

## MESSA ABC & ABC Rx

### Plan 1

Coverage Period: Beginning on or after January 1

Coverage for: Individual/Family | Plan Type: PPO

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



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

This is **only** a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.messa.org](http://www.messa.org) or call MESSA at 800-336-0013. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call MESSA at 800-336-0013 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$1,400 Individual/ \$2,800 Family	\$2,800 Individual/ \$5,600 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$2,400 Individual/ \$4,800 Family	\$4,800 Individual/ \$9,600 Family	The <u>out-of-pocket</u> limit is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket</u> limit must be met.
What is not included in the <u>out-of-pocket</u> limit?	Premiums, <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of <u>network providers</u> see <a href="http://www.messa.org">www.messa.org</a> or call MESSA at 800-336-0013.		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	No charge	20% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge	20% <u>coinsurance</u>	May require <u>preauthorization</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.messa.org">www.messa.org</a>	Generic or prescribed over-the-counter drugs	\$10 <u>copay</u> /prescription for retail 34-day supply, \$20 <u>copay</u> /prescription for 90-day supply	\$10 <u>copay</u> /prescription for retail 34-day supply, \$20 <u>copay</u> /prescription for 90-day supply plus an additional 25% of BCBSM approved amount for the drug	<u>Preventive</u> drugs covered in full. Mail order drugs are not covered out-of-network.
	Preferred brand-name drugs	\$40 <u>copay</u> /prescription for retail 34-day supply, \$80 <u>copay</u> /prescription for 90-day supply	\$40 <u>copay</u> /prescription for retail 34-day supply, \$80 <u>copay</u> /prescription for 90-day supply plus an additional 25% of BCBSM approved amount for the drug	
	Non-Preferred brand-name drugs	\$40 <u>copay</u> /prescription for retail 34-day supply, \$80 <u>copay</u> /prescription for 90-day supply	\$40 <u>copay</u> /prescription for retail 34-day supply, \$80 <u>copay</u> /prescription for 90-day supply plus an additional 25% of BCBSM approved amount for the drug	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	No charge	No charge	None
	<u>Emergency medical transportation</u>	No charge	No charge	Mileage limits apply.
	<u>Urgent care</u>	No charge	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fee	No charge	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or <u>substance use disorder</u> services	Outpatient services	No charge	20% <u>coinsurance</u>	None
	Inpatient services	No charge	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	No charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. <u>Cost sharing</u> does not apply to certain maternity services considered to be <u>preventive</u> .
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No charge	20% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	No charge	<u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	No charge	20% <u>coinsurance</u>	Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	No charge	20% <u>coinsurance</u>	Applied behavioral analysis (ABA) treatment for Autism – when rendered by an approved board-certified analyst – is covered through age 18, subject to preauthorization.
	<u>Skilled nursing care</u>	No charge	No charge	<u>Preauthorization</u> is required. Limited to a maximum of 120 days per member, per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	No charge	No charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No charge	No charge	<u>Preauthorization</u> is required. Unlimited visits.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None



## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight Loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See [www.messa.org](http://www.messa.org)
- Hearing Aids
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.
- Infertility treatment
- Non-Emergency care when travelling outside the U.S.
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 800-336-0013.

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

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

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

**Language Access Services: See Addendum**

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

## About these Coverage Examples:



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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,400
■ <u>Specialist copayment</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,400
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,440</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,400
■ <u>Specialist copayment</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,400
Copayments	\$790
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,190</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,400
■ <u>Specialist copayment</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic tests (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,400
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,400</b>



**UTICA COMMUNITY SCHOOLS Dental Benefits Plan**  
**Non-Affiliated & Food Service**

**Group # 9210**

**The Plan-at-a-Glance**

**PPO Networks: ADN Dental Network, DenteMax**

**Maximum Benefits**

**Plan year July 1<sup>st</sup> through June 30<sup>th</sup>**

Annual Maximum \$1000 per eligible individual for covered class I, II and III services.

