

**CONTRACT ADDENDUM  
BETWEEN THE  
AYERSVILLE EDUCATION ASSOCIATION  
AND THE  
AYERSVILLE LOCAL SCHOOL BOARD OF EDUCATION**

Whereas, the Ayersville Education Association and the Ayersville Local School Board of Education are parties to a negotiated agreement in effect until July 31, 2016; and

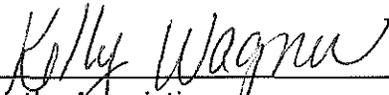
Whereas, during the recent negotiations of 2013, some tentative agreements were mistakenly left out of the ratification process and the Master Agreement; and

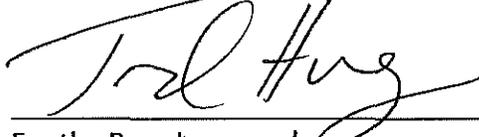
Whereas, the parties wish to include the tentative agreements into the Master Agreement upon ratification of the documents.

Now, therefore, the parties during negotiations tentatively agreed to the following:

1. The Board will pay the following amount of monthly premiums for the full time bargaining unit members for the high deductible health plan (HDHP):
  - a. Coverage beginning January 1, 2014 and ending December 31, 2016. Up to \$1,000 Family/\$400 Single.
2. Beginning January 1, 2014, the Board shall purchase from a carrier licensed by the State of Ohio, group Term life insurance for each certificated employee in the amount of \$40,000.
3. The changes made in Appendix G: Schedule of Covered Medical Expenses stated in the August 1, 2010 - July 31, 2013 Master Contract to be updated as per the party's agreement during the negotiating sessions of 2013 for the successor agreement. See amended Appendix G attached.

This Contract Addendum will be signed by the parties following ratification and attached to the current Master Agreement and becomes effective upon the ratification of the parties.

  
\_\_\_\_\_  
For the Association  
  
8-23-13  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
For the Board  
  
8/23/13  
\_\_\_\_\_  
Date

**CONTRACT ADDENDUM  
BETWEEN THE  
AYERSVILLE EDUCATION ASSOCIATION  
AND THE  
AYERSVILLE LOCAL SCHOOL BOARD OF EDUCATION**

Whereas, the Ayersville Education Association and the Ayersville Local School Board of Education are parties to a negotiated agreement in effect until July 31, 2016; and

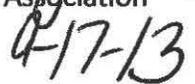
Whereas, during the recent negotiations of 2013, some tentative agreements were mistakenly left out of the ratification process and the Master Agreement; and

Whereas, the parties wish to include the tentative agreements into the Master Agreement upon ratification of the documents.

Now, therefore, the parties during negotiations tentatively agreed to the following:

1. The Board will pay the following amount of monthly premiums for the full time bargaining unit members for the high deductible health plan (HDHP):
  - a. Coverage beginning January 1, 2014 and ending December 31, 2016. Up to \$1,000 Family/\$400 Single.
2. Beginning January 1, 2014, the Board shall purchase from a carrier licensed by the State of Ohio, group Term life insurance for each certificated employee in the amount of \$40,000.
3. The changes made in Appendix E: Schedule of Covered Medical Expenses stated in the August 1, 2010 - July 31, 2013 Master Contract to be updated as per the party's agreement during the negotiating sessions of 2013 for the successor agreement. See amended Appendix E attached.

This Contract Addendum will be signed by the parties following ratification and attached to the current Master Agreement and becomes effective upon the ratification of the parties.

  
\_\_\_\_\_  
For the Association  
  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
For the Board  
  
\_\_\_\_\_  
Date

TA 8-23-13  
 L. M. M. M. M.

J.A. Tol H. H. H.  
 8/23/13  
 APPENDIX "G"

