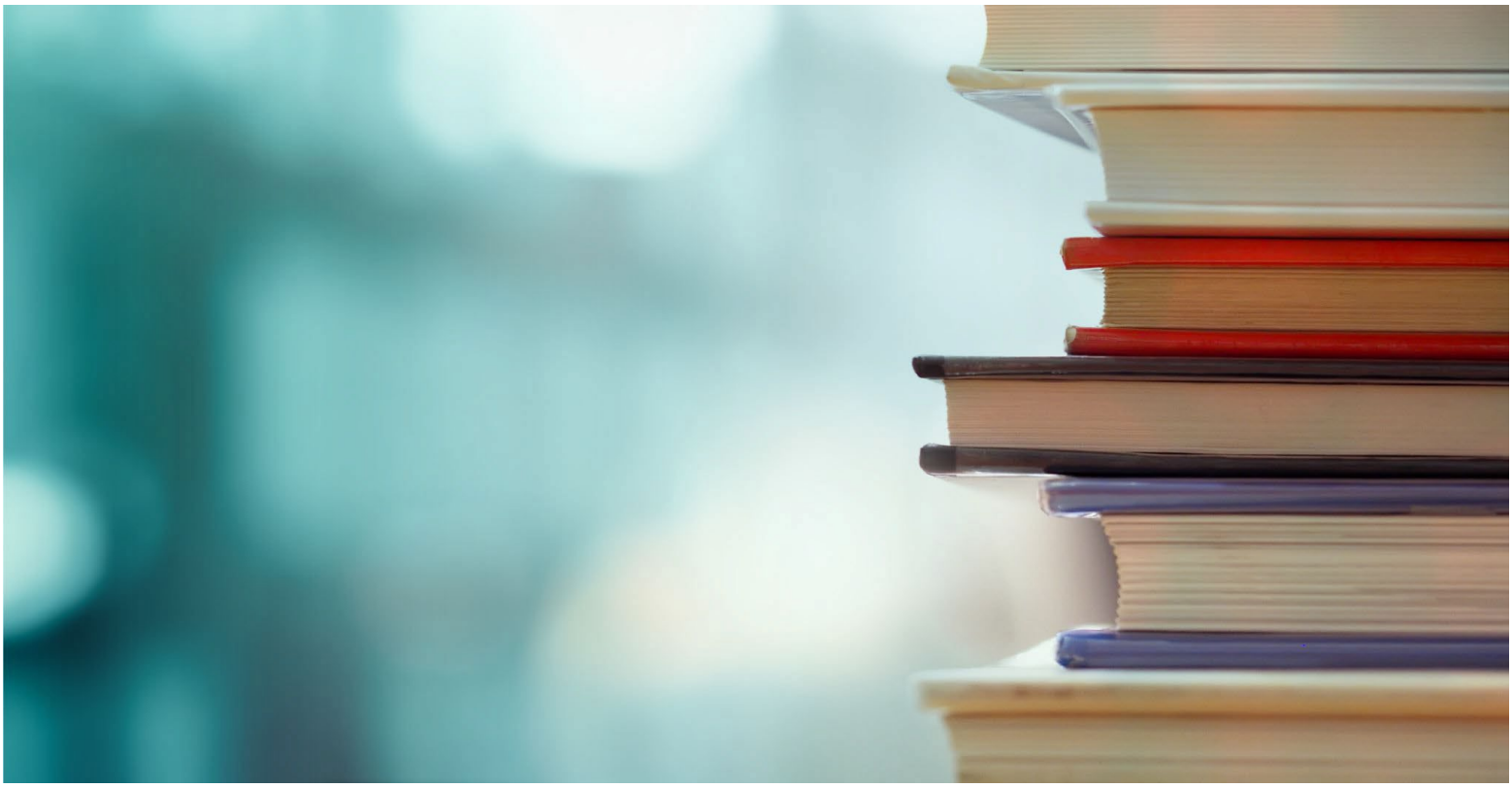

2026 Employee Benefits Guide

Shiawassee
Regional Education Service District

About Your Benefits

At Shiawassee RESD, we are committed to providing a comprehensive and affordable benefits package to you and your family. Review this guide to learn about your options so you can make the most of your Shiawassee RESD benefits. If you have any questions, feel free to reach out to Dawn Brandt at 989-743-3471 x2107 or brandt@sresd.org

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Eligibility and Enrollment

You are eligible to participate in the Shiawassee RESD's benefit plans if/when you meet the following criteria:

Average 20+ hours per week (Single/Employee Coverage Only)
Average 30+ hours per week option to enroll:

- Legal spouse
- Children up to age 26
- Unmarried children of any age who are mentally or physically disabled

Open Enrollment is held annually in November with a January 1st effective date.

