2026 Benefit Guide

Prepared For: Stockbridge Community Schools

STOCKBRIDGE COMMUNITY SCHOOLS

Our Employees Are Our Most Valuable Asset

Stockbridge Community Schools is committed to offering a comprehensive employee benefits program that helps our employees stay healthy, feel secure, and maintain a work-life balance.

Stay Healthy

- Medical, Dental, Vision
- Flexible Spending Accounts

Feeling Secure

- Disability Insurance
- MPSERS/403(b)/457 plan
- Life and Accidental Death & Dismemberment Insurance
- Identity Theft Program

Work-Life Balance

- Employee Assistance Program

Contact Information for Benefit Vendors

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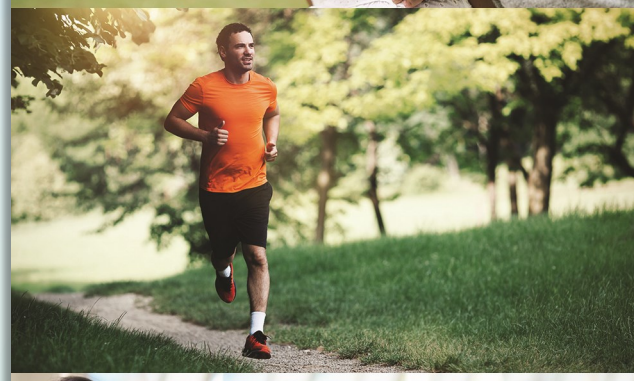

Health Insurance

Who is Eligible and When

Superintendent, Administrators, Supervisors, Admin Office Support, Teacher, Secretaries, Custodians, Bus Drivers, and 30 hour eligible ACA employees

Carrier Name and Website Address

Blue Cross Blue Shield of Michigan

www.bcbsm.com

Network Provider and Website Address

- BlueCross BlueShield Blue Care Network of Michigan
- Log in to Blue Cross Blue Shield of Michigan | BCBSM

Prescription Provider Name and Website Address

EHIM

www.ehimrx.com

Employee Pays

Refer to your employment contract or bargained agreement

Employer Pays

Refer to your employment contract or bargained agreement

Benefits You Receive

See attached Benefit Summary

Stockbridge Community Schools 1-1-2026 to 12-31-2024 Medical/Rx - Plan Highlights $1,000 Deductible HRA - BCBSM/EHIM		
Partial listing of covered services	In Network	Out of Network
Deductible and Out-of-Pocket		
Annual Deductible	$1,000 per person $2,000 per family	$10,000 per person $20,000 per family
Annual medical out-of-pocket maximum	$5,000 per person $10,000 per family	$12,700 per person $25,400 per family
Annual Rx out-of-pocket maximum	$800 per person $1,600 per family	Member could pay more due to U&C restrictions
Preventive Healthcare		
Annual physical	you pay nothing	Most preventative services not covered. Mammography and Colonoscopy covered at 40% member cost-share. See benefit summary or contact BCBSM for more details.
Immunizations and Prenatal		
Postnatal, family planning & screenings		
Preventative Care Drugs		
Office Visits		
Illness or injury	$20 Co-pay	you pay 40% after deductible
Physical, occupational therapy, speech therapy		
Chiropractic care		
Mental / Chemical health care		
Retail Clinic		
Emergency Care		
Care at an urgent care clinic or medical center	$40 Co-pay	you pay 40% after deductible
Emergency care at a hospital ER	$250 Co-pay	$250 Co-pay
Inpatient Hospital Care		
Illness or injury	you pay nothing after deductible	you pay 40% after deductible
Mental / Chemical health care		
Outpatient Care		
Scheduled outpatient procedures	you pay nothing after deductible	you pay 40% after deductible
MRI/CT		
Durable Medical Equipment (DME)		
Hearing Aids	$1,684 limit per ear for hearing aid, plus $250 for other services	
DME & prosthetic devices	you pay nothing after deductible	you pay 20% after deductible

Pharmacy Highlights		
Partial listing of covered services		
	Retail Pharmacy	
Generic preferred	$10 copay	$10 copay (member must pay in advance and then submit for reimbursement at usual and customary). Member may not be fully reimbursed based on Usual & Customary.
Brand preferred	$40 copay	$40 copay (member must pay in advance and then submit for reimbursement at usual and customary). Member may not be fully reimbursed based on Usual & Customary.
Non-preferred	$80 copay	$80 copay (member must pay in advance and then submit for reimbursement at usual and customary). Member may not be fully reimbursed based on Usual & Customary.
	Mail Order Pharmacy (up to a 90-day supply)	
Generic preferred	$20 copay	Not covered
Brand preferred	$80 copay	
Non-preferred	$160 copay	

