

MEMORANDUM OF UNDERSTANDING  
BETWEEN THE  
WEST GEAUGA BOARD OF EDUCATION  
AND THE  
WEST GEAUGA EDUCATION ASSOCIATION

10-27-15  
14-MED-02-0131  
0854-01  
K32277

The West Geauga Local Board of Education, hereinafter "Board," and the West Geauga Education Association, hereinafter "Association," mutually enter into this Memorandum of Understanding in accordance with and pursuant to O.R.C. 4117, the Ohio Public Employees' Collective Bargaining Law, to modify the terms and conditions of employment in regards to insurance, including medical, prescription, dental, and vision coverage.

This Memorandum of Understanding shall be attached to and become a part of the current Collective Bargaining Agreement dated, July 1, 2014 through June 30, 2017 and as such shall modify the current agreement with regard to insurance.

Whereas, the Board and Association fully intend to continue the current plan coverage for life insurance benefits, and

Whereas the Board and Association mutually agree to change the Health insurance plan to the Health insurance plan with Medical Mutual of Ohio, the Dental insurance plan with Superior Dental Care and increase the reimbursement amounts for vision coverage, the changes are agreed to as follows:

Article IX, Section J, pages 71- 74 and Appendices A, B, C and D, pages 80-105 shall be changed to the current language except for the amendments as described herein:

J. INSURANCES

The Board shall provide an eighty percent (80%) paid insurance package for all members of the bargaining unit and their dependents consisting of comprehensive hospitalization, major medical, prescription, and dental. Part-time employee's benefits shall be pro-rated on the same basis, as is currently the practice. The Board shall provide one hundred percent (100%) paid \$25,000 life insurance for all employees. Employees on maintenance prescription drugs should use the mail-in program. The Board will provide a reimbursable vision program as follows: \$ 150 per calendar year for employees with single dental coverage and \$ 300 per calendar year for employees with family dental coverage. For purposes of the vision payment, "family" shall include the tiers titled Family, Employee & Spouse, and Employee & child(ren). Coverage shall meet or exceed the insurance in effect as of December 1, 2002. Comprehensive Major Medical Expense Coverage through a Preferred Provider Organization/Network (PPO) has been added as a managed care plan. If available, individuals shall have the right to purchase and pay for more than \$25,000 life insurance with the same company.

The medical, prescription, and vision carrier and plan for the Board and Association effective January 1, 2015 shall be Medical Mutual of Ohio with the list of benefits or better than stated in Appendix B, 'Your Anthem Benefits, West Geauga Local Schools, Blue Access (PPO) Option 1 Summary of Benefits'. Any modifications which act to lessen the total aggregate of covered benefits in said insurance plan, except those modifications described in Article IX., J., 5., and J., 6., and Appendix C herein, shall be covered by the Board until the Contract expires, at which time said changes shall be a part of bargaining. (Changes in formulary or PPO doctor members are not a part of the above modifications to covered benefits.)

Dental coverage shall be provided by Superior Dental Care PPO plan with the attached list of benefits or better than stated in Appendix D. Any modifications which act to lessen the total aggregate of covered benefits in said insurance plan shall be covered by the Board until the Contract expires, at which time said changes shall be a part of bargaining. (Changes in members of the dental PPO are not a part of the above modifications to covered benefits.)

An ongoing insurance committee shall continue to study available plans and make recommendations to the membership, deal with transitions, issues and complaints, and plan for education of all members of the bargaining unit about the insurance plan benefits. No change in benefits will be made without the recommendation of the insurance committee and a vote of the parties.

1. All teachers employed by regular contract may elect to participate in the medical and/or dental plan according to the following schedule:

	<u>PER MONTH/SINGLE</u>	<u>PER MONTH/FAMILY</u>
0.75 of full-time	full Board contribution	full Board contribution
0.45 to 0.75 full-time	½ Board contribution	½ Board contribution
less than 0.45 full-time	0 Board contribution	0 Board contribution