Making Changes to Your Benefits

Each year, you have the opportunity to make changes to your benefit elections during open enrollment. You may make mid-year changes to your benefits only if you have a qualifying life event. Examples of qualifying life events include:

- Marriage or divorce
- Birth or adoption of a child
- Change in a dependent's eligibility status
- Change in employment status for you or your dependents resulting in the loss/gain of coverage
- A significant change in the cost or coverage of your dependent's benefits
- Change in the cost of dependent care (for dependent care flexible spending accounts only)
- Death of a dependent

Note: ***You have 30 days from your date of hire, date of eligibility or the date of a life event to enroll and/or make changes to your benefit elections. Be sure to contact HR immediately for information***.

Medical Coverage

Group #000071565

You have a choice of five medical plans through WMHIP/BCBSM. Review the chart below for the amount you will pay for the medical service listed.

BlueCross BlueShield THE POOL Western Michigan Health Insurance	Enhanced 500 Plan 1 – 151 PPO $500 100%	Enhanced 500 Plan 2 – 174 PPO $500 80%	Enhanced 1000 Plan 3 – 173 PPO $1,000 100%	Enhanced 1000 Plan 4 – 143 PPO $1,000 80%	Enhanced HSA 2000 Plan 5 – 121/122 HDHP $2000 100%
Annual Deductible	$500 Single $1,000 Family	$500 Single $1,000 Family	$1,000 Single $2,000 Family	$1,000 Single $2,000 Family	$2,000 Single $4,000 Family
Annual Coinsurance Maximum (Excludes Deductible)	0%	20% after deductible $1,000 Single $2,000 Family	0%	20% after deductible $2,500 Single $5,000 Family	0%
Annual Out-of-Pocket Maximum	$2,500 Single $5,000 Family	$3,000 Single $6,000 Family	$3,000 Single $6,000 Family	$4,500 Single $9,000 Family	$3,000 Single $6,000 Family
Doctor's Office					
Primary Care Office Visit	$10 copay	$20 copay	$20 copay	$20 copay	100% after deductible
Telemedicine Visits	$10 copay	$20 copay	$20 copay	$20 copay	100% after deductible
Specialist Visit	$10 copay	$20 copay	$20 copay	$20 copay	100% after deductible
Physician Urgent Care	100% after deductible	$20 copay	$20 copay	$20 copay	100% after deductible
Facility Urgent Care	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible
Preventive Care (Annual Health Maintenance Exams: Physical, OB/GYN Colonoscopy, Immunizations, Well Child Care, Mammography, etc.)	Covered 100% Not Subject to Deductible, CoPay or Coinsurance Annual limits apply	Covered 100% Not Subject to Deductible, CoPay or Coinsurance Annual limits apply	Covered 100% Not Subject to Deductible, CoPay or Coinsurance Annual limits apply	Covered 100% Not Subject to Deductible, CoPay or Coinsurance Annual limits apply	Covered 100% Not Subject to Deductible, CoPay or Coinsurance Annual limits apply
Hospital Services					
Emergency Room	$50 copay Waived if admitted	$50 copay Waived if admitted	$50 copay Waived if admitted	$50 copay Waived if admitted	100% after deductible

Finding In-network Providers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to www.bcbsm.com to find providers in the Blue Cross Blue Shield network.

PLEASE NOTE: This is a high level summary of the In-Network benefits. For full plan information please review the Benefit's at a Glance or SBC's available through the HR Department.

About Your Medical Plan

Common questions about your medical plan:

What is a copayment?

A copayment is a flat dollar amount you pay for services rendered. See your plan to determine if copayments contribute towards any out-of-pocket maximums.

What is coinsurance?

Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if your insurance's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. Your insurance pays the rest of the allowed amount.

What is a deductible?

The amount you owe for health care services before your insurance begins to pay. For example, if your deductible is $2,000, your plan won't pay anything until you've met your $2,000 deductible. The deductible may not apply to all services.

What is TrOOP or Annual Out of Pocket Max?

The TRUE out of pocket expenses you'll pay in network in a benefit year.

This includes copayments, deductibles and coinsurance.

This limit never includes premiums, balance-billed charges or non-covered services.

Is it Preventive or Diagnostic?

Have you ever received a bill for services rendered during a Preventive visit? Why did this happen when Preventive Services are supposed be provided at no cost sharing to members?

If a subsequent medically necessary procedure or test is performed during the same calendar year, it is subject to deductible and coinsurance. For instance, if a second mammogram or an ultrasound is required following your routine preventive mammogram, that test is billed to your deductible and coinsurance as a "diagnostic" test, rather than "preventive" test.

In addition, if during the course of a routine preventive office visit, your physician orders a test outside of the usual panel of preventive tests, those tests will be billed as "diagnostic" rather than "preventive" and charged towards your deductible and coinsurance.

Be sure to check with your physician on what tests are being ordered during your "preventive" visit and how they will be billed before they take place.