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2026 - 12/31/2026**

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

STOCKBRIDGE COMMUNITY SCHOOL

BEP HSA POS Certificate For Large Groups **Coverage for:** All Contract Types | **Plan Type: POS**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call 1-800-662-6667 . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at (https://www.healthcare.gov/sbc-glossary) or call 1-800-662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	In Network: $2,000/$4,000 Out of Network: $4,000/$8,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and routine maternity care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	In Network: $4,000/$8,000 Out of Network: $8,000/$16,000	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan,the overall family out-of-pocket limit must be met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See (www.BCBSM.com) or call customer service for a list of network providers and out-of-state coverage. 1-800-662-6667	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	20% coinsurance	No charge for in-network medical online visits with a BCN participating online provider. Deductible does not apply to preventive services. Michigan residents must select a BCN PCP.
	Specialist visit	No charge	20% coinsurance	20% coinsurance for out of network online visits. 30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician; not covered out-of-network.
	Preventive care/screening/immunization	No charge, deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Out of Network routine colonoscopy, mammography screening and routine prenatal care covered with 20% coinsurance.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	May require preauthorization for non-preventive services.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Requires preauthorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/hcdl	Preferred Generic Tier	$4 copay/30 days	Not covered	Prior-auth & step therapy apply to select drugs. No charge for Preferred Generic contraceptives and preventive drugs. Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum. 50% coinsurance for sexual dysfunction drugs. No charge for Tier 1A contraceptives. 84-90 day retail & 31-90 day mail order copays are 3x the 30-day copay minus $10.
	Non-Preferred Generic Tier	$15 copay/30 days	Not covered	
	Preferred Brand Tier	$40 copay/30 days	Not covered	
	Non-Preferred Brand Tier	$80 copay/30 days	Not covered	
	Preferred Specialty Tier	20% coinsurance	Not covered	$200 copay max. Limited to a 30 day supply. Specialty Drugs are covered only within the Exclusive Specialty Pharmacy Network.
	Non-Preferred Specialty Tier	20% coinsurance	Not covered	$300 copay max. Limited to a 30 day supply. Specialty Drugs are covered only within the Exclusive Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	May require preauthorization/50% coinsurance for weight reduction, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy. Out of network weight reduction procedures are not covered.
	Physician/surgeon fees	No charge	20% coinsurance	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	Non-emergent transport is covered when preauthorized.
	Urgent care	No charge	No charge	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Preauthorization is required. 50% coinsurance for weight reduction procedures. 50% coinsurance for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy. No charge for in and out of network transplant surgery. Transplants must be performed in an approved designated facility. Out of network weight reduction procedures are not covered.
	Physician/surgeon fee	No charge	20% coinsurance	See "Hospital stay facility fee"
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No charge	20% coinsurance	None
	Inpatient services	No charge	20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No charge for routine prenatal care. Deductible does not apply.	20% coinsurance	Deductible does not apply to routine maternity services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services, cost share may apply.
	Childbirth/delivery professional services	No charge	20% coinsurance	None
	Childbirth/delivery facility services	No charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Requires preauthorization. Custodial care not covered.
	Rehabilitation services	No charge	20% coinsurance	Requires preauthorization/Up to 60 visits per calendar year for any combination of outpatient rehabilitation therapies. Subject to meaningful improvement within 60 days.
	Habilitation services	ABA - No charge /No charge for PT/OT/ST	20% coinsurance	Habilitation services are limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders. PT/OT/ST for autism spectrum disorder has unlimited visits. Requires preauthorization.
	Skilled nursing care	No charge	20% coinsurance	Requires preauthorization/Limited to 45 days per calendar year. Custodial care not covered.
	Durable medical equipment	50% coinsurance	Not covered	Requires preauthorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered in full. Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.
	Hospice services	No charge	20% coinsurance	Inpatient care requires preauthorization. Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Contact your benefit administrator for coverage information.
	Children's glasses	Not covered	Not covered	Contact your benefit administrator for coverage information.
	Children's dental check-up	Not covered	Not covered	Contact your benefit administrator for coverage information.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental Care (Adult) • Hearing aids	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult)	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (Limited to one per lifetime. Requires preauthorization)	• Chiropractic care	• Infertility treatment (Coverage includes diagnosis/counseling/treatment of infertility when medically necessary and preauthorized by BCN. See Certificate of Coverage for exclusions)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform., or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact : Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284,Southfield, MI 48086 or fax. 1-866-522-7345. For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs; call 1-877-999-6442 or fax: 517-284-8838.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444- EBSA (3272) or www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this Plan Provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Plan Meet the Minimum Value Standard? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example, prescription drugs, through another carrier.)

Translation available
To get help reading in your language call the customer service number on the back of your ID card.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

If you are also covered by an account-type plan such as an integrated health reimbursement arrangement (HRA), and/or an health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses-like deductible, copayments, or coinsurance or benefits not otherwise covered.

The plan would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711. إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ، یان کەسێک کە تۆ یارمەتی دەدەیت، پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە خۆڕایی یارمەتی و زانیاری بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەرانەوە بکە کە لەسەر کارتەکەت هەیە، یان 877-469-2583 TTY:711، ئەگەر ئەندام نیت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2026 - 12/31/2026**

