FLEXIBLE BENEFITS PLAN

2012

KALAMAZOO VALLEY COMMUNITY COLLEGE

FLEXIBLE BENEFITS PROGRAM

Benefits At A Glance

Workbook

2012

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KALAMAZOO VALLEY COMMUNITY COLLEGE

"Benefits At A Glance 2012"

BENEFIT	CORE	
Medical Insurance	**Deductible: $175 individual** **$350 two person** **$400 family** **Co-pay:** 90% plan pays / 10% you pay **Prescriptions:** Generic Rx $10.00Copay / Brand Rx 80/20 Copay, with a minimum of $30, to a maximum of $50 **Vision coverage:** $225 Annual Maximum **Co-premium required**	OPT OUT **$3,500 cash rebate** *(Must provide proof of insurance coverage elsewhere)*

Co-premium required

Single	$1,584.00 annual	$132 per month	$66.00 per pay
Two Person	$ 3,144.00 annual	$262.00 per month	$131.00 per pay
Family	$4,248.00 annual	$354.00 per month	$177.00 per pay

BENEFIT	CORE	OPTION I	
Dental Insurance	100% Preventative 100% Minor Restorative 80% Major Restorative 60% Orthodontia Yearly max: $1100 Lifetime orthodontia max:$1000	60% Preventative 60% Minor Restorative 60% Major Restorative 60% Orthodontia Yearly max: $1100 Lifetime orthodontia max: $600 $75 cash rebate	OPT OUT $150 cash rebate
Long Term Disability Insurance	Max: 66 2/3% of earnings not to exceed $3,000/mo. Min: the greater of $100 or 10%	Employee can purchase Max: 70% of earnings not to exceed $5,000/mo. Min: the greater of $100 or 10%	
Term Life Accidental Death Insurance and Dismemberment	1 x Earnings	Employee can purchase an additional 1 X Earnings	Employee can purchase an additional 2 X Earnings

Dependent Care Reimbursement	Available
Uninsured Health Care Reimbursement	Available

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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. As a result, the Administration and Employee representatives of K.V.C.C. gathered together to create the **Kalamazoo Valley Community College Flexible Benefits Plan**.

The Flexible Benefits Plan is based on the concept that you are the best judge of your benefit needs. Therefore, the program provides you with a multiple coverage options, including 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 Benefits also provides you with an array of benefit alternatives 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 for them through the Flexible Benefits 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 Core benefits or purchase other benefits.

The opportunity to choose is accompanied by the responsibility of understanding your choices. This booklet provides general information about your Flexible Benefits Plan and the options that are available to you.
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 consultation since these are intended to assist you in making the proper benefit selections. Re-enrollment can only be held **once** each year so make sure that you are prepared.

For a detailed description of your benefits, ***please refer to the carrier's summary plan descriptions.***

Please note, the annual re-enrollment period is the only time you may change your selections unless you have a change in "family status". Qualifying "status change" for benefits provided under this plan are subject to approval by your employer and 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. It will always be to your best advantage to notify Human Resources as soon as possible. Human Resources must also be notified of dependent eligibility changes (i.e., marriage, graduation, insurance elsewhere, employment) within 30 days of the event.

PLAN OVERVIEW

Kalamazoo Valley Community College's Flexible Benefits Plan is made up of two components: The Core Program and Employee Options.

The Core Program - includes all the **current levels of coverage** offered by the college:

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

Employee Options - allow you to modify the Core Program, as you wish.
Included among your Employee Options are a number of different alternatives:

- No Medical Coverage in exchange for cash (you must provide proof of insurance coverage elsewhere to elect this option)
- Less Comprehensive Dental Coverage in exchange for cash
- No Dental Coverage in exchange for cash
- 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 Benefits menu, you will also have the opportunity to participate in other benefit programs through payroll deduction. Those programs include:

- Tax-Deferred Annuities
- Mutual Funds
- Permanent Life Insurance
- Michigan Education Savings Program

It is up to you to decide which of these employee options would best meet your needs.

ADMINISTRATOR

Marwil & Associates LLC is a Michigan-based TPA that specializes in the design, implementation and administration of pensions and employee benefits. Marwil & Associates will administer the entire Flexible Benefits Plan. Representatives are 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.

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	$_______	**TOTAL OUTSTANDING LIABILITIES**
Annual (monthly) Subtotal +	$_______ *	
TOTAL YEARLY EXPENSES	$_______	$_______

Core Medical Plan

The Core Medical Plan is separated into **two components**. Please note, **all benefits are based on medical necessity** (diagnosis related). The Core Plan Requires an employee co-premium.

The ***first component*** is the **Base Plan** which pays all covered benefits at 100% of reasonable and customary.

The ***second component*** is the **Major Medical Plan**. **All services are subject to the deductible and co-payment amounts up to the out-of-pocket maximum.**

Core Plan Deductible: **$175 Individual - $350 Two Person - $400 Family**
(Deductible does not apply toward the out-of-pocket maximum)

Coinsurance: **Plan pays 90%, you pay 10%** up to the out-of-pocket maximum of $1,000. (Per individual or family)
The Plan pays 100% of reasonable and customary thereafter.

Please refer to the carrier summary plan description for a detailed explanation of the covered benefits under the Core Plan.

Other Features

- Physicians Care Provider Network - www.physicianscare.com
- Medical services can be obtained from any licensed practitioner, but use of Physician Care Providers is encouraged.
- Annual Maximum $1,250,000.
- Maternity expenses are covered the same as illness expenses.
- Coverage for dependent child to age 26
- **All benefits are based on medical necessity** (diagnosis related)

Please note, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may effect the following Exclusion. Please contact Human Resource for details.

PRE-EXISTING CONDITION EXCLUSION

Definition: A condition for which diagnosis or treatment was recommended or received by a doctor within the three month period preceding an individual's effective date of coverage.

The plan will pay for the first $2,000 of incurred expenses relating to the pre-existing condition, subject to the plan provisions.

Items 1 and 3 below apply to all employees and all covered dependents, item 2 below applies to employees only. Expenses in excess of $2,000 will be payable only after meeting the following criteria:

1) If no treatment was provided for the pre-existing condition, during the first three consecutive months following an insured effective date of coverage, benefits in excess of $2,000 will be payable subject to the plan provisions.

2) If treatment was provided for the pre-existing condition, during the first three consecutive months of an insured effective date of coverage and the employee was actively at work and continuously insured for three consecutive months; at the completion of the six consecutive months from the effective date of an employee's coverage, the plan will pay benefits in excess of $2,000, subject to the plan provisions. This item applies to the KVCC employee only.

3) If treatment was provided for the pre-existing condition, during the first three consecutive months of an insured effective date of coverage, and the insured was not actively at work and continuously covered during the six consecutive months; at the completion of twelve consecutive months from the effective date of an employee's coverage, the plan will pay benefits in excess of $2,000 subject to the plan provisions.

The plan will not impose pre-existing condition exclusions or limitations on children of covered employees under the age of 19.

Cost Containment Features

The Core Medical Plan has several cost containment features. Each covered person is required to abide by the applicable cost containment provisions. **There is a 20% penalty for non-compliance with any of these requirements. Any payment required due to non-compliance will not count toward the out-of-pocket maximum. All of the cost containment features are listed on page 5.**

Cost Containment Features (Core)

The following cost containment features are included with your plan. If you follow the provisions under each feature, your benefits will be paid pursuant to the applicable plan provisions. A 20% penalty will be applicable for *non-compliance*. Any payment required due to non-compliance will not count toward the out-of-pocket maximum.

PRE-ADMISSION REVIEW PROGRAM

Pre-admission review is required for any non-emergency hospital admission.

If non-emergency admission is scheduled 2 weeks or more in advance, a pre-admission review form must be completed by your doctor. If a non-emergency admission is scheduled in less than 2 weeks, contact **Physicians Care Health Management at 800-638-0573 or 800-421-9037**. You can also refer to the number found on your ID card.

If there is an emergency admission to the hospital, the patient, patient's family member, Hospital or attending Physician must contact **Physicians Care Health Management** within **24 hours** of the first business day after the admission.