To see specific information on coverage for preventive services, please go to:

www.cdc.gov/prevention

Prescription Drug Coverage

Prescription drug coverage through BCBSM is included with all medical plans. Review the chart below for coverage amounts based on the medical plan selected.

	Plan 1 – 151 $500 100%	Plan 2 – 174 $500 80%	Plan 3 – 173 $1,000 100%	Plan 4 – 143 $1,000 80%	Plan 5 – 121/122 $2,000 100%
Retail 30-day supply					
Generic	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay after deductible
Preferred	20% co-insurance $40 min / $80 max	20% co-insurance $40 min / $80 max	20% co-insurance $40 min / $80 max	20% co-insurance $40 min / $80 max	20% coinsurance $40 min / $80 max after deductible
Non-Preferred	20% co-insurance $60 min / $100 max	20% co-insurance $60 min / $100 max	20% co-insurance $60 min / $100 max	20% co-insurance $60 min / $100 max	20% coinsurance $60 min / $100 max after deductible
****Prescriptions and refills obtained from a NON-NETWORK pharmacy are reimbursed at 75% of the approved amount, less the members copay.****					
Mail Order 90-day supply					
Generic	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay after deductible
Preferred	20% co-insurance $80 min / $160 max	20% co-insurance $80 min / $160 max	20% co-insurance $80 min / $160 max	20% co-insurance $80 min / $160 max	20% coinsurance $80 min / $160 max after deductible
Non-Preferred	20% co-insurance $120 min / $200 max	20% co-insurance $120 min / $200 max	20% co-insurance $120 min / $200 max	20% co-insurance $120 min / $200 max	20% coinsurance $120 min / $200 max after deductible
Specialty					
Generic	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay after deductible
Preferred	20% co-insurance $40 min / $80 max	20% co-insurance $40 min / $80 max	20% co-insurance $40 min / $80 max	20% co-insurance $40 min / $80 max	20% coinsurance $40 min / $80 max after deductible
Non-Preferred	20% co-insurance $60 min / $100 max	20% co-insurance $60 min / $100 max	20% co-insurance $60 min / $100 max	20% co-insurance $60 min / $100 max	20% coinsurance $60 min / $100 max after deductible
****Members are restricted to a 30-day supply at both retail and mail order and certain specialty drugs are limited to only a 15-day supply for each fill.****					

Generic Drugs

Generic drugs are FDA-approved, and shown to be just as safe and effective as their more expensive brand-name counterparts. If you choose a brand-name drug when a generic drug is available, you will pay the brand-name copay plus the cost difference between the generic equivalent and the brand-name drug.

Preferred Drugs

BCBSM regularly reviews the latest prescription drugs on the market and maintains a list of preferred drugs that are clinically effective and not cost-restrictive. These drugs are available at a lower price than those not included on the list, which are called non-preferred drugs.

Specialty Drugs

Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring. If you take a specialty medication, you could save money by using BCBSM's mail-order pharmacy. You can register for mail order pharmacy by logging on to www.optumrx.com.

Dental Coverage

Group #00043476

The Shiawassee RESD provides dental coverage through Guardian at no premium cost to the employee.

BENEFITS		
	All Eligible MESSA Employees	
	In-Network	Out-of-Network
Contribution/Participation	Contributory, Assumes 75% of eligible employees.	
Deductible	$0	
Period	Calendar Year	
Family Limit	N/A	
Waived For	Preventive	Preventive
Annual Maximum	**$2,000**	**Maximums for In-Network and Out-of-Network are inclusive**
Claim Payment Basis	Negotiated Fee Schedule	90th
Network	DentalGuard Preferred	
Coinsurance - Preventive	**100%**	**100%**
	• Oral Exams (twice/12 mos.) • Cleanings (twice/12 mos.) • X-Rays (Full-mouth series once/36 mos.) • Fluoride Treatment (to age 14, twice/12 mos.)	
Coinsurance - Basic	**90%**	**90%**
	• Fillings • Perio Maintenance Procedure (twice/12 mos.) • Periodontal Services (eg Scaling and Root Planing) • Periodontal Surgery • Simple Extractions • Complex Extractions • Endodontic Services (eg. Root Canal) • General Anesthesia • Sealants (to age 16, once/36 mos.) • Space Maintainers/Harmful Habit Appliances	
Coinsurance - Major	**90%**	**90%**
	• Bridges & Dentures • Implants • Single Crowns • Repair & Maintenance of Crowns, Bridges & Dentures • Inlays, Onlays & Veneers	
Coinsurance - Orthodontia	**90% for children (Orthodontia in Progress - covered)**	**90% for children (Orthodontia in Progress - covered)**
Orthodontia Lifetime Maximum	$2,000	$2,000
Replacement Age for Prosthetic Devices (Crowns, Bridges & Dentures)	5 Years	
Dependent Age Limits	To Age 26	
Waiting Periods	None	
Plan Type & Code	Network Access Plan (PX)	
Dental Contract	DentalGuard 2000	

PLAN HIGHLIGHTS

- **Guardian's Financial Strength:** Guardian has a long history of earning exemplary ratings from independent rating services which provide essential measures of a company's value as well as common ground for valid comparison. For additional details, visit our web site: http://www.guardianlife.com/AboutGuardian/FinancialHighlights/Ratings/index.htm

Strong Network Coverage Nationwide - providing choice and savings

- Guardian has one of the nation's largest selection of network dentists and we're growing fast, with over 115,000 dentists at more than 370,000 locations.
- It's easy to find a network dentist at GuardianAnytime.com.