**This is a general overview of the plans. Please refer to NBHP plan booklet and updates for current information.**

**PPO SCHEDULE OF COVERED EXPENSES AND PROVISIONS  
 (ACCESS+ 1A PLAN)**

**I. MEDICAL CARE BENEFITS:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Calendar Year Deductible</b> <i>(taken before benefits are payable unless waived). Charges applied to Deductible during last three months of a Calendar Year also apply toward Deductible for the next Calendar Year.</i>	\$375/person \$750/family	\$750/person \$1,500/family
<b>Deductible Carry-Over</b>	Any Covered Expenses incurred during October, November and/or December which are applied to the Covered Person's Deductible will also "carry-over" to the following year's Deductible	
<b>Out-of-Pocket Maximum per Calendar Year</b> <i>(excludes Deductibles). After amount is reached, 100% level of benefits applies for that Calendar Year. Co-pays, penalties, expenses not covered, and amounts over Plan maximums do not apply to, and are not affected by, this provision.</i>	\$1,650/person \$3,300/family	\$3,000/person \$6,000/family
<b>ANNUAL BENEFIT MAXIMUM</b> (see listing in "Definitions" for clarifying details)	\$2,000,000 per person	
<b>LIFETIME BENEFIT MAXIMUM</b>	Unlimited	
Benefits subject to the penalty as stated per occurrence <i>(in addition to Deductible)</i> when pre-certification procedures stated in the Pre-Certification section are not followed.	<b>TO PRE-CERTIFY, CALL THE TOLL-FREE NUMBER ON YOUR ID CARD</b>	
<b>Claims Filing Limit</b>	All charges, and corresponding requested documentation, must be submitted within 15 months of the date incurred.	
<b>Coordination of Benefits</b>	If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (carve out). This Plan will only pay the difference of what the Plan would have paid if it was the Primary Payer.	
<b>In-Network and Out-of-Network Deductibles and Out of Pocket Maximums are "separately tracked," such that covered expenses applied to one does not apply to the other.</b>		

**II. PRESCRIPTION DRUG BENEFIT:**

COVERED EXPENSES and PROVISIONS	
	In-Network      Out-of-Network
<p><b>Prescription Drug Card Benefit</b> (<i>up to 34-day supply through participating pharmacies</i>)  <u>Deductible does not apply</u> - see pages 15-16 for covered drugs and special considerations.   <b>Note:</b> <i>Maintenance drugs must be filled through Mail Order after 3 pharmacy fills</i></p>	<ul style="list-style-type: none"> <li>• Generic Drugs - \$10 co-pay per prescription or refill; then 100%</li> <li>• Formulary Brand Name Drugs - \$20 co-pay per prescription or refill; then 100%</li> <li>• Non Formulary Brand Name Drugs - \$30 co-pay per prescription or refill; then 100%</li> </ul>
<p><b>Mail Order Drug Benefit</b> (<i>up to 90-day supply through Mail Order vendor</i>)  <u>Deductible does not apply</u> – see page 16</p>	<ul style="list-style-type: none"> <li>• Generic Drugs - \$20 co-pay per prescription or refill; then 100%</li> <li>• Formulary Brand Name Drugs - \$40 co-pay per prescription or refill; then 100%</li> <li>• Non Formulary Brand Name Drugs - \$60 co-pay per prescription or refill; then 100%</li> </ul>
<p><b>Penalty for purchasing non-Generic when Generic Drug is Available</b></p>	<p>For both the Drug Card and Mail Order Drug benefit, if a Covered Person purchases a brand name medication when a generic is available, then, in addition to the brand co-pay, he must also pay the difference in price between the generic and brand medication.</p>

**Contraception and contraceptive counseling** - The Northern Buckeye Health Plan includes coverage for several types of contraceptives. Generic hormonal and emergency oral contraceptives, diaphragms and the Mirena IUD will be covered at no cost to you as the plan participant. Brand and Non-Formulary contraceptives will remain not covered. For additional information about your contraceptive benefits, including the applicable copay for a medication, please contact Express Scripts toll free at 1-866-275-0044 or online at [www.express-scripts.com](http://www.express-scripts.com).

**III. PREVENTIVE CARE SERVICES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<p><b>Preventive Care Services - (must be billed with a routine diagnosis).</b></p> <p>This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, mammograms (age 35 and older, 1 per Covered Person per Calendar Year), PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years) and every 5 Calendar Years, a choice between a sigmoidoscopy or a colonoscopy (age 50 and older), and counseling for smoking cessation.</p> <p><i>This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, and the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.</i></p> <p>This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests.</p>	<p>100% <u>Deductible</u> <u>Waived</u></p>	<p>60%</p>

**IV. ACCIDENT EXPENSE BENEFIT (Outpatient):**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Within First 72 hours of an Accident</b> <b>(Deductible waived)</b>	100%	100%
<b>After 72 hours (Facility Expenses)</b>	80%	60%
<b>After 72 hours (Professional Expenses)</b>	80%	60%

