



2010

Benefits Guide



Introduction



It's time for our Annual Open Enrollment. Any changes you make will be effective July 1, 2010, and continue until June 30, 2011.

MJ Management continues to be committed to offering our eligible employees and their family members comprehensive, affordable health care coverage. We, like most other employers, are struggling to deal with the increasing cost of healthcare. We've all read about this in the news and the problem is real. The cost of healthcare continues to rise at a much higher rate than inflation.

Please be sure to read the Open Enrollment Newsletter in its entirety. It contains important information on your benefits to help you make informed decisions regarding your health care participation for the 2010-2011 plan year.

Open Enrollment Process—What Do I Need To Do?

1. Read this booklet carefully. Familiarize yourself with each benefit plan option.
2. Review your current benefit elections.
3. Consider your health care needs. Think about the health care needs that you can anticipate for yourself and your covered family members in the coming year.
4. Determine how much to contribute to your Flexible Spending Account.
5. Ask Questions. If you have questions about your benefit plan options please contact Jenny Serbantez at (734) 675-5505.
6. Finalize your elections. **Please return all completed enrollment forms by June 18th.**

Important Dates to Remember

June 1-30, 2010– Open Enrollment

June 18, 2010- Enrollment Forms Due

July 1, 2010– Benefit Effective Date

Family Status Changes



Once your enrollment elections have been submitted you will not be permitted to change your benefit elections unless you experience a qualified change in family status. Family status changes include:

- Change in marital status (marriage/divorce)
- Birth, adoption or legal guardianship of a child
- Death of a spouse or dependent
- Termination of your spouse's employment
- Switch from full-time to part-time employment
- Begin or return from an unpaid leave of absence
- Change in dependent eligibility

You must report any family status change to MJ Management within **30 calendar days** of the date of the event. Otherwise, you will be required to wait until the next open enrollment period to add or remove any qualified dependents.

Eligibility

Who is eligible for benefits coverage with MJ Management?

For the purpose of health, dental, and vision benefits, "full-time" is defined as employees working at least 40 hours per week. "Part-time" employees may purchase benefits at cost.

Opt-Out Bonus

MJ Management will pay an "opt-out" bonus to employees who choose to opt-out of medical, dental and vision. The opt-out program allows employees to waive coverage and receive \$1,000 per year (\$500 paid on December 15th and \$500 paid on June 30th).

Medical Plan Options



MJ Management offers a PPO medical plan to its employees. With a PPO plan, you have complete freedom to see any doctor of your choice. If you choose doctors and hospitals within the BCBS PPO network, your out-of-pocket costs are lower than if you use other providers.

BCBS utilizes the Blue Cross Blue Shield PPO network of doctors and hospitals. This is the largest national network of hospitals and primary and specialty care physicians.

A high level comparison of the plan features has been provided for your review.

BCBSM Community Blue PPO Plan 12		
	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE		
Single	\$1,000	\$2,000
Family	\$2,000	\$4,000
Co-Insurance	80%	60%
CALENDAR YEAR OUT-OF- POCKET MAXIMUM (Deductibles not included):		
Single	\$3,500	\$5,000
Family	\$7,000	\$10,000
Lifetime Maximum Benefit	\$5,000,000	
PHYSICIAN OFFICE SERVICES		
Office Visit (Illness/Injury Related)	\$30 co-pay	60% after deductible
Preventive (Well Care) Services*	100%	Not Covered
EMERGENCY MEDICAL CARE		
ER Co-pay**	\$50	\$50
Urgent Care Visits <i>Must be medically necessary</i>	\$30 co-pay	60% after deductible
PRESCRIPTION DRUGS		
Generic Co-Pay	\$10	75%, less plan co-pay
Brand Name Co-Pay	\$40	75%, less plan co-pay
Mail Order Drug Program	2x retail co-pay for a 90-day supply	N/A

* \$500 per person maximum per year.

**Waived if admitted or for an accidental injury

Dental Benefits



MJ Management offers a dental plan through The Guardian.

Highlights of the in-network benefits are as follows:

Annual Deductible	None
Class I Services - Preventive & Diagnostic	Covered at 100%
Class II Services - Basic Restorative	Covered at 75%
Class III Services - Major Restorative	Covered at 50%
Class IV Services - Orthodontics	Covered at 50%. \$1,000 per member lifetime max
Benefit Year Maximum (based on calendar year)	\$1,000 per member per year for covered Class I, II, and III services

Vision Benefits

MJ Management offers a vision plan which is administered through Blue Cross Blue Shield of Michigan, utilizing the Vision Service Plan (VSP) network, the largest provider of vision care in the nation. Under this plan, you can receive services from one of VSP's over 23,000 member doctor locations or a non-participating provider.

