to complete when you use the In-Network participating doctors. In addition, participating doctors agree not to charge members any more than what Blue Cross Blue Shield pays for services, less any deductible and co-payment.

For the most up to date listing of participating doctors available please go to the Blue Cross Blue Shield of Michigan's website www.bcbsm.com . If you have questions regarding BCBS coverage, or need to check on the status of a claim, the toll-free number for **BCBS of Michigan** is 1-800-482-3606.

This plan also provides **Preventive Care Services** if you use a Blue Cross Blue Shield participating doctor. Preventive Services are covered to a maximum of \$500.00 per member for any combination of service. Refer to the applicable section for the actual covered preventive services.

Community BlueSM PPO

Benefits-at-a-Glance Plan 1

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

In-Network

Out-of-Network

Preventive Care Services – *Payment for preventive services is limited to a combined maximum of \$500 per member per calendar year

Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological Exam	Covered – 100%*, one per calendar year	Not covered
Pap Smear Screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-Baby and Child Care	Covered – 100%* •6 visits, birth through 12 months •6 visits, 13 months through 23 months •2 visits, 24 months through 35 months •2 visits, 36 months through 47 months •1 visit per birth year, 48 months through age 15	Not covered
Immunizations	Covered – 100%*, up through age 16	Not covered
Fecal Occult Blood Screening	Covered – 100%*, one per calendar year	Not covered
Flexible Sigmoidoscopy Exam	Covered – 100%*, one per calendar year	Not covered
Prostate Specific Antigen (PSA) Screening	Covered – 100%*, one per calendar year	Not covered

Mammography

Mammography Screening	Covered – 100%	Covered – 80% after deductible
One per calendar year, no age restrictions		

Physician Office Services

Office Visits	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary
Office Consultations	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary
Urgent Care Visits	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary

Emergency Medical Care

Hospital Emergency Room	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury
Ambulance Services – medically necessary	Covered – 100%	Covered – 100%

Diagnostic Services

Laboratory and Pathology Services	Covered – 100%	Covered – 80% after deductible
Diagnostic Tests and X-rays	Covered – 100%	Covered – 80% after deductible
Therapeutic Radiology	Covered – 100%	Covered – 80% after deductible

Maternity Services Provided by a Physician

Prenatal and Postnatal Care	Covered – 100%	Covered – 80% after deductible
Includes care provided by a certified nurse midwife		
Delivery and Nursery Care	Covered – 100%	Covered – 80% after deductible
Includes delivery provided by a certified nurse midwife		

Hospital Care

Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies Note: Nonemergency services must be rendered in a participating hospital	Covered – 100%	Covered – 80% after deductible
Unlimited days		
Inpatient Consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%	Covered – 100%
Up to 120 days per calendar year		
Hospice Care	Covered – 100%	Covered – 100%
Limited to dollar maximum which is adjusted periodically		
Home Health Care	Covered – 100%	Covered – 100%
Unlimited visits		

In-Network

Out-of-Network

Surgical Services

Surgery – includes related surgical services	Covered – 100%	Covered – 80% after deductible
Voluntary Sterilization	Covered – 100%	Covered – 80% after deductible

Human Organ Transplants

Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered – 100%	Covered – in designated facilities only
Up to \$1 million maximum per transplant type		
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	Covered – 100%	Covered – 80% after deductible
Kidney, Cornea and Skin	Covered – 100%	Covered – 80% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	Covered – 50%	Covered – 50% after deductible
	Unlimited days	
Inpatient Substance Abuse Treatment	Covered – 50%	Covered – 50% after deductible
	Unlimited days, up to \$15,000 annual, \$30,000 lifetime maximum	
Outpatient Mental Health Care •Facility and Clinic •Physician’s Office	Covered – 50%	Covered – 50%
	Covered – 50%	Covered – 50% after deductible
Outpatient Substance Abuse Treatment – in approved facilities	Covered – 50%	Covered – 50%
	Up to the state-dollar amount which is adjusted annually	

Other Services

Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy Testing and Therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic Spinal Manipulation	Covered – 100%	Covered – 80% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy •Facility and Clinic •Physician’s Office – excludes speech and occupational therapy	Covered – 100%	Covered – 100%
	Covered – 100%	Covered – 80% after deductible
	A combined 60-visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician’s office	
Durable Medical Equipment	Covered – 100%	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%	Covered – 100%
Private Duty Nursing	Covered – 50%	Covered – 50%
Prescription Drugs	See Rx page	See Rx page