Core Medical Plan (Pre-admission Review Program as it applies to the Core Medical Plan)
By following Pre-admission Review requirements, all covered hospital medical expenses will be paid at 100%. However, if you do not comply with Pre-admission-Review requirements, a 20% penalty will be applied to all covered hospital medical expenses incurred.

The following cost containment features are also applicable to the Core Medical Plan.

SURGICAL NECESSITY REVIEW

Anytime a surgery is recommended, you should call **Physicians Care Health Management at 800-638-0573 or 800-421-9037**, for the required Pre-Admission Review and to find out if a second opinion is required.

When a second opinion is required, a Nurse Reviewer will contact your doctor to determine the reason for surgery and the extent to which your doctor's information meets established medical criteria indicating the need for surgery. Very often, a Nurse Reviewer can waive the requirement for a second opinion. When a second opinion is required, a Nurse Reviewer can give you the names of up to three board certified doctors in your area from which you can choose a doctor to provide the second opinion. However, if you do not comply with the Surgical Necessity Review requirements, a 20% penalty will be applied to all covered surgical expenses incurred.

PRE-ADMISSION TESTING
Any pre-admission testing will be paid at 100% provided the testing is done on an outpatient basis. All tests must be medically related to surgery or hospital confinement and be performed no more than 7 days prior to surgery or hospital confinement. No benefits will be payable for non-compliance.

Cost Containment Features, Continued (Core)

MENTAL/NERVOUS & SUBSTANCE ABUSE PRE-CERTIFICATION
Anytime treatment is recommended for Mental/Nervous & Substance Abuse, you must call 1-269-372-4500 (Help Net) for an assessment. If you fail to do so, your benefits payable will be reduced by the 20% penalty.

HOME HEALTH CARE
Home Health Care is a progressive recovery procedure which enables the covered person to receive treatment for an illness at home rather than in the hospital. A plan is designed in writing, by a physician, which outlines the necessary care that you would receive.

There is a 120 visit limitation each calendar year from any licensed practitioner providing services to the covered individual. One visit is defined as up to 4 hours of home health care. Should additional days be necessary, they must be doctor approved and would be subject to your deductible and co-pay.

MEDICAL CASE MANAGEMENT PROGRAM
A qualified Health Care Consultant will assist you in finding the proper medical treatment as an alternative to costly long term hospital care.

Coordination of Benefits

These Cost Containment provisions must be followed when coordinating benefits with another plan.
The coordination of benefits provision for the KVCC Employee Health Benefit Plan utilizes the **"Birthday Rule"**. This rule is applicable to persons that have dual insurance for Employee Health Benefit Plan coverage under any plan (not just KVCC's). Whichever person's birthday (month, not birth year) occurs first during the calendar year is deemed to be the primary coverage for dependent children; the person with the birthday that occurs second during a calendar year is considered the secondary coverage. The primary plan will be the first plan to pay health claims; the secondary plan will be the second claim payor. **Please note, an employee is always considered primary on their respective employer's plan.**

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable KVCC Summary Plan Descriptions.

Opt Out of Medical Coverage

NO MEDICAL COVERAGE

In order to select this option, you must provide proof of other medical coverage at enrollment. Should you elect the No Medical Coverage Option, you will receive a cash rebate of **$3,500.** Cash rebates will be returned in equal installments over the annual pay schedule, and are considered taxable income.

Proof of other medical coverage must be provided each benefit year.

In addition to the Declination of Health Coverage Affidavit, we need a letter from the employer that is providing the health coverage or official document from your spouse's employer stating you are currently covered under their health insurance plan, which lists your name as an eligible dependent.

Your other medical coverage cannot be: Medicaid, Medicare, COBRA, a parent's insurance, or a plan purchased as an individual.

Janet's Law

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 include 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.

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Dependent Coverage

All Employees must complete the Coordination of Benefits Form/Dependent Affidavit each benefit year, or at time of Qualifying Status Change.

Due to Health Care Reform – dependency rules have changed.

- ***Dependent children will be covered until age 26. The child need not be an IRS dependent and is eligible even if married.***

Dependent is any one of the following persons:

(1) A covered Employee's Spouse

  a. The term "spouse" shall mean the legally recognized marital partner of a covered Employee. The Plan Administrator may require documentation proving a marital relationship.

(2) A covered Dependent child who is incapable of self-sustaining employment by reason of being Intellectually and Developmentally Disabled or physical handicap, primarily dependent upon the covered employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age.

(3) *IRC 152(f)(1) defines the term "child" to mean an individual who is: (1) a son, daughter, stepson, or stepdaughter of the taxpayer; or (2) an "eligible foster child" of the taxpayer. An "eligible foster child" means an individual who is placed with the taxpayer by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction. Any adopted children of the taxpayer are treated the same as natural born children. Plans and issuers that offer dependent coverage must offer coverage to enrollees' adult children until age 26, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. The new policy providing access for young adults applies to both married and unmarried children, although their own spouses and children do not qualify.*

These persons are excluded as Dependents: other individuals living in the covered employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the employee; any person who is on active duty in any military service of any country.

Eligibility Requirement For Spouse/Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage pursuant to the dependent eligibility as outlined in KVCC's Flexible Compensation Plan Summary Plan Description.

Should you choose to cover your spouse, and your spouse has coverage through his/her employer, then <u>KVCC's Health Benefit Plan will be secondary</u>.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by the applicable KVCC Flexible Compensation Plan Summary Plan Description.

The Household Member program is a pilot program which is effective May 1, 2011 through December 31, 2013. This program expands the eligibility criteria for enrollment in Kalamazoo Valley Community College's flexible benefits plan. Kalamazoo Valley Community College reserves the right to change the eligibility criteria or to suspend or terminate the Household Member benefit program at any time, including any coverage then being provided. Please contact Cheryl Grinnell in the Human Resources Department for proper enrollment forms and program information.

Vision Care Program (to coincide with Core Medical)

The program will pay for covered services rendered from any of the following licensed practitioners:

- an optometrist - a person who examines the eyes for fitting of glasses
- an optician - one who makes glasses
- an optometric laboratory
- an ophthalmologist - a medical eye doctor

The vision plan will provide payment for the following benefits:

Vision Examinations	100%*
Eyeglass Frames	100%
Eyeglass Lenses	100%
Contact Lenses	100% (all kinds including hard, soft, gas, permeable, and disposable)

The Maximum Benefit paid, for all eligible expenses, per Covered Person per Calendar Year: $225.00*

The plan will allow one exam and either eyeglasses (one set of frames with one pair of lenses) or contact lenses per Covered Person, per Calendar Year. If contact lenses are selected, the Plan will cover all contact lenses purchased up to the maximum benefit amount.

Claims for routine vision examinations incurred by covered persons under the age of 18 are not subject to the $225 annual maximum.

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable KVCC Summary Plan Descriptions.

Prescription Drug Plan (Core)

BENEFIT PAYABLE

If an individual incurs expenses for covered drugs prescribed by a physician in connection with an injury or sickness, payment will be made to the participating pharmacy after the copayment is paid by the member.

Generic Drug: $10 / **Brand Name Drug:** 20% of the purchase price ($30 minimum, $50 maximum)

Mail Order is available. You can receive a 90 day supply at 2x the required copay
Generic Drug: $20 / **Brand Name Drug:** 20% of the purchase price ($60 minimum, $100 maximum)

If covered drugs are obtained from a non-participating provider, you must pay the purchase price in full and then must submit the expense directly to the prescription drug card vendor for reimbursement.
Prescription drug card services are payable by **Navitus**.

COVERED DRUG MEANS:

1) a drug:
    (a) which requires a Prescription Order; and
    (b) which is required, under federal law, to bear the legend: "Caution: Federal law prohibits dispensing without prescription;" or
2) a drug which does not bear the legend, but which requires a Prescription Order under the jurisdictional state law; or
3) a compound medication of which at least one ingredient is a drug defined in (1) or (2) above; or
4) injectable insulin:
    (a) up to a 90 day supply of disposable needles and syringes if the supply of insulin is a 90 day supply.