Find an In-Network Dentist

You pay less for services when you use a dentist in the Guardian network. Find an in-network dentist by visiting www.guardianlife.com or, Call 1-800-541-7846

Vision Coverage

Group #3330000001

The Vision plan is through NVA and covers routine eye exams, lenses and more! Vision is another benefit provided at no premium cost to employees.

Vision Plan Benefits		
	In Network	**Out of Network**
Eye Exam (Once every calendar year)	Covered 100%	Reimbursement Amount up to $64
Lenses (Once every calendar year) Single Vision Bifocal Trifocal Lenticular	Covered 100%	$84 allowance $96 allowance $120 allowance $144 allowance
Frames (Once every calendar year)	Up to $130 allowance (20% off remaining balance)	Up to $130 allowance (20% off remaining balance)
Contact Lenses (Once every calendar year) Fitting Elective Medically Necessary	 Covered 100% Up to $200 allowance (15% off remaining balance conventional or 10% of remaining balance on disposable) Covered in full	 Up to $20/$30/$50 (Standard/Extended/Specialty) Up to $200 allowance Up to $210

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity, clearness of vision, refraction, tonometry (glaucoma test and dilation if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eye-glass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office.

Visit NVA's website to view the Benefit maximizer Program

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Finding In-network Eye Doctors

You can find an in-network eye doctor in the NVA network by visiting www.e-nva.com or by calling 800-672-7723.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen The National LASIK Network to serve their members. This network was developed by LCA Vision in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®.

Paying for Health Care

Shiawassee RESD offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

	HSA	FSA General Purpose	FSA Limited Purpose
What medical plan can I choose?	HDHP	Non HDHP plans	Any Plan
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for a full list)	Medical, prescription , dental & vision care (See IRS publication 502 for a full list)	Dental and Vision Care (See IRS publication 502 for a full list)
When can I use the funds?	Funds are available as you contribute to the account	All of the funds you elect for the year are available on January 1	All of the funds you elect for the year are available on January 1
Can I roll over funds each year?	Yes, funds roll over year-to-year and are yours to keep (even if you change jobs)	Yes, you can rollover up to $680 into the following plan year	Yes, you can rollover up to $680 into the following plan year
How do I pay for eligible expenses?	With your Health Equity debit card (You can also submit claims for reimbursement online at www.healthequity.com)	With your BASIC debit card (You can also submit claims for reimbursement online at www.basiconline.com)	With your BASIC debit card (You can also submit claims for reimbursement online at www.basiconline.com)
How much can I contribute for 2026? ***Note: HSA limits include employee and employer contributions combined, however the RESD does not currently contribute.***	You can contribute up to $4,400 for individual coverage $8,750 for 2 person & family Individuals 55 and older are eligible for an annual catch up provision of $1,000.	You can contribute up to $3,400 to your health care FSA in 2026.	You can contribute up to $3,400 to your health care FSA in 2026.
Can I change my contributions throughout the year?	Yes, you can request a HSA change form by contacting HR.	No, unless you have a qualifying life event.	No, unless you have a qualifying life event.

Flexible Spending Accounts

What is an FSA

Flexible Spending Accounts (FSA's) are part of Section 125, established by the IRS and allows employees to set aside money for future medical and/or child care costs on a pre-tax basis. They help you stretch your money and reduce your Federal, State, and Social-Security taxes.

These accounts help you SAVE money and are administered by BASIC.

There are three types of accounts under this plan:

- Health Care Flexible Spending Account (HCFSA)
- Dependent Care Flexible Spending Account (DCFSA)
- Limited Purpose Flexible Spending Account (LPFSA)

The difference between the HCFSA and the LPFSA is that the Limited Purpose is only for eligible dental and vision expenses. The LPFSA is used when you are also enrolled in a Health Savings Account (HSA).

2026 Annual Contribution/Rollover Limits:

Up to $3,400 per year to the Health Care FSA
Up to $7,500 per year to the Dependent Care FSA
Allowable Rollover Amount = $680.00

With any of these plans, you decide before the start of the plan year how much to contribute to each account. Your pre-tax contributions are withheld in equal amounts from your paychecks throughout the year. The money goes into an account(s) set up in your name. Use the money in your account(s) with the assigned debit card, or by filing a claim form for reimbursement. You may receive reimbursement by either check or direct deposit.