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

STOCKBRIDGE COMMUNITY SCHOOL

BEP HSA POS Certificate For Large Groups **Coverage for:** All Contract Types | **Plan Type: POS**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call 1-800-662-6667 . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at (https://www.healthcare.gov/sbc-glossary) or call 1-800-662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	In Network: $3,400/$6,800 Out of Network: $6,800/$13,600	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and routine maternity care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	In Network: $6,900/$13,800 Out of Network - $13,800/$27,600	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See (www.BCBSM.com) or call customer service for a list of network providers and out-of-state coverage. 1-800-662-6667	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	20% coinsurance	No charge for in-network medical online visits with a BCN participating online provider. Deductible does not apply to preventive services. Michigan residents must select a BCN PCP.
	Specialist visit	No charge	20% coinsurance	20% coinsurance for out of network online visits. 30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician; not covered out-of-network.
	Preventive care/screening/immunization	No charge, deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Out of Network routine colonoscopy, mammography screening and routine prenatal care covered with 20% coinsurance.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	May require preauthorization for non-preventive services.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Requires preauthorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/hcdl	Preferred Generic Tier	$4 copay/30 days	Not covered	Prior-auth & step therapy apply to select drugs. No charge for Preferred Generic contraceptives and preventive drugs. Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum. 50% coinsurance for sexual dysfunction drugs. No charge for Tier 1A contraceptives. 84-90 day retail & 31-90 day mail order copays are 3x the 30-day copay minus $10.
	Non-Preferred Generic Tier	$15 copay/30 days	Not covered	
	Preferred Brand Tier	$40 copay/30 days	Not covered	
	Non-Preferred Brand Tier	$80 copay/30 days	Not covered	
	Preferred Specialty Tier	20% coinsurance	Not covered	$200 copay max. Limited to a 30 day supply. Specialty Drugs are covered only within the Exclusive Specialty Pharmacy Network.
	Non-Preferred Specialty Tier	20% coinsurance	Not covered	$300 copay max. Limited to a 30 day supply. Specialty Drugs are covered only within the Exclusive Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	May require preauthorization/50% coinsurance for weight reduction, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy. Out of network weight reduction procedures are not covered.
	Physician/surgeon fees	No charge	20% coinsurance	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	Non-emergent transport is covered when preauthorized.
	Urgent care	No charge	No charge	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Preauthorization is required. 50% coinsurance for weight reduction procedures. 50% coinsurance for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy. No charge for in and out of network transplant surgery. Transplants must be performed in an approved designated facility. Out of network weight reduction procedures are not covered.
	Physician/surgeon fee	No charge	20% coinsurance	See "Hospital stay facility fee"
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No charge	20% coinsurance	None
	Inpatient services	No charge	20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No charge for routine prenatal care. Deductible does not apply.	20% coinsurance	Deductible does not apply to routine maternity services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services, cost share may apply.
	Childbirth/delivery professional services	No charge	20% coinsurance	None
	Childbirth/delivery facility services	No charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Requires preauthorization. Custodial care not covered.
	Rehabilitation services	No charge	20% coinsurance	Requires preauthorization/Up to 60 visits per calendar year for any combination of outpatient rehabilitation therapies. Subject to meaningful improvement within 60 days.
	Habilitation services	ABA - No charge /No charge for PT/OT/ST	20% coinsurance	Habilitation services are limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders. PT/OT/ST for autism spectrum disorder has unlimited visits. Requires preauthorization.
	Skilled nursing care	No charge	20% coinsurance	Requires preauthorization/Limited to 45 days per calendar year. Custodial care not covered.
	Durable medical equipment	50% coinsurance	Not covered	Requires preauthorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered in full. Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.
	Hospice services	No charge	20% coinsurance	Inpatient care requires preauthorization. Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Contact your benefit administrator for coverage information.
	Children's glasses	Not covered	Not covered	Contact your benefit administrator for coverage information.
	Children's dental check-up	Not covered	Not covered	Contact your benefit administrator for coverage information.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental Care (Adult) • Hearing aids	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult)	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (Limited to one per lifetime. Requires preauthorization)	• Chiropractic care	• Infertility treatment (Coverage includes diagnosis/counseling/treatment of infertility when medically necessary and preauthorized by BCN. See Certificate of Coverage for exclusions)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform., or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact : Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284,Southfield, MI 48086 or fax. 1-866-522-7345. For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs; call 1-877-999-6442 or fax: 517-284-8838.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444- EBSA (3272) or www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this Plan Provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Plan Meet the Minimum Value Standard? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example, prescription drugs, through another carrier.)

Translation available
To get help reading in your language call the customer service number on the back of your ID card.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3400
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,470**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3400
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3400
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

If you are also covered by an account-type plan such as an integrated health reimbursement arrangement (HRA), and/or an health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses-like deductible, copayments, or coinsurance or benefits not otherwise covered.

The plan would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711. إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ يان كەسێك كە يارمەتى دەدەيت، پێويستى بە يارمەتى هەيە، مافى ئەوەت هەيە بە خۆڕايى يارمەتى و زانيارى بە زمانەكەى خۆت وەربگرى. بۆ قسە كردن لەگەڵ وەرگێڕ، پەيوەندى بە ژمارەى خزمەتگوزارى كڕيارانەوە بكە كە لەپشت كارتەكەتەوە هەيە، يان 877-469-2583 TTY:711 بكە ئەگەر ئەندام نيت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

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You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Dental Insurance

Who is Eligible and When

Superintendent, Administrators, Supervisors, Admin Office Support, Teachers, Secretaries, Custodians,

Carrier Name and Website Address

ADN

www.adndental.com

Network Provider and Website Address

- PPO Network: ADN Dental Network: DenteMax
- portaladndental.com

Employee Pays

Refer to your employment contract or bargained agreement

Employer Pays

Refer to your employment contract or bargained agreement

Benefits You Receive

See attached Benefit Summary

ADN ADMINISTRATORS

PO Box 610
Southfield, MI 48037
248-901-3705

STOCKBRIDGE COMMUNITY SCHOOLS Dental Benefits Plan **Group #9898**
Policy

The Plan-at-a-Glance	**PPO Networks: ADN Dental Network, DenteMax**
Maximum Benefits	**Plan year July 1, 2025 through Dec 31, 2026*** **
Annual Maximum	$1500 per eligible individual for covered class I, II and III services***
Lifetime Maximum	$1500 per eligible individual for covered class IV services
Class I Preventive Services – 100%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year (includes Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Space Maintainers	Once per area per lifetime, up to age 14
Class II Restorative Services – 90%	
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Composite and Amalgam fillings	Once per tooth surface per 24 months
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment (includes prophylaxes)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 90%	
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Endosteal Implants	Once per permanent tooth per 60 months
Class IV Orthodontic Services – 90%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	