**Class I Preventive Services – 75% In-Network / 75% Out-of-Network**

Oral Examinations	Twice per plan year
Bitewing X-Rays	Once per plan year
Prophylaxis/Periodontal Maintenance	Twice per plan year
Topical Application of Fluoride	Twice per plan year to age 19
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Space Maintainers	Under age 16, initial appliance only, one bilateral per arch or One unilateral per quadrant, per lifetime

**Class II Restorative Services – 75% In-Network / 75% Out-of-Network**

Composite and Amalgam fillings	Once per tooth surface per 12 months
Root Canal Therapy / Endodontics	
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Limitations apply based on service
Oral Surgery and Extractions	
General Anesthesia or IV Sedation	With covered oral surgery
Consultations	Once per specialty per 12 months
Inlays, Onlays, Crowns**	Once per permanent tooth in 60 months
Denture Repair or Adjustment	
Denture Reline or Rebase	Once per 24 months, per arch
Addition of Teeth to Partial Dentures	
Occlusal Guards	Once per lifetime, only within 6 months following Osseous Surgery

**Class III Major Services – 50% In-Network / 50% Out-of-Network**

Complete and Partial Removable Dentures**	Once per arch per 60 months
Fixed Partial Dentures (Bridges)**	Once per arch per 60 months

**Not Covered**

Orthodontics      Sealants      Implants and Restorations over implants      Cosmetic Treatments  
 TMJ/TMD Treatment, Therapy, Appliances

Deductible – None

Missing Tooth Clause – None

12 Month Billing Limitation

Waiting Periods – None

COB – Standard

\*\*Porcelain and ceramic facings are not covered for posterior teeth, alternate benefit applies

\*\*Prosthetics are considered on seat/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 \$300.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**



# Your NVA Vision Benefit Summary

## Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
<b>Examination</b> Once Every Plan Year	<ul style="list-style-type: none"> <li>Covered 100% After \$6.50 copay</li> </ul>	<b>Reimbursed Amount</b> <ul style="list-style-type: none"> <li>Up to \$28.50 (OD)</li> <li>Up to \$38.50 (MD)</li> </ul>
<b>Lenses</b> Once Every Plan Year <ul style="list-style-type: none"> <li>Single Vision</li> <li>Bifocal</li> <li>Trifocal</li> <li>Lenticular</li> <li>Oversized</li> <li>Rimless Mounting</li> <li>Blended Bifocal (Segment)</li> <li>Glass Photogrey</li> <li>Transitions</li> <li>Polarized</li> <li>Single Vision</li> <li>Bifocal</li> <li>Trifocal</li> <li>Lenticular</li> <li>Tints</li> <li>Single Vision</li> <li>Bifocal</li> <li>Trifocal</li> <li>Lenticular</li> </ul>	<b>Standard Glass or Plastic</b> <ul style="list-style-type: none"> <li>Covered 100% After \$18 copay</li> <li>Covered 100%</li> <li>Covered 100%</li> <li>Covered 100%</li> <li>Covered 100%</li> <li>Covered 100%</li> <li>Covered 100%</li> <li>Covered 100%</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$29</li> <li>Up to \$51</li> <li>Up to \$63</li> <li>Up to \$75</li> <li>N/A</li> <li>N/A</li> <li>N/A</li> <li>N/A</li> <li>Up to \$18</li> <li>Up to \$30</li> <li>Up to \$38</li> <li>Up to \$44</li> <li>Up to \$4</li> <li>Up to \$10</li> <li>Up to \$12</li> <li>Up to \$14</li> </ul>
<b>Frame</b> Once Every Plan Year	<b>Retail Allowance</b> <ul style="list-style-type: none"> <li>Up to \$65 (20% discount off balance)*</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$44</li> </ul>
<b>Contact Lenses</b> Once Every Plan Year  <b>Elective Contact Lenses</b>	<b>In lieu of Lenses &amp; Frame</b> <ul style="list-style-type: none"> <li>Up to \$90 Retail<sup>Ⓞ</sup> (15% discount (Conventional) or 10% discount (Disposable) off balance)**</li> <li>Covered 100%</li> </ul>	<b>In lieu of Lenses &amp; Frame</b> <ul style="list-style-type: none"> <li>Up to \$90</li> <li>Up to \$175</li> </ul>
<b>Medically Necessary***</b>	<ul style="list-style-type: none"> <li>Covered 100%</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$175</li> </ul>

