2023-2026

MASTER AGREEMENT

BETWEEN THE

OTTAWA AREA INTERMEDIATE SCHOOL DISTRICT

AND THE

OTTAWA SERVICE EMPLOYEES ASSOCIATION

LOCAL 101

AN AFFILIATE OF

MICHIGAN EDUCATIONAL SUPPORT PERSONNEL ASSOCIATION

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PREAMBLE

THIS AGREEMENT is made and entered into by and between the OTTAWA SERVICE EMPLOYEES ASSOCIATION, LOCAL 101, an affiliate of the Michigan Education Support Personnel Association, MEA/NEA, a voluntary organization hereinafter called the "Association", and the OTTAWA AREA INTERMEDIATE SCHOOL DISTRICT, Ottawa, Muskegon and Allegan Counties, Michigan, 13565 Port Sheldon Street, Holland, Michigan, 49424, hereinafter called the "District". The signatories shall be the sole parties to this agreement.

WITNESSETH

Whereas, the parties have reached certain understandings which they desire to confirm in this Agreement.

In consideration of the following mutual covenants, it is hereby agreed as follows:

ARTICLE I

RECOGNITION

Pursuant to the provisions of Act 379 of the Public Acts of the State of Michigan, as amended, the District hereby recognizes the Association as the sole and exclusive bargaining representative for all aides employed at the Ottawa Area Center, Young Adult Services and the Early On Program (hired before July 1, 2013), but excluding: supervisors, teachers included in the Teachers' Bargaining Unit, Director of the Area Center, substitute aides who are not regularly employed with respect to hours, wages, terms and conditions of employment, behavioral, interpreter and health support aides, Registered Physical Therapy Assistants, Occupational Therapy Assistants, Secretaries, Custodians, Early On Program Aides (hired after July 1, 2013) and all other employees. The District agrees not to negotiate with or recognize any other organization other than the Association for the duration of this Agreement.

ARTICLE II

DEFINITIONS

A. The term “employee” when used in this Agreement shall mean Bargaining Unit Members.

B. Substitute aides are persons working in place of regularly employed aides.

C. The use of pronouns or other terms referring to the male gender shall include the female gender and the use of pronouns or other terms referring to the female gender shall include the male gender.

D. Whenever the term “District” is used it shall mean the Ottawa Area Intermediate School District, Ottawa, Muskegon, and Allegan Counties, Michigan, and shall include its designee upon whom the District has conferred authority to act in its place and stead.

E. Whenever the term “Agreement” is used, it shall mean this Agreement itself, together with all appendixes incorporated by reference, signed amendments to the Agreement, and Letters of Understanding.

F. Whenever the term “anniversary date of this Agreement” is used, it shall mean the day of the year upon which this Agreement shall terminate.

G. A “Letter of Understanding” is a temporary agreement between the District and Association which expires on the anniversary date of the contract unless incorporated into the new contract agreement.

ARTICLE III

DISTRICT RIGHTS

A. The District retains all rights, powers, and authority vested in it by the laws and constitution of Michigan and the United States. It is expressly agreed that all rights which ordinarily vest in the District, except those which are clearly and expressly relinquished herein by the District, shall continue to vest exclusively and be exercised exclusively by the District without prior negotiations with the Association, as to the taking of action under such rights or with respect to the consequence of such action during the life of this Agreement. Such rights except as specifically restricted by the terms of this Agreement, shall include by way of illustration and not by way of limitation, the right to:

1. Manage and control the school's business, the equipment and the operations and to direct the working forces and affairs of the Employer.

2. Continue its rights and past practice of assignment and direction of work to all of its personnel, determine the number of shifts and hours of work and starting times and scheduling of all the foregoing and the right to establish, modify, or change any work or business hours or days.

3. The right to direct the working forces, including the right to hire, promote, suspend and discharge employees, transfer employees, assign work or extra duties to employees, determine the size of the work force and to lay off employees.

4. Determine the services, supplies, and equipment necessary to continue its operation and to determine the methods, schedules and standards of operation, the means, methods, and processes of carrying on the work, including automation thereof or changes therein, the instruction of new and/or improved methods or changes therein.

5. Adopt reasonable rules and regulations, as long as such rules and regulations are not inconsistent with the terms of this Agreement.

6. Determine the qualifications of employees, including physical condition.

7. Determine the number and location or relocation of its facilities, including the establishment or relocation of new schools, buildings, departments, divisions or subdivisions thereof and the relocation or closing of offices, departments, divisions or subdivisions, buildings or other facilities.

8. Determine the placement of operations, production, service, maintenance or distribution of work, and the source of materials and supplies.

9. Determine the financial policies, including all accounting procedures, and all matters pertaining to public relations.

10. Determine the size of the management organization, its functions, authority, amount of supervision and table of organization.

11. Determine the policy affecting the selection, testing or training of employees, providing that such selection shall be based upon lawful criteria.

ARTICLE IV

ASSOCIATION RIGHTS

A. The Association and/or its representative shall have the right to use the Ottawa Area Center and Young Adult Services sites at reasonable hours for meetings, provided that advance approval has been obtained from the Superintendent or his designee at least forty-eight (48) hours prior to the scheduled meeting. No charge shall be made for the use of school rooms during school days from the hours 7:00 a.m. to 6:00 p.m. Outside of said hours, the District may make an appropriate charge for the use of the facilities. The District may also charge the Association for: Special custodial service when necessary, damages to District equipment, facilities, and other properties attributable to such use.

B. Duly authorized representatives of the Association shall be permitted to transact official Association business on school property before and after school hours, provided that this shall not interfere with or interrupt normal school operations.

C. The Association shall be permitted to use school facilities and equipment including typewriters, mimeographing machines, other duplicating equipment, calculating machines, and audiovisual equipment when such equipment is not in use and as permitted by the building supervisor. The Association shall pay for the cost of all materials, supplies and repairs incidental to such use.

D. The Association shall be permitted to post notices relating to Association business on a bulletin board at the Area Center.

E. The District shall make available to the Association, upon request, all regularly and routinely prepared information concerning the financial condition of the school, including annual financial statement, adopted budget, and other readily available and pertinent information which may be relevant to negotiations or the processing of a grievance. Nothing contained herein shall require the central administrative staff to research and assemble information.

F. The District agrees to provide to the Association a current seniority list of all bargaining unit members not later than November 1 of each year.

ARTICLE V

ASSOCIATION DUES AND PAYROLL DEDUCTIONS

A. The District will comply with all provisions of PA 349 of 2012. Employees shall either: (a) become a member of, and pay dues and initiation fees (if any) to, the Union; or (b) not become a member of the union and not pay dues or initiation fees (if any). No employee shall be required as a condition of employment to become or remain a member of the union.

B. Upon appropriate written authorization from the employee, the District shall make deductions from the pay of the employee and make appropriate remittance for up to three (3) annuity programs, credit unions, savings bonds, United Way, or any other plans or programs jointly approved by the Association and the District.

ARTICLE VI

EMPLOYEE RIGHTS

A. Nothing contained within this contract shall be construed to deny or restrict any bargaining unit member rights he/she may have under the Michigan General School Law.

B. All District policies, in regards to procedures for inspection and release of student records, applicable district policy and administrative rules and regulations, as determined by the district, shall be maintained on the district website. Changes or updates in these policies and procedures will normally be announced at staff meetings or by direct communication to employees, however, employees are welcomed and encouraged to access information on the district website. A handbook may also be distributed to employees with additional information or information employees may wish to take with them. Handbook information may contain tornado shelter locations, evacuation information, etc.

C. A description of duties, reflective of the respective program, will be provided to each new employee and upon request to the Building/Program Administrator. These descriptions are not intended to be an all-inclusive list of duties or responsibilities, but rather an outline of expectations and desired/required preparation or qualifications.

ARTICLE VII

SENIORITY

A. Seniority is defined as continuous length of service within the bargaining unit as of the employee's first working day. In the event of more than one person beginning employment on the same day, position on the seniority list shall be determined by ranking the last four digits of the employees' social security numbers, the higher number having greater seniority.

B. Employees shall be on probation for the first ninety (90) work days of employment. The probationary period may be extended another ninety (90) days if an individual is placed on a Plan of Assistance during the first ninety (90) days of employment. Upon completion of the probationary period, employees shall be entered on the seniority list and attain seniority ranking from their most recent "first working day" within the bargaining unit. There shall be no seniority among probationary employees.

C. Seniority shall not accrue during unpaid leaves, but shall accrue during paid leaves. Workers' Compensation leaves and LTD leaves are not considered paid leaves; provided, however, that seniority shall nevertheless accrue during Workers' Compensation leaves.

ARTICLE VIII

LAYOFF AND RECALL

When it becomes necessary to reduce the size of the work force for any reason as determined by the District, the following procedure shall be utilized:

A. Probationary employees shall be laid off first.

B. If a further reduction is instituted, employees shall be laid off in inverse order of seniority.

   If a change of position is necessary as a result of a room closing, room downsizing or the combining of two (2) or more rooms, the aide affected will have the option of taking one of the four (4) least senior positions or any other vacancy for which their seniority qualifies them.

C. The District shall give at least thirty (30) calendar days written notification (except in cases of emergency) of any such layoff before the effective day thereof.

D. When the work force is increased after a layoff or a vacancy exists, the most senior persons on layoff will be recalled first.

E. Notice of recall shall be sent to the employee at his/her last official address (as reflected by the District's records) by registered or certified mail, with a copy to the Association. If the employee fails to report for work within ten (10) work days of receipt of notice of recall (or on such later date as may be specified in notice), or if the employee fails to notify the District of his/her intent to return within five (5) calendar days of receipt of notice of recall, then the employee shall be considered a quit.

F. An employee who was laid off from a full-time position may decline recall to a part-time position without forfeiting future recall rights within the recall period (i.e. two years following layoff).

G. A recall list shall be maintained by the District. Any employee who is laid off for a period of two (2) years or more shall automatically lose all recall rights.

ARTICLE IX

HIRING, VACANCIES, PROMOTIONS AND TRANSFERS

A. A vacancy shall be defined for the purpose of this Article as a newly created position or an existing position within the Bargaining Unit which is unfilled and which the District intends to fill. No vacancy shall generally be filled until it has been posted for a period of (5) working days. Vacancies can be posted for a lesser period if both union leadership and administration agree that an expedited period would be beneficial. When a vacancy is filled from within the unit, the assignment will be made and posted within twenty (20) days after the date upon which the vacancy was initially posted.

B. Whenever a vacancy occurs, notice of such vacancy shall be posted as soon as reasonably possible through the district's website and emailed to all bargaining unit members.

C. Whenever vacancies occur in the YAS program during the normal summer months when regular school is not in session, the following procedure in addition to the procedures heretofore outlined, shall be followed:

1. Employees with specific interests in possible vacancies will notify the Building/Program Administrator of their interests by email, during the last regular week of school.

2. Should a vacancy occur, the employees who have expressed an interest in said position or a similar position shall be contacted by the Building/Program Administrator and notified of the vacancy.

3. The employees so notified shall have the responsibility of contacting the Building/Program Administrator indicating their interest in said position within three (3) working days of said notification.

D. When vacancies occur owing to a permanent separation of employment, or the creation of a new position, they shall generally be filled with the most senior, qualified applicant. If there are no applicants from within the bargaining unit, the Board shall have the right to permanently employ a new hire to fill the position.

E. When a vacancy occurs or a new position is added after November 1st of the current school year, the Building/Program Administrator shall fill the position from outside the bargaining unit on a temporary basis for the duration of the school year, unless a mutual agreement is reached to do otherwise.

F. Request for transfer shall be in writing and filed with the Building/Program Administrator.

G. An employee transferred on or after November 1 shall remain in any new assignment for the remainder of the school year before being eligible to apply for another transfer or vacancy, unless conditions prevail where a change would be in the best interest of the District and the employee, as determined by the District.

H. If it becomes necessary in the day-to-day programming to reassign staff to another classroom due to changes in student numbers or instructional needs, then every effort will be made to keep the affected staff members within the same building/program location, however, there is no guarantee.

I. Staff hired after July 1, 2023 may not apply for vacancies for one calendar year from the date of hire.

ARTICLE X

CONDITIONS OF EMPLOYMENT

A. The regular work day for an aide shall be seven and one half (7.5) hours concurrent with the teacher work day, plus time required for meetings (such as staff meetings or training), not to exceed a total of forty (40) hours per week. Further, these meetings or training activities shall not exceed 35 hours per year. Building administrators shall meet monthly with the Association leadership to discuss meeting/training schedules. Attendance at I.E.P.C. meetings normally will be voluntary.

   1. Additional hours of work scheduled and authorized by the building administrator, including those defined in paragraph "A" above, will be paid at the regular hourly rate, or be approved for compensatory time.

B. The regular work week for employees shall be five (5) consecutive days.

C. In the event that school is canceled because of inclement weather (e.g. heavy snow, excessive heat, etc.), any employees who are not required by the District to report for work shall receive pay for their regular work day. In the event that school or programming is canceled because of inclement weather or other emergency, employees shall not be required to report for work that day. If it becomes necessary (e.g. to avoid loss of funding and/or to meet state or federal mandated instructional requirements) to make up any such canceled days, and if such canceled days cannot be made up during the regular summer session, then the makeup days shall be worked without additional pay by any employee who received pay (and was not required to work) on the canceled day(s). However, any employee who was required to work on the canceled day(s) shall receive additional pay for the makeup day(s).

D. Overtime shall be paid as follows:

   1. Time and one-half shall be paid for each hour over forty (40) hours worked in one calendar week and for work authorized on Sunday.