Sealants Eposteal and Transosteal Implants TMJ/TMD Treatment Cosmetic Treatment

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Porcelain and ceramic not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Eligibility is determined at time of service. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitations. Benefits are payable at the applicable percentage level of the Usual and Customary or PPO Fee Schedule allowed amount for the procedure rendered. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $250.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

***Temporary extended plan year and annual maximum increase for plan year change to January going forward

Updated 1/14/2026

ADN ADMINISTRATORS

PO Box 610
Southfield, MI 48037
248-901-3705

STOCKBRIDGE COMMUNITY SCHOOLS Dental Benefits Plan **Group #9898**
Administrators

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year July 1, 2025 through Dec 31, 2026 *** **
Annual Maximum	$1500 per eligible individual for covered class I, II and III services***
Lifetime Maximum	$1500 per eligible individual for covered class IV services
Class I Preventive Services – 100%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year (includes Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Space Maintainers	Once per area per lifetime, up to age 14
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Class II Restorative Services – 90%	
Composite and Amalgam fillings	Once per tooth surface per 24 months
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment (includes prophylaxes)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 90%	
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Endosteal Implants	Once per permanent tooth per 60 months
Class IV Orthodontic Services – 90%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	
Sealants	Eposteal and Transosteal Implants
TMJ/TMD Treatment	Cosmetic Treatment

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Porcelain and ceramic not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Eligibility is determined at time of service. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitations. Benefits are payable at the applicable percentage level of the Usual and Customary or PPO Fee Schedule allowed amount for the procedure rendered. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $250.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

***Temporary extended plan year and annual maximum increase for plan year change to January going forward

Updated 1/14/2026

ADN ADMINISTRATORS

PO Box 610
Southfield, MI 48037
248-901-3705

STOCKBRIDGE COMMUNITY SCHOOLS Dental Benefits Plan **Group #9898**
Custodians

The Plan-at-a-Glance	**PPO Networks: ADN Dental Network, DenteMax**
Maximum Benefits	**Plan year Oct 1, 2025 through Dec 31, 2026*** **
Annual Maximum	$1000 per eligible individual for covered class I, II and III services***
Lifetime Maximum	$800 per eligible individual for covered class IV services
TMJ Lifetime Maximum	$500 per eligible individual for covered TMJ services
Class I Preventive Services – 80%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year
Topical Application of Fluoride	Once per plan year to age 18
Sealants	Once per 24 months; permanent molars to age 14
Bitewing X-Rays	Twice per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 36 months
All Other X-Rays	
Space Maintainers	Once per area per lifetime, up to age 19
Class II Restorative Services – 80%	
Composite and Amalgam fillings**	
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 24 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	Once per 24 months
Class III Major Services – 80%	
Inlays, Onlays and Crowns**	Once per permanent tooth per 60 months
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 24 months, per arch
Addition of Teeth to Partial Dentures	
Class IV Orthodontic Services – 50%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	
Implants Cosmetic Treatment	

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Composite, porcelain and ceramic not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Eligibility is determined at time of service. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitations. Benefits are payable at the applicable percentage level of the Usual and Customary or PPO Fee Schedule allowed amount for the procedure rendered. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $250.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

***Temporary extended plan year and annual maximum increase for plan year change to January going forward

Updated 1/14/2026

ADN ADMINISTRATORS

PO Box 610
Southfield, MI 48037
248-901-3705

STOCKBRIDGE COMMUNITY SCHOOLS Dental Benefits Plan **Group #9898**
Teachers, Secretaries (A)

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year Oct 1, 2025 through Dec 31, 2026*** **
Annual Maximum	$1250 per eligible individual for covered class I, II and III services***
Lifetime Maximum	$1500 per eligible individual for covered class IV services
Class I Preventive Services – 100%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year (includes Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Space Maintainers	Once per area per lifetime, up to age 14
Class II Restorative Services – 90%	
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Consultations	Allowed for Non-Treating provider only
Composite and Amalgam fillings	Once per tooth surface per 24 months
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment (includes prophylaxes)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 90%	
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Endosteal Implants	Once per permanent tooth per 60 months
Class IV Orthodontic Services – 90%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	
Sealants	Eposteal and Transosteal Implants
TMJ/TMD Treatment	Cosmetic Treatment

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Porcelain and ceramic not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Eligibility is determined at time of service. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitations. Benefits are payable at the applicable percentage level of the Usual and Customary or PPO Fee Schedule allowed amount for the procedure rendered. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $250.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

***Temporary extended plan year and annual maximum increase for plan year change to January going forward

Updated 1/14/2026

ADN ADMINISTRATORS

PO Box 610
Southfield, MI 48037
248-901-3705

STOCKBRIDGE COMMUNITY SCHOOLS Dental Benefits Plan **Group #9898**
Teachers, Secretaries (B)

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year Oct 1, 2025 through Dec 31, 2026*** **
Annual Maximum	$1250 per eligible individual for covered class I, II and III services***
Lifetime Maximum	$1500 per eligible individual for covered class IV services
Class I Preventive Services – 100%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year (includes Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Space Maintainers	Once per area per lifetime, up to age 14
Class II Restorative Services – 90%	
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Consultations	Allowed for Non-Treating provider only
Composite and Amalgam fillings	Once per tooth surface per 24 months
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment (includes prophylaxes)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 90%	
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Endosteal Implants	Once per permanent tooth per 60 months
Class IV Orthodontic Services – 90%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	
Sealants	Eposteal and Transosteal Implants
TMJ/TMD Treatment	Cosmetic Treatment

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Porcelain and ceramic not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Eligibility is determined at time of service. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitations. Benefits are payable at the applicable percentage level of the Usual and Customary or PPO Fee Schedule allowed amount for the procedure rendered. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $250.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