## Utica Community Schools (NVA2)

Effective 07/01/2008

Revised 07/01/2019

Group Number #8169

### 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 once every plan year.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

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 provider, please visit our website at [www.e-nva.com](http://www.e-nva.com), or download our mobile app by searching NVA Vision, 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. Be sure to choose the NVA Network 2 vision plan from the drop down box and enter group number 8169000101 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) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers. \*\*\*Pre-approval from NVA required.

<sup>Ⓞ</sup>Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

### Due to their everyday low prices (EDLP) the amounts listed below may not be applicable at Wal-Mart/Sam's Club.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- \$50 Progressive Lenses Standard      \$100 Progressive Lenses Premium
- \$10 Standard Scratch-Resistant Coating      \$12 Ultraviolet Coating
- \$40 Standard Anti-Reflective      \$25 Polycarbonate (Single Vision)
- \$55 High Index      \$30 Polycarbonate (Multi-Focal)

Fixed Pricing not available in certain states.

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

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 when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

**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](http://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
<b>Eye Examination:</b>	<b>Member Cost:</b> Retail Less \$10	\$12 Solid Tint/ Gradient Tint \$50 Standard Progressive Lenses \$75 Polarized Lenses \$65 Transitions Single Vision Standard \$70 Transitions Multi-Focal Standard \$15 Standard Scratch Coating \$12 UV Coating \$35 Polycarbonate \$45 Standard Anti-Reflective
<b>Contact Lens Fitting:</b>	Retail Less 10%	
<b>Lenses:</b>	Glass or Plastic	
Single Vision	\$35.00	
Bifocal	\$55.00	
Trifocal or Lenticular	\$70.00	
<b>Frame:</b>	Retail Less 35%	
<b>Contact Lenses*:</b>	<b>Member Cost:</b>	
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.

Insurance coverage provided by National Guardian Life Insurance Company (NGLIC), 2E Gilman, Madison, WI 53703. Policy NVIGRP 5/07. NGLIC is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life. A full description of your coverage, its limitations, exclusions and conditions is contained in the Insurance Policy issued to your Plan Sponsor at its place of business. That full description in the form of a Certificate of Coverage can be made available to you by requesting it from your Plan Sponsor.

**Exclusions / Limitations:** No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. □ PO Box 2187 □ Clifton, NJ 07015  
 Web: [www.e-nva.com](http://www.e-nva.com) □ Toll-Free: 1.800.672.7723  
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*This document is intended as a program overview only and is not a certified document of the individual plan parameters.*



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**GROUP LIFE AND ACCIDENTAL DEATH  
AND DISMEMBERMENT INSURANCE  
PROGRAM**

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# **GROUP LIFE INSURANCE**

## SCHEDULE OF BENEFITS

**EFFECTIVE DATE:** May 1, 2011, as amended in the Policy through July 1, 2015

**ELIGIBLE CLASSES:** Each active, Full-time Community Education Coordinator, Cluster Attendance Coordinator, Orthopedic Assistant, CCMS Operator, Food Service Coordinator, School Nurse, Montessori Preschool Teacher, Community Education, Secretary, ULA Counselor and Voluntary School of Choice Assistant, except any person employed on a temporary or seasonal basis.

**INDIVIDUAL EFFECTIVE DATE:** The first of the month following the day you become eligible.

**INDIVIDUAL REINSTATEMENT:** Not Applicable

### **AMOUNT OF INSURANCE:**

**Basic Life:** \$8,000.

The Life amount will be reduced by any benefit paid under the Living Benefit Rider.

