# Health Savings Account Guidelines

Midland Public Schools offered health plan, MESSA ABC 1, is a High Deductible Health Plan with a Health Savings Account (HSA). There are certain eligibility requirements which must be met in order for you and/or MPS to contribute funds to the HSA.

We are asking you to read over the eligibility requirements below, and if you will qualify for the HSA, print out the attached *HSA Employee Enrollment Form* and return the completed form to the Benefits Department. **We must have a completed *HSA Employee Enrollment Form* before MPS will make its employer contribution to your account, and before you can make payroll contributions.**

**If you want to make your own additional payroll contributions to your HSA please complete the attached *HSA Salary Reduction Agreement* form.** This election can be changed at any time.

**If you do not meet the eligibility requirements for the HSA, or just decide that you want to opt out of the account, please print out the attached *HSA Waiver Form*, complete it and return it to the Benefits Department.**

To qualify for an HSA, an employee:

- Must be covered by a HSA-qualified high-deductible plan (MESSA ABC plans are HSA qualified).
- Cannot be claimed as a dependent on someone else's tax return.
- Cannot be covered by another person's health plan **if** the other person's plan is **not** a HSA-qualified medical plan.
- Can still be eligible for an HSA if spouse has a non-HSA-qualified plan, provided the employee is not covered by the spouse's health plan.
- Cannot be enrolled in Medicare or Medicaid.
- Cannot have utilized VA benefits in the three months leading up to enrollment in the HSA plan.
- Generally cannot make contributions to an HSA if he/she has a medical flexible spending account (FSA) or a health reimbursement account (HRA) that reimburses qualified medical expenses (even if the employee is covered by a high-deductible health plan).

For additional information on eligibility, review IRS publication 969 at https://www.irs.gov/publications/p969.

For the 2020 plan year, MPS will contribute $1,050 for single coverage and $2,100 for two person/family coverage. These contributions will be made in two parts. The first 2/3rd of the contribution ($1,400 for 2 person/family or $700 for single) will be available the first week in January and the second 1/3rd contribution $700 for 2 person/family or $350 for single) will be available the first week of September.

If your deductible reaches $700 for single or $2,100 for two person/family before the September contribution you will be able to request the 2nd contribution to be made early by filling out the *HSA Early Contribution Request* form (found on the MPS website) and submitting it to Kim Wood in the Business Office.

# Health Savings Account (HSA) Employee Enrollment Form

HealthEquity
Building Health Savings™

Return completed forms to your Human Resources Department.

## Employer Information

Enrollment cannot be processed without your employer's name.

| Employer Name |
|---|
| |

## Account Holder Information

| First Name | | M.I. | Last Name | |
|---|---|---|---|---|
| SSN | | Gender ☐ Male ☐ Female | Date of Birth (mm/dd/yyyy) | |
| Email Address | | | Home Phone ( ) | |
| Physical Street Address | City | | State | ZIP |
| Mailing Address (if different) | City | | State | ZIP |

## Insurance Coverage

| Insurance Carrier | |
|---|---|
| Coverage Effective Date | Coverage Type ☐ Single ☐ Family |

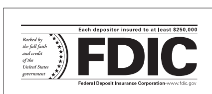
## Authorization and Certification

By opening a health savings account (HSA) with HealthEquity, you accept the terms of HSA enrollment and the custodial agreement. You may view the HSA custodial agreement here: http://healthequity.com/en/Site/EducationCenter/Forms.aspx by looking under Health Account Forms and Agreements. Upon enrollment, you understand and agree to the following:

- You are covered by a qualified high deductible health plan (HDHP).
- You are not covered by any other non-qualified health coverage, including Medicare.
- You do not have access to dollars in a flexible spending account (FSA) to pay for any medical expenses before the required HDHP deductible is met, including a spouse's FSA.
- You are not claimed as a dependent on another individual's tax return.
- HealthEquity must verify your identity in order to open your HSA.

For further information regarding HSA laws, go to http://www.irs.gov/pub/irs-pdf/p969.pdf.

| Print Name | Signature | Date |
|---|---|---|
| | | |




The balances in all HealthEquity HSAs are FDIC-insured unless invested in mutual funds.

**MIDLAND PUBLIC SCHOOLS**
**CAFETERIA PLAN**
**SALARY REDUCTION AGREEMENT**
**[HSA CONTRIBUTIONS, ONLY]**

Participant's Name:______________________________________________________________

Address:_________________________________________________________________

Employee No.________________

**THIS SALARY REDUCTION AGREEMENT** is entered into on the date shown below by and between Midland Public Schools (the "Employer") and you, the Participant named above.