Covered Services Include:

- Internal and external eye exams
- Glaucoma testing
- Cost and fitting for either frames or contact lenses

With a VSP Participating Provider, you receive:

- Lower out-of-pocket expenses
- No claims to file
- 100% coverage for eye exams after \$5 co-pay
- 100% coverage for lenses/frames to the allowed amount after \$10 co-pay

Frequency: Optical benefits for exams, lenses, and frames are payable once every 12 months.

Flexible Spending Accounts



The Flexible Spending Accounts (FSA) for the medical and dependent reimbursement plans will continue to be available to all eligible Marshall Academy employees. The FSAs allow you to pay for certain health care expenses (e.g., deductibles, co-pays and prescription drug co-pays and dependent day care expenses) with tax-free dollars. One of the easiest ways to estimate your out-of-pocket health care expenses and day care expenses is to base it upon expenses you incurred in the 2009-2010 plan year.

The IRS requires you to re-enroll in the FSA accounts each year. If you are not enrolled, this is the time to consider the importance of this money saving, pre-tax benefit option. The 2010-2011 maximum FSA pre-tax annual deduction limits are \$3,000 for health care expenses and \$5,000 for dependent care expenses.

Eligible Healthcare Expenses

- Deductibles, co-pays, doctor's office, clinic visits
- Routine physical exams
- Mental health / substance abuse services
- Vision care (glasses and contacts)
- Dental expenses
- Prescription / over-the-counter medications

Eligible Dependent Care Expenses

- Child care (licensed daycare / preschool)
- Before/after school care
- Day camps
- Transportation

* Please note that starting in January 2011, healthcare FSA accounts will no longer reimburse for over-the-counter medicine (except insulin) unless it is prescribed by a physician. Regular prescribed medications can still be run through your FSA, as well as all other previously eligible medical expenses.

Additional Benefits

MJ Management offers the following benefits to all Marshall Academy employees:

- **Basic Life/AD&D**
- **Disability Income**

Your Rights Under Federal Law



Special Enrollment Events/Changes in Family Status

If you decline coverage for yourself and/or your dependents (including your spouse) now because you are covered by another health insurance plan, you may be able to enroll yourself or your dependents in this plan in the future. If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the event. These events are referred to as changes in "family status." In addition, if you were to lose coverage, you must request enrollment within 30 days after the coverage ends and if the event qualifies as a "family status" change. When you become enrolled as the result of a Special Enrollment Event, coverage will be made effective on the date of the event.

Women's Health and Cancer Rights Act of 1998 - Annual Notice

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
- ◆ Prosthesis 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 - Annual Notice

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 and your physician agrees that is safe to do so.

Michelle's Law - For plans renewing on or after October 9, 2009

Michelle's Law requires group health plans to continue coverage for up to one year for seriously ill or injured college students who leave school due to a medically necessary leave of absence. The child's treating physician must provide to the plan a written certification that states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

Medicaid /CHIP Special Enrollment Period - Effective April 1, 2009

If you or a dependent is covered under a Medicaid or a State child health medical plan (CHIP) plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s). However, you must request enrollment within 60 days after the date eligibility is lost.

Finally, if you or a dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, you may be able to enroll yourself and/or your dependent(s). However, you must request enrollment within 60 days after you or your dependent is determined to be eligible for State premium assistance. Please note that premium assistance is not available in all states.

GINA

The Genetic Information Nondiscrimination Act of 2008 (P.L. 110-233, 122 Stat. 881), also referred to as GINA, is a new Federal law that prohibits discrimination in the health coverage and employment based on genetic information. The President signed the act into law on May 21, 2008.

YOUR Benefit RESOURCES



Medical	BCBSM-PPO www.bcbsm.com (800) 637-2227	
Prescription	Medco www.medcohealth.com (800) 903-8346	
Dental	Guardian www.glic.com (800) 541-7846	
Vision	BCBSM (VSP) www.vsp.com (800) 877-7195	
Life/Disability	Guardian www.glic.com (800) 541-7846	
Flexible Spending Account	AFLAC www.aflac.com (800) 992-3522	

This guide summarize certain features of the company's benefits plans. Full details of the plans can be found in the official plan documents, the official plan documents will govern. The company reserves the right to amend or terminate these benefits at any time. The information in this guide does not constitute a contract of employment. If you have any questions about the benefit plans described in this guide, please contact your Human Resources Representative.