   2. Double time shall be paid for all hours on holidays recognized in Article XVII of this Agreement.

E. Aides shall be entitled to a paid thirty (30) minute break daily, provided they remain onsite at their work location. Except in the case of emergency, this break shall be duty free and shall take place in a duty free location (if available). Off-site breaks shall be unpaid.

F. One (1) hour minimum pay shall be paid when an employee is called in for unscheduled hours. (Snow days excluded.)

G. Aides will generally not be expected to administer the following medical procedures to students: insertion of tubes for catheterization, gavage, and fecal impactions. However, in the event of an emergency or unanticipated situation, or if a trained nurse is unavailable or otherwise occupied, Aides will be expected to perform the above-noted procedure(s) on a voluntary basis. In the event that no member of the unit is willing to volunteer to perform the above-noted procedure(s), then Administration shall assign the responsibility to a qualified member of the bargaining unit.

ARTICLE XI

DISCIPLINE OF EMPLOYEES

A. No employee shall be disciplined without just cause. Any such discipline may be subject to the grievance procedure. Upon written request from the Association, the District shall provide a written response explaining the basis for said action.

B. An employee shall be entitled to have present a representative of the Association when disciplinary action, which will become part of the employee's personnel file, is being taken.

C. Complaints received by the Administration, which are to become a part of the employee's personnel file shall be promptly called to the attention of the employee.

ARTICLE XII

LEGAL PROTECTION

A. Employees are provided legal protection from liabilities arising in the scope of employment under a liability insurance policy purchased by the District.

B. It is expressly agreed that such protection arises from, and is subject to the terms and conditions of the policy.

C. Time lost as a result of legal action arising from an assault upon an employee by a student shall not be charged to the employee. Time lost as a result of being complained against if sued by reason of disciplinary action taken by the employee shall not be charged against the employee if his action is upheld.

D. The District agrees to reimburse employees for damage or destruction of clothing or other personal property worn by an employee caused by a student while the employee is acting within the scope of his/her employment provided:

1. If the damage is reimbursable through an insurance plan under which the employee is covered, the District shall not be liable. However, the District will pay the deductible if the damage is reimbursable pursuant to this provision.

2. That, in the opinion of the District, the employee was exercising reasonable care in dealing with the student.

3. That within three (3) days of the occurrence the employee shall file a written report with his supervisor detailing the incident, and itemizing the damages, loss or destruction of clothing or personal property.

4. That the District shall reimburse the employee for a reasonable amount.

E. Any case of physical assault upon an employee arising out of the performance of the employee's professional responsibilities at school or school-sponsored functions will be promptly reported to Administration. If required by statute and/or policy, the District shall promptly notify the appropriate law enforcement agency.

ARTICLE XIII

SICK LEAVE

A. At the beginning of the school year each OAC employee will be credited with eleven (11) sick days, equivalent to 82.5 hours and each YAS employee will be credited with ten (10) sick days, equivalent to 75 hours. For the purposes of use and accrual, one day is equal to seven and one half (7.5) hours. Employees hired after the beginning of the school year will receive a prorated number of sick days. Should an individual's employment terminate during the school year, that employee shall receive a proportionate deduction from his/her final paycheck for any used but unearned sick leave. The unused portion of sick leave shall accumulate to a maximum of thirty (30) days, provided however, that no employee covered by this agreement shall forfeit days in excess of thirty (30) accumulated prior to August 31, 1994.

B. Employees may use sick leave to recover from a period of illness/disability provided, however, that sick leave payments are subject to the employee having performed all duties until physically sick/disabled and returned to service as soon as physically able to perform all duties. Employees may also use up to five (5) days of sick leave per year for non-FMLA qualifying serious illness to mother, father, mother-in-law, father-in-law, and those members of the immediate family in the same household.

C. Employees who are on an FMLA-qualifying leave for their own serious health condition/disability, will not be required to serve more than one consecutive 30-calendar day waiting period per rolling year (365 days) to reach Short Term Disability status at which point the employee will no longer be required to use their own sick leave in order to be paid. The rolling year period will be measured from the start of the first day of the FMLA leave. At calendar day 91 of the employee's own serious health condition/disability, Short Term Disability benefits cease, and the employee may be eligible for Long Term Disability Benefits paid according to the District's insurance policy.

D. The District may require a physician's certification verifying an illness or disability when said illness or disability has caused an employee to be absent from his/her employment responsibility in excess of three (3) consecutive days or at any other time the District believes there has been an abuse of sick leave.

E. The District will furnish a written statement to each employee by October 1 of each school year, setting forth the total days of sick leave accumulated.

F. An employee who is unable to work because of personal illness or disability, and who has exhausted all sick leave available shall be granted a leave of absence without pay for the duration of such illness or disability, or one year, whichever is lesser.

G. Earned but unused sick leave days shall be retained by an employee in the following cases:

1. Employees absent while on authorized leaves of absence.

2. Employees who are recalled from a layoff.

H. For FMLA/LTD qualifying leave related to the employee's own health condition, the employee will be responsible for the first 30 calendar days of illness/disability.

I. For FMLA qualifying leaves not related to the employee's own health condition (for example: care of a critically ill member of the employee's immediate family) all accumulated sick leave will be exhausted.

J. Physician's verification is required for a qualifying FMLA leave and/or long term disability leave. A physician authorized "return to work" slip is required before an aide on FMLA leave (for his/her own health condition) and/or disability leave can return to the job.

K. Injury Days: With approval of Administrator, and verification of a physical injury by the District's occupational health provider, an employee will be paid up to 2 days per occurrence, with a maximum of six (6) days per school year when an injury occurs on the job as the result of managing a student behavior. However, should the employee receive any Workers' Compensation benefits for any such day, the employer shall have the right to reimbursement by adjustment or withholding of pay, without the signed authorization of the employee.

ARTICLE XIV

PERSONAL LEAVE

A. Aides shall be granted up to a total of two days (equivalent to 15 hours) of personal leave, per year, for the following purposes:

   1. Absence to attend a funeral other than a member of the immediate family.

   2. Absence because of a required Court appearance.

   3. Absence for personal business to be used for handling matters which cannot be conducted outside working hours or during vacation periods.

      Employees shall make written application for personal leave at least one week in advance, except where circumstances do not permit notification. Unused personal leave days shall be non-accumulative.

B. An employee requesting personal leave shall provide the following:

   1. Reason(s) for the request.

   2. Expected duration of the leave.

C. An employee taking leave under the provisions of this Article may be required to provide evidence of the validity of the reason for the leave.

D. Up to 7.5 hours of leave which remains unused at the end of the school year will be converted to sick leave.

E. If a personal day is scheduled on a day in which the building is closed due to inclement weather or health/safety reasons, the employee may retroactively cancel the request utilizing the employee self-service portal.

F. In addition to Paragraph A, members working in the OAC program will be granted one (1) non-cumulative Paid Time Off (PTO) day per year, to be used for any reason except personal gain. Requests shall be made at least forty-eight (48) hours in advance except in cases of emergency. Pre-approval by the Building/Program Supervisor is required and shall not be reasonably withheld unless related to classroom/building staffing needs.

ARTICLE XV

LEAVES OF ABSENCE

A. General Leave —Except in FMLA qualifying cases and per federal law and district practice as it pertains to FMLA, any employee desiring a leave of absence without pay may make written application for such leave to the District. An Unpaid Leave of Absence not exceeding one (1) year may be granted for the following purposes:

1. Child Care
2. Service as an Association Officer
3. Service in Public Office
4. Other reasons not herein before specified.

Applications for such leaves shall set forth the following minimal information:

1. Name, date and applicant's signature
2. Nature of request
3. Reason for the request and any additional data or documentation the employee feels will bear on the merits of the requested leave of absence
4. Dates the applicant desires to commence and terminate the leave of absence. Upon receipt of proper application, the District will review the request and the reasons advanced in support thereof. The granting or denial of an unpaid leave of absence shall be discretionary with the District. Within ten (10) days of the receipt of proper application, the District shall render a decision in writing regarding the approval or denial of unpaid leave.

B. Unpaid leaves of absence, as provided for in paragraph A (above), shall be without pay, fringe benefits, experience credit, seniority, or sick leave accumulation unless otherwise expressly and specifically provided in this Agreement; provided, however, that an employee returning from an authorized unpaid leave of absence shall be entitled to accrued benefits earned prior to said leave. An employee returning from an authorized unpaid leave of absence shall be entitled to advancement on the wage scale (at such time as all other bargaining unit members are considered for such advancement) if, but only if, the employee worked a minimum of ninety (90) work days during the preceding regular (i.e. 180 day) school year. Upon return from an authorized unpaid leave of absence, the employee shall be restored to the same position as when he/she left if available.

For those on a general leave as outlined in paragraph A, notification of the intent NOT to return will be made by April 1st of the year preceding the year of scheduled return.

C. During the period of an unpaid leave of absence, employees shall not be entitled to insurance benefits at District expense, except as provided under FMLA. Upon application, the approval thereof, and subject to the limitations established by the respective insurance carrier, insurance benefits may be continued at the employee's expense by paying the appropriate premiums at the payroll office.

D. Jury Duty Leave –An employee who is summoned for jury duty and is not relieved from such duty shall be granted a jury duty leave of absence for that purpose, provided evidence of such jury duty is presented to the District at the earliest possible date. Employees shall work their scheduled hours when not serving as jurors, and an employee not selected to serve on a particular jury shall report for work immediately after selection of said jury. The employee shall receive his/her basic rate of pay for the time lost from regularly scheduled work less any amount received for such jury duty excluding travel allowances and reimbursement for expenses.

E. Bereavement Leave days, without loss of pay, require approval of the superintendent or designee. Bereavement leave may be requested during regularly scheduled work days (to include summer school).

In the event of the death of a family member as defined below, an employee may take up to three days (unless otherwise noted) of paid leave to attend the funeral/memorial service.

In the event of the death of an employee's aunt or uncle, the employee may take up to one day of paid bereavement leave.

In the event of the death of a parent, spouse, child (including a step or foster child), or grandchild (including step or foster), the employee may take up to an additional five days of sick leave for bereavement. In the event of the death of a close friend or other family member not identified below, an OAISD staff person may take up to one day of paid leave to attend the funeral/memorial service. In the event of an OAC student death, up to one full day may be granted for staff in the student's current classroom to attend the funeral/memorial/visitation.

Definition of Family Member (for the purposes of this Article only) – Includes all the following family relationships whether established by marriage, court order, or common residence: Spouse, child, brother, sister, aunt, uncle, parent, grandparents, and grandchild. Examples include but are not limited to parents and parents-in-law, brother-in-law/sister-in-law, step-child/step-grandchild, half-brother/ sister, foster child, or any family member who lives with you, or whom you raised/raised you.

All leave must be approved by the building administrator.

G. The undersigned parties do hereby agree that, irrespective of Article XVI, Section C (above), the District shall, upon application for same, continue to contribute its normal obligation towards health care benefits (as provided in Article XXII) for those employees on unpaid leave necessitated by a circumstance to which Workers' Compensation has

been determined as applicable. However, the District shall in no way be so obligated for more than one (1) month beyond the month in which the injury occurred. Upon written application, an extension not to exceed three (3) additional months may be granted by the Superintendent. If an employee continues group health care benefits at his/her own expense during an unpaid leave with respect to which a Workers' Compensation claim is pending (but has not yet been determined as applicable), and if the claim is ultimately determined to be compensable under Workers' Compensation, then the District will reimburse the employee for its share of the group health care benefit premiums having been paid by the employee during the period not exceeding that prescribed above (i.e. one (1) month subject to possible extension for three (3) additional months).

ARTICLE XVI

WAIVER

The parties acknowledge that during the negotiations which resulted in this Agreement each had the unlimited right and opportunity to make demands and proposals with respect to any subject or matter not removed by law from the area of collective bargaining, and that the understandings and agreements arrived at by the parties after the exercise of that right and opportunity are set forth in this Agreement. Therefore, the District and the Association, for the life of this Agreement, each voluntarily and unqualifiedly waive the right, and each agrees that the other shall not be obligated, to bargain collectively with respect to any subject or matter referred to or covered in this Agreement, or with respect to any subject or matter not specifically referred to or covered in this Agreement even though such subjects or matters may not have been within the knowledge or contemplation of either or both of the parties at the time they negotiated or signed this Agreement.

ARTICLE XVII

CONTINUITY OF OPERATIONS

The Association and District recognize that strikes and other forms of work stoppages by employees are contrary to law and public policy. The Association and District subscribe to the principle that differences shall be resolved by peaceful and appropriate means without interruption of the school program. The Association therefore agrees that its officers, representatives and members shall not authorize, instigate, cause, aid, encourage, ratify or condone, nor shall any employee take part in any strike, slowdown or stoppage of work, boycott, picketing or other interruption to the detriment of the children or the educational process in the Ottawa Area Center. Failure or refusal on the part of any employee to comply with the provisions of this Article may result in disciplinary action as deemed necessary by the District.

The Association accepts full responsibility and shall be liable for all illegal work stoppages during the life of this Agreement as herein above described for which it can be demonstrated in a court of law that they authorized, instigated, caused, aided, encouraged, ratified or condoned.

ARTICLE XVIII

GRIEVANCE PROCEDURE

A. A grievance shall be an alleged violation of the expressed terms of this contract.

B. The Association shall designate one representative to handle grievances when requested by the grievant. The District hereby designates the principal to act as its representative at Level One as hereinafter described and the Superintendent or his designated representative to act at Level Two as hereinafter described.