Deductible, Copays and Dollar Maximums

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

Deductible	None	\$250 per member, \$500 family per calendar year
Copays •Fixed Dollar Copays •Percent Copays	\$10 for office visits and \$50 for emergency room visits	\$50 for emergency room visits
	50% for mental health care, substance abuse treatment and private duty nursing	20% for general services and 50% for mental health care, substance abuse treatment and private duty nursing Note: Services without a network are covered at the in-network level.
Copay Dollar Maximums •Fixed Dollar Copays •Percent Copays – excludes mental health care, substance abuse treatment and private duty nursing copays	None	None
	Not applicable	\$2,000 per member, \$4,000 per family per calendar year
Dollar Maximums	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted above for individual services	

Health Maintenance Organizations (Option II)

A Health Maintenance Organization is a program for providing comprehensive health care for members and their families. Most services are pre-paid, however, certain care may require a co-payment. There are no claim forms. All HMOs require that their members receive their health care services from contracted HMO centers and physicians. Any services in or out of the hospital not performed, prescribed, arranged or authorized by a BNC Physician, are not covered.



Blue Care Network Benefits-at-a-Glance Washtenaw Intermediate School District

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

Preventive Services

Health Maintenance Exam	Covered – \$10 copay
Annual Gynecological Exam	Covered – \$10 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$0 copay for well child visits through age 6 Over age 6, \$10 copay per visit
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – Office visit copay may apply per member per visit

Mammography

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

Office Visits	Covered – \$10 copay
Consulting Specialist Care – when referred	Covered – \$10 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – \$25 copay
Urgent Care Center	Covered – \$10 copay
Ambulance Services – medically necessary	Covered – 100%, ground and air services

Diagnostic Services

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

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$10 copay first initial visit only; thereafter, no copay
Delivery and Nursery Care	Covered – 100%

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%
Outpatient Surgery – see member certificate for specific surgical copay	Covered – 100%

Health Maintenance Organizations (Option II) Continued

Alternatives to Hospital Care

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

Surgical Services

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

Mental Health Care and Substance Abuse Treatment

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

Other Services

Allergy Testing and Therapy	Covered – Office visit copay may apply per member per visit
Chiropractic Spinal Manipulation – when referred	Covered – \$10 copay
Outpatient Physical, Speech and Occupational Therapy	Covered – 100%, limited to 60 consecutive days per episode per year for a combination of therapies; subject to significant improvement within 60 days
Infertility (excluding In-vitro fertilization)	Covered – 50% for consultation, diagnostic testing and treatment when authorized by BCN
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%
Weight Reduction Procedures	Covered – \$1,000 copay on all associated costs
Elective First Trimester Termination	Covered – 100%, one procedure every 24 months
Hearing Aid	One hearing exam and one hearing aid prescription every 36 months. Office visit copay may apply.
Prescription Drugs	Covered – \$15 generic, \$50 brand. Closed Formulary. Mail order covered 2x copay, 90 day supply

Deductible, Copays and Dollar Maximums

Deductible	None
Copays	
• Fixed Dollar Copay	\$10 for office visits, \$15 for outpatient mental health and outpatient substance abuse; \$10 for urgent care visits, \$25 for emergency room visits, and \$1,000 for weight reduction procedures
• Percent Copay	50% for infertility services
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Copay	None

The Women's Health and Cancer Rights Act of 1998

RIGHTS TO CERTAIN COVERAGE FOLLOWING A MASTECTOMY:

The Women's Health and Cancer Rights Act of 1998 (also known as Janet's Law) requires that Plan coverage for mastectomy expenses also included charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Option III

NO MEDICAL COVERAGE

In order to select this option you **must** provide proof of other medical coverage at enrollment. You will be required to complete and sign a form verifying information regarding the medical insurance provided to you elsewhere.

Prescription Drug Program (BCBSM PPO plans only)

Under the Blue Cross and Blue Shield of Michigan Prescription Drug Program, the member simply presents the Blue Cross and Blue Shield ID Card and pays a **\$10.00 Generic or \$60.00 Brand Name** copayment to the participating pharmacy (or doctor) to have the prescription filled. There is a 50% copay for Lifestyle drugs.