***Temporary extended plan year and annual maximum increase for plan year change to January going forward

Updated 1/14/2026

Vision Insurance

Who is Eligible and When

Superintendent, Administrators, Supervisors, Admin Office Support, Teachers, Secretaries, Custodians,

Carrier Name and Website Address

ADN

www.adndental.com

Network Provider and Website Address

- adndental.com

Employee Pays

Refer to your employment contract or bargained agreement

Employer Pays

Refer to your employment contract or bargained agreement

Benefits You Receive

See attached Benefit Summary

ADN ADMINISTRATORS

STOCKBRIDGE COMMUNITY SCHOOLS - Vision Benefits Plan **Group # 9898**
Administrators, Policy

The Plan-at-a-Glance	**Benefit Year – July 1 through June 30**
Vision Examination	Covered at 100% of Reasonable & Customary (R&C)
Spectacle Lenses (Pair):	
Single Vision	Covered at 100% of R&C
Bifocal	According to Limits & Exclusions
Trifocal	
Lenticular	
Frames	Covered Up to $65
Contact Lenses (Pair)	
Cosmetic/Elective (Includes Vision Exam and Fitting)	Covered Up to $115
Medically Necessary	Covered at 100% of R&C

Extra Lens Features – Tinted, Photochromic (Transition), Polycarbonate, Polarized, Oversize and Blended Lenses, Rimless Drill

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. The additional cost of progressive lenses
10. Charges for contact lenses, including the exam, prescription and fitting fee, that exceed the one-time annual plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges for each insured person.

PO Box 610, Southfield, MI 48037 248-901-3705

ADN ADMINISTRATORS

STOCKBRIDGE COMMUNITY SCHOOLS - Vision Benefits Plan **Group # 9898**
Teachers & Secretaries A

The Plan-at-a-Glance	**Benefit Year – October 1 through September 30**
Vision Examination	Covered at 100% of Reasonable & Customary (R&C) Following $6.50 Copay
Spectacle Lenses (Pair):	
Single Vision Bifocal Trifocal Lenticular	Covered at 100% of R&C Following $18 Combined Deductible for Lenses and Frames According to Limits & Exclusions
Frames	Covered Up to $65 Following $18 Combined Deductible for Frames and Lenses
Contact Lenses (Pair)	
Cosmetic/Elective (Includes Vision Exam and Fitting)	Covered Up to $90
Medically Necessary	Covered at 100% of R&C

Extra Lens Features – Tinted, Photochromic (Transition), Polycarbonate, Polarized, Oversize and Blended Lenses, Rimless Drill

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. The additional cost of progressive lenses
10. Charges for contact lenses, including the exam, prescription and fitting fee, that exceed the one-time annual plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges for each insured person.

PO Box 610, Southfield, MI 48037 248-901-3705

ADN ADMINISTRATORS

STOCKBRIDGE COMMUNITY SCHOOLS - Vision Benefits Plan **Group # 9898**
Teachers & Secretaries B

The Plan-at-a-Glance	**Benefit Year – October 1 through September 30**
Vision Examination	Covered at 100% of Reasonable & Customary (R&C)
Spectacle Lenses (Pair):	
Single Vision	Covered at 100% of R&C
Bifocal	According to Limits & Exclusions
Trifocal	
Lenticular	
Frames	Covered Up to $65
Contact Lenses (Pair)	
Cosmetic/Elective (Includes Vision Exam and Fitting)	Covered Up to $115
Medically Necessary	Covered at 100% of R&C

Extra Lens Features – Tinted, Photochromic (Transition), Polycarbonate, Polarized, Oversize and Blended Lenses, Rimless Drill

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. The additional cost of progressive lenses
10. Charges for contact lenses, including the exam, prescription and fitting fee, that exceed the one-time annual plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges for each insured person.

PO Box 610, Southfield, MI 48037 248-901-3705

ADN ADMINISTRATORS

STOCKBRIDGE COMMUNITY SCHOOLS - Vision Benefits Plan **Group # 9898**
Custodians

The Plan-at-a-Glance	**Benefit Year – October 1 through September 30**
Vision Examination	Covered at 100% of Reasonable & Customary (R&C) Following $5.00 Copay
Spectacle Lenses (Pair):	
Single Vision	Covered at 100% of R&C
Bifocal	Following $7.50 Combined Copay for Lenses and Frames
Trifocal	According to Limits & Exclusions
Lenticular	
Frames	Covered at 100% of R&C Following $7.50 Combined Copay for Frames and Lenses
Contact Lenses (Pair)	Covered Up to $80

Extra Lens Features – Rose Tint 1 and 2

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features.
9. The additional cost of progressive lenses
10. Charges for contact lenses, including the prescription and fitting fee, that exceed the one-time annual plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges for each insured person.