**V. URGENT CARE FACILITY & PHYSICIAN EXPENSES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Within First 72 hours of onset</b> <b>(Deductible waived)</b>	100%	100%
<b>After 72 hours (Facility Expenses)</b>	80%	60%
<b>After 72 hours (Professional Expenses)</b>	80%	60%

**VI. PHYSICIAN SERVICES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Office Visit Charge</b> *Primary Care Physician is an M.D., D.O., or a Nurse Practitioner who is a general or family practitioner, obstetrician/gynecologist, internist, pediatrician, or covered mental health provider who has contracted with the PPO organization.	*PCP - \$20 co-pay per visit, then 100%. <u>Deductible waived</u>  Specialist - \$40 co-pay per visit, then 100%. <u>Deductible waived</u>	60%          60%
<b>All Other Expenses in Office (except as stated above or under "Other Professional Services")</b>	80%	

**VII. OUTPATIENT (non-office) X-RAY/LAB AND DIAGNOSTIC TESTING EXPENSES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Facility Expenses</b> <b>Professional Expenses</b>	80% 80%	60% 60%

**VIII. OTHER PROFESSIONAL SERVICES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Second Surgical Opinions</b>	100% (Deductible waived)	100% (Deductible waived)
<b>Chiropractic Treatment (maximum of 24 visits per Calendar Year)</b>	\$20 co-pay per visit, then 100% (Deductible waived)	60%
<b>Therapy Services (including, but not limited to, physical, occupational and speech therapy).</b>	\$20 co-pay per visit, then 100% (Deductible waived)	60%
<b>Inpatient Physician Visits (limited to one visit per Physician per day)</b>	80%	60%

**VIII. OTHER PROFESSIONAL SERVICES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>All Other Covered Professional Expenses</b> (except as previously stated or as listed under "Emergency Room Services", or as clarified under "Additional Coverage Details.")	80%	60%

**IX. HOSPITAL SERVICES AND SPECIALIZED TREATMENT FACILITIES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Inpatient Hospital Facility Services</b> limited to facility's semi-private room rate (unless private room is medically required for isolation) and all Medically Necessary services including, but not limited to, intensive care and cardiac care.	80%	60%
<b>Outpatient Hospital Facility Services</b> including Ambulatory Surgical Center Facility services	80%	60%
<b>Emergency Room Services</b> including all related expenses performed during the same visit.  <i>*Co-pay waived if admitted.</i>	\$110 co-pay*, then 100% (Deductible waived)	\$110 co-pay*, then 100% (Deductible waived)
<b>Birthing Center Facility Services</b>	80%	60%
<b>Rehabilitation Facility</b>	80%	60%
<b>Skilled Nursing Facility Services</b> (Limited to a Maximum of 60 visits per Calendar Year)	80%	60%

**X. MISCELLANEOUS SERVICES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Home Health Care (Facility Expenses)</b>	80%	60%
<b>Home Health Care (Professional Expenses)</b>	80%	60%
<b>Home Health Aide Services</b>	50%	50%
<b>Hospice Care</b> (Inpatient and/or Home services).	80% (facility)	60% (facility)
	80% (professional)	60% (professional)
<b>Inpatient /Outpatient Private Duty Nursing</b>	80%	60%
<b>Ambulance Services</b> *subject to the In-Network Deductible and Out of Pocket Maximum	80%	*80%

**X. MISCELLANEOUS SERVICES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
Human Organ and Tissue Transplants (see also "Additional Coverage Details")	80%	Not Applicable
Durable Medical Equipment	80%	60%
Morbid Obesity (surgery or any other treatment for) See also "Additional Coverage Details."	80%	60%
Other Covered Services/Items (see "Additional Coverage Details" and "General Limitations" for possible impact or clarifications to coverage as shown at right).	80%	60%- Professional 60%- Facility