C. The term "days" as used herein shall mean days in which school is in session.

D. Written grievances as required herein shall contain the following:

1. It shall be signed by the grievant or grievants;

2. It shall be specific;

3. It shall contain a synopsis of the facts giving rise to the alleged violation;

4. It shall cite the section or subsections of this contract alleged to have been violated;

5. It shall contain the date of the alleged violation;

6. It shall specify the relief requested.

E. **Level One** - An employee alleging a violation of the express terms of this contract, shall, within ten (10) days of the alleged violation(s) occurrence, or such date as the employee should have reasonably become aware of the alleged violation, orally discuss the grievance with the principal in an attempt to resolve same.

If no resolution is obtained within three (3) days after the oral discussion with the principal, the employee shall, within five (5) days of such oral discussion, reduce the grievance to writing and deliver it to the principal. If the employee does not receive an answer within five (5) days thereafter, or if the written answer is unacceptable, the employee shall within ten (10) days of the date on which the written grievance was submitted to the principal, file the grievance at Level Two.

A copy of the written decision of the principal shall be forwarded to the Superintendent of Schools for permanent filing.

Level Two - A copy of the written grievance shall be filed with the Superintendent or his designated agent as specified in Level One with the endorsement thereon of the approval or disapproval of the Association. Within five (5) days of receipt of the grievance, the Superintendent or his designated agent shall arrange a meeting with the grievant and/or the designated Association representative, at the option of the grievant, to discuss the

grievance. Within five (5) days of the discussion, the Superintendent or his designated agent, shall render his decision in writing, transmitting a copy of the same to the grievant, the Association secretary, and the principal and place a copy of the same in a permanent file in his office.

If no decision is rendered within five (5) days of the discussion or the decision is unsatisfactory to the grievant and the Association, the grievant may appeal same to the Board of Education by filing the written grievance along with the decision of the Superintendent with the officer of the Board in charge of drawing up the agenda for the Board's meeting not less than five (5) days prior to the next regularly scheduled Board meeting.

Level Three - Upon proper application as specified in Level Two, the Board of Education shall allow the employee or the Association representative an opportunity for a private hearing at their next regular meeting to the extent permitted by the Open Meetings Act, MCLA 15.261 et. seq. Within fifteen (15) days from the hearing of the grievance the Board shall render its decision in writing. The Board of Education may hold future hearings therein, may designate one or more of its members to hold future hearings therein, or otherwise investigate the grievance provided however, that in no event except with express written consent of the Association shall final determination of the grievance be made by the Board of Education more than fifteen (15) days after the initial hearing.

A copy of the written decision of the Board of Education shall be forwarded to the Superintendent for permanent filing, the principal, the grievant, and the secretary of the Association.

Level Four - Individual employees shall not have the right to process a grievance at Level Four.

1. If the Association is not satisfied with the disposition of the grievance at Level Three, it may within ten (10) days after the decision of the Board has been rendered refer the matter for arbitration to the American Arbitration Association in writing and request the appointment of an arbitrator to hear the grievance. If the parties cannot agree upon an arbitrator, he shall be selected in accordance with the rules of the American Arbitration Association.

2. Neither party may raise a new defense or ground at Level Four not previously raised or disclosed at other written levels. Each party shall submit to the other party not less than three (3) days prior to the hearing a pre-hearing statement alleging facts, grounds and defenses which will be proven at the hearing and hold a conference at that time in an attempt to settle the grievance.

3. The decision of the arbitrator shall be final and conclusive and binding upon employee, the District and the Association. Subject to the right of the District or the Association to judicial review, any lawful decision of the arbitrator shall be forthwith placed into effect.

4. Powers of the arbitrator are subject to the following limitations:

    a. He shall have no power to add to, subtract from, disregard, alter or modify any of the terms of this Agreement.

    b. He shall not hear any grievance barred from the scope of the grievance procedure.

    c. Where no financial loss has been caused by the action of the District complained of, the District shall be under no obligation to make monetary adjustments and the arbitrator shall have no power to award punitive damages.

    d. Arbitration awards or grievance settlements will not be made retroactive beyond the date of the occurrence or non-occurrence of the event upon which the grievance is based.

    e. He shall have no power to change any practice, policy or rule of the District nor substitute his judgment for that of the District as to the reasonableness of any such practice, policy, rule or action taken by the district unless such practice, policy, rule or action of the District is in violation of this Agreement.

    f. He shall have no power to decide any question which, under this Agreement, is within the responsibility of the management to decide.

    g. Not more than one grievance may be considered by the arbitrator at one time except by mutual consent.

    h. The arbitrator shall not interpret state or federal statutes.

F. The fees and expenses of the arbitrator shall be equally shared between the parties.

G. Should an employee fail to institute a grievance within the time limits specified, the grievance will not be processed. Should an employee fail to appeal a decision within the limits specified, or leave the employ of the District (except a claim involving a remedy directly benefiting the grievant regardless of his employment), all further proceedings on a previously instituted grievance shall be barred.

H. All preparation, filing, presentation or consideration of grievance shall be held at times other than when an employee or participating Association representative are to be at their assigned duty stations. Upon receipt of adequate advance notice, the District will release from work employees to be called as witnesses in a grievance arbitration hearing. Any loss of pay or leave time incurred by any such witness, however, shall be borne by the party (i.e. District or Association) requesting the employee's release.

I. The time limits provided in this Article shall be strictly observed but may be extended by written agreement of the parties

J. The following matters shall not be subject to the grievance procedure:

1. Failure to re-employ a probationary employee.

2. Any claim or complaint in which the employee has initiated remedial procedures via a forum established by law or by regulation having the force of the law.

K. All copies of formal grievance shall be filed separately from the personnel records of the participants.

ARTICLE XIX

COMPENSATION

A. When an employee is required by his/her supervisor to use his/her own automobile for the District's business, including requested participation in Special Olympics and 4-H, he/she shall be paid mileage at the maximum rate allowed (without taxable consequences) by the I.R.S. for all such required use; provided, however, that any changes in the mileage rate need only be made at such time as changes are made for any other employee group. To be reimbursed, employees must submit a mileage reimbursement request detailing, at a minimum, date and time of use, number of miles driven and the purpose of the trip. Such request must be filed within one (1) week following use of the automobile.

B. All employees required by the District to attend training sessions, conferences, conventions or schools shall be paid approved expenses and shall suffer no loss of pay.

C. Any physical or psychiatric examination an employee is required by the District to take shall be at the expense of the District and may be by a physician appointed by the District.

D. Base Pay Increase:

2023-2024

- YAS members will receive a $1.00 per hour increase.
- OAC members will receive a $2.00 per hour increase.
- The minimum wage rate will be $16.00 per hour for both OAC and YAS.

2024-2025

- YAS members will receive a $1.00 per hour increase
- OAC members will receive a $1.50 per hour increase

2025-2026

- YAS members will receive a $1.00 per hour increase.
- OAC members will receive a $1.50 per hour increase.

If, in any of the years noted above, an OAC member moves to a YAS Program, their hourly compensation will be reduced by the cumulative difference in wage increase for the year(s) that have ensued since the inception of this provision.

If, in any of the years noted above, a YAS member moves to the OAC Program, their hourly compensation will be increased by the cumulative difference in wage increase for the year(s) that have ensued since the inception of this provision.

ARTICLE XX

FRINGE BENEFITS

A. The District will contribute up to the state mandated cap toward the cost of single subscriber coverage for the selected medical plan. Any additional premium cost including buying up to two-person or full family coverage will be at the employee's expense through payroll deduction.

   If the employee declines insurance coverage, the District will provide a cash in lieu of benefit equal to $10,000 for YAS staff and $12,400 for OAC staff, spread over the total number of pays for the respective program.

B. All health benefit (medical, dental, vision) plan choices will remain the same as non-union staff. Any new options that the district adds that would result in a lower employee premium share cost will also be available to the group as they are established for other groups.

   The cost of dental and vision coverage will be the responsibility of the employee.

C. Group Life Insurance: 100% of the monthly premium cost for group term life insurance coverage in the amount of $15,000, with AD&D, from a carrier of the Board's choosing.

D. Group Long Term Disability Insurance: 100% of the monthly premium cost for group long term disability insurance (S.E.T. Policy #G 5050.5 or equivalent). This policy shall provide 90 calendar day waiting period, 70% benefit level. The covered employee shall be responsible for the first 30 calendar days of illness/disability, with the Board as employer providing additional sick days for coverage through the 89th calendar day.

E. Subject to the terms and provisions of this Agreement, eligible employees shall elect (in writing) the insurance (or other benefit) option they desire during open enrollment each year. Thereafter, for the remainder of the year (including any subsequent summer session), such employees shall not be allowed to change their insurance (or other benefit) option election; provided, however, that an eligible employee may change to a group health insurance option if he/she loses medical coverage under another group medical plan. As a condition of allowing any such change, however, the District may require reasonable verification of the fact that the employee is no longer covered under another group medical plan.

F. Any member of the bargaining unit (and/or of a bargaining unit member's family) who is covered by other group medical coverage similar to the group health insurance described above, shall not be eligible for group health insurance at District expense under the provisions of this Article. The determination of similar medical coverage shall be the decision of the District; provided, however, that any disagreement with such decision may be processed as a grievance, pursuant to the grievance procedures prescribed in this Agreement.

G. Part-Time Aides/Insurance Benefits: Group insurance benefits for regular part-time Aides

(i.e., those regularly scheduled for less than 35 hours per week or less than 180 days per school year) shall be prorated based upon their scheduled work week - as follows:

- Less than 15 hours per week - none.
- 15 hours or more per week - for health and life - prorated based upon scheduled work week.
- 20 hours or more per week - for dental and long term disability - prorated based on scheduled work week.

H. Any and all group insurance benefit costs in excess of the contributions (as provided in this Article) to be made by the District shall be timely (i.e., in advance) paid by the covered employees, on behalf of themselves and their covered and eligible dependents, through payroll deduction.

I. Any and all group insurance benefits provided pursuant to this Agreement are subject to the availability of such coverage and to all such terms, conditions and/or limitation (including but not limited to minimum eligibility requirements) as may be prescribed by any such plan(s) or policy(ies) of insurance. The District's responsibility with respect to any such group insurance benefits is limited to the payment of its share of the cost of such insurance benefits on behalf of eligible employees. With respect to the various group insurance provisions of this Article, wherever the phrase "or equivalent" is used in connection with a particular group insurance program, the District will not change group insurance plans or carriers without first consulting with the Association and unless it is also changing such plans or carriers with one or more other District employee groups.

J. Commencement/Termination of Coverage: Group insurance coverage pursuant to this Article, for eligible employees, commences, continues, or terminates as follows:

1. New hire at beginning of school year:

- Coverage starts on the first day of work.

2. New hire during school year:
- Coverage starts on the first day of the month following the first day of work.

3. Unpaid leave of absence for more than twenty (20) work days, (unless otherwise expressly and specifically provided in this Agreement):

- District contributions toward the cost of coverage stop at the end of the month during which the last day of work or paid leave occurs, and resume the first day of the month following the month in which the employee returns to work.

4. Terminations:

- District contributions toward the cost of coverage stop at the end of the month during which the last day of work occurs.

K. Employees who become ineligible for continuation of group insurance benefits provided by the District, through termination of employment or otherwise, may have continuation rights or conversion privileges, at their own expense, pursuant to the provisions of "COBRA" (in the case of health insurance) or the provisions of other policies. Any employee desiring to continue or convert such coverage, at their own expense, must arrange to do so promptly (before any such rights or privileges are lost.)

ARTICLE XXI

MISCELLANEOUS PROVISIONS

A. This represents the full and complete commitments between both parties and may be altered, added to, deleted from or modified only through voluntary, mutual consent of the parties in written and signed amendments to this Agreement.

B. This Agreement shall supersede any rules, regulations or practices of the District which shall be contrary to or inconsistent with its terms.

D. If any provisions of this Agreement or any application of this Agreement to any employee or group of employees shall be found contrary to law, then such provisions or applications shall be null and void except to the extent required by law, but all other provisions or applications shall continue in full force and effect. Representatives of the Association and District shall meet with the intent to agree to replacement language.

E. Copies of this Agreement shall be available electronically within (30) days of the signing of the Agreement and presented to all employees.

ARTICLE XXII

VOLUNTARY JOB SHARING

A. Two (2) bargaining unit members may, with prior written approval by the District's administration, share a position which either of them holds alone; provided, however, that any such job sharing shall be subject to all of the following terms and conditions:

1. The unit member shall notify the president of their desire to job share by April 25, and the president shall notify the rest of the unit members within 5 working days. The member interested in sharing the position shall notify the member wishing to share their position within 5 working days.

2. The shared time position will be made up of 2 bargaining unit members. If no one from the unit is interested, then the bargaining unit member can go outside the unit to share the position.

3. No job sharing request or approval shall be for a period longer than one (1) year at a time.

4. Administrative approval or disapproval of any job sharing request shall be in the sole discretion of the Superintendent (or his designee).

5. Job sharing requests must be made in writing, and must be given to the Director on or before May 1st for the following year.

6. The District shall receive the same number of hours of service it would receive if the position was filled by one (1) person. The working hours will be split between the two (2) employees in a manner approved in writing by both the participating employees and the administration prior to final job sharing approval.

7. Each participating employee shall be paid for the hours which he/she works, and each such employee shall be paid on the experience step which he/she would be entitled to if employed on a full-time basis. Participating employees shall not, by reason of such job sharing, be denied such advancement on the wage schedule to which they would otherwise be entitled during the following school year.