Special Notes about Prescription Drug Benefits:

1. The pharmacy will dispense generic drugs unless the prescribing physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the covered person refuses an available generic equivalent and the prescribing physician has not requested DAW, the covered person must pay the applicable co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.
2. A covered person taking a maintenance medication may have the prescription filled at a retail pharmacy two times (the initial fill and one refill for a total 60-day supply). After this 60-day supply has been dispensed, the Covered Person must use the Mail Service Program for all subsequent refills. **If the Covered Person does not use the Mail Service Program for subsequent refills, the co-payment charged for the prescription drug when refilled at a retail pharmacy will double as a penalty.** For additional information about this provision, please contact Navitus at (866) 333-2757 or visit its Website at www.navitus.com.

Details on limitations are included in the plan booklet
NO PAYMENT WILL BE MADE FOR:

- Drugs received before this coverage starts.
- Experimental drugs or drugs limited by law to investigational use.
- Administration of any medication or for any medication administered in the place where it is dispensed.
- Any refill of a prescription over a year old.
- Any prescription costing **$10.00** or less.
- More than a 30-day supply of any medication.
- Drugs obtainable without the prescription of a physician.
- The administration of legend drugs and inject-able insulin.
- Drugs prescribed for treatment of an occupational injury or sickness (Worker's Compensation).

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable KVCC Summary Plan Descriptions.

Dental Insurance

The schedule below provides a comparison of all dental options available. Each employee must elect one option only. Should you elect coverage with a cash rebate, that rebate will be returned in equal installments over the annual pay schedule. You may also spend your rebated dollars on other coverage elsewhere in the menu. Dependent coverage is available with either dental option.

		CORE	OPTION I	OPTION II
Deductible	Up front payment by employee	0	0	---
Coinsurance	**Type I:** Preventive & Diagnostic *	100%	60%	---
	Type II: Minor Restorative (Fillings, etc)	100%	60%	---
	Type III: Major Restorative (Prosthodontics, Crown, etc)	80%	60%	---
	Type IV: Orthodontics (Limited to dependent children to age 19)	60%	60%	---
Annual Maximum	Each member is entitled to maximum benefits of this amount every contract year.	$1,100*	$1,100*	---
Orthodontic Lifetime	Each member has a lifetime maximum of this amount available for orthodontic services. Limited to dependent children to age 19.	$1,000	$ 600	---
Cash Rebate		$ 0	$ 75	$150

Claims for Type I preventive dental services incurred by covered persons under the age of 18 are not subject to the $1,100/$600 annual maximum. Type I services include: oral examination, complete series or panorex x-ray, individual periapical x-rays, occlusal x-rays, extraoral x-rays, bite-wing x-rays, bacteriologic cultures, teeth cleaning, fluoride treatment, palliative treatment, sedative fillings.

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable KVCC Summary Plan Descriptions.

Long-Term Disability

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

CORE

Upon approval of a claim the payments will ***begin 180 days after the onset of your disability.***
The LTD plan replace **66 2/3%** of your base monthly salary.
The minimum benefit is **$100** or **10%** of your gross income.
The maximum benefit is **$3,000** per month.
Coverage is effective the date of hire as long as the employee is actively at work.

Disability benefits will continue 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, Workers Compensation, and the MPSERS Pension/ORP.

EMPLOYEE OPTIONS

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.

	Core Plan	**Option I**
Percent of Monthly Salary	66 2/3%	70%
Maximum Monthly Benefit	$3,000	$5,000

The cost to elect this coverage is shown on the "*Optional Long Term Disability Rate Sheet"* page. Rates were correct at time of printing, however, they are subject to change.

LONG-TERM DISABILITY WORKSHEET

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

Step 1 $______________ (Monthly base salary) X 66 2/3% (Core benefit) = $________________ (Gross monthly disability payment)

Step 2 $______________ (Gross monthly disability payment) -- $___________ (66 2/3 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 probably purchase additional coverage unless you have additional income from other sources to cover the deficit.

Optional Long-Term Disability
Rate Sheet

To calculate the cost of additional Long Term Disability:

(1)	$__________ Annual Salary	x	.0015	=	$__________ Annual Cost
(2)	$__________ Annual Cost	÷	______ # of Pays	=	$____________ Cost Per Pay

EXAMPLE:

- Annual Salary $25,000
- Would like to purchase additional long term disability benefits
- 24 pays per year

(1)	$ $25,000 Annual Salary	x	.0015	=	$ $37.50 Annual Cost
(2)	$ $37.50 Annual Cost	÷	24 # of Pays	=	$ $1.56 Cost Per Pay

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.

CORE
The following is your Core Term Life insurance benefit:

1 x Annual Salary

Should you be employed on or after the first day of the calendar month in which you reach age 65, both your Term Life Insurance benefit and Accidental Death and Dismemberment benefit will be reduced (see life book for actual schedule). Term Life coverage will cease at retirement. Coverage is effective the date of full time hire as long as the employee is actively at work.

EMPLOYEE OPTIONS

OPTION I	OPTION II
Additional 1 x Annual Salary	**Additional 2 x Annual Salary**

If you wish, you may add to your Core coverage by purchasing additional Term Life Insurance. Option I provides you with the opportunity to purchase an additional one times your annual salary. Option II allows you to purchase an additional two times your annual salary. Both alternatives are in addition to your Core Life Insurance Benefit. The maximum allowable amount of coverage Core plus Optional Insurance is $300,000. The first $50,000 of coverage can be paid for with pre-tax dollars. With amounts in excess of $50,000, the Internal Revenue Service requires taxation on a portion of your premium. The cost to provide this coverage is shown on the "*Optional Life Insurance Rate Sheet"* page. Rates were correct at time of printing; however, they are subject to change. Any purchase of additional Life Insurance must be coordinated by an identical purchase of Accidental Death & Dismemberment Insurance. New employees have 31 days from date of hire to purchase Optional Life Insurance without proof of medical insurability. **Current employees will have to submit an Evidence of Insurability form if they wish to purchase more than their current level of coverage.**

To determine the amount of life insurance that you need, take the numbers from the "*Liability Worksheet"* 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 $__________________

Accidental Death and Dismemberment

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

CORE **Same as Term Life insurance section**
EMPLOYEE OPTIONS **Same as Term Life insurance section**

Optional Term Life/Accidental Death & Dismemberment

Rate Sheet ***(these rates are Term Life and ADD combined)***

AGE	Cost per thousand per month
0 - 25	$ .0740
25 - 29	$ .0740
30 - 34	$ .0740
35 - 39	$ .0909
40 - 44	$ .1235
45 - 49	$ .1779
50 - 54	$ .2629
55 - 59	$ .4008
60 - 64	$ .5719
65 - 69	$ .8593
70 - 74	$1.7673
75 - 80	$4.1030

To calculate the cost of additional Term Life Insurance/Accidental Death & Dismemberment:

1) Find your age and corresponding monthly cost per thousand

2) ______ (Cost per thousand) X ______ (Life ins. amount (omit 000)) = ______ (Monthly Cost)

3) ______ (Monthly Cost) X 12 (months) = ______ (Annual Cost)

4) ______ (Annual Cost) / ______ (No. of pays) = ______ (Cost per pay)

EXAMPLE:

- 42 years old (.1235 per thousand)
- Annual salary $25,000
- would like to purchase additional one (1) x salary
- 24 pays per year

2) .1235 (Cost per thousand) X 25 (Life ins. amount (omit 000)) = $3.0875 (Monthly Cost)

3) $3.0875 (Monthly Cost) X 12 (months) = $37.05 (Annual Cost)

4) $37.05 (Annual Cost) / 24 (No. of pays) = $1.54 (Cost per pay)

Employee Reimbursement Account

One of the most attractive features of the Flexible Benefits Plan 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 but not reimbursed by your insurance plans.