- a. Teachers scheduled to work nine or more months per year will be eligible for the respective Board contribution for the entire twelve months in accordance with the direction given by the Treasurer's office.
2. The Board shall provide one hundred percent (100%) paid insurance package, either in the form of two single plans or one family plan, for members of the bargaining unit who meet all of the following criteria:
  - a) A bargaining unit member legally married to another bargaining unit member, and
  - b) where both are employed prior to June 15, 1998, and
  - c) where both are currently employed.
3. Any bargaining unit member who becomes legally married to another bargaining unit member after June 15, 1998 will receive benefits based upon Article IX, Section J.
4. A four tier medical insurance plan will be offered. The tiers are Single, Employee & Spouse, Employee & Child(ren), and Family. Eligible employees who previously enrolled in the Single or Family plans may elect to change their coverage to Employee & Spouse or Employee & Child(ren) during the open enrollment period.
  - a. Members will be notified of the rate structure for Single, Employee & Spouse, Employee & Child(ren), and Family medical insurance plans before the conclusion of the open enrollment period each insurance plan year.

	Current PPO	Alternate
PPO Single	\$129.28	108.19
EE + Spouse	\$ 271.45	\$ 227.16
EE + Children	\$ 245.60	\$ 205.53
Family	\$ 400.69	\$ 335.31

- b. For purposes of this agreement "family" as indicated in Article IX, Appendix A, Appendix B, and Appendix C shall include the tiers titled Family, Employee & Spouse, and Employee & Child(ren).
5. An alternate medical insurance plan will be offered. The alternate medical, prescription, and vision carrier and plan for the Board and Association effective January 1, 2015 shall be Medical Mutual of Ohio Alternate Plan, with the list of benefits or better than stated in Appendix C, 'Your Anthem Benefits, West Geauga Local Schools, Blue Access (PPO) Alternate Plan Summary of Benefits'.
- a. Eligible employees may elect to change their coverage to the Medical Mutual of Ohio Alternative Plan during the open enrollment period for the 2015 insurance plan year and subsequent years by completing the appropriate enrollment form(s).
  - b. Employees shall have the right to enroll in the Medical Mutual of Ohio Option 1 plan during the open enrollment period for any plan year regardless of previous enrollment Alternate Plan.
  - c. For purposes of this agreement "family" as indicated in Article IX, Section J, Appendix A, Appendix B, and Appendix C shall include the tiers titled Family, Employee & Spouse, and Employee & Child(ren).
6. Beginning with the 2015 insurance plan year (calendar year), the Medical Mutual of Ohio Option 1 and the Medical Mutual of Ohio Alternate Plan, with the list of benefits or better than stated in Appendix B, 'Your Anthem Benefits, West Geauga Local Schools, Blue Access (PPO) Option 1 Summary of Benefits', and Appendix C, 'Your Anthem Benefits, West Geauga Local Schools, Blue Access (PPO) Alternate Plan Summary of Benefits' shall include a mandatory mail service pharmacy provision for maintenance medications.
- a. The penalty for using a retail pharmacy rather than the mail service pharmacy for maintenance medications shall not exceed 100% of the drugs' discounted retail price.
  - b. Employees may fill a prescription for maintenance medications up to three times at a network retail pharmacy, paying the applicable co-pay, before switching to the mail service pharmacy.

Appendix A – Medical Mutual of Ohio – Summary of Benefits

Appendix D – Superior Dental Care – Summary of Benefits

## APPENDIX B – INSURANCE PLAN SUMMARY

# Your Anthem Benefits



**West Geauga Local Schools**  
**Blue Access<sup>SM</sup> (PPO) Option 1 - Current Plan**  
**Summary of Benefits, Effective 01/01/2010**