8. Each participating employee shall receive fringe benefits on a prorated basis, based on his/her respective share of the position being split; provided, however, that the District shall not be obligated to pay or provide more fringe benefits than would be required if the shared position was filled by one (1) person; and provided further, that each participant shall remain subject to any eligibility requirements of this Agreement and/or of any applicable insurance policy or program. The proration of such fringe benefits shall be reviewed by the participating employees and by the Superintendent (or his designee) prior to final job sharing approval.

9. Seniority will be prorated based on each participant's hours of work in relation to full-time status.

10. During the first school year of any job sharing arrangement, each participating employee shall have for the following school year the option to return to his/her previous position if that position is available; provided, however, that any such participating employee must notify the Director (in writing), on or before May 1st, of his/her desire to do so. Thereafter, if the job sharing arrangement continues into the second school year, each participating employee shall have the right to return to full-time status in accordance with paragraph number 12 below.

11. Neither participant in a job sharing arrangement may exercise his/her seniority rights to displace the other participant from any portion of the shared position.

12. After the termination of a shared-time assignment, the participating employees may apply for any vacancies that may be available. If no vacancies are available, said employees may displace the least senior full-time person(s) in the unit. Displacement will occur only if the least senior person has less seniority than the employee requesting full-time employment. When the job share is terminated, the position will be posted as a full-time position.

13. In the event one of the job sharing employees leaves the employment of the District during the course of the school year, for any reason, the other employee shall automatically assume full-time status in the position being shared for the remainder of that school year. This provision may be waived upon the written approval of the District's administration.

B. Except as altered or modified in this Article, all other articles of this Agreement shall remain in full force and effect.

ARTICLE XXIII

REGULARLY EMPLOYED SUBSTITUTE AIDES

A regularly employed substitute aide shall be defined as either an individual who is hired as a substitute for a full time aide on leave of absence and has worked 12 or more consecutive weeks or as an individual who is hired to fill a vacancy and has worked 12 consecutive weeks during the school year.

The following terms and conditions will apply to regularly employed substitute aides:

1. Will be hired on a substitute basis.

2. Experience credit toward wages, but not seniority, will be granted for working a full year.

3. Benefits as defined in Article XXII and Article XVII will be granted after obtaining regularly employed substitute status.

4. In the case of a leave of absence, there is no posting requirement unless the position is vacated by the employee on leave.

5. A regularly employed substitute aide as defined above, who has filled a full time position, shall be considered for a permanent position if it has not been filled from within the Bargaining Unit.

6. Any regularly employed substitute Aide who works at least one full year in a continuous assignment and is subsequently hired for a permanent position shall be given seniority credit for the time employed as a substitute Aide.

ARTICLE XXIV

TUITION REIMBURSEMENT

The Intermediate District will reimburse the cost of tuition for coursework related to a program of study leading to a degree or certification in special education, social work, or a related degree such as occupational, speech or physical therapy with the following conditions:

1. Appropriate course work must be pre-approved, by class, by administration. While approval should be sought prior to the start of the class, exception will be made for situations outside of the staff member's control, as long as the class meets the criteria for reimbursement.

2. Total reimbursement is limited to the total dollar amount derived by averaging the tuition rates, per semester hour, for GVSU, WMU, and FSU and multiplying by three (3). Costs for tuition and related course or admission fees are eligible for reimbursement up to the dollar limit. Expenses incurred for books, transportation/parking or late registration are not eligible for reimbursement.

3. Claim for reimbursement will be submitted with expense report after successful completion of course. A copy of the transcript or passing grade report showing course credit, and evidence of actual cost (itemized college billing statement) must accompany submission of claim. Other proof of successful completion may be accepted by the administration until transcripts and/or grade reports are available for submission. Under no circumstances will the District pay for the same course twice for the same employee.

4. No reimbursements will be granted by the Intermediate District if tuition and/or fees were covered by some other grant or fellowship.

5. Reimbursement will be prorated for part time employees.

6. The tax liability for any reimbursement tuition expense is the responsibility of the employee.

7. Aides who leave employment (for reasons other than retirement) during the fiscal year (July 1 – June 30), in which tuition costs are reimbursed, must refund the district the amount of tuition reimbursement incurred and paid in that fiscal year. The district reserves the right to deduct the refund from the employee's final paycheck.

ARTICLE XXV

EMERGENCY MANAGER

Section 15(7) of the Public Employment Relations Act (PERA) mandates that any contract entered into include a statement that allows an Emergency Manager appointed under the Local Government and School District Fiscal Accountability Act to reject, modify, or terminate the collective bargaining agreement as provided in the Local Government and School District Fiscal Accountability Act. This provision is intended to satisfy this requirement. No grievances may be processed contesting actions taken by an Emergency Manager.

ARTICLE XXVI

DURATION

This Agreement shall be effective upon ratification by all parties and shall continue in full force and effect until June 30, 2026.

IN WITNESS WHEREOF, the parties have executed this Agreement, by their duly authorized representatives, this 3 day of October, 2023.

For the Association:

For the District

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 005
Section Code(s): 1010, 1110
PPO - Versatile Plan 3, Hearing, RX 1
Effective Date: 01/01/2020
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$250 per member $500 per family	$500 per member $1,000 per family
Copays • Fixed Dollar Copays	$20 copay for : • Office visits • Professional Urgent care services $50 copay for : • Facility medical emergency	$50 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	10% up to a maximum of: $1,000 per member $2,000 per family	30% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$2,500 per member $5,000 per family Includes Deductible, Coinsurance and Copays	$2,500 per member $5,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 70% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Telemedicine Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 100% after $20 copay	Not Covered
Office Consultations	Covered - 100% after $20 copay	Covered - 70% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 70% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - $50 copay then 90% after deductible; copay waived if admitted or for an accidental injury	Covered - $50 copay then 90% after deductible; copay waived if admitted or for an accidental injury
Non-Emergency use of the Emergency Room	Covered - $50 copay then 90% after deductible	Covered - $50 copay then 70% after deductible
Facility Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Physician Urgent Care Services	Covered - 100% after $20 copay	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 90% after deductible	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 90% after deductible	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care	Covered - 90% after deductible	Covered - 70% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Medical Care	Covered - 90% after deductible	Covered - 70% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 90% after deductible	Covered - 90% after deductible
Home Health Care	Covered - 90% after deductible	Covered - 90% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 90% after deductible	Covered - 90% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after deductible
Bariatric Surgery	Covered - 90% after deductible	Covered - 70% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 90% after deductible	Covered - 90% after in-network deductible
Sterilization - males only excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 90% after deductible	Covered - 70% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Substance Use Disorder Treatment	Covered - 90% after deductible	Covered - 90% after deductible
Outpatient Mental Health Care • Telemedicine Mental Health Care • Blue Cross Online Mental Health Care	Covered - 100% after $20 copay Covered - 100% after $20 copay Covered - 100% after $20 copay	Covered - 70% after deductible Covered - 70% after deductible Not Covered
Outpatient Substance Use Disorder Treatment	Covered - 100% after $20 copay	Covered - 90% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 90% after deductible	Covered - 70% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 90% after deductible	Covered - 70% after deductible
Nutritional Counseling	Covered - 90% after deductible	Covered - 70% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per member, per calendar year	Covered - 90% after deductible	Covered - 70% after deductible
Durable Medical Equipment	Covered - 90% after deductible	Covered - 70% after deductible
Prosthetic and Orthotic Devices	Covered - 90% after deductible	Covered - 70% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 90% after deductible	Covered - 70% after deductible
Private Duty Nursing Care	Covered - 90% after deductible	Covered - 90% after deductible
Allergy Testing and Therapy	Covered - 90% after deductible	Covered - 70% after deductible
Facility Clinic Visit	Covered - 90% after deductible	Covered - 70% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible
Massage Therapy Limited to a maximum of 24 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 005
Section Code(s): 1010, 1110
Hearing Care Coverage
Effective Date: 09/01/2012
Benefits-at-a-glance

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BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 005
Section Code(s): 1010, 1110
Prescription Drugs
Effective Date: 01/01/2021
Benefits-at-a-glance

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BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$10 copay - Generic drugs $40 copay - Brand drugs $0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$20 copay - Generic drugs $80 copay - Brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay - Generic drugs $40 copay - Brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance.

Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 008
Section Code(s): 1010, 1110
PPO - Versatile 4 PPO, Hearing, RX25
Effective Date: 01/01/2020
Benefits-at-a-glance

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BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$500 per member $1,000 per family	$1,000 per member $2,000 per family
Copays • Fixed Dollar Copays	$20 copay for : • Office visits • Professional Urgent care services $50 copay for : • Facility medical emergency	$50 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	10% up to a maximum of: $1,000 per member $2,000 per family	30% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$3,000 per member $6,000 per family Includes Deductible, Coinsurance and Copays	$3,000 per member $6,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 70% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Telemedicine Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 100% after $20 copay	Not Covered
Office Consultations	Covered - 100% after $20 copay	Covered - 70% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 70% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - $50 copay then 90% after deductible; copay waived if admitted or for an accidental injury	Covered - $50 copay then 90% after deductible; copay waived if admitted or for an accidental injury
Non-Emergency use of the Emergency Room	Covered - $50 copay then 90% after deductible	Covered - $50 copay then 70% after deductible
Facility Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Physician Urgent Care Services	Covered - 100% after $20 copay	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 90% after deductible	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 90% after deductible	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care	Covered - 90% after deductible	Covered - 70% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Medical Care	Covered - 90% after deductible	Covered - 70% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 90% after deductible	Covered - 90% after deductible
Home Health Care	Covered - 90% after deductible	Covered - 90% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 90% after deductible	Covered - 90% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after deductible
Bariatric Surgery	Covered - 90% after deductible	Covered - 70% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 90% after deductible	Covered - 90% after in-network deductible
Sterilization - males only excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 90% after deductible	Covered - 70% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Substance Use Disorder Treatment	Covered - 90% after deductible	Covered - 90% after deductible
Outpatient Mental Health Care	Covered - 100% after $20 copay	Covered - 70% after deductible
• Telemedicine Mental Health Care	Covered - 100% after $20 copay	Covered - 70% after deductible
• Blue Cross Online Mental Health Care	Covered - 100% after $20 copay	Not Covered
Outpatient Substance Use Disorder Treatment	Covered - 100% after $20 copay	Covered - 90% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 90% after deductible	Covered - 70% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 90% after deductible	Covered - 70% after deductible
Nutritional Counseling	Covered - 90% after deductible	Covered - 70% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per member, per calendar year	Covered - 90% after deductible	Covered - 70% after deductible
Durable Medical Equipment	Covered - 90% after deductible	Covered - 70% after deductible
Prosthetic and Orthotic Devices	Covered - 90% after deductible	Covered - 70% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 90% after deductible	Covered - 70% after deductible
Private Duty Nursing Care	Covered - 90% after deductible	Covered - 90% after deductible
Allergy Testing and Therapy	Covered - 90% after deductible	Covered - 70% after deductible
Facility Clinic Visit	Covered - 90% after deductible	Covered - 70% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible
Massage Therapy Limited to a maximum of 24 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 008
Section Code(s): 1010, 1110
Hearing Care Coverage
Effective Date: 09/01/2012
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 008
Section Code(s): 1010, 1110
Prescription Drugs
Effective Date: 01/01/2021
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$10 copay - Generic drugs $40 copay - Brand drugs $0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$20 copay - Generic drugs $80 copay - Brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay - Generic drugs $40 copay - Brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance.

Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 029
Section Code(s): 1020, 1120, 1200
PPO - PPO Plan 3, Hearing, RX 14
Effective Date: 01/01/2020
Benefits-at-a-glance

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Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$1,000 per member $2,000 per family	$2,000 per member $4,000 per family
Copays • Fixed Dollar Copays	$20 copay for : • Office visits • Chiropractic spinal manipulations • Professional Urgent care services $50 copay for : • Facility medical emergency	$50 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20% up to a maximum of: $2,500 per member $5,000 per family	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$4,500 per member $9,000 per family Includes Deductible, Coinsurance and Copays	$7,000 per member $14,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $20 copay	Covered - 60% after deductible
Telemedicine Visits	Covered - 100% after $20 copay	Covered - 60% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 100% after $20 copay	Not Covered
Office Consultations	Covered - 100% after $20 copay	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $50 copay; copay waived if admitted or for an accidental injury	Covered - 100% after $50 copay; copay waived if admitted or for an accidental injury
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 100% after $20 copay	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100%	Covered - 100%
Home Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 80% after deductible	Covered - 80% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after $20 copay	Covered - 60% after deductible
• Telemedicine Mental Health Care	Covered - 100% after $20 copay	Covered - 60% after deductible
• Blue Cross Online Mental Health Care	Covered - 100% after $20 copay	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per, member, per calendar year	Covered - 100% after $20 copay	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Covered - 50% after deductible	Covered - 50% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 60% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 029
Section Code(s): 1020, 1120, 1200
Hearing Care Coverage
Effective Date: 01/01/2021
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 029
Section Code(s): 1020, 1120, 1200
Prescription Drugs
Effective Date: 01/01/2021
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$10 copay - Generic drugs $40 copay - Brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90 day supply	$10 copay - Generic drugs $40 copay - Brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay - Generic drugs $40 copay - Brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance.

Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 059, 060
Section Code(s): 3000, 3100
PPO - Minimal Essential Plan, Hearing, RX 23
Effective Date: 01/01/2020
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$3,000 per member $6,000 per family	$6,000 per member $12,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	20%	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums All members on the contract can contribute to the family out of pocket maximum; however, a single member will not exceed the individual out of pocket maximum.	$4,000 per member $6,550 per member in family plan $8,000 per family Includes Deductible, Coinsurance and Copays	$8,000 per member $16,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Visits	Covered - 80% after deductible	Covered - 60% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 80% after deductible	Not Covered
Office Consultations	Covered - 80% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 80% after deductible	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 80% after deductible	Covered - 80% after deductible
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal Care Visits	Covered - 100%	Covered - 60% after deductible
Postnatal Care Visits	Covered - 80% after deductible	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 80% after deductible	Covered - 80% after deductible
Home Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to a maximum of 90 days per calendar year	Covered - 80% after deductible	Covered - 80% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 80% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment • Telemedicine Mental Health Care • Blue Cross Online Mental Health Care	Covered - 80% after deductible Covered - 80% after deductible Covered - 80% after deductible	Covered - 60% after deductible Covered - 60% after deductible Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 12 visits per member, calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 059, 060
Section Code(s): 3000, 3100
Hearing Care Coverage
Effective Date: 01/01/2021
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 059, 060
Section Code(s): 3000, 3100
Prescription Drugs
Effective Date: 01/01/2021
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Deductible	$3,000 per individual $6,000 per family
Retail - 30 day supply	$10 copay after deductible - Generic drugs $40 copay after deductible - Preferred brand drugs $80 copay after deductible - Non-Preferred brand drugs $0 copay after deductible – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90 day supply	$20 copay after deductible - Generic drugs $80 copay after deductible - Preferred brand drugs $160 copay after deductible - Non-Preferred brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay after deductible - Generic drugs $40 copay after deductible - Preferred brand drugs $80 copay after deductible - Non-Preferred brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance.

Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement . • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

OAISD Health Care Plan Choices

	Highest Deductible HSA - $3,000/$6,000 Deductible		Higher Deductible Plan PPO 12 - $1,000/$2,000 Deductible		Alternate Base Plan PPO Versatile - $500/$1,000 Deductible		Base Plan PPO Versatile - $250/$500 Deductible	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible	$3,000/$6,000	$6,000/$12,000	$1,000/$2,000	$2,000 /$4,000	$500 /$1,000	$1,000 /$2,000	$250 /$500	$500/$1,000
Coinsurance	20% AD	40%	20% ($2,500/5,000 cap)	40%	10% ($1,000/2,000 cap)	30%	10% ($1,000/2,000 cap)	30%
Office Visit	80% AD	60% AD	$20 co-pay	60% AD	$20 co-pay	70% AD	$20 co-pay	70% AD
Health Maintenance Exam (5 yrs +)	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered
Well Child Care to age 4	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered
Chiropractic	80% AD (12 visits)	60% AD (12 visits)	$20 co-pay (24 visits)	60% AD	90% AD	70% AD	90% AD	70% AD
Emergency Use of ER	80% AD	80% AD	$50 co-pay/100%	$50 co-pay/100%	$50 co-pay/90% AD	$50 co-pay/90% AD	$50 co-pay/90% AD	$50 co-pay/90% AD
Non-Emergency use of ER	Not Covered	Not Covered	Not Covered	Not Covered	$50 co-pay/90% AD	$50 co-pay/70% AD	$50 co-pay/90% AD	$50 co-pay/70% AD
Urgent Care	80% AD	60% AD	Facility 80% AD; Professional 100% after $20 copay	Facility 60% AD; Professional 60% AD	Facility 90% AD; Professional 100% after $20 copay	Facility 70% AD; Professional 70% AD	Facility 90% AD; Professional 100% after $20 copay	Facility 70% AD; Professional 70% AD
Maternity Prenatal Care Visit	Covered 100%	60% AD	Covered 100%	60% AD	Covered 100%	70% AD	Covered 100%	70% AD
Maternity Postnatal Care Visit	80% AD	60% AD	Covered 100%	60% AD	Covered 100%	70% AD	Covered 100%	70% AD
Delivery & Nursery Care	80% AD	60% AD	80% AD	60% AD	90% AD	70% AD	90% AD	70% AD
Annual GYN Exam	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered
Mammogram Screening	Covered 100%	60% AD	Covered 100%	60% AD	Covered 100%	70% AD	Covered 100%	70% AD
PSA Screening	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered
Endoscopic Exam	100% routine	60% AD	Covered 100%	60% AD	100% routine	70% AD	100% routine	70% AD
Routine Hearing Exam	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered
Hearing Aids	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered
Diagnostic test, X-rays, Lab, MRI, PET, CAT scans	80% AD	60% AD	80% AD	60% AD	90% AD	70% AD	90% AD	70% AD
Chemotherapy/Radiation	80% AD	60% AD	80% AD	60% AD	90% AD	70% AD	90% AD	70% AD
Immunizations	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Not Covered
Hospital Care	80% AD	60% AD	80% AD	60% AD	90% AD	70% AD	90% AD	70% AD
Skilled Nursing Facility	80% AD	80% AD	80% AD	80% AD	90% AD	90% AD	90% AD	90% AD
Surgery	80% AD	60% AD	80% AD	60% AD	90% AD	70% AD	90% AD	70% AD
Oral Surgery	Not Covered	Not Covered	Not Covered	Not Covered	90% AD	90% After in-network deductible	90% AD	90% After in-network deductible
Durable Medical Equipment	80% AD	60% AD	80% AD	60% AD	90% AD	70% AD	90% AD	70% AD
Physical, Occupational, Speech Therapy	80% AD	60% AD	80% AD	60% AD	90% AD	70% AD	90% AD	70% AD
Massage Therapy	Not Covered	Not Covered	Not Covered	Not Covered	90% AD (24 visits)	70% AD (24 visits)	90% AD (24 visits)	70% AD (24 visits)
RX- Generic/Brand Name	$10/$40/80 AD	75% approved amt.-copay	$10/$40	75% approved amt.-copay	$10/$40	75% approved amt. -copay	$10/$40	75% approved amt. -copay
Mail Order 90 day supply	$20/$80/160 AD	Not Covered	$10/$40	Not Covered	$20/$80	Not Covered	$20/$80	Not Covered
Over the Counter Drugs (Claritin, Zyrtec, Prilosec OTC) *	$0 copay AD	75% approved amt.-copay	Not Covered	Not Covered	$0 copay AD	75% approved amt.-copay	$0 copay AD	75% approved amt.-copay

***** $3000/$6000 Yellow Plan Only***** Employer 7/1/23 - 12/31/23 HSA Contribution: | Single HSA Employer Contribution: $1,229.67 | 2 Person HSA Employer Contribution: $1,592.52 | Family HSA Employer Contribution: $2,904.87

NOTES:

AD is After Deductible in the columns.

See Benefits-at-a-glance for specific detail on coverage, available on our website: oaisd.org/staff/support/human-resources/benefit-information

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

OTTAWA AREA ISD Dental Benefits Plan — Group # 9949

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year January 1 through December 31**
Annual Maximum	$1500 per eligible individual for covered class I, II and III services.
Lifetime Maximum	$2000 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
Topical Application of Fluoride	Twice per plan year to age 18
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 36 months
All Other X-Rays	
Space Maintainers	To age 14
Class II Restorative Services – 100%	
Composite and Amalgam fillings**	
Inlays, Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year, following treatment
Periodontal Root Planing	Once per quadrant per 12 months
Periodontal Surgery	
Oral Surgery and Extractions	Medical coverage primary for surgical procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 70%	
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	
Class IV Orthodontic Services – 70%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, to age 19
Comprehensive Treatment	Fixed Appliance Therapy, to age 19
Not Covered	

Sealants Implants and Related Restorations TMJ/TMD Treatment 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. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $200.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Ottawa Area ISD
Effective 01/01/2012
Revised 01/01/2016
Group Number# 51821

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every Calendar Year	▪ Covered 100% After $20 Copay	Reimbursed Amount ▪ Up to $32
Lenses Once Every Calendar Year	Standard Glass or Plastic	
▪ Single Vision	▪ Covered 100% After $50 Copay	▪ Up to $42
▪ Bifocal		▪ Up to $48
▪ Trifocal		▪ Up to $60
▪ Lenticular		▪ Up to $72
▪ Glass Photogrey	▪ Covered 100%	▪ Up to $7.50
▪ Transitions	▪ Covered 100%	▪ Up to $32.50
▪ Polycarbonates (under age 19)	▪ Covered 100%	▪ Up to $10
▪ Standard Progressives	▪ Covered 100%	▪ Up to $25
▪ Solid Tint	▪ Covered 100%	▪ Up to $5
▪ Fashion Gradient Tint	▪ Covered 100%	▪ Up to $5
▪ Ultraviolet Coating	▪ Covered 100%	▪ Up to $6
▪ Standard Scratch Coating	▪ Covered 100%	▪ Up to $5
Frame Once Every Calendar Year	Retail Allowance ▪ Up to $70 (20% discount off balance)*	▪ Up to $50
Contact Lenses Once Every Calendar Year	In lieu of Lenses & Frame	In lieu of Lenses & Frame
Elective Contact Lenses	▪ Up to $105 Retail (15% discount (Conventional) or 10% discount (Disposable) off balance)**	▪ Up to $105
Fit/Follow-Up***		
Standard Daily Wear	▪ Covered 100%	▪ Up to $20
Standard Extended Wear	▪ Covered 100%	▪ Up to $30
Medically Necessary****	▪ Covered 100%	▪ Up to $210

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses and contact lens evaluation/fitting once every calendar year.

At the start of the program, if authorized by your employer you may receive identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, you must indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 51821000001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Wal-Mart / Sam's Club locations or for certain proprietary brands. **Does not apply to Wal-Mart/Sam's Club or Contact Fill (NVA Mail Order) may be prohibited by some manufacturers. ***Only covered if you choose Contact Lenses. ****Pre-approval from NVA required.

Due to their everyday low prices (EDLP) the amounts listed below may not be applicable at Wal-Mart/Sam's Club.
Lens options & services purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $100 Progressive Lenses Premium*
- $75 Polarized
- $55 High Index
- $30 Blended Bifocal (Segment)
- $40 Standard Anti-Reflective
- $30 Polycarbonate (Multi-Focal) 19 & over
- $25 Polycarbonate (Single Vision) 19 & over
- $50 Specialty Wear Fitting

***Fixed Pricing not available on certain brands**
Options not listed will be priced by NVA providers at their R&C retail price less 20%.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

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

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

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization.

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

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

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only

Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint $50 Standard Progressive Lenses
Contact Lens Fitting:	Retail Less 10%	$75 Polarized Lenses $65 Transitions Single Vision Standard $70 Transitions Multi-Focal Standard
Lenses:	Glass or Plastic	$15 Standard Scratch Coating
Single Vision	$35.00	$12 UV Coating
Bifocal	$55.00	$35 Polycarbonate
Trifocal or Lenticular	$70.00	$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at their reasonable & customary retail price less 20%.

Wal-Mart / Sam's Club Stores: Due to their everyday low prices (EDLP) Wal-Mart / Sam's Club stores do not provide additional discounts.

At NVA, We Work Only for Our Clients.

The proposed vision insurance program is insured through Fidelity Security Life Insurance Company (FSL) Kansas City, MO. Fidelity Security Life Insurance Company brings over 45 years of underwriting experience in the insurance industry since 1969.

Fidelity Security Life Insurance Company has been rated A- (Excellent), based on an analysis of financial position and operating performance, by A.M. Best Company, an independent analyst of the insurance industry, For the latest rating, access www.ambest.com.

Some provisions benefits, exclusions or limitations listed herein may vary depending on your state of residence.

Exclusions: The following benefits are not payable under this Policy for services or materials connected with or charges arising from (unless otherwise indicated in the Proposed Schedule of Benefits): Aniseikonic Lenses; Subnormal visual aids; Orthoptics, vision training, and any associated supplemental testing; Broken, lost or stolen lenses, contact lenses, or frames will not be replaced except in the next Benefit Frequency when Vision Materials would next become available; Services or materials provide as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Services rendered after the date an insured Person ceases to be covered under the policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan; Medical and/or surgical treatment of the eye, eyes or supporting structures; Two pair of glasses in lieu of bifocals; Plano (non-prescription) lenses; non-prescription sunglasses

Limitations: Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider, such fees or materials are not covered under the Policy. For Contact Lenses, any remaining balance may be used within the same Benefit Frequency. Where the Insured Person previously utilized an In-Network Provider, the remaining balance must be used with the same or any other In-Network Provider. Where the Insured Person previously utilized an Out-of-Network Provider, the remaining balance must be used with the same or any other Out-of-Network Provider.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

Policy Nos. VC-108, VC-109, VC-110; Form NOS. M-9142, M-9143, M-9144.

A Flexible Spending Account (FSA) is Part of Your Employee Benefit Plan

What Will You Do

With the Money?

A Flexible Spending Account Will Put More Money in Your Pocket by Paying for Health, Dental, Vision & Dependent Care with Tax-Free Dollars

Learn How Inside this Brochure

The Flexible Spending Account Plan is as Easy as 1, 2, 3!

1. Elect an annual election amount based on your estimated expenses for the next Plan Year. Keep in mind that the Medical FSA and Dependent Care FSA are separate accounts, so please make your elections accordingly.
2. Your Employer will begin withholding funds from your check on a PRE-TAX basis and depositing them into your FSA account(s).
3. When you incur an expense, submit the itemized receipt to Flex Administrators, Inc. and receive reimbursement with your TAX-FREE money.

How Much Do I Really Save in Taxes Using This Account?