PO Box 610, Southfield, MI 48037 248-901-3705

Long Term Disability Insurance

Who is Eligible and When

Classes 01 - 02: First day of Active Work

Classes 03 - 04, 06: First of month following completion of the Waiting Period if hired during the school year; 9/1 if hired during the summer

Carrier Name and Website Address

Madison National Life Insurance

www.nisbenefits.com

Employee Pays

10%

Employer Pays

90%

Benefits You Receive

See attached Benefit Summary

Class #	Class Title and Eligibility (Minimum Hour Requirement)	Maximum Annual Covered Salary / Maximum Monthly Benefit	Benefit	Elimination Period
01	Superintendent (40 hours per week)	$170,004 / $8,500	60%	Length of accumulated sick leave, or 90 calendar days of Disability accumulated in any twelve (12) consecutive months, whichever is later. The last three (3) sick days or days of Disability must be consecutive and due to the same or a related cause; OR Three (3) consecutive days of Disability occurring during a school year in which the Elimination Period was previously satisfied.
02	Administrators, Supervisors and Administration Office Support (40 hours per week)	$99,996 / $5,000	60%	Length of accumulated sick leave, or 90 calendar days of Disability accumulated in any twelve (12) consecutive months, whichever is later. The last three (3) sick days or days of Disability must be consecutive and due to the same or a related cause; OR Three (3) consecutive days of Disability occurring during a school year in which the Elimination Period was previously satisfied.
03	Teachers and Nurses (33.75 hours per week)	$50,004 / $2,500	60%	Length of accumulated sick leave, or 90 calendar days of Disability accumulated in any twelve (12) consecutive months, whichever is later. The last three (3) sick days or days of Disability must be consecutive and due to the same or a related cause; OR Three (3) consecutive days of Disability occurring during a school year in which the Elimination Period was previously satisfied.
04	Support Staff (40 hours per week)	$50,004 / $2,500	60%	Length of accumulated sick leave, or 90 calendar days of Disability accumulated in any twelve (12) consecutive months, whichever is later. The last three (3) sick days or days of Disability must be consecutive and due to the same or a related cause; OR Three (3) consecutive days of Disability occurring during a school year in which the Elimination Period was previously satisfied.
06	Part-Time Teacher & Part-Time Counselors (15 hours per week)	$50,004 / $2,500	60%	Length of accumulated sick leave, or 90 calendar days of Disability accumulated in any twelve (12) consecutive months, whichever is later. The last three (3) sick days or days of Disability must be consecutive and due to the same or a related cause; OR Three (3) consecutive days of Disability occurring during a school year in which the Elimination Period was previously satisfied.

Life and AD&D Insurance

Who is Eligible and When

Classes 01 - 02, 07 - 08, 12, 14: First of month following completion of the Waiting Period if hired during the school year; 9/1 if hired during the summer

Classes 03 - 04, 06, 11, 13: First day of Active Work

Class 10: First of month following 90 days

Carrier Name and Website Address

Madison National Life Insurance

www.nisbenefits.com

Employer Pays

Classes 01-02, 04, 06-08, 11-12, 14: 90%

Class 03, 13: 100%

Class 10: 80%

Employee Pays

Classes 01-02, 04, 06-08, 11-12, 14:10%

Class 03, 13: 0%

Class 10: 20%

Benefits You Receive

See attached Benefit Summary

Class #	Class Title and Eligibility (Minimum Hour Requirement)	Basic Life and AD&D
01	Teachers with Medical (33.75 hours per week)	$25,000
02	Teachers without Medical (33.75 hours per week)	$35,000
03	Superintendent (40 hours per week)	Two times annual salary, rounded to the nearest $1,000 to a maximum of $300,000
04	Administrators & Department Heads (40 hours per week)	$55,000
06	Administration Office Support (40 hours per week)	$40,000
07	Support Staff with Medical (40 hours per week)	$25,000
08	Support Staff without Medical (40 hours per week)	$35,000
10	Custodians (40 hours per week)	$20,000
11	Maintenance Director (40 hours per week)	$35,000
12	Part-Time Teachers & Part-Time Counselors (15 hours per week)	$17,500
13	Nurses (33.75 hours per week)	$35,000
14	Transportation Employee with Medical (30 hours per week)	$20,000

Flexible Spending Account

Who is Eligible and When

All employees

Benefits You Receive:

Flexible Spending Accounts (FSAs) provide you with an important tax advantage that can help you pay for health care and dependent care expenses on a pre-tax basis. By estimating your family's health care and dependent care costs for the next year, you can lower your taxable income and save money.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses with a prescription not covered by their insurance plan with pre-tax dollars. The current limit on salary reduction contributions to a health FSA offered under a cafeteria plan is $3,400 and is applicable to both grandfathered and non-grandfathered health FSAs. This limit is indexed for cost-of-living adjustments in subsequent years. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations, and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

Dependent Care FSA

The Dependent Care FSA lets employees use pre-tax dollars toward qualified dependent care such as caring for children under the age of 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $7,500 (or $3,750 if married and filing separately) per calendar year. This is a use it or lose it account, no carry over to future years. This is a tax savings benefit. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Health Savings Account

Who is Eligible and When

- Employees enrolled in a High-Deductible Health Plan option (and not enrolled in Medicare), who choose the funded HSA Option.

Benefits You Receive

- For 2026, Stockbridge Community Schools will make contributions into an HSA account with HealthEquity on quarterly basis— January 1, April 1, July 1, October 1. The contribution amounts will equal the in-network single, two-persons, or family deductible of the plan chose.

Using an HSA

- A Health Savings Account (HSA) is managed by the account holder, giving you the choice of when to use your HSA dollars. You can begin using your HSA money as soon as your account is activated and contributions have been made. Contributions to your HSA can be made by anyone, including you, your employer, or a family member; the combined contributions of you and your employer (and anyone else making contributions to your HSA) cannot exceed the HSA maximum contribution limit. For 2026, the maximum is $4,400 for single coverage and $8,750 for family coverage. Individuals who are age 55 and older can also make additional "catch-up" contributions of up to $1,000 annually.

- You can use your HSA account for any purpose, including paying expenses that are not qualified medical expenses. However, you only get the tax benefits of an HSA when you use the account for qualified medical expenses. If you use it for another purpose, you will be required to pay income tax on the withdrawal, and you may also be required to pay another 20 percent tax, unless you make the withdrawal after you reach age 65, become disabled or after your death.