Covered Benefits	Network	Non-Network
<b>Deductible (Single/Family)</b>	None	\$300/\$600
<b>Out-of-Pocket Limit (Single/Family)</b>	\$1,000/\$2,000	\$2,000/\$4,000
<b>Physician Home and Office Services (PCP/SCP)</b> Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> <li>• allergy injections (PCP and SCP)</li> <li>• allergy testing</li> <li>• routine and non-routine mammograms (regardless of outpatient setting)</li> <li>• diabetic education (regardless of outpatient setting)</li> <li>• certain medical nutritional therapy (regardless of outpatient setting)</li> <li>• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds</li> </ul>	\$10/\$10  \$5 No copayment/coinsurance \$10 \$10 \$10 No copayment/coinsurance	20%  20% 20% 20% 20% Not Covered 20%
<b>Preventive Care Services</b> Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams <ul style="list-style-type: none"> <li>• Physician Home and Office Visits (PCP/SCP)</li> <li>• Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>	\$10/\$10 No copayment/coinsurance	20% 20%
<b>Emergency and Urgent Care</b> <ul style="list-style-type: none"> <li>• Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted)</li> <li>• Urgent Care Center Services</li> </ul>	\$75 \$35	\$75 \$35
<b>Inpatient and Outpatient Professional Services</b> Include but are not limited to: <ul style="list-style-type: none"> <li>• Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>	No copayment/coinsurance	20%
<b>Inpatient Facility Services</b> Unlimited days except for: <ul style="list-style-type: none"> <li>• 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>• 90 days Network/Non-Network combined for skilled nursing facility</li> </ul>	No copayment/coinsurance	20%
<b>Outpatient Surgery Hospital/Alternative Care Facility</b> <ul style="list-style-type: none"> <li>• Surgery and administration of general anesthesia</li> </ul>	No copayment/coinsurance	20%
<b>Other Outpatient Services (including but not limited to):</b> <ul style="list-style-type: none"> <li>• Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services.</li> <li>• Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)</li> <li>• Durable Medical Equipment and Orthotics (Network/Non-network combined) \$4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies)</li> <li>• Prosthetic Devices \$4,000 benefit maximum</li> <li>• Physical Medicine Therapy Day Rehabilitation programs</li> <li>• Hospice Care</li> <li>• Ambulance Services</li> </ul>	No copayment/coinsurance          No copayment/coinsurance No copayment/coinsurance	20%          No copayment/coinsurance No copayment/coinsurance

**West Gauga Local Schools - Blue Access 3.0 PPO Benefit Summary - Current Plan (continued)**

Covered Benefits	Network	Non-Network
<b>Outpatient Therapy Services</b> (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> Limits apply to: <ul style="list-style-type: none"> <li>Physical therapy: 20 visits</li> <li>Occupational therapy: 20 visits</li> <li>Manipulation therapy: 12 visits</li> <li>Speech therapy: 20 visits</li> </ul>	\$10/\$10 No copayment/coinsurance	20% 20%
<b>Behavioral Health Services</b>	Copayments/Coinsurance based on setting where covered services are received	Copayments/Coinsurance based on setting where covered services are received
<b>Human Organ and Tissue Transplants<sup>3</sup></b> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	No copayment/coinsurance	50%
<b>Prescription Drugs<sup>4</sup></b> Network Tier structure equals 1/2/3 (and 4, if applicable) <ul style="list-style-type: none"> <li><b>Network Retail Pharmacies:</b> (30-day supply) Includes diabetic test strip</li> <li><b>Anthem Rx Direct Mail Service:</b> (90-day supply) Includes diabetic test strip</li> </ul> Mandatory mail after 3 retail fills for maintenance medication Medicare Rx - Wrap Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	\$10/\$15/\$30  \$25/\$37/\$75	50%, min \$30 <sup>5</sup>  Not covered
<b>Lifetime Maximum (Combined Network and Non-network)<sup>6</sup></b>	\$5 million	\$5 million

**Notes:**

- Flat dollar copayments are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance and Non-network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the calendar year which the child attains age 19, or to the end of the calendar year which the child attains age 25 if the child qualifies as a full-time student.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty group of practices.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period - calendar year

<sup>1</sup>These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

<sup>2</sup>We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

<sup>3</sup>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

<sup>4</sup>If applicable, all prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies. Also if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-Service combined.

<sup>5</sup>Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

<sup>6</sup>Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.