	Without Flex	With Flex
Annual Salary	$40,000	$40,000
Health Care or Dependent Care Spending Account	-0-	-2,500
	Spending Account Deduction	
Taxable Salary (W-2 Income)	40,000	37,500
Federal Tax (15%)	6,000	5,625
State Tax* (4%)	1,600	1,500
Social Security Tax (7.65%)	3,060	2,869
Total Taxes	10,660	9,994
After-Tax Out-of-Pocket Medical Expenses	2,500	-0-
Annual Take-Home Pay	$26,840	$27,506
Annual Tax Savings with Flex Plan		**$666**
		Your Tax Savings

* Taxes may vary by state.
** Reimbursement is through W-2, not reimbursed as an expense through third party administrator.

What Kind of Medical FSA Expenses are Eligible?

Qualifying health care expenses may be incurred for you, your legally married spouse, your natural child, your adopted child, a child placed with you for adoption, your step-child or your foster child through December 31 of the calendar year the child turns age 26; or other children, relatives and members of your household who are your "qualifying Child" or "qualifying relative" under IRS guidelines. For a complete definition of Qualifying Child or Qualifying Relative, please contact our office. Your expenses must be incurred (incurred means date of service, NOT date of payment) within the plan year or prior to your employment termination date.

What Do I Need to Submit in Order to Get Reimbursement?

We accept the following forms of documentation for reimbursement:

Explanation of Benefits form (EOB) from your insurance company.

Itemized receipt from the Service Provider which includes the provider's name and address, date of service, patient name, description of service(s) and the amount of the charge.

Cash Register Receipt for OTC or Prescription Expenses will be accepted as long as the name of the provider, the date of service and the description of the expense is visible on the receipt.

Eligible Health Care Expenses

The following list is not intended to be comprehensive, but contains some of the more common medical expenses. The Internal Revenue Service determines the expenses that are allowable and disallowable. IRS Publication 502, Medical and Dental Expenses, has a checklist of the medical expenses that can be deducted under the Health Care Spending Account.

- Acupuncture
- Ambulance
- Arch supports, knee and wrist braces
- Artificial limbs
- Breast Pump
- Chiropractors' fees
- Christian Science Practitioners' fees
- Coinsurance
- Contact lens solutions/ cleaners
- Crutches
- Dentists' fees including fluoride treatments (cosmetic services are typically not covered)
- Dentures
- Dermatologists
- Diabetic supplies
- Eye exams
- First aid supplies
- Gynecologists' fees
- Health/Dental/Vision insurance deductibles and copays
- Hearing aids/batteries
- Infertility treatments
- Laboratory fees
- Laser eye surgery
- Mileage related specifically to an eligible medical visit
- Nutrition Counseling (specific medical condition)
- Obstetrical fees
- Orthodontia
- Orthopedic shoes
- Over-the-counter items purchased to alleviate or treat an illness or injury
- Physical therapists' fees
- Podiatrists
- Prescription drugs (for non-cosmetic reasons)
- Prescription eyeglasses and/or contact lenses
- Psychiatrists' fees
- Psychologists' fees
- Psychotherapists' fees
- Retin-A used to treat acne
- Routine physicals
- Seeing-eye dog (purchase, training, and care)
- Skilled nurses' fees
- Smoking cessation programs
- Special education for the handicapped
- Speech therapists' fees
- Sterilization fees
- TMJ related treatments
- Therapy treatments (specific medical condition)
- Transportation expenses (for medical reasons)
- Substance addiction treatment
- Wheelchair
- X-rays

Ineligible

- Warranty
- Dates of Service outside of the Plan Year
- Service Fees/Late Fees
- Electric Toothbrushes
- Vitamins & Supplements (unless prescribed by a physician to treat illness or injury.)

Over-the-Counter Medications

As of January 1, 2020, over-the-counter items are once again eligible for reimbursement. The 5 most common expenses eligible without a prescription are: Pain relief medications, cold and flu products, allergy products, heartburn medications and menstrual products. For more information regarding OTC product eligibility, please visit our website.

Orthodontia Reimbursement

Please note: Orthodontia reimbursement is based on when the service is incurred, not when payment is made. Also, all first time orthodontia requests must include the Truth in Lending Statement or treatment contract. For assistance in determining what orthodontia expenses would be eligible for reimbursement from this Plan Year please contact our office directly or reference our website for additional information.

FSA Store
THE FLEXIBLE SPENDING ACCOUNT SITE

FSA Store

Flex Administrators, Inc. has partnered with FSAStore to help you understand the many available uses of your Flexible Spending Account. The site helps make purchasing FSA eligible items simple. You can access the store through our website at www.flexadministrators.com. You can use the coupon code to save on your first purchase.

What Kind of Dependent Care FSA Expenses are Eligible?

Who is eligible for the dependent care account?

If you are married, you can use the account if you and your spouse work, or in some situations, if your spouse goes to school. You can also use the account if your spouse is disabled and unable to care for the children. Single parents can also use the account.

Which dependents are eligible?

An eligible person is defined as an individual who qualifies as a dependent for income tax purposes and is:

- Under the age of 13, or physically or mentally unable to care for himself or herself; or
- Your spouse, or other dependent (child and/or parent) who is physically or mentally unable to care for himself or herself.

If the care is provided outside your home, the expenses can be reimbursed only if the eligible person regularly spends at least 8 hours a day in your home.

What Expenses Are Eligible for Reimbursement?

The following types of care are reimbursable from a Dependent Care Spending Account:

- Care provided inside or outside your home by anyone other than: your spouse, a person you list as your dependent for income tax purposes, or one of your children under age 19.
- Cost of care for school-age children through age 12. This includes nursery school expenses, even if the school also furnishes lunch & educational services. Educational expenses for a child in kindergarten or higher are not considered expenses for care. If dependent is in kindergarten or higher, the cost of schooling must be separated from the cost of care.
- A dependent care center or child care center (if the center cares for more than six children, it must comply with applicable state & local regulations).

NOTE: If you participate in the Dependent Care Spending Account, the IRS will require you to report the Social Security number or Taxpayer Identification number of your provider on your federal income tax return by completing Form 2441.

- A housekeeper, au pair, or nanny whose services include, in part, providing care for a qualifying dependent.
- Day care costs while in day camps
- Before/after school care
- Preschool or nursery school
- FICA and FUTA taxes

How Much Can I Contribute to the Dependent Care Spending Account?

The Internal Revenue Service places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Spending Account.

Generally, your contributions may not exceed the lesser of:

1. $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns);
2. your taxable income; or
3. your spouse's income (for calculation purposes, a spouse who is a full-time student or incapable of caring for himself/herself is considered to have a monthly income of $250 for one dependent or $500 for two or more dependents).

What Do I Need to Submit in Order to Get Reimbursement?

You will need an **Itemized Receipt** from the day care provider. The receipt must reference the from/through date of service and be signed by the provider (or on the provider's letterhead).

You can prepare your own receipts for your day care provider to complete using the sample below:

Receipt for Child Care Services

For the Time Period: __/__/__ through __/__/__

For the Amount of $ _____

Paid by: _____

Received by: _____

Date: __/__/_____

How Do I Submit Claims?

In order to receive reimbursement from your account, please collect the proper documentation and submit your claim via one of the options below.

Ways to File a Claim

1. Via your online account at https://Flexadministrators.lh1ondemand.com. Please Note: This online portal was new as of 8/1/19. If you have not logged into your account since 8/1/19, please select "New User", and follow the prompts.
2. Via "Flex Administrators Mobile", our mobile app available for your phone or tablet, available at the App Store, or Google Play. Mobile App login is the same as website login.
3. E-mail your Claim to: claims@flexadministrators.com*
4. Submit via Fax at 616-454-6090*
5. Submit via Mail at*: Flex Administrators, Inc.
   3980 Chicago Drive, Suite 230
   Grandville, MI 49418

FREE App

For Apple iOS

For Android

*If you choose to file your claim via email, fax or mail, please use a Request for Reimbursement Form.

Also, please note we cannot accept Word (.doc, .docx), Excel (.xls, .xlsx), TIF (.tif) or Photoshop PSD (.psd) file types as attachments for claims submissions. In order to ensure claim receipt, please submit attachments as either an Image (.jpg) or Adobe Acrobat (.pdf) file type.

If you submit a claim by email you will receive an email response verifying that your claim was received.

CLAIM PROCESSING TIME PERIOD: 2 Business Days from time claim is received.

(This includes processing documentation requested for Flex Administrators VISA Card Transactions.)

Things to Consider

For help making your election, consider the following questions.

- How much have I spent for myself and my dependents on out-of-pocket medically related expenses in the past 12 months?
- How much will I spend for ongoing medical expenses next year?
- Am I better off having dependent care expenses paid through the Dependent Care Spending Account or taking the child care tax credit?
- Does my spouse also contribute to a Dependent Care Spending Account? The maximum amount any one family can contribute during a calendar year is $5,000.
- Do I understand that I cannot take a federal income tax deduction for expenses I am reimbursed for from my Dependent Care Spending Account?
- **If you or any member of your family is enrolled in a high deductible health plan with an HSA, you may be limited in your participation of the medical FSA plan.**

Be conservative in estimating your plan year contribution. You may not claim any other tax deduction under this Plan, although the balance of your eligible dependent care expenses may be eligible for the dependent care tax credit. The Dependent Care Spending Account is generally more advantageous than taking a federal tax deduction if you fall into general annual salary categories based on how you file your federal income tax and your adjusted gross income. See the dependent care worksheet that compares the tax credit to the Dependent Care Spending Account plan.

Legal Requirements of the Plan

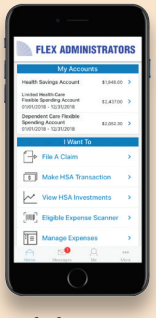
1 Binding Contribution: When a participant signs up to make a contribution, the amount decided upon is "locked in" unless they incur a "change in status" (explained below).

2 Use-it or Lose-it Rule: Please refer to your plan specifics sheet to determine if this may or may not impact you.

3 "Advance Reimbursement" applies only to the Health Care Spending Account and allows a participant to be reimbursed up to the maximum of their plan year election prior to their full year contribution.

Ways to Manage Your Account

"Flex Administrators Mobile" is Available on the App Store & Google Play



The app lets you view balances, claims and card transactions as well as submit a claim! No more faxing receipts! You can file a claim directly from your mobile device with a photo of the receipt.

You can check account balances 24/7 ***securely*** since no information is stored on the mobile device.

Online Claim Filing

You have the option to enter your claim on our website and then upload your receipts without having to mail or fax anything to our office! Simply log in to your account and choose REIMBURSE MYSELF. From there the website will walk you through entering your claims information and then uploading your receipts.

Check Balances, Reimbursement Status, and get Answers to Your Questions at www.flexadministrators.com

Check your balances, see your last reimbursement and get answers to your questions by logging into your account at www.flexadministrators.com. Please note: This portal was new as of August 2019. Please select the NEW USER option below the Login and Password boxes and follow the prompts if you have not used the website since August of 2019.

This chart will help to explain the Use-it or Lose-it rule.	
$25.00 Weekly Contribution x 52 Weeks	$1,300.00
15% Federal Income Tax Savings	$195.00
7.65% Social Security Tax Savings	$99.45
4% State Tax Savings*	$52.00
Total Tax Savings.	$346.45
Money Left in account at the end of the year	$100.00
Tax Savings Even With Money Left In Account.	$246.45

*Tax rates may vary by state.

Use-it or Lose-it. Is it that bad?

Flexible Spending Account regulations require that money not used by the end of the plan year must be forfeited, so it's important to plan carefully. Keep in mind that you cannot transfer Flexible Spending Account monies from the Health Care Account to the Dependent Care Account and vice versa. This table shows the tax savings even if there is money left in the account. As you can see, the example leaves $100.00 which is forfeited because of non use. Yet because of the tax savings this individual would still be tax dollars ahead by participating.

Can I Change My "Plan Year" Election?

Generally, no. You may not change your contribution during the plan year, unless you have an IRS "change in status," and the change in your contribution is "due to and on account of" the change in status. The IRS defines a change in status as:

1 Change in employee's legal marital status – including marriage, divorce, death of spouse, legal separation, and annulment.
2 Change in number of dependents – including birth, adoption, placement for adoption, and death.
3 Change in employment status – Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent qualify: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in work site.
4 Dependent satisfies (or ceases to satisfy) dependent eligibility requirements – an event that causes the dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, gain or loss of student status, marriage, or any similar circumstances.
5 Residence change – a change in the place of residence of an employee, spouse, or dependent (if the residence change affects the employee's eligibility for coverage).

You can also change your contribution to the dependent care account during the plan year in the following situations:

- When the dependent ceases to qualify as a dependent (for example, the child reaches age 13);
- When the employee switches to a new dependent care provider; and,
- When the cost of the dependent care expense increases or decreases. However, a mid-year election change due to cost is not allowed where the dependent care provider is a relative of the employee.

If a change in status occurs, you must inform your employer of your new election within 30 days of the occurrence.

FLEX ADMINISTRATORS, INC

Flex Administrators
3980 Chicago Drive, Suite 230
Grandville, MI 49418
PHONE: 616.456.7908
Outside of 616 area code: 800.968.3539

www.flexadministrators.com

Fill This Out To Save

Worksheet: Estimated Unreimbursed Health Care Expenses

The following is a worksheet to assist you in identifying your health care expenses. This worksheet only identifies a few of the most common expenses. There are many more eligible expenses reimbursable under the plan. Please refer to your communication brochure for a more extensive list of eligible expenses.