What is a prescription drug?

- Prescription Legend Drug - which by law must be labeled: "Caution: Federal Law prohibits dispensing without prescription."
- Injectable Insulin - which does *not* require a prescription order.

Are there any special provisions?

- There must have been a charge of over \$10.00 for the drug. Free samples would not be covered.
- Up to a 34-day supply (or more with some maintenance drugs) may be dispensed at a time.
- Up to a 90-day supply, or the normal quantity, with needles, syringes and insulin, may be dispensed at a time for mail order fillings. (One copay is required of 2x the regular copayment).
- Refills in excess of the number specified by the physician or refills dispensed after one year from the physician's order would not be covered.
- Charges for drug administration are not covered.

What is excluded?

- Therapeutic devices and appliances.
- Drugs and medicines that are covered under the Basic Blue Cross and Blue Shield of Michigan certificates.

Where can prescriptions be obtained?

- From participating pharmacies or physicians legally licensed to dispense drugs. The member pays the \$10.00 Generic/\$60.00 Brand copayment and the Plan pays the balance of the drug charge directly to the provider.
- From nonparticipating pharmacies and physicians legally licensed to dispense drugs. The member pays the full cost of the drug and the Plan reimburses the member 75% of the reasonable charge - less the \$10.00 Generic/\$60.00 Brand copayment.
- From out-of-Michigan pharmacies or physicians legally licensed to dispense drugs. The member pays the full cost of the drug and the Plan reimburses the member 100% of the reasonable charge - less the \$10.00 Generic/\$60.00 Brand copayment.
- From Merck-Medco Rx Service, Inc. The member remits the specific paperwork (contained in their mail order packet) and applicable copay (**2x copay for 90 day supply**) via mail. The Plan pays the remainder of the drug charge. The web site address for Merck-Medco is www.medcohealth.com
- General questions regarding mail service program: **1-800-903-8346** Monday through Friday 8am to midnight eastern time; Saturday 8am to 6pm eastern time.
- For refills through the mail service program, please call **1-800-4REFILL (1-800-473-3455.)**

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable certificates and riders.

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Employee Reimbursement Account

One of the most attractive features of the Flexible Compensation Program is your Employee Reimbursement Account. It enables you to pay a portion of your uninsured Health Care and Dependent Care expenses with pretax dollars. This can save you a considerable amount in taxes.

The Employee Reimbursement Account has two parts: one for Uninsured Health Care expenses and one for Dependent Care expenses. Just before the beginning of each plan year, you will have the opportunity to elect to fund your Reimbursement Account for the coming year. The amount that you select will be deducted from your gross salary through automatic payroll deductions. Then, during the plan year, you may submit claims to the Administrator to reimburse yourself for Dependent Care expenses and/or Health Care expenses incurred during the plan year that were not reimbursed by your insurance plans.

FSA ADMINISTRATOR

The Administrator of your Employee Reimbursement Account is **Employee Benefit Concepts, Inc. (EBC)**.

During the year, you should keep receipts for all qualified expenses. To receive reimbursements, just fill out a Claim form, attach your receipts, and submit them to the FSA Plan Administrator, Employee Benefit Concepts. You may submit claims anytime. Reimbursement checks are run on a weekly basis.

- **For the Un-reimbursed Medical portion of the plan**, you can incur claims through the "Expense Period". The Expense Period is the 12 month plan year, of 1/1 to 12/31, plus an additional 2 ½ months after the plan year end (3/15).
- **For the entire Employee Reimbursement Account**, the final check run is 90 days after the plan year end (3/15), otherwise any remaining balance in the account will be forfeited.

EBC's mailing address is:

28800 Orchard Lake Road, Suite 210
Farmington Hills, MI 48334

EBC= phone and facsimile numbers are:

248-855-8040
1-800-355-8040 (outside of 248 area code only)
248-855-2454 (fax)

EBC=s Web site:

www.myflexonline.com

Claim forms are located on the website, or you may contact your Human Resources Department.