Note: Funds remaining in the account that exceed the annual rollover limit will be forfeited.

Medical & Limited Purpose FSA

A Medical FSA can be used to cover:

- Medical - deductibles, co-pays and coinsurance
- Prescriptions
- Dental or vision expenses
- Over-the-counter medicine or menstrual products
- PPE (i.e. masks, hand sanitizer)

Limited Purpose FSA can be used to cover:

- Dental expenses
- Orthodontia
- Vision expenses (i.e. contact lenses to cataract surgery)

Dependent Care FSA

Provider Requirements:

- Provider may not be a minor child or dependent for income tax purposes (i.e. an older child)
- Service provider must claim payments as income and comply with state regulations
- Services must be for the physical care of the child, not for education, meals, etc.
- Overnight camps are not eligible for reimbursement.
- Expenses paid for Pre-K are eligible but kindergarten and higher is not.

Health Savings Account

Health Savings Accounts

A Health Savings Account (HSA) is a cross between a flexible spending account (FSA), an IRA, and a 401(k)/403(b). Only those who enroll in the High Deductible Health Plan (HDHP) have the option to participate in the HSA, if eligible. You can access your HSA to pay for eligible expenses. In addition, your account has the ability to grow, year-to-year, tax deferred. HealthEquity will be the HSA third party administrator. The HSA account is your property. Like a 401(k)/403(b), it is your money and stays with you.

Eligibility

You must meet certain other requirements in order to participate in the HSA Contribution Feature. To be eligible, you must:

(a) be covered by a High Deductible Health Plan;

(b) Not be claimed as another person's tax dependent;

(c) Not be actually covered by Medicare; and

(d) Not have any health coverage other than coverage under a High Deductible Health Plan. Other coverage that will disqualify you from being eligible for the HSA contribution feature includes, but not limited to: coverage under your spouse's health plan if his/hers is not considered a HDHP plan under IRS guidelines, coverage under your spouse's medical reimbursement plan or flexible spending account, and coverage under a health reimbursement arrangement, including your spouse's health reimbursement arrangement.

Important Consideration

A HSA is an employee's property and HSA account holders are responsible for ensuring they meet the eligibility requirements for the pre-tax benefit as well as ensuring the funds are used to pay for qualified medical expenses. The HSA is separate from the medical high deductible plan and is a bank account used to help pay for those expenses not covered by the plan with pre-tax dollars. We encourage you to contact your tax adviser with specific HSA questions as the impact of these accounts changes based on circumstances. The following provides an overview of the important requirements as well as some commonly asked questions.

HSA Funding - Employee and Employer

The Statutory Maximum HSA Contribution for 2026 calendar year is $4,400 for a single and $8,750 for two person or a family. If you are age 55 or older, you can make an additional catch-up contribution amount of $1,000 in 2026. The HSA cannot receive contributions after you have enrolled in Medicare. The maximum contribution includes any employer contributions to your HSA.

You have the ability to adjust your HSA pre-tax election by filling out a change form and submitting it to Payroll.

Using Your HSA

Money in your HSA can be used to pay for a variety of healthcare-related expenses for you and your IRS eligible dependents (any out of pocket medical, dental and vision coverage after the insurance plan pays or processes the claim) ranging from office visits to prescription drugs. A full listing of eligible expenses can be found at: http://www.irs.gov/pub/irs-pdf/p969.pdf. To pay for expenses, you simply present your HSA debit card to your provider, and money will be deducted directly from your HSA.

Keeping track of your account balance is easy. You can review your account information 24/7 by logging onto www.healthequity.com or by calling HealthEquity at 866-346-5800.

Health Savings Account

Your HSA money is tax-free as long as it is used to pay for qualified medical expenses. If you use the money for any other reason, you will be required to pay income tax and a 20% tax penalty on that amount (you will not pay a penalty if you are disabled or age 65 or older).

Please note that you are not required to submit receipts for the purchases that you make. It is up to you to keep the supporting records to show the Internal Revenue Service whether you used the funds to pay for qualified medical expenses.

For tax filing purposes, HSA contributions will appear on your W-2 as a line item.

HSA Frequently Asked Questions

What is my HSA?

Your HSA is a health savings account (as defined under the Internal Revenue Code) established by you with a third party trustee/custodian (e.g., bank or insurance company) that is authorized to be the trustee of HSAs. Your Employer does not establish or sponsor your HSA. Furthermore, your Employer does not own your HSA; it is owned by you.

You may invest the funds in your HSA as allowed by the trustee/custodian of the account. Your employer has no control of or responsibility for the investment of your HSA.

What are the limits on the amount of contributions?

The total contributions made by you and/or made on your behalf (i.e., contributions by your Employer) into HSAs owned by you are subject to a maximum contribution limit. Generally, the maximum contribution you may receive in a year is an indexed amount as follows: $4,400 if you have self-only coverage or $8,750 if you have 2 person or family coverage (for 2026).