**CHANGES IN AMOUNT OF INSURANCE:** Increases and decreases in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of the Basic Insurance.

## SCHEDULE OF BENEFITS

**EFFECTIVE DATE:** May 1, 2011, as amended in the Policy through July 1, 2015

**ELIGIBLE CLASSES:** Each active, Full-time Career Development Facilitator, Transportation Department Dispatcher, Computer Technician, Computer Technician Leader, Network Technician, Technology Leader and Energy Manager, except any person employed on a temporary or seasonal basis.

**INDIVIDUAL EFFECTIVE DATE:** The first of the month following the day you become eligible.

**INDIVIDUAL REINSTATEMENT:** Not Applicable

### **AMOUNT OF INSURANCE:**

**Basic Life:** \$12,500.

The Life amount will be reduced by any benefit paid under the Living Benefit Rider.

**CHANGES IN AMOUNT OF INSURANCE:** Increases and decreases in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of the Basic Insurance.

**GROUP ACCIDENTAL DEATH AND  
DISMEMBERMENT INSURANCE**

## **SCHEDULE OF BENEFITS**

**ELIGIBILITY:** Each active, Full-time Community Education Coordinator, Cluster Attendance Coordinator, Orthopedic Assistant, CCMS Operator, Food Service Coordinator, School Nurse, Montessori Preschool Teacher, Community Education, Secretary, ULA Counselor and Voluntary School of Choice Assistant, except any person employed on a temporary or seasonal basis.

**INDIVIDUAL EFFECTIVE DATE:** The first of the month following the day you become eligible.

**INDIVIDUAL REINSTATEMENT:** Not Applicable

**AMOUNT OF INSURANCE:      PRINCIPAL SUM:**

**INSURED PERSONS:**

\$8,000

**CHANGES IN AMOUNT OF INSURANCE:** Increases and decreases in the Amount of Insurance because of changes in age, class or Earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date of the change. If you are not Actively at Work when the change should take effect, the change will take effect on the day after you have been Actively at Work for one full day.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of your insurance coverage.

## **SCHEDULE OF BENEFITS**

**ELIGIBILITY:** Each active, Full-time Career Development Facilitator, Transportation Department Dispatcher, Computer Technician, Computer Technician Leader, Network Technician, Technology Leader and Energy Manager, except any person employed on a temporary or seasonal basis.

**INDIVIDUAL EFFECTIVE DATE:** The first of the month following the day you become eligible.

**INDIVIDUAL REINSTATEMENT:** Not Applicable

**AMOUNT OF INSURANCE:      PRINCIPAL SUM:**

**INSURED PERSONS:**

\$12,500

**CHANGES IN AMOUNT OF INSURANCE:** Increases and decreases in the Amount of Insurance because of changes in age, class or Earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date of the change. If you are not Actively at Work when the change should take effect, the change will take effect on the day after you have been Actively at Work for one full day.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of your insurance coverage.



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**GROUP LONG TERM DISABILITY  
INSURANCE PROGRAM**

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## SCHEDULE OF BENEFITS

**EFFECTIVE DATE:** May 1, 2011, as amended in the Policy through July 1, 2011

**ELIGIBLE CLASSES:** Each active, Full-time Office Employee and Non Affiliated Employee including CCMS Operator, ULA Counselor, Montessori Preschool Teacher, Transportation Department Dispatch, UAW, Inventory Control Clerk and Community Education Secretary working 6 hours or more per day, except any person employed on a temporary or seasonal basis.