Please keep these important considerations in mind:

1. **The Internal Revenue Service (IRS) requires that any money left in your account at the end of the Plan Year must be forfeited.** This means you should allocate only as much to the Account as you feel certain you will incur in reimbursable expenses during the year. All expenses must be incurred prior to the end of the plan year (December 31st) All expenses incurred during a plan year must be submitted for reimbursement by November 15th. Otherwise, any money left in the Account will be forfeited. In the unlikely event of a forfeiture, there may still be substantial tax savings to the employee. For example, assume an employee contributes \$2,400 to the plan, but only incurs \$2,000 of expenses. The \$2,000 of expenses are reimbursed tax free and the unused \$400, in this case, would be forfeited. An employee in the 30% tax bracket (combined Federal, State, FICA) saves \$720 in taxes on the \$2,400 set aside ($\$2,400 \times 30\% = \720). If you subtract the \$400 loss attributable to the forfeiture from the \$720 tax savings, the employee still comes out \$320 ahead.
2. If you elect to participate, the amount you designate will be withheld automatically from your paycheck in equal installments. The minimum contribution to the Account is \$5 per month.
3. The annual re-enrollment period is the only time you may change your selections unless you have a change in "family status". Qualifying "status changes" for benefits provided under this plan are subject to approval of your employer, must be on account of a particular event, and satisfy any specific consistency rules that may apply to the particular benefit. Please reference your summary plan description for a detailed list of qualified status changes. Examples include:
 - ▶ Change in your legal marital status, on account of marriage, divorce, death of your spouse, legal separation or annulment;
 - ▶ Change in the number of your dependents, due to birth, adoption, placement for adoption, or death of a dependent;
 - ▶ Change in employment status for you, your spouse, or a dependent;
 - ▶ Change because your dependent satisfies (or ceases to satisfy) the eligibility requirements;
 - ▶ Significant cost increases in a qualifying benefit (other than Uninsured Health Care accounts);
 - ▶ A change in coverage in a spouse's or dependent's Section 125 Plan;
 - ▶ A leave under the Family Medical Leave Act;**It is very important for you to understand that you must notify Human Resources within 30 days of a "status change" in order to be allowed to select different benefit options. This includes adding dependent coverage. If you have a status change, the new coverage becomes effective as of the date you notify Human Resources of the change or, if administratively possible, the date of the status change. It will always be to your best advantage to notify Human Resources as soon as possible.**
4. Although you have only one Reimbursement Account, the Uninsured Health Care portion and Dependent Care portion are entirely separate. Only Uninsured Health Care expenses may be reimbursed from the Uninsured Health Care portion; only Dependent Care expenses may be reimbursed from the Dependent Care portion. Once a given portion is used up for the year, no more expenses may be reimbursed for that year. You cannot transfer funds from one portion of the Account to the other.
5. The Dependent Care portion of the Account cannot reimburse you for more money than has been deposited on to it by the date you make a claim. Remember, your contributions are deducted each pay, so funds build up gradually in your Dependent Care Reimbursement Account. If you do submit a claim for more than the amount in your Account at that time, any excess will be held for reimbursement until sufficient funds have accumulated.
6. If you should terminate employment during the plan year, you will have 45 days from your date of termination to file for reimbursable expenses incurred during the period in which you were an eligible participant of the plan. In addition, you may continue in the Uninsured Health Care Reimbursement Account for the remainder of the plan year with proper contributions.
7. Keep in mind that the funds you contribute to your Reimbursement Account are deducted before taxes are withheld, so you have not paid any taxes on them. Therefore, any items submitted through your Employee Reimbursement Account cannot be used as either a tax credit or deduction.

NOTE: There is a worksheet following the Dependent Care section which is designed to help those employees with Dependent Care decide whether it is more beneficial to pay those expenses from their Reimbursement Account or take the income tax credit.

Uninsured Health Care Expenses

You may contribute up to **\$7,000** of your earned income per calendar year to the Health Care portion of the Account to reimburse yourself for expenses incurred by you or an eligible dependent during the plan year. Common examples include:

- Plan deductibles
- Medical, Dental and Vision expenses not reimbursed by your plan.

*Please note, an eligible expense must be a medically necessary expense incurred for diagnosis, cure, treatment, mitigation, or prevention of disease, or for the purpose of affecting any bodily function or structure. Drugs must be prescription drugs or insulin.