NOTES ABOUT YOUR ACCOUNT

During the year, you should keep receipts for all qualified expenses. To receive reimbursements, just fill out an Employee Reimbursement Account claim form, attach your receipts, and submit them to the Administrator, **ASR / Physicians Care**. You may submit claims anytime. Reimbursement checks are run on a weekly basis. *The final check run is 75 days after the plan year ends, otherwise any remaining balance in the account will be forfeited.*

ASR / Physicians Care is the administrator of your Flexible Spending Account. Representatives are available to answer any questions with regards to your Flexible Spending Account that you may have, either prior to or during enrollment. They will also be responsible for handling the Flexible Spending Account plan on an ongoing basis.

For assistance with your Flexible Spending Account please call: **(800) 968-2449**

You can also locate ASR on the web at www.asrhealthbenefits.com

You may access your account at www.asrhealthbenefits.com

The address for mailing claims is:
P.O. Box 6392
Grand Rapids, MI 49516-6392

You may fax your claims to:
(616)-464-4458

Or you can e-mail your claims to:
submitflexclaim@asrhealthbenefits.com

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.

	With Account	Without Account
Annual Gross Salary	24,000	24,000
Dependent Care	1,800	0
Health Care Expenses	700	0
Taxable Income	**21,500**	**24,000**
Federal Tax (18.5% blended)	3,978	4,440
FICA (7.65%)	1,645	1,836
State Tax (4.35%)	935	1,044
(Total taxes = 30.50%)		
After-Tax Income	14,942	16,680
After-Tax Dependent Care	0	1,800
After-Tax Health Care	0	700
Spendable Income	$14,942	$14,180
NET PAY RAISE	**$762.00**	

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.")***

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 incurred during a plan year must be submitted for reimbursement by ***March 15th*** of the following year. Otherwise, any money left in the Account will be forfeited. In the unlikely event of 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 x 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 $130 per calendar year.**

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 Health Care expenses may be reimbursed from the 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 into 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. 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.*

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

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

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 ($2,500 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, living in your home.

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 Employee Benefit Concepts (EBC).

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 $________________

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 Workers Compensation and Social Security disability and survivorship benefits. This potential disadvantage is easily overcome if the employee invests part of his/her tax savings into either a 403(b) annuity or a cash value life insurance policy. ***(This cash value life insurance can also be used to maximize your Michigan Public School Employee Retirement pension.)***

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 benefit goes up the longer the employee is in the plan.

Other Benefits

In addition to what is being offered through the Flexible Benefits menu, other benefits will be made available on a payroll deduction basis for your convenience. You may use your tax savings or money received from the menu, as well as, money from your paycheck to purchase these benefits.

TAX-DEFERRED ANNUITIES
A popular savings vehicle available to employees of non-profit organizations is the tax-deferred annuity.
A tax-deferred annuity (TDA) is a type of interest earning account. It is often referred to as a tax sheltered annuity (TSA). This account allows your contributions and any interest earned to accumulate on a tax- deferred basis until you withdraw the funds. Since you pay no taxes on contributions or earned interest prior to withdrawal, your TDA can grow much faster than a traditional savings account. Several TDA alternatives are available. Information regarding other TDA's are available through Human Resources Benefit Coordinator.

MUTUAL FUNDS
For those employees who are looking to invest money in the market, several mutual funds are available.
A mutual fund offers a single investor with a small sum of money, risk reduction, diversification and professional fund management. Information regarding Mutual Funds are available please contact your Human Resources Benefit Coordinator for details.

PERMANENT LIFE INSURANCE (Non-Group)
Various permanent life insurance (Non-Group) programs are also available. Interest sensitive, cash value, universal and single premium life policies can be used to save for your children's educational expenses or maximize your pension payout. These types of programs build cash values and generally allow your funds to grow on a tax-deferred basis. Information regarding Permanent Life Insurance is available please contact your Human Resources Benefit Coordinator for details.

MICHIGAN EDUCATION SAVINGS PROGRAM
Through TIAA-CREF, please contact your Human Resources Benefit Coordinator for details.

Participation in optional benefits is strictly voluntary. Any advice received does not necessarily reflect that of your employer. This service is being provided on a non-fee arrangement.

Making Your Selections

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

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 re-enrollment period allows you to assess those changes as they pertain to your own personal situation. ***You are required to participate in the annual re-enrollments 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. Please do not forget that Marwil & Associates is available to help. Representatives will be happy to answer any questions that you may have about the various plans that make up the Kalamazoo Valley Community College Flexible Benefits Plan. 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

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PhysiciansCare™ ASR health benefits

Kalamazoo Valley Community College, G-688

Benefit Description	Core Medical Plan
Benefit Year	January 1 through December 31
Deductible per Benefit Year	$175/single coverage $350/two-person coverage $400/family coverage
General Benefit Percentage	90% after deductible
Out-Of-Pocket Maximum per Benefit Year (Includes Benefit Percentage Only)	$1,000/single coverage* $1,000/two-person coverage* $1,000/family coverage*
*Does not include deductibles, co-payments of any type, or expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, are subject to the Pre-Existing Conditions limitation, or are otherwise excluded.	
Annual Maximum Paid per Covered Person per Benefit Year (Includes Prescription Drugs Purchased Through the Prescription Drug Card Program or the Prescription Drug Mail Service Program)	$1,250,000
Ambulance Transportation	100%; deductible waived
Anesthesia	
Inpatient Services	100%; deductible waived
Outpatient Services	100% after deductible
Behavioral Care (includes Mental Health Care and Addictions Treatment) Inpatient/Partial Hospitalization Services Outpatient/Intensive Outpatient Services	Paid the same as any other illness
If a covered person seeks treatment for behavioral care that will result in a hospital confinement or stay, that treatment should be reviewed before its commencement. Call HelpNet at (269) 372-4500 or (800) 523-0591 as soon as possible before beginning the treatment, but no later than 48 hours following the first treatment. If a covered person fails to comply with this certification provision, the Plan's benefit for charges related to the hospital confinement or stay will be reduced by 20%.	
Birthing Centers	100%; deductible waived
Chemotherapy	100%; deductible waived
Chiropractic Care	
Spinal Manipulations and Therapy Treatments	90% after deductible
Diagnostic Spinal X-Rays	100%; deductible waived
Physician's Fee for an Initial or Periodic Evaluation	90% after deductible
Maximum Number of Visits Allowed per Covered Person per Condition	20 visits
Convalescent Care 120 days* per Covered Person per Benefit Year	100%; deductible waived
*If additional treatment days are needed, convalescent care days in excess of the 120 day annual maximum may be covered under the Plan at the general benefit percentage.	
Emergency Room Treatment	
Physician's Fee for an Examination in the Emergency Room	$200 co-payment per visit (waived for a medical emergency, an accidental injury, or if admitted to the hospital as an inpatient), then 100% (deductible waived)
All Other Charges Billed by the Physician in Connection with the Emergency Room Treatment	100%; deductible waived
Hospital's Fee for the Use of the Emergency Room	100%; deductible waived
All Other Services Billed by the Hospital in Connection with the Emergency Room Visit	100%; deductible waived
Hearing Aids (includes Exam and Fitting) $400 Maximum Paid per Covered Person per Benefit year	90% after deductible
Hemodialysis	
Inpatient Services	100%; deductible waived
Outpatient Services	90% after deductible
Home Health Care 120 days* per Covered Person per Benefit Year	100%; deductible waived
*If additional treatment days are needed, home health care days in excess of the 120 day annual maximum may be covered under the Plan at the general benefit percentage.	
Hospice Care	100%; deductible waived

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Benefit Description	Core Medical Plan
Hospital-Billed Charges Inpatient Services – Room and Board Inpatient Services - Miscellaneous Outpatient Services	 100%; deductible waived 100%; deductible waived 100%; deductible waived

If a covered person is scheduled for any hospital confinement or stay, the services should be reviewed before the admission. The covered person must call the number on the front of his or her ID card as soon as possible before a hospital admission, but in no event later than 48 hours following the admission. If a covered person fails to comply with this certification provision, the Plan's benefit for charges related to the hospital confinement or stay will be reduced by 20%.