Medical

Deductibles	$ _____
Coinsurance payments*	$ _____
Copayments	$ _____
Office Visit Copays	$ _____
Well-baby care	$ _____
Physicals/Annual checkups	$ _____
Pap Smears	$ _____
Immunizations	$ _____
Prescription Drugs	$ _____
Contraceptives	$ _____
Insulin	$ _____
Laboratory tests	$ _____
Splints, supports, corrective devices	$ _____
Hearing devices	$ _____
Therapy treatments (medical reasons only)	$ _____
Other expenses	$ _____

Dental

Deductibles	$ _____
Coinsurance payments*	$ _____
Fillings/crowns/bridges	$ _____
X-Rays	$ _____
Cleaning	$ _____
Fluoride treatments	$ _____
Dentures	$ _____
Orthodontia**	$ _____

** Please see Brochure regarding Orthodontia before entering your estimated cost here.

Vision

Deductibles	$ _____
Coinsurance payments*	$ _____
Examinations	$ _____
Lenses	$ _____
Frames	$ _____
Contact Lenses	$ _____
Contact Solution	$ _____

Over-the-Counter Items & Medications

Used to treat or alleviate an injury or illness. Common OTC items are pain relief medications, cold and flu products, allergy products, heartburn medications, and menstrual products.

$ _____

Total Annual Unreimbursed Health Care Expenses

Cannot exceed your plan maximum.

$ _____

Estimated Dependent Day Care Expenses

(when you *and* your spouse work)

Child care/Day care centers	$ _____
Child care in home	$ _____
After-school care	$ _____
Care of other dependents	$ _____

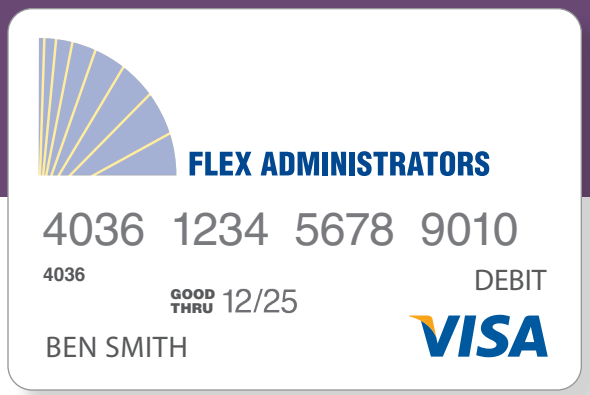
Total Annual Dependent Day Care Expenses (Cannot exceed $5,000 per calendar year or earned income of employee or spouse, whichever is less.)

Total Dependent Care $ _____

* Please keep in mind that any coordination of benefits with another group plan will reduce your out-of-pocket expenses.

Flex Administrators: 3980 Chicago Drive, Suite 230, Grandville, MI 49418

Flex Administrators Visa Debit Card 101



Following the steps below will make using your Debit Card easy.

1 Activate Your Debit Cards

You can activate your debit cards by calling the toll-free number located on the activation sticker on the front of your flex card or by visiting the website on the back of the card.

2 Use Your Flex Card to Pay

Use your Flex Administrators VISA card when paying for eligible medical, dental, vision or dependent care expenses. Your eligible expenses will be determined by your plan design.

3 Save Your Statements

You may be asked to submit documentation to verify that your expenses comply with IRS guidelines. Each itemized statement must show: the provider/merchant's name, the service received or items purchased, the date of service/purchase, and the amount charged for the services/items purchased. You may also submit an Explanation of Benefits (EOB) from your insurance provider to support your debit card purchases.

4 Check Your Email

You may be required to support a purchase. If documentation is requested, you will receive a request via email only, 1-2 days following your debit card swipe. You will have 30 days from the date of the first emailed request to submit your documentation. If it is not received at the end of 30 days, your debit card will automatically be suspended until either the documentation is submitted or a repayment is made to your account. Please see your Flex Administrators brochure for instructions on how to submit documentation.

Log Into Your Account Any Time

Access your account with the online portal or the Flex Administrators Mobile App at any time to check your balance, view required tasks, submit receipts, and more! You may also call Flex Administrators at (616) 456-7908 from Monday-Friday 8:30am - 5:00pm EST and speak with our receptionist who will assist you with questions, or connect you with your account manager for further assistance.

The other side of this sheet contains answers to the most frequently asked questions.

Flex Administrators Debit Card FAQs

1 Is the Flex Card Just Like Other Visa® Cards?

No. The Flex Card is a special-purpose Visa Card that can be used only for eligible health care/benefits expenses. It cannot be used, for instance, at gas stations or restaurants. There are no monthly bills and no interest.

2 How Many Flex Cards Will I Receive?

You will receive two Cards, both in the participant's name. An eligible Dependent can use the other card by signing the back.

3 Will I Receive a New Flex Card Each Year?

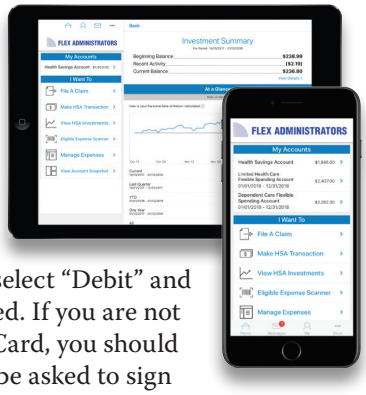
No, you will not receive a new Card each year. The Card will be loaded with the new annual election amount at the start of each plan year or incrementally with each pay period, based on the type of account you have. If you have a card that will expire, new cards will automatically be requested and mailed for you with adequate time to be received before the current card expiration date.

4 What if the Flex Card is Lost or Stolen?

Contact Flex Administrators at (616) 456-7908 or email service@flexadministrators.com. Report a Card lost or stolen as soon as you realize it is missing, so your card can be canceled and a replacement card can be issued. There may be a fee for replacement cards.

5 How Much is on the Flex Card When it is Activated?

For Health Care FSAs, your annual election amount will be loaded onto the card. Some other types of accounts, like HSAs and HRAs, are funded incrementally at each pay period, so it is especially important to be aware of your account balances in order to avoid having your Card declined at the point of service. When you incur an expense that is greater than the amount remaining in your account, you may be able to split the cost at the register. (Check with the merchant.)



6 If Asked, Should I Select "Debit" or "Credit"?

If the you have elected to use a PIN (Personal Identification Number) with your Flex Card, you should select "Debit" and enter the PIN when prompted. If you are not using a PIN with your Flex Card, you should select "Credit" and you will be asked to sign for the benefit card purchase. You cannot get cash with the Flex Card.

7 How Will I Know to Submit Receipts to Verify a Charge?

You will receive an email from our automated system if there is a need to submit documentation. All documentation should be saved per the IRS regulations.

8 Will Supporting Documentation Be Required for All Purchases Made with the Flex Card?

No. Typically purchases made at major pharmacies and/or copay amounts from your group's medical health plan will auto-process – meaning you will not need to turn in supporting documentation. However, if automated processing is unable to approve a transaction, the IRS requires that either an itemized statement or Explanation of Benefits be submitted to validate the expense. These notifications will be sent by email.

Get the Free "Flex Administrators Mobile" App By Pointing Your Camera at the QR Code

For Apple iOS

For Android

FLEX ADMINISTRATORS, INC

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www.flexadministrators.com

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VOLUNTARY BENEFITS

SET SEG Employee Benefits provides a variety of options to enhance your employer-sponsored benefit plan. In this book, you'll find a description of each benefit and the rates for coverage to help you decide which benefit is right for you and your family. For more information about the products listed in this book, contact SET SEG Employee Benefits at (800) 292-5421.

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FOR INFORMATION ON HOW TO FILE A CLAIM

To file a claim for any of the benefits listed in this book, contact the insured employee's human resources office for necessary paperwork and further instructions.

Disclaimer: None of the limitations and conditions of any policies outlined in this booklet are waived or modified by reason of any omission from or description in this booklet. For the full terms and conditions of any coverage listed, please refer to your insurance certificate.

SET VOLUNTARY TERM LIFE

ELIGIBILITY

Note: Some of the following benefits are limited by employee selection, and may not be available to you or be listed in your certificate of coverage.

To purchase this coverage, you must be a full-time employee working at least 15 hours per week. Your employer must participate in the Voluntary Group Term Life and Voluntary Accidental Death and Dismemberment plans.

EFFECTIVE DATE OF COVERAGE

If your request for coverage is approved by Reliance Standard Life Insurance Company for initial or additional amounts, your insurance coverage will become effective on the first day of the month coinciding with or next following the date your application is signed, provided you are actively at work on a full-time basis at your usual place of business on that date, and any required premium has been paid.

The effective date of coverage for dependents who are home or hospital confined on the date they would otherwise become insured will be deferred until the day after confinement ends.

INITIAL PREMIUM

The initial premium will be determined by your age and your spouse's age on the last birthday preceding the policy anniversary date. After the insurance goes into effect, premium adjustments based on age will occur each year on the policy anniversary date.

TERMINATION OF INSURANCE

All insurance will terminate due to the following circumstances:

- Upon the end of employment with a participating employer
- If you are no longer defined as an eligible employee
- If required contributions are discontinued
- If your employer ceases to participate in the plan or if the master policy is terminated
- If you enter military service

Dependent insurance will terminate for your spouse and/or children when they no longer meet the definition of an eligible dependent.

Voluntary Term Life and Accidental Death and Dismemberment Insurance are underwritten by Reliance Standard Insurance Company. Pages 4-13 contain brief descriptions of these plans, which are described in more detail in the certificates issued to insured persons. None of the limitations and conditions of such policy are waived or modified by reason of any omission from or description in this booklet. If a conflict exists between a statement in this booklet and any provision in the policy, the policy will govern.

LIFE INSURANCE

GUARANTEED ISSUE

- A guaranteed issue amount of $30,000 is available for employees under age 60. For employees aged 60-69, the guaranteed issue amount is $10,000. Employees must apply for coverage within 31 days of eligibility to receive guaranteed issue amounts.
- A guaranteed issue amount of $20,000 is available for an employee's spouse under age 60; there is no guaranteed issue for spouses age 60 and older.

INSURANCE AMOUNTS FOR EMPLOYEES

Up to $500,000 of coverage in $10,000 increments may be elected. If this insurance is purchased prior to age 75, the table on the right shows the amount insurance will be reduced in accordance with your age on the policy anniversary date.

AGE	PERCENTAGE OF YOUR BENEFIT AMOUNT (PRE-AGE 75)
75	60%
80	35%
85	27.5%
90	20%
95	7.5%
100	5%


DEPENDENT LIFE INSURANCE

- Spouse option – up to $500,000 of coverage, in increments of $10,000, may be elected for your spouse. A spouse is eligible for coverage until age 75; however, your spouse must be under age 70 on the date of application.
- Children option – up to $10,000 of coverage, in increments of $2,500, may be elected for each eligible, unmarried, dependent child, from ages six months to 20 years (age 26 if a full-time student). Children ages 14 days to six months are provided $1,000 coverage. You or your spouse must be insured for any eligible, dependent children to be insured. All dependent child coverage is guaranteed issue.

COST OF COVERAGE

- Use the table below and on the right to determine the cost of coverage for employees, spouses and dependent children.

MONTHLY RATES FOR EMPLOYEES AND THEIR SPOUSES	
AGE	**RATE PER $10,000 BENEFIT**
Up to age 29	$0.44
30-34	$0.52
35-39	$0.76
40-44	$1.24
45-49	$2.06
50-54	$3.50
55-59	$5.83
60-64	$7.23
65-69	$10.57
70+	$20.22

MONTHLY RATES FOR DEPENDENT CHILDREN				
AGE	**OPTION 1**	**OPTION 2**	**OPTION 3**	**OPTION 4**
14 days – 6 months	$1,000			
6 months – age 20; 26 for full-time students	$2,500	$5,000	$7,500	$10,000
RATE*	$0.42	$0.82	$1.22	$1.62

*There is one rate for all eligible children, regardless of the number of children covered

LIMITATION

Benefits are not paid for death from suicide during the first two years the insurance is in effect. Only premium amounts previously paid will be payable in the event of a suicide that occurs within 2 years of the effective date.

OTHER BENEFITS

Disability Waiver of Premium Benefit

We will extend the amount of insurance during a period of total disability for 1 year if:

1. The employee becomes totally disabled prior to age 60;
2. The total disability lasts for at least 6 months in a row;
3. We receive proof of total disability within 1 year from the date it began; and
4. The premium continues to be paid during the 6 month period.

"Total disability/totally disabled" means: an employee's complete inability to engage in any type of work for wage or profit for which such employee is suited by education, training or experience.

After proof of total disability is approved by us, premium payment for the insured and his insured dependants is not required for 1 year. Also, any premiums paid from the start of the total disability will be returned.

The employee must submit annual proof of continued total disability to have insurance extended for additional 1 year periods.

Disabilities excluded from coverage include those stemming from intentionally self-inflicted injury and those that result from an act of war (declared or undeclared). Please see your individual certificate for more information.

Living Benefit

Reliance Standard will advance up to 50 percent of the applicable death benefit if you, your insured spouse or child have a terminal illness that results in an expected life span of less than 12 months. Payment of this benefit is subject to certain coverage requirements as described in the policy and is subject to a $250,000 cap. Consult your tax advisor about the tax treatment of a living benefit.