**PPO SCHEDULE OF COVERED EXPENSES AND PROVISIONS**

**(HDHP PLAN)**

**I. MEDICAL CARE BENEFITS:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
Calendar Year Deductible <i>*There is no limit to the amount that any one person may apply towards the family deductible. However, note that the entire family deductible amount must be met before any benefits are payable for any individual in the family (except for Wellness benefits where Deductible is waived).</i>	\$1,500/Employee only Plan \$3,000/family Plan*	\$3,000/Employee Only Plan \$6,000/family Plan*
Deductible Carry-Over	N/A	
Out-of-Pocket Maximum per Calendar Year ( <i>excludes</i> Deductibles). After amount is reached, 100% level of benefits applies for that Calendar Year. Penalties, expenses not covered, and amounts over Plan maximums do not apply to, and are not affected by, this provision.	\$1,000/person \$2,000/family	\$2,000/person \$3,000/family
ANNUAL BENEFIT MAXIMUM (see listing in "Definitions" for clarifying details)	\$2,000,000 per person	
LIFETIME BENEFIT MAXIMUM	Unlimited	
Benefits subject to the penalty as stated per occurrence ( <i>in addition to Deductible</i> ) when pre-certification procedures stated in the Pre-Certification section are not followed.	TO PRE-CERTIFY, CALL THE TOLL-FREE NUMBER ON YOUR ID CARD	

**I. MEDICAL CARE BENEFITS:**

COVERED EXPENSES and PROVISIONS	
	In-Network      Out-of-Network
<b>Claims Filing Limit</b>	All charges, and corresponding requested documentation, must be submitted within 15 months of the date incurred.
<b>Coordination of Benefits</b>	If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (carve out). This Plan will only pay the difference of what the Plan would have paid if it was the Primary Payer.
<b>In-Network and Out-of-Network Deductibles are "aggregated," such that covered expenses applied to one also applies to the other.</b>	
<b>In-Network and Out-of-Network Out of Pocket Maximums are "separately tracked," such that covered expenses applied to one does not apply to the other.</b>	

**II. PRESCRIPTION DRUG BENEFIT:**

COVERED EXPENSES and PROVISIONS	
	In-Network      Out-of-Network
<p><b>Prescription Drug Card Benefit (up to 34-day supply through participating pharmacies)</b>                      See pages 15-16 for covered drugs and special considerations.                      Covered drugs may be obtained through participating pharmacies and paid at 100% "out of pocket" (note that substantial discounts are available through these pharmacies) until the In-Network Calendar Year Deductible is met. After that Deductible is met, additional covered drugs are available at the co-pays shown at right for the remainder of that Calendar Year.</p>	<p>The following co-pays per prescription or refill apply <b>only after</b> the In-Network Calendar Year Deductible is met. These co-pays will apply to the In-Network Out of Pocket Maximum.</p> <ul style="list-style-type: none"> <li>• \$10 co-pay Generic</li> <li>• \$25 co-pay Formulary Brand</li> <li>• \$45 co-pay Non-Formulary Brand</li> </ul>
<p><b>Mail Order Drug Benefit (up to 90-day supply through Mail Order vendor)</b>                      Covered maintenance drugs may be obtained through contracted Mail Order Program and paid at 100% "out of pocket" (note that substantial discounts are available through this program) until the In-Network Calendar Year Deductible is met. After that Deductible is met, additional covered drugs are available at the co-pays shown at right for the remainder of that Calendar Year.</p>	<p>The following co-pays per prescription or refill apply <b>only after</b> the In-Network Calendar Year Deductible is met. . These co-pays will apply to the In-Network Out of Pocket Maximum.</p> <ul style="list-style-type: none"> <li>• \$20 co-pay Generic</li> <li>• \$40 co-pay Formulary Brand</li> <li>• \$60 co-pay Non-Formulary Brand</li> </ul>
<p><b>Penalty (applies to co-pay structure shown above after In-Network Calendar Year Deductible is met) for purchasing non-Generic when Generic Drug is Available</b></p>	<p>For both the Drug Card and Mail Order Drug benefit, if a Covered Person purchases a brand name medication when a generic is available, then, in addition to the brand co-pay, he must also pay the difference in price between the generic and brand medication.</p>

**Contraception and contraceptive counseling** - This Plan includes coverage for several types of contraceptives. Generic hormonal and emergency oral contraceptives, diaphragms and the Mirena IUD will be covered at no cost to you as the plan participant. Brand and Non-Formulary contraceptives will remain not covered. For additional information about your contraceptive benefits, including the applicable co-pay for a medication, please contact Express Scripts toll free at 1-866-275-0044 or online at [www.express-scripts.com](http://www.express-scripts.com).