**1. Introduction**. The Employer is the sponsor of The Restated Midland Public Schools Cafeteria Plan (the "Plan"), a copy of which is available to you upon request to the Administrator. The Plan is intended to be a cafeteria plan within the meaning of Section 125 of the Internal Revenue Code (the "Code"). You are entering into this Agreement with the Employer for the purpose of participating in the Plan and to reduce your salary in order that you may make contributions to a Health Savings Account under the Plan.

**2. Participation**. You agree to participate under the Plan and to reduce your salary by the amount shown below:

| 2019 Annual HSA Contributions | |
|---|---|
| Coverage Type | Total Annual Contribution* |
| Self only | $3,500.00 |
| Two person/Family | $7,000.00 |

*catch up contribution (age 55+): additional $1000/year

| **Total Annual Contributions** | | **Employer Contribution** | | **Total Eligible Amount** |
|---|---|---|---|---|
| 2019 Self Only $3,500 | - minus | $ 1,050.00 | = | $ 2,450.00 |
| 2019 Two Person/Family $7,000 | - minus | $ 2,100.00 | = | $ 4,900.00 |

| **Total Eligible Election Amount** | | **Enter number of pay periods** | | **Per Pay Max Withholding** |
|---|---|---|---|---|
| | **/ (divided)** | | = | |

**3. Duration**. The reduction of salary described in paragraph 2 shall be effective as of [***Insert first day on which you wish to have salary withheld***] ____________________________, as to compensation not yet earned as of that date, and shall continue, subject to modification only as permitted under the Plan, until the earlier of (a) the last day of the Plan Year for which this Agreement has been entered in to by you and the Employer; or (b) you becoming ineligible to participate in the Plan, such as by virtue of your termination of employment with the Employer. This Agreement revokes and supersedes all prior salary reduction agreements that you have entered into in conjunction with the Plan pertaining to HSA contributions.

**4.** **Handling of Deferred Amounts**. The Employer agrees that all amounts deferred under this Agreement will not be paid to you but will be credited by the Employer in even increments that coincide with your paychecks over the course of the Plan Year, to the HSA account that you establish in conjunction with the Plan.

**5.** **Modification**. Prior to each Plan Year, you will be given the opportunity to make elections under the Plan for the new Plan Year**. If you do not make elections at that time, you will be treated as having elected not to participate in the Plan for the Plan Year.** Notwithstanding the "Permitted Election Changes" section in the Plan, this Agreement may be revoked or amended at any time during the Plan Year, subject to reasonable administrative rules established by the Employer.

**6.** **Preservation of Plan Status**. The Employer may, unilaterally and without prior notice to you, reduce the amount shown in paragraph 2 if, in the sole judgment of the Employer, a reduction is necessary to continue the favorable status of the Plan, or any of its constituent plans, under the Code and related regulations.

**7.** **Pay-out of Benefits**. Amounts credited to your HSA will be distributed only in accordance with the terms of your HSA in effect at the time of the distribution. Distributions are administered by the HSA trustee/custodian, and the Employer is in no way responsible for the administration of your HSA by the HSA trustee/custodian.

**8.** **Forfeiture of Unused Amounts**. The forfeiture rules applicable to other forms of Benefits under the Plan do not apply to your HSA and all amounts in your HSA account and will remain your property.

**9.** **Employer not Liable**. By providing you with the opportunity to elect to make HSA contributions under the Plan, the Employer is **not** assuming liability for any of your medical expenses of any nature.

**10.** **Incorporation of Plan**. The terms and conditions of the Plan are hereby incorporated by reference into, and made a part of, this Agreement, as if fully set forth in this Agreement.

**11.** **Acknowledgments**. You hereby acknowledge that you have received a copy of this Agreement, and either received, or had an opportunity to receive, a copy of the Plan; that you have read this Agreement, and either read, or had an opportunity to read, the Plan; that by signing this Agreement you are voluntarily electing to participate in the Plan; that neither this Agreement nor the Plan constitute an agreement for continued employment.

| **PARTICIPANT SIGNATURE** | **DATE** |
|---|---|
| ______________________________ | ________________________ |

**MIDLAND PUBLIC SCHOOLS**

By:________________________________

Date:_______________________________

**MIDLAND PUBLIC SCHOOLS**
**CAFETERIA PLAN**
**SALARY REDUCTION AGREEMENT**
**[HSA CONTRIBUTIONS, ONLY]**

# 2019 Waiver of Right to Participate

Employee Name:______________________________________________________________

Address:_________________________________________________________________

Employee No.________________

I am currently enrolled in the Midland Public Schools MESSA ABC 1 High Deductible Health Plan. A Health Savings Account is offered with the MESSA ABC 1 plan.

☐ I understand that I am eligible to participate in the Health Savings Account offering, but I hereby waive my right to participate.

☐ I am ineligible to participate in the Health Savings Account

Employee Signature: ______________________________ Date: ______________

This form must be returned to the Benefits Department. Please call 923-5067 with questions.