PORTABILITY PRIVILEGES

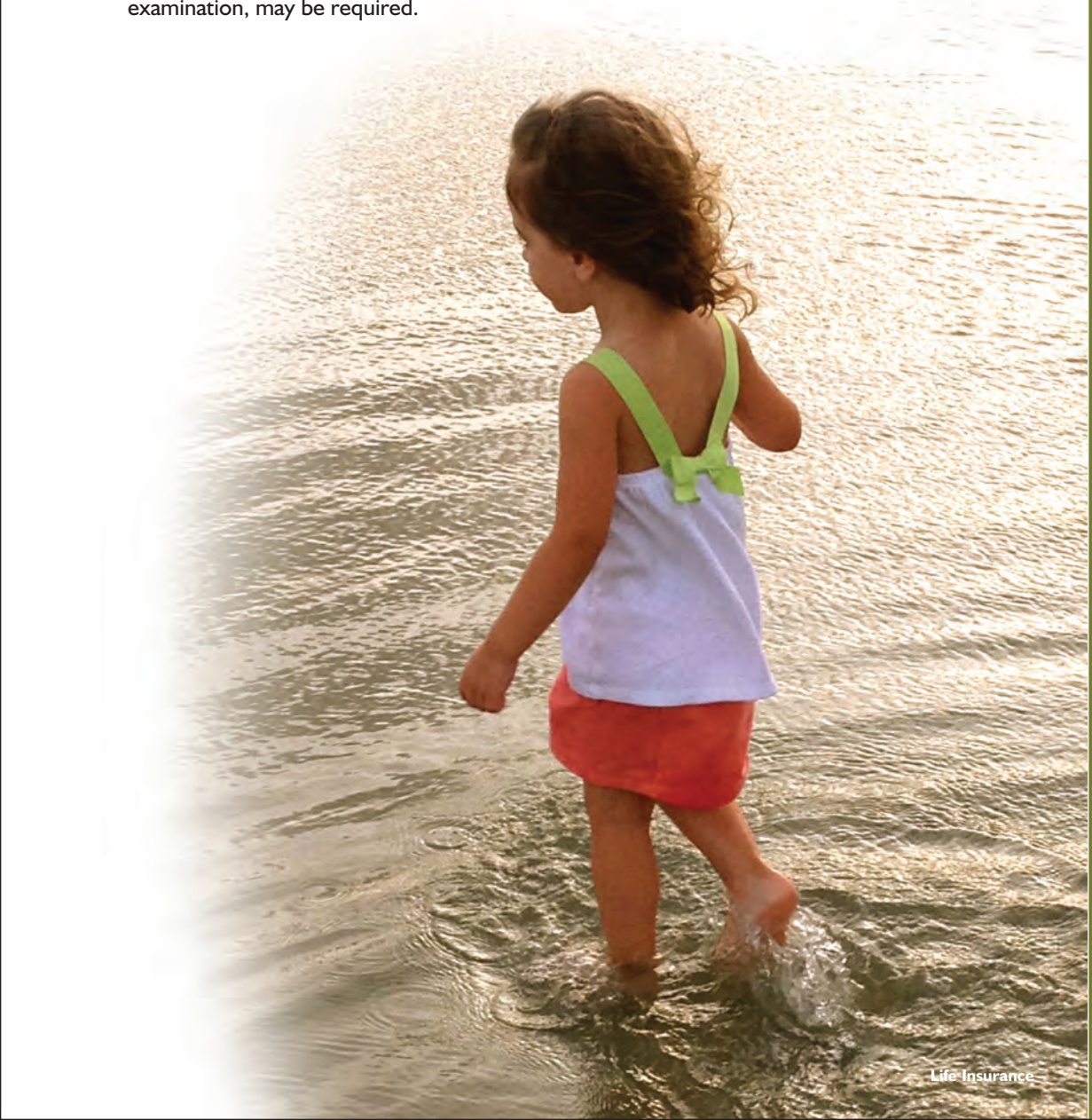
If you leave your employer, you may keep your Voluntary Term Life insurance and that of your insured dependents under the plan's portability of coverage feature by electing, within 31 days, to pay premiums directly to Reliance Standard. Contact SET SEG at (800) 292-5421 for portability rates.

CONVERSION PRIVILEGES

If your coverage terminates for any reason other than non-payment of premium, you may convert to an individual whole life policy without submitting evidence of insurability. An insured employee or spouse under age 70 may convert to an individual whole life policy up to the amount of their current life insurance. When an insured dependent child attains the maximum age for eligibility, he or she is also eligible to convert up to five times his or her current amount of life insurance to an individual whole life policy.

EVIDENCE OF INSURABILITY

Proof of good health is required for all amounts of new or additional life or dependent life insurance, except as provided by the guaranteed issue. The answers to health questions on the enrollment request form are sufficient for underwriting in most cases; however, additional proof of good health, such as an attending physician's statement or a physical examination, may be required.



ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

In the event of accidental death, this elective provides coverage in amounts ranging from $10,000 to $500,000, in $10,000 increments, for employees, their spouses and dependent children. An employee must elect AD&D coverage in order for a spouse and/or dependent children to become eligible to elect coverage. Amounts above $150,000 cannot exceed 10 times the employee's earnings. At age 75, benefit amounts reduce by 50 percent of the pre-age 75 amount. At age 80, benefit amounts reduce by 75 percent of the pre-age 75 benefit. Benefit terminates upon retirement.

Eligible dependent children may be insured up to a maximum of $100,000. The amount of dependent coverage cannot exceed the employee's or spouse's coverage amount.

DESCRIPTION OF COVERAGE

If an injury results in death or dismemberment within one year of a covered accident occurring while insured, benefits will be paid as follows:

- Loss of life – total benefit amount
- Loss of two or more members – total benefit amount
- Loss of speech or hearing – 50 percent to total benefit amount (depends on severity of the loss)
- Loss of one member – 50 percent of the benefit amount
- Thumb and index finger of the same hand – 25 percent of the benefit amount

Only one benefit, the largest amount to which the insured is entitled, will be paid if an insured suffers more than one loss in the same accident.

Losses must result directly and independently from injury with no other contributing cause.

- A member is a hand, foot or eye
- Loss with regard to hand or foot is the complete severance through or above the wrist or ankle joint
- Loss with regard to an eye is the total and irrecoverable loss of sight
- Loss with regard to speech or hearing means the total and irrecoverable loss of either function
- With regard to thumb and index finder, it means the complete severance through or above the knuckle joints

COST OF COVERAGE

Monthly rates for employee, spouse and dependent children are $0.03 per thousand dollars of benefit to a maximum of $500,000. Voluntary AD&D benefits cannot exceed 10 times the employee's basic annual earnings for amounts of $150,000 or more.

TOTAL LOSS OF USE BENEFIT

If you are in a covered accident and suffer the total loss of use of an arm, leg or both within 12 months of that accident you are eligible for benefits according to the table below:

LOSS OF USE	PERCENTAGE OF FULL BENEFIT AMOUNT
Both arms and both legs	100%
Both arms and one leg OR both legs and one arm	75%
Both arms or both legs	66.67%
One arm and one leg	66.67%
One arm or one leg	50%

Proper medical authority is required at the end of the 12-month period to certify that the total loss of use is continuous and permanent. Only one benefit will be paid for more than one total loss of use resulting from any one accident; however, the largest amount will be used.

OTHER BENEFITS

Exposure and Disappearance

If an insured is exposed to the elements due to an accident and sustains a loss for which benefits would otherwise be payable, that loss will be covered. Reliance Standard will presume an insured suffered loss of life due to an injury if the insured is riding in conveyance that is involved in a covered accident and, as a result of the accident, the conveyance is wrecked, sinks, or disappears, and the body is not found within one year of the accident.

Reserve National Guard Coverage

If you or your insured dependent is a member of an organized Reserve Corps or National Guard unit, the following is covered:

- En route to or from or attending any regularly scheduled or routine training of less than 60 days

- Taking part in any authorized inactive duty training
- Taking part as a unit member in a parade or exhibition authorized by official orders
- Attending a service school operated by or on behalf of the United States of America

No benefit is payable for any loss that occurs during active duty.

Seat Belt/Air Bag Benefit

If you or your insured dependent dies as a result of a covered automobile accident, additional benefits may be paid in the following situations:

- You or your insured dependent were operating or riding in an automobile and using a seat belt, an additional benefit equal to 10 percent of the benefit amount will be paid
- An additional 5 percent of the benefit amount will be paid if the vehicle is equipped with a factory-installed air bag

Total maximum payable for this benefit is $25,000. Use of seat belts and evidence that the air bag inflated properly upon impact must be established in the police report of the accident. Losses sustained while driving or riding in a vehicle used for a race, speed or endurance test, or for acrobatic or stunt diving are not covered. This benefit is not payable for any loss sustained if the seat belt was not worn, regardless of the reason. This benefit is also not payable for a loss sustained due to a defect in the air bag's diagnostic system.

Education Benefit

This benefit pays for educational expenses for your spouse and dependents in the event of your death due to a covered accident. The family plan must be in effect on the date of the accident. Benefit includes:

- For your spouse, actual tuition expense, up to $3,000 annually for the cost of attendance at an institute of higher education (see policy for definition) is payable. Attendance must be intended to provide a means of support for your spouse, and the cost must be incurred within 30 months of your death.
- A dependent child who is in grade 12 and enrolls within one year of your death, or a dependent child who is already enrolled on the date of your accident, as a full-time student, in any institute of higher learning beyond grade 12 is eligible for this benefit.
- Annual payments for up to four consecutive years while the dependent is enrolled will equal 5 percent of your benefit amount, subject to a minimum of $1,000 and a maximum of $5,000 per year.

Coma Benefit

If you lapse into a coma as a result of an accident and it lasts for more than 30 days, this benefit will pay 1 percent of your benefit amount on a monthly basis. For this benefit to be payable, the coma does not need to be continuous, as long as recurrences are not due to an unrelated cause. You must be confined in a hospital or other medical facility and diagnosed as being in a coma by a licensed physician. The benefit will start on the day 31 of the coma. Benefits will continue until the coma ends, your death, or after 100 consecutive months, whichever occurs first. You are only eligible for one coma benefit for each eligible accident.

Day Care Benefit

In the event that you or your spouse dies due to injury, this monthly benefit covers the cost of day care up to 2 percent of your benefit amount, not to exceed $2,400, in any one calendar year for each insured dependent child under age 14. The children must be in day care within 48 months from the date of death. For each child, the benefit will terminate on the date he/she turns 14 or the end of a period of four consecutive years from date of your or your spouse's death, whichever occurs first.

CONVERSION PROVISIONS

If your coverage terminates for reasons other than termination of the policy, you may convert to an individual policy without proof of good health. Application and premium payment must be made within 31 days of termination. The amount of insurance will not be more than your benefit amount under this plan or $250,000, whichever is less. The conversion privilege is also available to a dependent when insurance ends due to eligibility constraints.

EXCLUSIONS

The policy does not cover any loss:

- Caused by or resulting from war or any act of war, declared or undeclared.
- Caused by an accident that occurs while in the armed forces of any country, except as shown under Reserve National Guard coverage.
- Caused by or resulting from riding in, getting into or out of any aircraft, except if:
  - The aircraft is any tested and approved civilian aircraft;
  - The aircraft is being used at the time for transporting passengers;
  - The aircraft is operated by the then-current rules of the authority having jurisdiction over the operation of the aircraft;
  - The insured is a passenger and not a pilot or crew member;
  - The aircraft is not owned, leased or operated by or on behalf of the policyholder, a participating member firm, the insured or the employer of the insured, if other than the policyholder, unless a specific written agreement has been obtained from the Reliance Standard.
- To which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor.
- Caused by suicide or intentional self-inflicted injuries.
- Sustained during the insured's commission or attempted commission of an assault or felony.

Notice Concerning Medical Information Bureau (read and retain this information)

Information regarding your insurability will be treated as confidential; however, Reliance Standard Life Insurance Company may make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies operating an information exchange on behalf of its members. Upon request, the Bureau will arrange disclosure of information in your file (non-medical information will be disclosed to you and medical information to your attending physician). If you question the accuracy of the information, you may contact the Bureau at www.mib.com to seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting guidelines.

VOLUNTARY BENEFITS

SET SEG

School Insurance Specialists

415 W. Kalamazoo St.
Lansing, MI 48933
(800) 292-5421
www.setseg.org

We Are Your EAP Provider

-Employee Assistance Program

Ottawa Area ISD®
Learn. Serve. Lead.

An Employee Assistance Program (EAP) is a way your employer shows that they care about you and your quality of life.

Not only do they care about you—they care about your dependents too! Mosaic Counseling is excited to be your contracted EAP provider and will provide ***you and your dependents*** with **TWO (2)** complimentary sessions annually with a local professional therapist who specializes in your particular presenting challenge. These sessions will be of no cost to you... no copays, no deductibles. We do not share with your employer when you use our services.

How does it work?

1. Call our office to make an appointment for a personal or over-the-phone intake conversation with one of our intake specialists **(616 842 9160)**.
2. You will be "matched" with a local professional therapist, who specializes in helping people with your type of concern.
3. Go to your appointments and receive the support and help you or a family member are needing.

Locations

Each of our 140+ therapists have existing private practices. Depending upon who you are referred to, a convenient location for your sessions will be planned.

Why Might I need it?

Many people think going to a counselor means that they have a serious mental illness that requires treatment. That is not true. People meet with counselors all of the time to help them manage any number of issues including:

- Addictions
- Anxiety
- Couples and Marital Counseling
- Covid-19 Related
- Depression
- Eating Disorders
- Grief
- Sexual Abuse
- Substance Abuse
- Thoughts of Suicide
- Trauma
- And More...

Mosaic Counseling
– Connecting you to hope and healing