You are allowed to make or receive an additional catch up contribution for the year in which you will attain age 55 before the end of the year and for any year thereafter while you remain eligible. The catch-up contribution is currently $1,000 per year.

If you are eligible for contributions for only a portion of the year, your maximum contribution (including catch up contributions) is determined in accordance with the following rules:

(a) Not Eligible on December 1st. If you cease to be eligible for contributions prior to December 1st of a particular year, the contribution limit for that year will be a fraction of the maximum contribution for the full year based upon the number of months in which you were eligible.

For Example, if you have single coverage under a qualifying High Deductible Health Plan, are not eligible for catch up contributions, but are eligible only during January through June (i.e., six months of the year), your maximum contribution limit is $2,200.

(b) Eligible on December 1st. If you become eligible for HSA contributions during a particular year and you are eligible as of December 1st of that year, your maximum contribution for that year is the full indexed amount.

However, if you become ineligible for HSA contributions during the twelve (12) month period beginning with December of that year, you will not be entitled to the full maximum contribution. Instead, your maximum contribution will be a fraction of the maximum contribution for the full year based upon the number of months in which you were eligible during that year. The excess contributions will be included in your gross income and a 10% additional tax will be imposed on those contributions.

If you are married and both you and your spouse have coverage under a Qualifying High Deductible Health Plan, the lower annual deductible is used to determine the contribution limit. If both you and your spouse have health savings accounts, the limit is divided equally between you (unless you agree to a different allocation.)

Rollover contributions may also be made to an HSA from another health savings account or from an Archer MSA. Rollover contributions are not subject to the contribution limit described above.

Health Savings Account

What happens if my contributions exceed the contribution limit?

If the contributions to your HSA exceed the applicable maximum contribution limit for a year, generally the excess contributions will be included in your income and an excise tax will be imposed upon them. You will also be taxed on any earnings on the excess amounts. However, you can avoid the excess tax if you take a distribution of the excess contributions (and the net income attributable to the excess contribution) before the last day (including extensions) for filing your federal income tax return. This distribution must be included as taxable income when you file your taxes.

What are the tax consequences of the HSA Contribution Feature?

The contributions made under this HSA Contribution Feature will not be included in your gross income, unless they exceed the applicable maximum contribution limit as discussed above.

What are the rules regarding distributions from my HSA?

Your Employer has no control over or involvement with distributions made from your HSA. Your Employer does not substantiate expenses for which such distributions are made. Information regarding the procedure for obtaining distributions or the consequences of taking distributions is available from Health Equity and IRS Publication 969.

When does my participation end?

Participation in the HSA Contribution Feature ends upon the earlier of the date your participation in Plan ceases or the date you no longer satisfy the eligibility requirements of the plan. You need not be a participant in the HSA Contribution Feature (or be employed by the Employer) in order to obtain distributions from your HSA. In addition, you may make contributions to your HSA outside this Plan, provided you are eligible to do so under IRS rules, after you have left employment with the Employer or have ceased to be a participant in the Plan.

NOTE: This HSA Contribution Feature is **not** a group health plan for purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), the Family and Medical Leave Act (FMLA), and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). COBRA, FMLA, and USERRA do not apply to this HSA Contribution Feature. However, COBRA, FMLA, and USSERRA may apply to the Qualifying High Deductible Health Plan.

Can the contributions made to my HSA be forfeited?

No, once the contributions have been deposited in your HSA, you will have a nonforfeitable interest in the funds. You will be free to request a distribution of the funds or to move them to another provider of HSAs, to the extent allowed by law.

What are the reporting requirements?

Your Employer is responsible for reporting contributions made to your HSA through this HSA Contribution Feature on your Form W-2. You are also responsible for reporting contributions to your HSA, and for reporting distributions from your HSA, on appropriate forms available from the IRS.

The intent of this analysis is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal or tax advice.

Life/AD&D and Long Term Disability Insurance

Life and Accidental Death & Dismemberment Insurance

Insured by Reliance Standard

Life Insurance

Life insurance provides financial security for the people who depend on you. The Shiawassee RESD provides eligible employees with coverage for those times that may happen without notice. Assigned beneficiaries will be eligible to receive payment in the event of your death while employed by Shiawassee RESD. Please review your Reliance Standard certificate or contact Human Resources for more details.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Please review your Reliance Standard certificate or contact Human Resources for more details.

Assign a Beneficiary

When completing your enrollment form don't forget to complete the section for beneficiaries. Also, make sure to keep this information updated from year to year to ensure that your benefit is paid according to your wishes.

Long Term Disability insurance

Insured by Reliance Standard

Shiawassee RESD provides all eligible employees with Long Term Disability insurance through Reliance Standard Insurance Co.