The following is a *representative* list of Health Care expenses allowable under the Internal Revenue Code:

Acupuncture.....	Performed by a licensed practitioner	Learning disability....	Tutoring by licensed school or therapist for a child with severe learning disabilities
Alcoholism or drug dependency.....	Payment to a treatment center	Lifetime care.....	Advance payment to private institution for lifetime care, treatment or training of mentally or physically handicapped patient
Ambulance	If medically necessary	Medicines.....	Prescribed and legally obtained drugs and medicines
Birth control pills....	Special controls for the handicapped	Nursing home.....	Confinement for treatment of illness or injury
Car controls.....	Services within the scope of license	Nursing service.....	By registered nurse or licensed practical nurse for medical care
Chiropractors.....	Balances not paid by other vision insurance	Optometrist.....	Services within scope of license
Contact lenses.....	Balances not paid by other health insurance	Over The Counter Medications (OTC)	<i>Please refer to EBC Web site for detailed list of items allowable.</i>
Copayments.....	For medically necessary procedures	Oxygen.....	If medically necessary
Cosmetic surgery.....	Purchase or rental	Psychologist.....	Services within scope of license
Crutches.....	Balances not paid by other health insurance	Psychotherapy.....	If by a licensed practitioner
Deductibles and coinsurance.....	X-rays, fillings, braces, extractions, false teeth, orthodontia services, treatments (non cosmetic procedures only), etc.	Schools.....	Special schooling to relieve handicap
Dental fees.....	<i>Cosmetic teeth whitening is not reimbursable.</i>	Smoke ender programs.....	If prescribed by a doctor
Doctor's fees	Charges not paid by other health insurance	Surgery.....	Including experimental and medically necessary cosmetic procedures
Excess charges.....	Lenses, frames, examinations	Syringes, needles, and injections	Special for the deaf
Eyeglasses.....	RK Surgery	Telephone.....	Audio display equipment for the deaf
Eye Care.....	Monthly or lump sum fee to a retirement home (covers portion specifically for medical care)	Television.....	Physical or occupational therapy by a licensed therapist
Founder's fee.....	Purchase, for blind or deaf	Therapy.....	Charges for medical care included in the tuition fee of a college or university (if billed separately)
Guide dog.....	Care to help individual adjust from life in a mental hospital to community living	Transplants	If medically necessary
Halfway house.....	Not of general use as articles of furniture, household items or appliances	Tuition fee.....	
Health care equipment.....	Including private room coverage	Wheelchairs.....	
Hearing aids	For treatment of illness		
Hospitalization.....			
Hypnosis.....			
Laboratory fees			

Note: *Currently, in order to receive a tax deduction for medical expenses on your tax return; expenses must exceed 7.5% of your adjusted gross income. Therefore, your Uninsured Health Care expense account provides you with the only opportunity to receive full credit for ALL medical expenses incurred regardless of income.*

Estimating Health Care Expenses For You and Your Family

(You should refer to the sections entitled "Medical/Dental Options" to help you accurately estimate your expenses.)

	Previous Year (Actual)	This Year (Expected)
Medical plan deductibles	\$ _____	\$ _____
Medical plan coinsurance (the percentage that your plan does not pay)	\$ _____	\$ _____
Dental or orthodontic expenses that are not covered by your plan	\$ _____	\$ _____
Vision care expenses that are not covered by your plan	\$ _____	\$ _____
Hearing aids	\$ _____	\$ _____
Medicine or drugs prescribed by a doctor but not covered by your plan	\$ _____	\$ _____
Other qualified expenses not paid by your plan	\$ _____	\$ _____
YOUR TOTAL HEALTH CARE EXPENSES:	\$ _____	\$ _____

Dependent Care Expenses

The Employee Reimbursement Account can be used to pay for Dependent Care expenses that enable you and your spouse to work or to search actively for work.

Reimbursement Limitations: A married employee may only be reimbursed for Dependent Care expenses up to the lesser of:

- a. **\$5,000 (\$2500 if married filing a separate return); or**
- b. 50% of the employee's compensation; or
- c. the earned income of the employee's spouse.

Therefore, a married employee whose spouse does not work is generally not entitled to Dependent Care assistance reimbursement. However, if the employee's spouse is a full-time student or incapable of caring for himself or herself then the employee will be allowed a limited benefit under the plan. The allowable limit of reimbursement for each month the spouse is a full-time student is \$200 if the employee has one dependent or \$400 if the employee has two or more. If the employee's spouse is incapacitated, the allowable limit is \$200 per month if the employee has one or more additional dependents.