Kalamazoo Valley Community College offers a $1,000 incentive to any covered person who chooses inpatient treatment at a Kent County Hospital. The $1,000 incentive will be paid to the employee via payroll following the completion of the inpatient stay. If you require a procedure or treatment that will require an inpatient hospital stay, discuss with your doctor your preference to receive inpatient care at a Kent County Hospital. After your stay in the hospital is complete, ASR health benefits will send you an Explanation of Benefits (EOB), detailing the charges from your stay. You may also access and print a copy of this EOB at any time by logging on to the ASR Website at www.asrhealthbenefits.com. Highlight the eligible facility charge and submit a copy to:

Kalamazoo Valley Community College
Attn: HR Department
6767 West "O" Avenue
P.O. Box 4070
Kalamazoo, Michigan 49003-4070

The care received during the inpatient hospital stay must be eligible for coverage under the Plan in order for the $1,000 incentive to apply. Kalamazoo Valley Community College reserves the right to amend or terminate the available incentive payment program at any time.

Benefit Description	Core Medical Plan
Laboratory Services	100%; deductible waived
Occupational Therapy Inpatient Services Outpatient Services	 100%; deductible waived 90% after deductible
Physical Therapy Inpatient Services Outpatient Services	 100%; deductible waived 90% after deductible
Physician Visits Physician's Fee for an Inpatient Examination Physician's Fee for an Outpatient Examination, including Exams Performed in a Physician's Office or an Immediate Care Center All Other Charges Billed in Connection with the Examination	 100%; deductible waived 90% after deductible Paid the same as any other Illness; benefit percentage depends upon the type of service rendered
Pre-Admission Testing	100%; deductible waived
Pre-Existing Conditions	Claims resulting from Pre-Existing Conditions are temporarily limited to $2,000 in benefits payable under the Plan for up to six months (employee) or 12 months (dependent) from the covered person's enrollment date. The Pre-Existing period will be reduced by the covered person's days of prior creditable coverage (HIPAA). The term Pre-Existing Condition means a physical or mental condition of a covered person for which medical advice, diagnosis, care, or treatment was recommended or received within the three months before the covered person's enrollment date. The Pre-Existing Condition exclusion shall not apply to an individual who is under the age of 19.
Prescription Drugs Retail Prescription Drug Co-payments (30-Day Supply) Mail-Order Prescription Drug Co-payments (90-Day Supply)	 $10/generic drug, 20% of the purchase price ($30 minimum, $50 maximum)/brand-name drug $20/generic drug, 20% of the purchase price ($60 minimum, $100 maximum)/brand-name drug

Special Notes about Prescription Drug Benefits:

1. The pharmacy will dispense generic drugs unless the prescribing physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the covered person refuses an available generic equivalent and the prescribing physician has not requested DAW, the covered person must pay the applicable co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.

2. A covered person taking a maintenance medication may have the prescription filled at a retail pharmacy two times (the initial fill and one refill for a total 60-day supply). After this 60-day supply has been dispensed, the Covered Person must use the Mail Service Program for all subsequent refills. **If the Covered Person does not use the Mail Service Program for subsequent refills, the co-payment charged for the prescription drug when refilled at a retail pharmacy will double as a penalty.** For additional information about this provision, please contact Navitus at (866) 333-2757 or visit its Website at www.navitus.com.

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Benefit Description	Core Medical Plan
Routine Preventive Care	
Physician's Fee for an Examination	100%; deductible waived
Routine X-Rays and Lab	100%; deductible waived
Flu Shots and Other Routine Immunizations (Please Refer to the Preventative Care Summary for Adults and the CDC Recommended Immunizations Schedule for Children)	100%; deductible waived
Mammograms, Colonoscopies, and Other Routine Services	100%; deductible waived

Special Notes about Routine Preventive Care:

1. Co-insurance or an office visit co-payment may be imposed on preventive care services if either the visit is billed separately from the preventive care service or the services are provided during an office visit whose primary purpose is not preventive care (and the services are not billed separately).
2. The Routine Preventive Care Benefit will provide coverage for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women's preventive care and screenings in comprehensive guidelines supported by the HRSA.

Benefit Description	Core Medical Plan
Second Surgical Opinion	100%; deductible waived
Speech Therapy	
Inpatient Services	100%; deductible waived
Outpatient Services	90% after deductible
Supplemental Accident Benefit $300 Maximum Benefit Paid per Covered Person per Accident	100%; deductible waived

Charges in excess of the above maximum may be covered under the Plan the same as any other illness or injury.

Benefit Description	Core Medical Plan
Surgery	
Inpatient Services – Room and Board	100%; deductible waived
Inpatient Services - Miscellaneous	100%; deductible waived
Transplants	Services not covered by the Organ and Tissue Transplant Policy are paid the same as for any other surgery, contingent upon prior approval of health plan.
Outpatient Services	100% after deductible

If a covered person is scheduled for an elective (non-emergency) surgical procedure to be performed at a hospital or outpatient facility, the procedure should be reviewed before it is performed. The covered person must call the number on the front of his or her ID card as soon as possible before an elective (non-emergency) surgical procedure, but in no event later than 48 hours following the surgery. A second surgical opinion may be required. If a covered person fails to comply with this certification provision, the Plan's benefit for charges related to the surgery will be reduced by 20%. Outpatient surgical procedures performed in a physician's office or in a hospital emergency room do not require certification.

Benefit Description	Core Medical Plan
Therapeutic Radiology	100%; deductible waived
X-Rays	100%; deductible waived

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents

The following special coordination rule applies regarding automobile insurance. If a covered person is injured in an accident involving an automobile, this Plan shall be the primary plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

Special Provision for Spouses with Health Plan Coverage Available through His/Her Employer

A participant's spouse who is eligible for coverage under his or her own employer's group health plan must enroll for that coverage in order to be eligible to enroll for coverage under this Plan. Coverage under the spouse's own employer's group health plan will be considered his or her primary coverage, and this Plan will be the secondary coverage. A participant's spouse who is required to pay the entire cost for coverage under his or her own employer's group health plan will not be subject to this provision.

Voluntary Outpatient Services Certification

A covered person may voluntarily certify the following services by calling the number on the front of his or her ID card:

1. **Home and outpatient rehabilitative therapy**
2. **Rental and purchase of durable medical equipment**
3. **Home health care**
4. **Purchase of custom-made orthotic or prosthetic appliances**
5. **Oncology treatment**

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Benefit Description	Core Vision Plan
	Limits
Benefit Year	January 1 through December 31
Benefit Percentage Vision Examinations Eyeglass Frames Eyeglass Lenses Contact Lenses	 100% 100% 100% 100%
Maximum Benefit Paid per Covered Person per Benefit Year for All Eligible Vision Services Claims for routine vision examinations incurred by covered persons under age 18 are not subject to the Benefit Year dollar maximum.	$225
NOTE: The Plan will allow one exam and **either** eyeglasses (one set of frames with one pair of lenses) **or** up to a year's supply of contact lenses per covered person in any Benefit Year. If contact lenses are selected, the Plan will only cover all contact lenses purchased up to the maximum benefit amount if a year's supply exceeds the annual maximum stated above.	