**YOUR EFFECTIVE DATE:** The first of the month following the day you become eligible.

**INDIVIDUAL REINSTATEMENT:** Not Applicable

### LONG TERM DISABILITY BENEFIT

**ELIMINATION PERIOD:** 180 consecutive days of Total Disability.

**MONTHLY BENEFIT:** The Monthly Benefit is an amount equal to 66 2/3% of Covered Monthly Earnings.

To figure this benefit amount payable:

- (1) multiply your Covered Monthly Earnings by the benefit percentage(s) shown above;
- (2) take the lesser of the amount:
  - (a) of step (1) above; or
  - (b) the Maximum Monthly Benefit shown below; and
- (3) subtract Other Income Benefits, as shown below, from step (2), above.

We will pay at least the Minimum Monthly Benefit as follows.

**OTHER INCOME BENEFITS:** Other Income Benefits are:

- (1) disability income benefits you are eligible to receive because of your Total Disability under any group insurance plan(s);
- (2) disability income benefits you are eligible to receive because of your Total Disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
- (3) all benefits (except medical or death benefits) including any settlement made in place of such benefits (whether or not liability is admitted) you are eligible to receive because of your Total disability under:
  - (a) Workers' Compensation Laws;
  - (b) occupational disease law;



- (c) any other laws of like intent as (a) or (b) above; and
- (d) any compulsory benefit law;
- (4) any of the following that you are eligible to receive from the Policyholder:
  - (a) any formal salary continuance plan;
  - (b) wages, salary or other compensation, excluding the amount allowable when engaged in Rehabilitative Employment; and
  - (c) commissions or monies, including vested renewal commissions, but, excluding commissions or monies that you earned prior to Total Disability which are paid after Total Disability has begun;
- (5) that part of disability benefits paid for by the Policyholder which you are eligible to receive because of your Total disability under a group retirement plan; and
- (6) that part of Retirement Benefits paid for by the Policyholder which you are eligible to receive under a group retirement plan; and
- (7) disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
  - (a) you are eligible to receive because of your Total Disability or eligibility for Retirement Benefits; and
  - (b) your dependents are eligible to receive due to (a) above.

Disability and early Retirement Benefits will be offset only if such benefits are elected by you or if election would not reduce the amount of your accrued normal Retirement Benefits then funded.

Retirement Benefits under number (7) above will not apply to disabilities which begin after age 70 if you are already receiving Social Security Retirement Benefits while continuing to work beyond age 70.

**MINIMUM MONTHLY BENEFIT:** In no event will the Monthly Benefit payable to you be less than the greater of:

- (1) 10% of the Covered Monthly Earnings multiplied by the Monthly Benefit percentage(s) as shown above; or
- (2) \$100

**MAXIMUM MONTHLY BENEFIT:** \$1,500 (this is equal to a maximum Covered Monthly Earnings of \$2,250).

**MAXIMUM DURATION OF BENEFITS:** Benefits will not accrue beyond the duration specified below:

<u>Age at Disablement</u>	<u>Duration of Benefits</u>
Less than 69	The lesser of: (1) 60 months; or
69 or more	(2) to age 70 12 months

**CHANGES IN MONTHLY BENEFIT:** Increases in the Monthly Benefit are effective on the first of the Policy month coinciding with or next following the date of the change, provided you are Actively at Work on the effective date of the change. If you are not Actively at Work on that date, the effective date of the increase in the benefit amount will be deferred until the date you return to Active Work. Decreases in the Monthly Benefit are effective on the first of the Policy month coinciding with or next following the date the change occurs.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of this insurance.

Premium contributions will not be included in your gross income.

For purposes of filing your Federal Income Tax Return, this means that under the law as of the date the Policy was issued, your Monthly Benefit might be treated as taxable. It is recommended that you contact your personal tax advisor.

## SCHEDULE OF BENEFITS

**EFFECTIVE DATE:** May 1, 2011, as amended in the Policy through July 1, 2011

**ELIGIBLE CLASSES:** Each active, Full-time Administrator, Community Education Coordinator, Energy Manager and Administrative Support Staff, except any person employed on a temporary or seasonal basis.