Long Term Disability income provides an important source of income if you become disabled and are unable to work for an extended period of time. The plan provides a monthly benefit of 70% of covered monthly earnings up to a maximum monthly benefit of $5,000.

Please review your Reliance Standard certificate or contact Human Resources for more details.

Coverage Costs

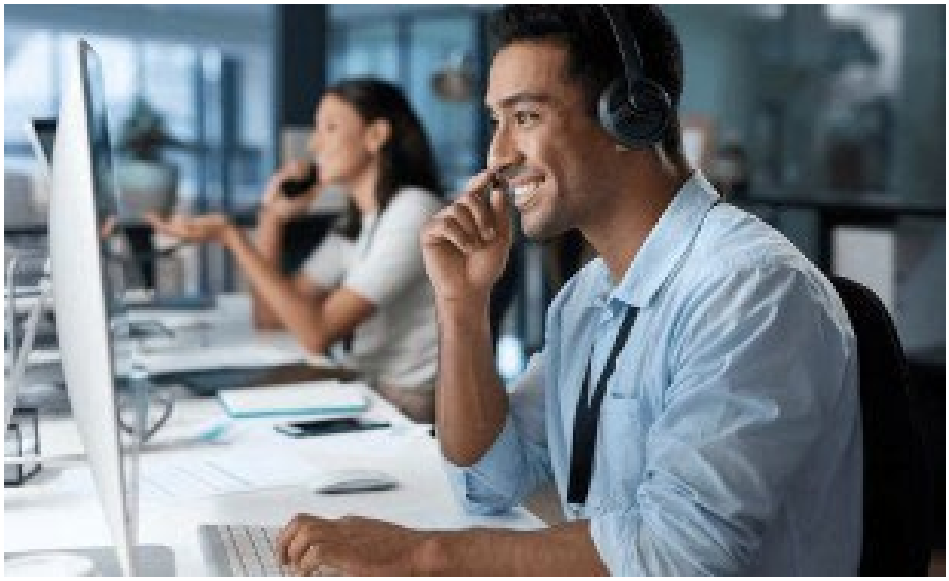
The chart below reflects the amount you will pay for the plan and tier you elect.
These amounts are **per paycheck** and will follow the number of pay checks you receive (with the exception of Drivers)

Medical Coverage Tier	BI-WEEKLY- 26 PAY	BI-WEEKLY -21 Pay	BI-WEEKLY-20 Pay (Drivers Only)
Plan 1 - 151, $500 100%	Single: $94.94 Employee+1: $262.07 Family: $288.03	Single: $117.54 Employee+1: $324.47 Family: $356.60	Single: $123.42 Employee+1: $340.69 Family: $374.43
Plan 2 - 174, $500 80%	Single: $71.21 Employee+1: $208.69 Family: $221.60	Single: $88.17 Employee+1: $258.37 Family: $274.36	Single: $92.57 Employee+1: $271.29 Family: $288.08
Plan 3 - 173, $1,000 100%	Single: $45.46 Employee+1: $150.75 Family: $149.49	Single: $56.29 Employee+1: $186.64 Family: $185.08	Single: $59.10 Employee+1: $195.98 Family: $194.34
Plan 4 - 143, $1,000 80%	Single: $28.34 Employee+1: $112.23 Family: $101.55	Single: $35.09 Employee+1: $138.95 Family: $125.73	Single: $36.84 Employee+1: $145.89 Family: $132.02
Plan 5 - 121/122, $2,000 100%	Single: $15.63 Employee+1: $83.62 Family: $65.96	Single: $19.35 Employee+1: $103.53 Family: $81.66	Single: $20.32 Employee+1: $108.71 Family: $85.74

Employer Benefits		
Dental	Guardian	Employer Paid
Vision	NVA	
Life AD&D	Reliance	
Long Term Disability	Reliance	

Contact Information

Benefit	Vendor	Group Number	Phone	Website or Email
Medical	BCBSM	000071565	877-752-1233	www.bcbsm.com
Dental	Guardian	G-00043476	888-482-7342	www.guardianlife.com
Vision	NVA	3330000001	800-672-7723	www.e-nva.com
Flexible Spending Account	BASIC	N/A	800-444-1922	www.Basiconline.com
Health Savings Account	HealthEquity	N/A	866-346-5800	www.healthequity.com



Legal Notices

Special Enrollment Notice & HIPAA Notice

Shiawassee RESD is committed to the privacy of your health information. The administrators of the (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Dawn Brandt, HR Coordinator at 989-743-3471 or brandt@sresd.org. The notice is also available on-line at sresd.org

Special Enrollment Notice: If you decline enrollment for yourself or an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new depend-ents. However, you must request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption. Further, if you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

HIPAA Privacy Notice - The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact **Dawn Brandt.**

Full Privacy Notice This notice describes how the Plan may use and disclose your protected health information (PHI) and how you can get access to this information. **Please review it carefully.** If you have any questions about this Notice, please contact the Privacy Officer at **Dawn Brandt.**

Our Policy Regarding PHI. We understand that health information about you obtained in connection with the Plan is personal, and we are committed to protecting your health information. For Plan administration purposes, we may maintain information related to your coverage under the Plan that iden-tifies you and relates to your physical or mental health, related health care services, and payment for health care. This information is called Protected Health Information, or PHI.