An unmarried employee may be reimbursed for all Dependent Care expenses up to the lesser of:

- a. **\$5,000;** or
- b. 50% of the employee's compensation

For the purpose of Dependent Care expenses, a dependent includes anyone you claim as a dependent on your income tax return and who is:

Age 12 or younger, or

Physically or mentally incapable of caring for himself or herself (for example, a disabled spouse or an elderly parent). A person other than your spouse must rely on you for more than one-half of his or her support to qualify as a dependent.

Eligible Dependent Care expenses include:

Payments made for services provided in your home (babysitters, for example). These services cannot be provided by someone you claim as a dependent or someone who is a relative.

Payment made for dependent child care services outside your home. If you use the services of a dependent care center that provides care for at least six people (other than residents), the center must be in compliance with the state and local laws.

Payments made for care outside your home for a dependent (other than a child), if the dependent spends at least eight hours a day in your home. (For example, 24-hour nursing home care for a dependent parent would not qualify).

If you utilize a Dependent Care Reimbursement Account, you must furnish the name, address and tax identification (social security number or corporate tax ID) number for the provider of dependent care services to The FSA Plan Administrator, Employee Benefit Concepts.

Estimating Your Dependent Care Expenses

Previous Year

(Actual) \$ _____ x _____ = \$ _____
 weekly expense number of weeks annual total

This Year

(Expected) \$ _____ x _____ = \$ _____
 weekly expense number of weeks annual total* (B)

Total contributions to your Dependent Care Reimbursement Account (B) \$ _____

Divide by # pay periods for total deduction per paycheck \$ _____

Employee Reimbursement Account vs. Dependent Care Tax Credit

EMPLOYEE REIMBURSEMENT ACCOUNT

- A. Enter your gross adjusted annual pay (for you and your spouse, if applicable) before taxes. *Example* reflects Joint Return.
- B. Enter the estimated cost of dependent care for the upcoming year (maximum of \$5,000).
- C. To estimate the percentage you will save in current taxes, use the income tax table below. Select the percentage which fits you best.
- D. Enter the amount from line B.
- E. Multiply the expenses on line D by the percentage on line C to estimate tax savings by using the dependent care account.

YOU

EXAMPLE

(Reflects Joint return)

A _____ \$ 45,000
 B _____ \$ 3,000
 C _____ 25%
 D _____ \$ 3,000
 E _____ \$ 750

To determine the percentage for line C, do the following:

- 1) Enter total taxes due (use chart below) on line 1.
- 2) Enter your annual salary on line 2.
- 3) Divide line 1 by line 2 = answer is a percentage entered on line C above.

1) _____ ÷ 2) _____ = 3) _____
(TOTAL TAX DUE) (ANNUAL SALARY) (% ENTERED ON LINE C)

Estimated Federal, State Income Taxes and Social Security

Joint Return

0 - 12,000	21.65%		
12,000 - 47,450	\$ 2,598	+	26.65% of the amount over 12,000
47,450 - 114,650	\$ 12,045	+	38.65% of the amount over 47,450
114,650 - 174,700	\$ 38,018	+	41.65% of the amount over 114,650
174,700 - 311,950	\$ 63,029	+	46.65% of the amount over 174,700
311,950 -	\$127,056	+	50.25% of the amount over 311,950

Single

0 - 6,000	21.65%		
6,000 - 28,400	\$ 1,299	+	26.65% of the amount over 6,000
28,400 - 68,800	\$ 7,269	+	38.65% of the amount over 28,400
68,800 - 143,500	\$ 22,884	+	41.65% of the amount over 68,800
143,500 - 311,950	\$ 53,997	+	46.65% of the amount over 143,500
311,950 -	\$132,579	+	50.25% of the amount over 311,950

Head of Household

0 - 10,000	21.65%		
10,000 - 38,050	\$ 2,165	+	26.65% of the amount over 10,000
38,050 - 98,250	\$ 9,640	+	38.65% of the amount over 38,050
98,250 - 159,100	\$ 32,907	+	41.65% of the amount over 98,250
159,100 - 311,950	\$ 58,251	+	46.65% of the amount over 159,100
311,950 -	\$ 129,556	+	50.25% of the amount over 311,950

Important Note:

This table is created for your general use only in filling out this worksheet. It is intended for illustrative purposes only and should not be construed as tax advice. Your specific circumstances may change the actual amount of taxes that you may pay. It is recommended that you consult your tax advisor to discuss your specific situation. These tables represent a blended tax rate combining Federal and State income tax, Medicare and Social Security taxes, each of which is based on different taxable income deductions. For tax returns and dependent care accounts you will have to identify (name and address) and provide Social Security numbers of individuals providing dependent care services. Failure to provide such information will result in disallowance of credit unless reasonable cause is shown for the omission.