**YOUR EFFECTIVE DATE:** The first of the month following the day you become eligible.

**INDIVIDUAL REINSTATEMENT:** Not Applicable

### LONG TERM DISABILITY BENEFIT

**ELIMINATION PERIOD:** 90 consecutive days of Total Disability.

**MONTHLY BENEFIT:** The Monthly Benefit is an amount equal to 66 2/3% of Covered Monthly Earnings.

To figure this benefit amount payable:

- (1) multiply your Covered Monthly Earnings by the benefit percentage(s) shown above;
- (2) take the lesser of the amount:
  - (a) of step (1) above; or
  - (b) the Maximum Monthly Benefit shown below; and
- (3) subtract Other Income Benefits, as shown below, from step (2), above.

We will pay at least the Minimum Monthly Benefit as follows.

**OTHER INCOME BENEFITS:** Other Income Benefits are:

- (1) disability income benefits you are eligible to receive because of your Total Disability under any group insurance plan(s);
- (2) disability income benefits you are eligible to receive because of your Total Disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
- (3) all benefits (except medical or death benefits) including any settlement made in place of such benefits (whether or not liability is admitted) you are eligible to receive because of your Total disability under:
  - (a) Workers' Compensation Laws;
  - (b) occupational disease law;
  - (c) any other laws of like intent as (a) or (b) above; and
  - (d) any compulsory benefit law;



- (4) any of the following that you are eligible to receive from the Policyholder:
  - (a) any formal salary continuance plan;
  - (b) wages, salary or other compensation, excluding the amount allowable when engaged in Rehabilitative Employment; and
  - (c) commissions or monies, including vested renewal commissions, but, excluding commissions or monies that you earned prior to Total Disability which are paid after Total Disability has begun;
- (5) that part of disability benefits paid for by the Policyholder which you are eligible to receive because of your Total disability under a group retirement plan; and
- (6) that part of Retirement Benefits paid for by the Policyholder which you are eligible to receive under a group retirement plan; and
- (7) disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
  - (a) you are eligible to receive because of your Total Disability or eligibility for Retirement Benefits; and
  - (b) your dependents are eligible to receive due to (a) above.

Disability and early Retirement Benefits will be offset only if such benefits are elected by you or if election would not reduce the amount of your accrued normal Retirement Benefits then funded.

Retirement Benefits under number (7) above will not apply to disabilities which begin after age 70 if you are already receiving Social Security Retirement Benefits while continuing to work beyond age 70.

**MINIMUM MONTHLY BENEFIT:** In no event will the Monthly Benefit payable to you be less than the greater of:

- (1) 10% of the Covered Monthly Earnings multiplied by the Monthly Benefit percentage(s) as shown above; or
- (2) \$100

**MAXIMUM MONTHLY BENEFIT:** \$12,000 (this is equal to a maximum Covered Monthly Earnings of \$17,999).

**MAXIMUM DURATION OF BENEFITS:** Benefits will not accrue beyond the duration specified below:

<u>Age at Disablement</u>	<u>Duration of Benefits</u>
Less than 69	To Age 70
69 or more	12 months

**CHANGES IN MONTHLY BENEFIT:** Increases in the Monthly Benefit are effective on the first of the Policy month coinciding with or next following the date of the change, provided you are Actively at Work on the effective date of the change. If you are not Actively at Work on that date, the effective date of the increase in the benefit amount will be deferred until the date you return to Active Work. Decreases in the Monthly Benefit are effective on the first of the Policy month coinciding with or next following the date the change occurs.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of this insurance.

Premium contributions will not be included in your gross income.

For purposes of filing your Federal Income Tax Return, this means that under the law as of the date the Policy was issued, your Monthly Benefit might be treated as taxable. It is recommended that you contact your personal tax advisor.

## **SCHEDULE OF BENEFITS**

**EFFECTIVE DATE:** May 1, 2011, as amended in the Policy through July 1, 2011

**ELIGIBLE CLASSES:** Each active, Full-time Employee of the Employer classified as a Non Affiliated including food Service Coordinator, School Nurse, Computer Tech, Computer Tech Leader, Network Tech & Technology Leader and Performing Arts Coordinator working 7 hours per day., except any person employed on a temporary or seasonal basis.