Benefit Description	Core Dental Plan
Benefit Year	January 1 through December 31
Benefit Percentage Type I - Preventive Dental Services Type II - Minor Restorative Dental Services Type III - Major Restorative Dental Services	 100% 100% 80%
Maximum Benefit Paid per Covered Person per Benefit Year for Types I, II & III Dental Services Claims for Type I Preventive Dental Services incurred by covered persons under age 18 are not subject to the Benefit Year dollar maximum.	$1,100
Benefit Percentage Type IV - Orthodontic Services (for Dependent children age 19 and under only)	60%
Lifetime Maximum Benefit Paid per Eligible Dependent Child for Type IV Orthodontic Services	$1,000

Benefit Description	Option I Dental Plan
Benefit Year	January 1 through December 31
Benefit Percentage Type I - Oral Examinations and Fluoride Treatment for Covered Person Under Age 18 Type I – All Other Preventive Dental Services, Including Oral Examinations for Covered Persons Over Age 18 Type II - Minor Restorative Dental Services Type III - Major Restorative Dental Services	 100% 60% 60% 60%
Maximum Benefit Paid per Covered Person per Benefit Year for Types I, II & III Dental Services Claims for Type I Preventive Dental Services incurred by covered persons under age 18 are not subject to the Benefit Year dollar maximum.	$1,100
Benefit Percentage Type IV - Orthodontic Services (for Dependent children age 19 and under only)	60%
Lifetime Maximum Benefit Paid per Eligible Dependent Child for Type IV Orthodontic Services	$600

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Summary of Dental Procedures – Core and Option I Plans	
Services:	***Special Limitations:***
Type I: Preventive Dental Services	
A. Oral Examination	**Dependent Children Under Age 18:** No special limitations **All Other Covered Persons:** Limited to two times in any calendar year.
B. Complete Series or Panorex X-ray	Limited to one time in any 36-consecutive-month period.
C. Occlusal, Extraoral, and Individual Periapical X-Rays	No special limitations.
D. Bite-Wing X-rays	Limited to two times in any calendar year.
E. Bacteriologic Cultures	No special limitations.
F. Dental Prophylaxis (cleaning teeth)	Limited to two times in any calendar year.
G. Fluoride Treatment	**Dependent Children Under Age 18:** No special limitations **Dependent Children Age 18:** Two in any calendar year. **Dependent Children Age 19 and Over, and All Other Covered Persons:** Not covered
H. Palliative Treatment	No special limitations.
I. Sedative Fillings	No special limitations.
J. Space Maintainers	Dependent children under age 25 only. Used to replace primary teeth only.
K. Emergency Treatment	For purposes of pain relief only.
Type II: Minor Restorative Dental Services	
A. Periodontal Exams	No special limitations.
B. Periodontal Prophylaxis	No special limitations.
C. Diagnostic Casts	No special limitations. Casts made prior to, or as part of, orthodontic treatment will be covered as a Type IV expense.
D. Stainless Steel Crowns	No special limitations.
E. Re-cement Inlays, Onlays, & Crowns	No special limitations.
F. Pulpotomy and Osseous Surgery	No special limitations.
G. Root Canal Therapy	No special limitations.
H. Apicoectomy and Retrograde Filling	No special limitations.
I. Scaling and Root Planing	No special limitations.
J. Repairs to Full Dentures, Partial Dentures, Bridges	No special limitations.
K. Relining Dentures	No special limitations.
L. Re-cement Bridges	No special limitations.
M. Simple Extraction	No special limitations.
N. Surgical Extraction of Impacted Teeth, Alveoplasty, Gingivectomy, & Vestibuloplasty	Not covered as a dental expense if covered under the Employer's medical plan.
O. Root Recovery	No special limitations.
P. Incision and Drainage	No special limitations.
Q. Local and General Anesthesia	No special limitations.
R. Amalgam Restorations (fillings)	No special limitations.
S. Silicate, Plastic, and Composite Restorations (fillings)	No special limitations.
T. Pin Retention	No special limitations.
U. Gingival Curettage	No special limitations.
V. Osseous Graft	No special limitations.
W. Frenectomy	No special limitations.
Type III: Major Restorative Dental Services NOTE: For replacement of items A., C., E., F., G., H., and I. below, see the subsection entitled "EXCLUSIONS AND LIMITATIONS" in the Plan document.	
A. Gold Inlays and Onlays	Covered only when the tooth cannot be restored by an amalgam, silicate, plastic, or composite restoration.
B. Porcelain Restorations	No special limitations.
C. Crowns	No special limitations.
D. Post and Core	No special limitations.
E. Replacement of Teeth to Bridges and Dentures	No special limitations.
F. Full or Partial Dentures	No special limitations.
G. Fixed Bridges	No special limitations.
H. Dental Implants	No special limitations.
Type IV: Orthodontic Services (Dependent Children Under Age 19 Only)	
Orthodontic Diagnostic Procedures, Surgical Therapy, and Appliance Therapy	No special limitations.

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Kalamazoo Valley Community College, G-688

Benefit Description	Core Dental Plan
Benefit Year	January 1 through December 31
Benefit Percentage Type I - Preventive Dental Services Type II - Minor Restorative Dental Services Type III - Major Restorative Dental Services	 100% 100% 80%
Maximum Benefit Paid per Covered Person per Benefit Year for Types I, II & III Dental Services Claims for Type I Preventive Dental Services incurred by covered persons under age 18 are not subject to the Benefit Year dollar maximum.	$1,100
Benefit Percentage Type IV - Orthodontic Services (for Dependent children age 19 and under only)	60%
Lifetime Maximum Benefit Paid per Eligible Dependent Child for Type IV Orthodontic Services	$1,000

Benefit Description	Option I Dental Plan
Benefit Year	January 1 through December 31
Benefit Percentage Type I - Oral Examinations and Fluoride Treatment for Covered Person Under Age 18 Type I – All Other Preventive Dental Services, Including Oral Examinations for Covered Persons Over Age 18 Type II - Minor Restorative Dental Services Type III - Major Restorative Dental Services	 100% 60% 60% 60%
Maximum Benefit Paid per Covered Person per Benefit Year for Types I, II & III Dental Services Claims for Type I Preventive Dental Services incurred by covered persons under age 18 are not subject to the Benefit Year dollar maximum.	$1,100
Benefit Percentage Type IV - Orthodontic Services (for Dependent children age 19 and under only)	60%
Lifetime Maximum Benefit Paid per Eligible Dependent Child for Type IV Orthodontic Services	$600

Summary of Dental Procedures – Core and Option I Plans	
Services:	***Special Limitations:***
Type I: Preventive Dental Services	
A. Oral Examination	**Dependent Children Under Age 18:** No special limitations **All Other Covered Persons:** Limited to two times in any calendar year.
B. Complete Series or Panorex X-ray	Limited to one time in any 36-consecutive-month period.
C. Occlusal, Extraoral, and Individual Periapical X-Rays	No special limitations.
D. Bite-Wing X-rays	Limited to two times in any calendar year.
E. Bacteriologic Cultures	No special limitations.
F. Dental Prophylaxis (cleaning teeth)	Limited to two times in any calendar year.
G. Fluoride Treatment	**Dependent Children Under Age 18:** No special limitations **Dependent Children Age 18:** Two in any calendar year. **Dependent Children Age 19 and Over, and All Other Covered Persons:** Not covered
H. Palliative Treatment	No special limitations.
I. Sedative Fillings	No special limitations.
J. Space Maintainers	Dependent children under age 25 only. Used to replace primary teeth only.
K. Emergency Treatment	For purposes of pain relief only.

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Summary of Dental Procedures – Core and Option I Plans	
Services:	***Special Limitations:***
Type II: Minor Restorative Dental Services	
A. Periodontal Exams	No special limitations.
B. Periodontal Prophylaxis	No special limitations.
C. Diagnostic Casts	No special limitations. Casts made prior to, or as part of, orthodontic treatment will be covered as a Type IV expense.
D. Stainless Steel Crowns	No special limitations.
E. Re-cement Inlays, Onlays, & Crowns	No special limitations.
F. Pulpotomy and Osseous Surgery	No special limitations.
G. Root Canal Therapy	No special limitations.
H. Apicoectomy and Retrograde Filling	No special limitations.
I. Scaling and Root Planing	No special limitations.
J. Repairs to Full Dentures, Partial Dentures, Bridges	No special limitations.
K. Relining Dentures	No special limitations.
L. Re-cement Bridges	No special limitations.
M. Simple Extraction	No special limitations.
N. Surgical Extraction of Impacted Teeth, Alveoplasty, Gingivectomy, & Vestibuloplasty	Not covered as a dental expense if covered under the Employer's medical plan.
O. Root Recovery	No special limitations.
P. Incision and Drainage	No special limitations.
Q. Local and General Anesthesia	No special limitations.
R. Amalgam Restorations (fillings)	No special limitations.
S. Silicate, Plastic, and Composite Restorations (fillings)	No special limitations.
T. Pin Retention	No special limitations.
U. Gingival Curettage	No special limitations.
V. Osseous Graft	No special limitations.
W. Frenectomy	No special limitations.
Type III: Major Restorative Dental Services **NOTE: For replacement of items A., C., E., F., G., H., and I. below, see the subsection entitled "EXCLUSIONS AND LIMITATIONS" in the Plan document.**	
A. Gold Inlays and Onlays	Covered only when the tooth cannot be restored by an amalgam, silicate, plastic, or composite restoration.
B. Porcelain Restorations	No special limitations.
C. Crowns	No special limitations.
D. Post and Core	No special limitations.
E. Replacement of Teeth to Bridges and Dentures	No special limitations.
F. Full or Partial Dentures	No special limitations.
G. Fixed Bridges	No special limitations.
H. Dental Implants	No special limitations.
Type IV: Orthodontic Services (Dependent Children Under Age 19 Only)	
Orthodontic Diagnostic Procedures, Surgical Therapy, and Appliance Therapy	No special limitations.