This Notice tells you the ways in which we may use and disclose your PHI. It also describes our obligations and your rights regarding the use and disclosure of PHI.

We are required by law to:
- Keep PHI obtained and created by the Plan private
- Provide you with certain rights with respect to your PHI
- Give you this Notice of our legal duties and privacy practices
- Follow the terms of the Notice of Privacy Practices that is currently in effect
- Notify affected individuals if a breach occurs that may have compromised the privacy or security of PHI

How We May Use and Disclose PHI:
The following categories describe how we may use and disclose PHI without your written authorization.

We may use and disclose PHI:

For treatment To facilitate health treatment or services by providers.

For payment To determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care pro-viders, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigatory, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your PHI with a utilization review or pre-certification service provider. Likewise, we may share your PHI with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For health care operations For operations necessary to run the Plan. For example, we may use PHI for underwriting, premium rating, and other activities relating to Plan coverage, to submit claims for stop-loss coverage; conduct or arrange for health review, legal services, audit services, and fraud and abuse detection; business planning and develop-ing such as cost management; and general Plan administrative activities. However, we will not use your genetic information for underwriting pur-poses.

To communicate with business associates Some services are provided to the Plan through contracts with "business associate." We may disclose PHI to our business associates so that they can perform a service for the Plan. To protect your PHI, we require business associates to agree in writing to appropriately safeguard your information.

Disclosure to health plan sponsor Information may be disclosed to your employer's personnel solely for purposes of administering benefits under the Plan. However, those employees are permitted to use or disclose your information only as necessary to perform plan administration func-tions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Other For other reasons permitted under HIPAA, such as when required to do so by law, for workers' compensation or similar programs, or in response to a court or administrative order.

Your Rights
You have the following rights with respect to your protected health information:

Right to Inspectand Copy - You may inspect and copy certain PHI that may be used to make decisions about your Plan benefits.

Right to Amend - You may amend incorrect or incomplete PHI if you provide a reason that supports your request.

Legal Notices

Special Enrollment Notice & HIPAA Notice, CONT'D

Right to an Accounting of Disclosures. You may request a list (an "accounting") of the times we have shared your protected health information with others. The accounting will not include disclosures for purposes of treatment, payment, or health care operations; disclosures made to you; disclosures made pursuant to your authorization; or disclosures made for certain governmental functions.

Right to Request Restrictions. You may request a restriction or limitation on the disclosure of your PHI for treatment, payment, or health care operations, or to someone who is involved in your care or the payment for your care, such as a family member or friend.

Right to Request Confidential Communications. You may request that we communicate with you about your PHI in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to a Paper Copy of This Notice. You may ask for a paper copy of this Notice at any time. Even if you have agreed to receive this notice electroni-cally, you are still entitled to a paper copy of this Notice.

Complaints. If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

Changes to this Notice. We may revise this Notice and reserve the right to make the revised Notice effective for PHI we possess as of the date of the revision as well as any information we receive after the change. The new Notice will be available, upon request, and we will distribute a paper copy.

Women's Health & Cancer Rights Act

If you receive plan benefits in connection with a mastectomy, you are entitled to coverage for the following under the plan:

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

The plan will determine the manner of coverage in consultation with you and your attending doctor. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan. If you would like further information about the Women's Health & Cancer Rights Act, please contact your medical carrier or your employer.

Disclosure about the Benefit Enrollment Communications

The benefit enrollment communications (the Benefit Guide, etc.) contains a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. Shiawassee RESD reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents.

Michelle's Law

Michelle's Law requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under Shiawassee RESD's Group Health Plan because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under Shiawassee RESD's Group Health Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under Shiawassee RESD's Group Health Plan and was enrolled as a student at a post-secondary educational institution.

A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that: (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan – for example, by reaching age 26.

If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle's Law coverage continuation period.

Legal Notices

CREDITABLE COVERAGE NOTICE

About Your Prescription Drug Coverage and Medicare

IF YOU (AND ALL OFYOURDEPENDENTS)ARENOT ELIGIBLE FORMEDICARE, YOUMAY DISREGARDTHIS NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Shiawassee RESD has determined that the prescription drug coverage offered by the Shiawassee RESD Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Shiawassee RESD coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

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

You should also know that if you drop or lose your current coverage with Shiawassee RESD and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Shiawassee RESD changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

Legal Notices

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP).

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866-444-EBSA (3272)**

To see what states have a premium assistance program, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext 61565

This benefit summary prepared by

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.