HealthEquity®

MAYBE YOU'VE HAD AN HSA BEFORE, BUT YOU'VE NEVER HAD AN HSA LIKE THIS

Get support 24/7

Call us day or night. Our US-based service team measures success by problems solved. We'll do whatever it takes.

Say goodbye to hassle

Log in and manage everything via our simple mobile app.[4] Want to submit a claim? Easy. Just snap a photo and you're on your way.

Stay informed

Check out our vast library of webinars, tutorials, videos, calculators, and more. You'll find tips and tricks to make the most of your HSA.

JOIN FIVE MILLION+ HEALTH SAVERS

For more than two decades we've empowered some of the biggest companies in the world—and the smartest savers on the block.

Enroll today. Talk to your benefits team.

866.735.8195 | HealthEquity.com/Learn

[4]Accounts must be activated via the HealthEquity website in order to use the mobile app.

HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life changing decisions.

Blue Cross Blue Shield Blue Care Network of Michigan

HealthEquity

Account mentors

We are available to help, every hour of every day

We understand the significance of your benefits selection. Our team of specialists based in Salt Lake City is available 24 hours a day, providing you with insight to help you optimize your health savings account. Call today.

866.346.5800

HealthEquity.com/BCBSM

7

Employee Assistance Program

Who Is Eligible and When

All employees covered under group life insurance with Madison National Life

Benefits You Receive

When you are dealing with personal situations , it can be difficult to be your best at work or at home. That's why Stockbridge Community Schools offers the Employee Assistance Program (EAP) administrated by TELUS Health. The EAP gives you a place to turn for support any time of the day, or night, and 365 days a year. Support is available for whatever issues employees might be facing, including depression, marriage and relationships, legal issues, child/elder care challenges, parenting issues, financial concerns, grief management or substance abuse.

You can contact our FREE Employee Assistance Program toll-free at 866-451-5465, or you can visit the website at www.niseap.com

Employee Pays

0$

Employer Pays

100%

Embedded Employee Assistance Program (EAP) with Claimant Assist

Support for Employees* with Life or Disability Insurance Through National Insurance Services

The EAP Program

Everyday life can be stressful and can affect your health, well-being, and performance. Fortunately, our Employee Assistance Program can aid in finding solutions. When facing personal problems, you might struggle with where to turn for help. The first step is usually the hardest, and guidance is often the key. That's why National Insurance Services (NIS) offers an Employee Assistance Program (EAP). An EAP offers a confidential place to find the answers that work for you.

Your EAP Service Provider

TELUS Health is a leader in the field of Employee Assistance and has been providing employee assistance services for over 40 years. TELUS Health has the experience to provide the broad range of services and guidance that is paramount to an EAP – whether it's help with day-to-day concerns or guidance through a challenging crisis. The information you discuss through the EAP is kept confidential in accordance with federal and state laws.

The EAP Process

When you access the EAP, TELUS Health counselors listen and take action toward finding solutions. The next step may include meeting with a mental health counselor for up to three face-to-face visits, negotiating health insurance benefits, or referrals to community resources for legal and financial services.

Referrals and Resources

You can receive information and a listing of childcare and eldercare resources with confirmed vacancies meeting your specifications. If face-to-face mental health counseling sessions are required, TELUS Health counselors will refer you for counseling at a location that is convenient to your home or work. TELUS Health counselors can also refer you to self-help groups such as Alcoholics Anonymous or Gamblers Anonymous and community financial and legal resources for debt management.

Claimant Assist

NIS's Claimant Assist program offers special services to Long Term Disability claimants or Life Insurance beneficiaries at no charge. If you have Disability insurance coverage through NIS, our Long Term Disability Claimant Services are available to guide and counsel claimants and their immediate family

(over)

Under our EAP you can receive no-cost, confidential help for a wide variety of needs and concerns:

- Alcohol or Drug Addictions
- Anxiety
- Childcare
- Depression
- Eating Disorders
- Eldercare
- Family Conflict
- Financial or Legal Concerns
- Marital Difficulties
- Parenting Concerns
- Problem Gambling
- Relationship Problems
- Stress Management

EAP Services Are Available to You Two Ways:

Phone: 866.451.5465

Online: www.niseap.com
Login: NISEAP | **Password:** EAP
(Note: Password Is Case-Sensitive)

Claimant Assist Services Are Available:

866.472.2734

members. If you have Life insurance coverage through NIS, our Beneficiary Services Program provides counseling and assistance to beneficiaries when faced with the challenge of coping with loss.

Virtual Fitness

You have access to a virtual fitness platform through the EAP. LIFT session, one of the leading fitness providers, provides you with an easily accessible, effective and affordable way to reach your fitness goals anytime, anywhere for better health and well-being.

You can work out on your own with personalized programs and access coaches if you have questions, or choose to work under the live supervision of a coach online, in 1-1 personal or group sessions.

Access to Masters-Degreed Counselors 24-Hours a Day Through a Toll-Free Number

Up to three in-person assessment and counseling sessions.

- **Legal Assistance:** Counselors may refer you to a telephone and/or one in-person consultation with an attorney.
- **Financial Assistance:** Telephone consultation with a financial consultant to address questions on budgeting, taxes, and debt consolidation.
- **Eldercare Assistance:** Our specialists can help you locate eldercare options, such as residential care or in home care, provide support in dealing with the emotions of retirement, or legal aspects like estate planning. Use our website to find resources on retirement, from financial planning and calculators, to articles on coping with retirement stress, and filing your retirement days with meaningful activities.
- **Childcare Assistance:** Telephone consultation with a work-life professional to provide information, referrals, and resources related to childcare concerns.
- **Memorial Planning Assistance:** Telephone consultation with a work-life specialist to assist with memorial and funeral planning. Services include identifying potential locations, associated costs for services, and providing information to help coordinate logistics (Available to Life insurance beneficiaries only).