This brochure represents only a summary of your group health benefits plan as it applies to all eligible employees and dependents. This brochure is not the Plan Document or the Summary Plan Description and shall not be relied upon to establish or determine eligibility, benefits, procedures, or the content or validity of any section or provision of the Health Benefits Plan. Please refer to the Health Benefits Plan Document for specific information regarding plan provisions.

PhysiciansCare health plans

Summary Information for Preventive Care Services without Cost Sharing		
Category	**Summary**	
Required Preventive Care Services Applies only to non-grandfathered plans (Grandfathered status in plan document)	**Service**	**Recommendation**
Covered Preventive Services for Adults	Abdominal aortic aneurysm	One-time screening in men aged 65 to 75 who have ever smoked
	Alcohol misuse	Screening and behavioral counseling
	Aspirin to prevent CVD	Use of aspirin for men aged 45 to 79 years and women aged 55 to 79 years
	Blood pressure screening	Screening for high blood pressure in adults aged 18 and older
	Cholesterol screening	Screening for adults of certain ages or at higher risk
	Colorectal cancer screening	Screening for adults over 50
	Depression	Screening for adults
	Diabetes (type 2)	Screening for adults with high blood pressure
	Diet	Counseling for adults at increased risk for chronic disease
	HIV	Screening for all adults at increased risk
	Immunization vaccines for adults	Hepatitis A; Hepatitis B; Herpes Zoster; Human Papillomavirus; Influenza; Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Tetanus, Diphtheria, Pertussis; Varicella (doses, recommended ages and recommended populations vary)
	Obesity	Screening and counseling for all adults
	Sexually transmitted infection (STI)	Prevention counseling for adults at increased risk
	Tobacco use	Screening for all adults and cessation interventions for tobacco users
	Syphilis	Screening for all adults at increased risk
Covered Preventive Services for Women, Including Pregnant Women	Anemia	Screening on a routine basis for pregnant women
	Bacteriuria	Urinary tract or other infection screening for pregnant women
	BRCA screening (Breast Cancer Susceptibility Genes 1 and 2)	Counseling about genetic testing for women at increased risk
	Breast cancer mammography	Screenings every 1-2 years for women aged 40 and older
	Breast cancer chemoprevention	Counseling for women at higher risk
	Breast feeding	Interventions to promote and support breastfeeding
	Cervical cancer	Screening for sexually active women
	Chlamydia infection	Screening for younger women and other women at increased risk
	Folic acid	Supplements for women who may become pregnant
	Gonorrhea	Screening for all women at increased risk
	Hepatitis B	Screening for pregnant women at their first prenatal visit
	Osteoporosis	Screening for women over age 60 depending on risk factors
	Rh incompatibility	Screening for all pregnant women and follow-up testing for women at increased risk
	Tobacco use	Screening and interventions for all women and expanded counseling for pregnant tobacco users
	Syphilis	Screening for all pregnant women or other women at increased risk
Covered Preventive Services for Children	Alcohol and drug use	Assessments for adolescents
	Autism	Screening for children at 18 and 24 months
	Behavioral assessments	Assessments for children of all ages
	Cervical dysplasia	Screening for sexually active females

PhysiciansCare health plans

Summary Information for Preventive Care Services without Cost Sharing

Category	Summary	
Required Preventive Care Services Applies only to non-grandfathered plans (Grandfathered status in plan document)	**Service**	**Recommendation**
Covered Preventive Services for Children (continued)	Congenital hypothyroidism	Screening for newborns
	Developmental screening	Screening for children under age 3 and surveillance throughout childhood
	Dyslipidemia	Screening for children at higher risk of lipid disorders
	Fluoride Chemoprevention	Supplements for children without fluoride in their water source
	Gonorrhea	Preventive medication for the eyes of all newborns
	Hearing	Screening for all newborn
	Height, weight, body mass index, head circ., and BP	Measurements for children
	Hematocrit or Hemoglobin	Screening for children
	Hemoglobinopathies (sickle-cell disease)	Screening for newborns
	Heritable Disorders	Screening for newborns
	HIV	Screening for adolescents at increased risk
	Immunization vaccines for children from birth to age 18	Diphtheria, Tetanus, Pertussis ; Haemophilus influenzae type b; Hepatitis A; Hepatitis B; Human Papillomavirus; Inactivated Poliovirus; Influenza; Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Rotavirus; Varicela (doses, recommended ages, and recommended populations vary)
	Iron	Supplements for children aged 6 to 12 months at risk for anemia
	Lead	Screening for children at risk of exposure
	Medical History	Screening for all children throughout development
	Obesity	Screening and counseling
	Oral health	Risk assessment for young children
	Phenylketonuria (PKU)	Screening for PKU in newborns
	STI	Prevention counseling for adolescents at increased risk
	Tuberculin testing	Testing for children at increased risk of tuberculosis
	Vision screening	Screening for all children

Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind—United States • 2011

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
PERSONS AGED 4 MONTHS THROUGH 6 YEARS					
Hepatitis B[1]	Birth	**4 weeks**	**8 weeks** (and at least 16 weeks after first dose)		
Rotavirus[2]	6 wks	**4 weeks**	**4 weeks**[2]		
Diphtheria, Tetanus, Pertussis[3]	6 wks	**4 weeks**	**4 weeks**	**6 months**	**6 months**[3]
Haemophilus influenzae type b[4]	6 wks	**4 weeks** if first dose administered at younger than age 12 months **8 weeks (as final dose)** if first dose administered at age 12–14 months **No further doses needed** if first dose administered at age 15 months or older	**4 weeks**[4] if current age is younger than 12 months **8 weeks (as final dose)**[4] if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months **No further doses needed** if previous dose administered at age 15 months or older	**8 weeks (as final dose)** This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal[5]	6 wks	**4 weeks** if first dose administered at younger than age 12 months **8 weeks (as final dose for healthy children)** if first dose administered at age 12 months or older or current age 24 through 59 months **No further doses needed** for healthy children if first dose administered at age 24 months or older	**4 weeks** if current age is younger than 12 months **8 weeks** **(as final dose for healthy children)** if current age is 12 months or older **No further doses needed** for healthy children if previous dose administered at age 24 months or older	**8 weeks (as final dose)** This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated Poliovirus[6]	6 wks	**4 weeks**	**4 weeks**	**6 months**[6]	
Measles, Mumps, Rubella[7]	12 mos	**4 weeks**			
Varicella[8]	12 mos	**3 months**			
Hepatitis A[9]	12 mos	**6 months**			
PERSONS AGED 7 THROUGH 18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis[10]	7 yrs[10]	**4 weeks**	**4 weeks** if first dose administered at younger than age 12 months **6 months** if first dose administered at 12 months or older	**6 months** if first dose administered at younger than age 12 months	
Human Papillomavirus[11]	9 yrs	**Routine dosing intervals are recommended (females)**[11]			
Hepatitis A[9]	12 mos	**6 months**			
Hepatitis B[1]	Birth	**4 weeks**	**8 weeks** (and at least 16 weeks after first dose)		
Inactivated Poliovirus[6]	6 wks	**4 weeks**	**4 weeks**[6]	**6 months**[6]	
Measles, Mumps, Rubella[7]	12 mos	**4 weeks**			
Varicella[8]	12 mos	**3 months** if person is younger than age 13 years **4 weeks** if person is aged 13 years or older			