**III. PREVENTIVE CARE SERVICES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<p><b>Preventive Care Services - (must be billed with a routine diagnosis).</b></p> <p>This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, mammograms (age 35 and older, 1 per Covered Person per Calendar Year), PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years) and every 5 Calendar Years, a choice between a sigmoidoscopy or a colonoscopy (age 50 and older), and counseling for smoking cessation.</p> <p><i>This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, and the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.</i></p> <p>This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests.</p>	<p>100% <u>Deductible</u> <u>Waived</u></p>	<p>70% after Deductible</p>

**IV. PHYSICIAN SERVICES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<p><b>Office /Urgent Care Visit (Exam) Charge</b></p>	<p>80% after Deductible</p>	<p>70% after Deductible</p>
<p><b>All Other Expenses In Office (except as stated above or under "Other Professional Services")</b></p>	<p>80% after Deductible</p>	<p>70% after Deductible</p>

**V. OUTPATIENT (non-office) X-RAY/LAB AND DIAGNOSTIC TESTING EXPENSES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<p><b>Facility Expenses</b></p>	<p>80% after Deductible</p>	<p>70% after Deductible</p>
<p><b>Professional Expenses</b></p>	<p>80% after Deductible</p>	<p>70% after Deductible</p>

**VI. OTHER PROFESSIONAL SERVICES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Second Surgical Opinions</b>	80% after Deductible	70% after Deductible
<b>Chiropractic Treatment (maximum of 24 visits per Calendar Year)</b>	80% after Deductible	70% after Deductible
<b>Therapy Services (including, but not limited to, physical, occupational and speech therapy).</b>	80% after Deductible	70% after Deductible
<b>Inpatient Physician Visits (limited to one visit per Physician per day)</b>	80% after Deductible	70% after Deductible
<b>All Other Covered Professional Expenses (except as previously stated or as listed under "Emergency Room Services", or as clarified under "Additional Coverage Details.")</b>	80% after Deductible	70% after Deductible

**VII. HOSPITAL SERVICES AND SPECIALIZED TREATMENT FACILITIES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Inpatient Hospital Facility Services limited to facility's semi-private room rate (unless private room is medically required for isolation) and all Medically Necessary services including, but not limited to, intensive care and cardiac care.</b>	80% after Deductible	70% after Deductible
<b>Outpatient Hospital Facility Services including Ambulatory Surgical Center Facility services</b>	80% after Deductible	70% after Deductible
<b>Emergency Room Services including all related expenses performed during the same visit.</b>	80% after Deductible	80% after In-Network Deductible and subject to In-Network Out-of-Pocket Maximum.
<b>Birth Center Facility Services</b>	80% after Deductible	70% after Deductible
<b>Rehabilitation Facility</b>	80% after Deductible	70% after Deductible
<b>Skilled Nursing Facility Services (Limited to a Maximum of 60 visits per Calendar Year)</b>	80% after Deductible	70% after Deductible

**VIII. MISCELLANEOUS SERVICES:**

COVERED EXPENSES and PROVISIONS		
	In-Network	Out-of-Network
<b>Home Health Care (Facility and Professional Expenses)</b>	80% after Deductible	70% after Deductible
<b>Home Health Aide Services</b>	50% after Deductible	50% after Deductible
<b>Hospice Care</b> <i>(Inpatient and/or Home services).</i>	80% after Deductible	70% after Deductible
<b>Inpatient /Outpatient Private Duty Nursing</b>	80% after Deductible	70% after Deductible
<b>Ambulance Services</b> <i>*subject to the In-Network Deductible and Out of Pocket Maximum</i>	80% after Deductible	*80% after Deductible
<b>Human Organ and Tissue Transplants</b> <i>(see also "Additional Coverage Details")</i>	80% after Deductible	Not Applicable
<b>Durable Medical Equipment</b>	80% after Deductible	70% after Deductible
<b>Morbid Obesity</b> <i>(surgery or any other treatment for) See also "Additional Coverage Details."</i>	80% after Deductible	70% after Deductible
<b>Other Covered Services/Items</b> <i>(see "Additional Coverage Details" and "General Limitations" for possible impact or clarifications to coverage as shown at right).</i>	80% after Deductible	70% after Deductible