**West Geauga Local Schools - Blue Access 3.0 PPO Benefit Summary - Current Plan (continued)**

**Precertification:**

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

Pre-existing Exclusion Period: None

**Exceptions (subject to medical policy guidelines):**

- *Plan would provide coverage for sexual dysfunction.*

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

**APPENDIX C – ALTERNATE INSURANCE PLAN SUMMARY**

**Your Anthem Benefits**



West Geauga Local Schools  
 Blue Access<sup>SM</sup> (PPO) - Alternate Plan  
 Summary of Benefits, Effective 01/01/2010

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	\$500/\$1,000	\$1,000/\$2,000
Out-of-Pocket Limit (Single/Family)	\$1,500/\$3,000	\$3,000/\$6,000
<b>Physician Home and Office Services (PCP/SCP)</b> Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • allergy injections (PCP and SCP) • allergy testing • routine and non-routine mammograms (regardless of outpatient setting) • diabetic education (regardless of outpatient setting) • certain medical nutritional therapy (regardless of outpatient setting) • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds	\$25/\$25  \$5 10% \$25  \$25 \$25 10%	30%  30% 30% 30% 30% Not Covered 30%
<b>Preventive Care Services</b> Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	\$25/\$25 10%	30% 30%
<b>Emergency and Urgent Care</b> • Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted) • Urgent Care Center Services	\$75  \$35	\$75  \$35
<b>Inpatient and Outpatient Professional Services</b> Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	10%	30%
<b>Inpatient Facility Services</b> Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days Network/Non-Network combined for skilled nursing facility	10%	30%
<b>Outpatient Surgery Hospital/Alternative Care Facility</b> • Surgery and administration of general anesthesia	10%	30%
<b>Other Outpatient Services (including but not limited to):</b> • Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (Network/Non-network combined) \$4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) • Prosthetic Devices \$4,000 benefit maximum • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	10%      10% 10%	30%        10% 10%

West Gauga Local Schools - Blue Access 3.0 PPO Benefit Summary -  
 Alternate Plan (continued)

Covered Benefits	Network	Non-Network
<b>Outpatient Therapy Services</b> (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> Limits apply to: <ul style="list-style-type: none"> <li>Physical therapy: 20 visits</li> <li>Occupational therapy: 20 visits</li> <li>Manipulation therapy: 12 visits</li> <li>Speech therapy: 20 visits</li> </ul>	\$25/\$25 10%	30% 30%
<b>Behavioral Health Services</b>	Copayments/Coinsurance based on setting where covered services are received	Copayments/Coinsurance based on setting where covered services are received
<b>Human Organ and Tissue Transplants<sup>3</sup></b> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	No copayment/coinsurance	50%
<b>Prescription Drugs<sup>4</sup></b> Network Tier structure equals 1/2/3 (and 4, if applicable) <ul style="list-style-type: none"> <li><b>Network Retail Pharmacies:</b> (30-day supply) Includes diabetic test strip</li> <li><b>Anthem Rx Direct Mail Service:</b> (90-day supply) Includes diabetic test strip</li> </ul> Mandatory mail after 3 retail fills for maintenance medication <b>Medicare Rx - Wrap</b> Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	\$10/\$30/\$80  \$25/\$75/\$150	50%, min \$30 <sup>5</sup>  Not covered
<b>Lifetime Maximum (Combined Network and Non-network)<sup>6</sup></b>	\$5 million	\$5 million

**Notes:**

- Flat dollar copayments are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance and Non-network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the calendar year which the child attains age 19; or to the end of the calendar year which the child attains age 25 if the child qualifies as a full-time student.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period = calendar year

<sup>1</sup>These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

<sup>2</sup>We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

<sup>3</sup>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

<sup>4</sup>If applicable, all prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies. Also if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-Service combined.

<sup>5</sup>Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

<sup>6</sup>Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.

**West Gauga Local Schools - Blue Access 3.0 PPO Benefit Summary -  
Alternate Plan (continued)**

**Precertification:**

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Exclusion Period: None

**Exceptions (subject to medical policy guidelines):**

- Plan would provide coverage for sexual dysfunction.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

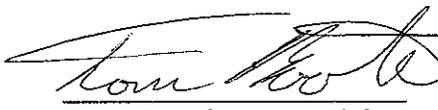
Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

This Memorandum of Understanding is agreed to by the Board and Association; their representatives have signed their names below on the date noted.

FOR THE BOARD:

FOR THE ASSOCIATION:

  
 \_\_\_\_\_  
 Michael Nutter, Superintendent

  
 \_\_\_\_\_  
 Tom Booth, President

11-25-14  
 \_\_\_\_\_  
 Date

11-25-14  
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 Date