1. **Hepatitis B vaccine (HepB).**
   - Administer the 3-dose series to those not previously vaccinated.
   - The minimum age for the third dose of HepB is 24 weeks.
   - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
2. **Rotavirus vaccine (RV).**
   - The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
   - The maximum age for the final dose in the series is 8 months 0 days.
   - If Rotarix was administered for the first and second doses, a third dose is not indicated.
3. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).**
   - The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
4. ***Haemophilus influenzae* type b conjugate vaccine (Hib).**
   - 1 dose of Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy.
   - If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
   - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.
5. **Pneumococcal vaccine.**
   - Administer 1 dose of 13-valent pneumococcal conjugate vaccine (PCV13) to all healthy children aged 24 through 59 months with any incomplete PCV schedule (PCV7 or PCV13).
   - For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV13 if 3 doses of PCV were received previously or administer 2 doses of PCV13 at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
   - A single dose of PCV13 is recommended for certain children with underlying medical conditions through 18 years of age. See age-specific schedules for details.
   - Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant, at least 8 weeks after the last dose of PCV. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See *MMWR* 2010;59(No. RR-11).
6. **Inactivated poliovirus vaccine (IPV).**
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months following the previous dose.
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
7. **Measles, mumps, and rubella vaccine (MMR).**
   - Administer the second dose routinely at age 4 through 6 years. The minimum interval between the 2 doses of MMR is 4 weeks.
8. **Varicella vaccine.**
   - Administer the second dose routinely at age 4 through 6 years.
   - If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
9. **Hepatitis A vaccine (HepA).**
   - HepA is recommended for children aged older than age 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
10. **Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).**
    - Doses of DTaP are counted as part of the Td/Tdap series.
    - Tdap should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years or as a booster for children aged 11 through 18 years; use Td for other doses.
11. **Human papillomavirus vaccine (HPV).**
    - Administer the series to females at age 13 through 18 years if not previously vaccinated or have not completed the vaccine series.
    - Quadrivalent HPV vaccine (HPV4) may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
    - Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 1 to 2 and 6 months after the first dose). The minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be administered at least 24 weeks after the first dose.

Recommended Immunization Schedules for Persons Aged 0 Through 18 Years

UNITED STATES, 2011

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at http://www.vaers.hhs.gov or by telephone, 800-822-7967. Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the

Advisory Committee on Immunization Practices
(www.cdc.gov/vaccines/recs/acip)

American Academy of Pediatrics
(http://www.aap.org)

American Academy of Family Physicians
(http://www.aafp.org)

Department of Health and Human Services
Centers for Disease Control and Prevention

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2011

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB			HepB						
Rotavirus[2]			RV	RV	RV[2]						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	see footnote[3]	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	Hib[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus[6]			IPV	IPV	IPV						IPV
Influenza[7]					Influenza (Yearly)						
Measles, Mumps, Rubella[8]						MMR		see footnote[8]			MMR
Varicella[9]						Varicella		see footnote[9]			Varicella
Hepatitis A[10]						HepA (2 doses)				HepA Series	
Meningococcal[11]										MCV4	

Range of recommended ages for all children

Range of recommended ages for certain high-risk groups

1. **Hepatitis B vaccine (HepB).** (Minimum age: birth)
   At birth:
   - Administer monovalent HepB to all newborns before hospital discharge.
   - If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
   - If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

   Doses following the birth dose:
   - The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 weeks.
   - Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
   - Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose.
   - Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1, and 6 months.
   - The final (3rd or 4th) dose in the HepB series should be administered no earlier than age 24 weeks.
2. **Rotavirus vaccine (RV).** (Minimum age: 6 weeks)
   - Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
   - The maximum age for the final dose in the series is 8 months 0 days
   - If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
3. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** (Minimum age: 6 weeks)
   - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
4. ***Haemophilus influenzae* type b conjugate vaccine (Hib).** (Minimum age: 6 weeks)
   - If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
   - Hiberix should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.
5. **Pneumococcal vaccine.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
   - A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
   - A single supplemental dose of PCV13 is recommended for all children aged 60 through 71 months with underlying medical conditions who have received an age-appropriate series of PCV7.
   - The supplemental dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7. See *MMWR* 2010:59(No. RR-11).
   - Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant.
6. **Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
   - If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
7. **Influenza vaccine (seasonal).** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
   - For healthy children aged 2 years and older (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
   - Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
   - Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.
8. **Measles, mumps, and rubella vaccine (MMR).** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
9. **Varicella vaccine.** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
   - For children aged 12 months through 12 years the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
10. **Hepatitis A vaccine (HepA).** (Minimum age: 12 months)
    - Administer 2 doses at least 6 months apart.
    - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
11. **Meningococcal conjugate vaccine, quadrivalent (MCV4).** (Minimum age: 2 years)
    - Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
    - Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
    - Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
    - Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2011

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼ Age ▶	7–10 years	11–12 years	13–18 years
Tetanus, Diphtheria, Pertussis[1]		Tdap	Tdap
Human Papillomavirus[2]	see footnote[2]	HPV (3 doses)(females)	HPV Series
Meningococcal[3]	MCV4	MCV4	MCV4
Influenza[4]	Influenza (Yearly)		
Pneumococcal[5]	Pneumococcal		
Hepatitis A[6]	HepA Series		
Hepatitis B[7]	Hep B Series		
Inactivated Poliovirus[8]	IPV Series		
Measles, Mumps, Rubella[9]	MMR Series		
Varicella[10]	Varicella Series		

Range of recommended ages for all children

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

1. **Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
   - Persons aged 11 through 18 years who have not received Tdap should receive a dose followed by Td booster doses every 10 years thereafter.
   - Persons aged 7 through 10 years who are not fully immunized against pertussis (including those never vaccinated or with unknown pertussis vaccination status) should receive a single dose of Tdap. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid–containing vaccine are needed.
   - Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid–containing vaccine.
2. **Human papillomavirus vaccine (HPV).** (Minimum age: 9 years)
   - Quadrivalent HPV vaccine (HPV4) or bivalent HPV vaccine (HPV2) is recommended for the prevention of cervical precancers and cancers in females.
   - HPV4 is recommended for prevention of cervical precancers, cancers, and genital warts in females.
   - HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
   - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
3. **Meningococcal conjugate vaccine, quadrivalent (MCV4).** (Minimum age: 2 years)
   - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
   - Administer 1 dose at age 13 through 18 years if not previously vaccinated.
   - Persons who received their first dose at age 13 through 15 years should receive a booster dose at age 16 through 18 years.
   - Administer 1 dose to previously unvaccinated college freshmen living in a dormitory.
   - Administer 2 doses at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
   - Persons with HIV infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
   - Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
   - Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older).
4. **Influenza vaccine (seasonal).**
   - For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
   - Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
   - Children 6 months through 8 years of age who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010-2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.
5. **Pneumococcal vaccines.**
   - A single dose of 13-valent pneumococcal conjugate vaccine (PCV13) may be administered to children aged 6 through 18 years who have functional or anatomic asplenia, HIV infection or other immunocompromising condition, cochlear implant or CSF leak. See *MMWR* 2010;59(No. RR-11).
   - The dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7.
   - Administer pneumococcal polysaccharide vaccine at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition.
6. **Hepatitis A vaccine (HepA).**
   - Administer 2 doses at least 6 months apart.
   - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
7. **Hepatitis B vaccine (HepB).**
   - Administer the 3-dose series to those not previously vaccinated. For those with incomplete vaccination, follow the catch-up schedule.
   - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
8. **Inactivated poliovirus vaccine (IPV).**
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
9. **Measles, mumps, and rubella vaccine (MMR).**
   - The minimum interval between the 2 doses of MMR is 4 weeks.
10. **Varicella vaccine.**
    - For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
    - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
    - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.