**YOUR EFFECTIVE DATE:** The first of the month following the day you become eligible.

**INDIVIDUAL REINSTATEMENT:** Not Applicable

### **LONG TERM DISABILITY BENEFIT**

**ELIMINATION PERIOD:** 180 consecutive days of Total Disability.

**MONTHLY BENEFIT:** The Monthly Benefit is an amount equal to 66 2/3% of Covered Monthly Earnings.

To figure this benefit amount payable:

- (1) multiply your Covered Monthly Earnings by the benefit percentage(s) shown above;
- (2) take the lesser of the amount:
  - (a) of step (1) above; or
  - (b) the Maximum Monthly Benefit shown below; and
- (3) subtract Other Income Benefits, as shown below, from step (2), above.

We will pay at least the Minimum Monthly Benefit as follows.

**OTHER INCOME BENEFITS:** Other Income Benefits are:

- (1) disability income benefits you are eligible to receive because of your Total Disability under any group insurance plan(s);
- (2) disability income benefits you are eligible to receive because of your Total Disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
- (3) all benefits (except medical or death benefits) including any settlement made in place of such benefits (whether or not liability is admitted) you are eligible to receive because of your Total disability under:
  - (a) Workers' Compensation Laws;
  - (b) occupational disease law;



- (c) any other laws of like intent as (a) or (b) above; and
- (d) any compulsory benefit law;
- (4) any of the following that you are eligible to receive from the Policyholder:
  - (a) any formal salary continuance plan;
  - (b) wages, salary or other compensation, excluding the amount allowable when engaged in Rehabilitative Employment; and
  - (c) commissions or monies, including vested renewal commissions, but, excluding commissions or monies that you earned prior to Total Disability which are paid after Total Disability has begun;
- (5) that part of disability benefits paid for by the Policyholder which you are eligible to receive because of your Total disability under a group retirement plan; and
- (6) that part of Retirement Benefits paid for by the Policyholder which you are eligible to receive under a group retirement plan; and
- (7) disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
  - (a) you are eligible to receive because of your Total Disability or eligibility for Retirement Benefits; and
  - (b) your dependents are eligible to receive due to (a) above.

Disability and early Retirement Benefits will be offset only if such benefits are elected by you or if election would not reduce the amount of your accrued normal Retirement Benefits then funded.

Retirement Benefits under number (7) above will not apply to disabilities which begin after age 70 if you are already receiving Social Security Retirement Benefits while continuing to work beyond age 70.

**MINIMUM MONTHLY BENEFIT:** In no event will the Monthly Benefit payable to you be less than the greater of:

- (1) 10% of the Covered Monthly Earnings multiplied by the Monthly Benefit percentage(s) as shown above; or
- (2) \$100

**MAXIMUM MONTHLY BENEFIT:** \$3,000 (this is equal to a maximum Covered Monthly Earnings of \$4,500).

**MAXIMUM DURATION OF BENEFITS:** Benefits will not accrue beyond the duration specified below:

<u>Age at Disablement</u>	<u>Duration of Benefits</u>
Less than 69	The lesser of: (1) 60 months; or
69 or more	(2) to age 70 12 months

**CHANGES IN MONTHLY BENEFIT:** Increases in the Monthly Benefit are effective on the first of the Policy month coinciding with or next following the date of the change, provided you are Actively at Work on the effective date of the change. If you are not Actively at Work on that date, the effective date of the increase in the benefit amount will be deferred until the date you return to Active Work. Decreases in the Monthly Benefit are effective on the first of the Policy month coinciding with or next following the date the change occurs.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of this insurance.

Premium contributions will not be included in your gross income.

For purposes of filing your Federal Income Tax Return, this means that under the law as of the date the Policy was issued, your Monthly Benefit might be treated as taxable. It is recommended that you contact your personal tax advisor.