DEPENDENT CARE FEDERAL TAX CREDIT

- F. Enter your dependent care expenses again on line F, up to \$3,000 for one child / up to a maximum of \$6,000 for two or more children.
- G. Based on the total adjusted gross annual income of you and your spouse, if applicable, (adjusted gross income is calculated after all the adjustments listed on the first page of your tax return), select the appropriate tax credit from the table below and enter that percentage on line G.
- H. Multiply line F by the percentage on line G to estimate your federal dependent care income tax credit.

F _____ \$ 3,000
 G _____ \$ 20%
 H _____ \$ 600

Total Adjusted Gross Annual Income	Tax Credit	Total Adjusted Gross Annual Income	Tax Credit	Total Adjusted Gross Annual Income	Tax Credit
Up to \$15,000	35%	25,001 to 27,000	29%	37,001 to 39,000	23%
15,001 to 17,000	34%	27,001 to 29,000	28%	39,001 to 41,000	22%
17,001 to 19,000	33%	29,001 to 31,000	27%	41,001 to 43,000	21%
19,001 to 21,000	32%	31,001 to 33,000	26%	43,001 to 45,000	20%
21,001 to 23,000	31%	33,001 to 35,000	25%	45,001 and up	20%
23,001 to 25,000	30%	35,001 to 37,000	24%		

Making Your Decision

Compare line (E) to line (H). If the tax savings on line (E) is greater than the Dependent Care Federal Tax Credit on line (H), you should contribute the amount shown on line (D) to the Employee Reimbursement Account for Dependent Care. If the Dependent Care Federal Tax Credit on line (H) is greater than the tax savings on line (E), then you should not enroll in the Employee Reimbursement Account for Dependent Care. The example on this worksheet shows that you would save more by using the Employee Reimbursement Account for Dependent Care. However, your situation might be different. Be sure to talk with a tax advisor if you have questions about your personal situation.

How To Avoid Potential Disadvantages Should You Fund Your Employee Reimbursement Account

Since contributions to your Employee Reimbursement Accounts are treated as a reduction in income, there will be a slight reduction in Worker's Compensation and Social Security disability, survivorship and retirement benefits. This potential disadvantage is easily overcome, if the employee invests part of his/her tax savings into either a 403(b) plan or 457 plan.

Typically, for every \$100 reduction in income for Social Security purposes, at age 40, an employee only has to invest \$5.00 out of \$22.00 in tax savings to have more benefits at retirement than the Social Security system would provide.

The amount of tax savings that have to be reinvested to make up for the lost Social Security or MPSERS benefit goes up the longer the employee is in the plan.

Making Your Selections

Once you have reviewed the Flexible Compensation Workbook, you can start planning your selections for coverage's and your Employee Reimbursement Account.

The first time you enroll in the Program, you may choose any of the benefit coverage levels offered. If you do not make any selections, you will be enrolled automatically in the Employer Provided Benefits. (There is no cost to you for this coverage).

Each year, you will have an opportunity to either reconfirm or change your selections during the annual enrollment process. Should any costs or levels of coverage be changed, the reenrollment period allows you to assess those changes as they pertain to your own personal situation. ***Therefore, it is in everyone's best interest to participate in the annual reenrollments to make certain that your benefit choices remain consistent with your objectives.***

Take the time to plan a customized package that will be best for you and your family. And do not forget that Marwil & Associates is available to help. Representatives will be happy to answer any questions you may have about the various plans that make up the Washtenaw Intermediate School District Flexible Compensation Program. They will also be available to assist you during the enrollment process. The number to call is:

1-(877)-681-1525

NOTE: ***Payment of any benefits is subject to the terms and conditions of the plan document rather than any information given here. This description does not change in any way the provisions set forth in the plan document.***

Notes