Your EAP and Claimant Assist Administrator:

TELUS Health

134 North LaSalle Street, Suite 2200
Chicago, IL 60602

Telephone Assistance:

EAP: 866.451.5465

Claimant Assist: 866.472.2734

Online:

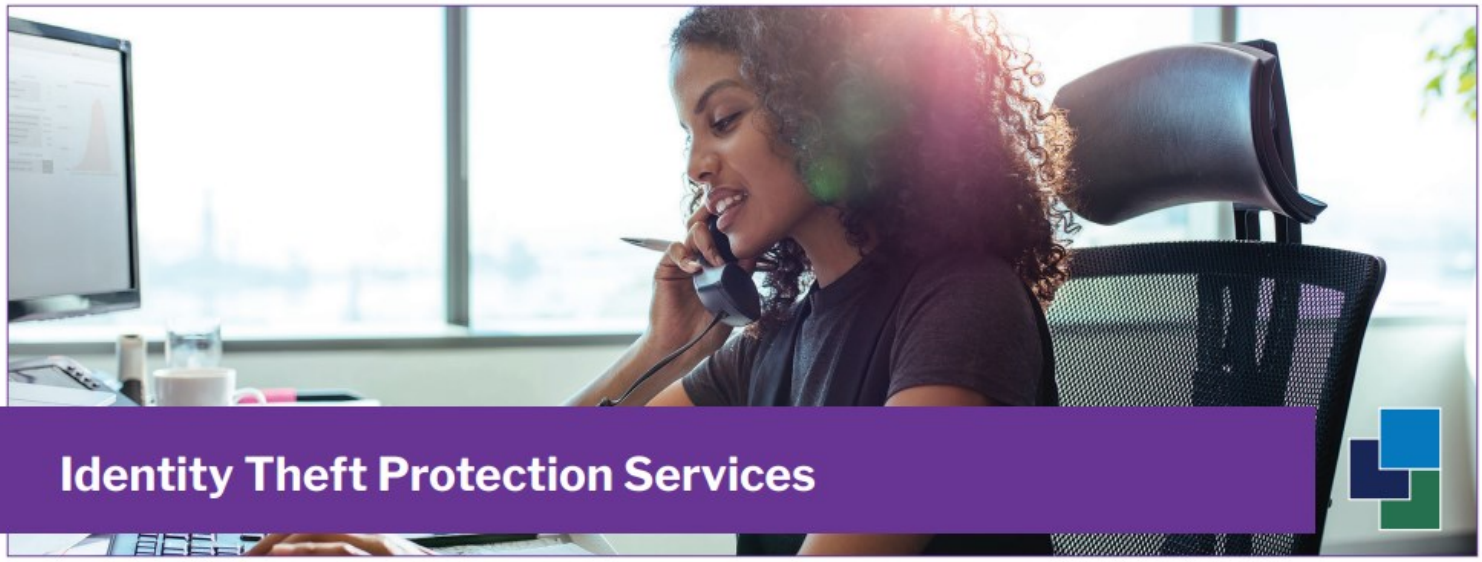
www.niseap.com | Login: NISEAP | Password: EAP
(Note: Password Is Case-Sensitive)

***The EAP is for use by the covered employee only. While issues may concern family members, all contacts to the EAP must be made by the employee.**

Identity Theft Program

Benefits You Receive

The Identity Theft Program is offered to all employees and immediate family members that receive life and or disability insurance from Madison National Life Insurance Company, Inc.



Identity Theft Protection Services

In 2022, identity theft impacted at least 422 million individuals.[1] If you are a victim, the IDX Identity Theft Recovery specialists will provide concierge-style service every step of the way. Their expertise will save valuable time during this stressful process.

Your dedicated recovery specialist will work with you until the identity is restored to pre-fraud status. Support may include:

- Assistance with investigation of the suspected identity theft
- Guidance through the recovery process
- Recovery for all 9 types of identity theft
- Advice from trained professionals in identity protection
- Single point-of-contact if you are a victim
- Assistance with notifying law enforcement or local government agencies
- Limited Power of Attorney to work on the victim's behalf
- Documentation including fraud affidavit
- And much more

IDX™
The Privacy Platform

https://app.idx.us/account-creation/NIS
855.205.6010

"It was great knowing I had someone to help me resolve my identity theft issues and I didn't have to spend hours trying to figure out how to handle it on my own" - IDX member, Needham, MA

[1] https://www.iii.org/fact-statistic/facts-statistics-identity-theft-and-cybercrime

Resolution services offered to you by your employer and:

NIS
National Insurance Services
Corporate Headquarters: 300 North Corporate Drive, Suite 300
Brookfield, WI 53045
Offices Nationwide: 800.627.3660 | **www.NISBenefits.com**

Madison National Life
a Horace Mann company
PO Box 5008, Madison, WI 53705

Identity theft assistance services are provided by IDX, which is not affiliated with Madison National Life Insurance Company, Inc. Services provided by IDX are not part of Madison National Life's insurance products, and Madison National Life is not responsible for any acts or omissions of IDX in connection with or arising under identify theft assistance services. Access to IDX program is conditioned upon your employer remaining a Madison National Life customer and the program terms and conditions. This program does not provide credit repair services or any form of legal advice.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact HR.