Child Development Services Benefits Summary

The health and well-being of our staff and their families is very important. Therefore, we are committed to providing our employees with a comprehensive benefit program that helps our staff maintain a healthy work-life balance, stay healthy, and feel secure. CDS offers a generous benefit program. Insurance benefits are available to employees that regularly work 30 hours or more. These benefits become effective the first of the month following sixty days of employment. Employee contributions made toward medical, dental, and life insurance coverage will be made through pre-tax payroll deductions. Our insurance representative will meet with employees approximately 30 days before their coverage will be effective to review insurance benefits and to assist employees in making the best decisions on coverage for the employee's needs.

Benefits to help employees maintain a healthy work/life balance

Paid Time Off (PTO). A generous PTO plan is provided for **full and part-time** employees after 90 days of employment. PTO can be used for sick time, vacation time, or personal time off. Accrual starts from the first day of hire, but employees are not eligible to use PTO until they have completed 90 days of employment. PTO accruals increase after 5 years and after 10 years of employment.

Holiday Pay. **Full and part-time** employees become eligible for Holiday pay after 90 days of employment. The following holidays are observed if it falls on the employee's regular scheduled workday: July Fourth, Christmas Eve Day, Christmas Day, Memorial Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, New Year's Eve Day, and New Year's Day.

Professional Development and Training. CDS encourages personal and professional growth and offers many training opportunities for its **full and part-time** employees. Training funds are allocated to ensure employees have the opportunities to grow in their careers.

Transfers and Internal Promotions. To promote longevity and growth opportunities within our agency, CDS will post job openings at each center and on our website to give all employees the opportunity to apply for positions in which they are qualified to perform.

Childcare. If enrollment allows, children of **full and part-time** employees may be enrolled in a CDS childcare program. There is a reduced charge of $1.00 per day above the lowest full day rate for childcare. Employee families that qualify by income for the lowest rate will be charged the lowest rate.

Benefits to help employees stay healthy

Medical Insurance. We offer all **full-time employees** and their dependents options for medical insurance plans with varying benefits and premiums to best suit the employee's individual needs and affordability. Coverage is provided by Priority Health.

Dental Insurance. Dental coverage is offered for all **full-time employees** through Met Life with varying benefits and premium costs. Coverage may be purchased for dependents as well.

Insurance Waiver Package. If an employee is eligible for coverage at CDS, but receives medical and/or dental coverage through another source and can provide proof of coverage, the employee may elect to waive medical and/or dental coverage. Employee will receive the following compensation based on eligibility. If the employee is:

- eligible for single or double medical coverage, the waiver amount is $100 a month.
- eligible for family medical coverage, the waiver amount is $125 a month.
- eligible for dental coverage, the waiver amount is $20.00 a month.

Vision Insurance. **Full-time employees** are eligible for vision coverage through EyeMed.

Benefits to help employees feel secure

Basic Life and Accidental Death and Dismemberment Insurance. $15,000 in Life Insurance through Mutual of Omaha is provided for all **full-time employees**.

Voluntary Life and Accidental Death and Dismemberment Insurance. **Full-time employees** have the ability to purchase additional coverage for themselves and family members to best fit their family's needs.

Aflac Supplemental Coverage. Aflac policies are available for all **full-time employees**. Polices are available for Disability, Accident, Sickness, Cancer, Critical Care, and more.

Long Term Sick Pay. CDS offers a long-term sick plan. On the first payday in August of every year, CDS will add a total of one week of hours based on the employee's regular work schedule to the **full-time employee's** Long Term Sick bank.

401(k) Program with company match. After 90 days of employment, **full and part-time** staff become eligible to participate in the CDS 401(k) plan. CDS will provide a 10% match of the employee's contribution as long as funds are available.

Benefits summary:
HMO PriorityHSA

PriorityHealth

Coverage period: 08.01.2019 to 07.31.2020

Empowering members to take greater control of their health care spending

Child Development Services

This document is intended to be an easy-to-read summary to provide a general overview of your benefits. It is not a contract or legal document. Additional limitations and exclusions may apply to covered services. This plan has a specific network of providers, so check the Provider Directory prior to receiving services. Prior authorizations for certain services may apply. A complete description of benefits is contained in the Certificate of Coverage, Schedule or Agreement as applicable.

Member cost-sharing	
Deductible *The amount you pay before we begin to pay.*	$1,350 individual/$2,700 family Deductible costs don't apply towards your coinsurance maximum. Out-of-network services not covered.
Coinsurance *Your share of the costs of a covered health care service.*	No cost for services after deductible is met, except where noted. Out-of-network services not covered.
Coinsurance maximum *The most coinsurance cost share you'll pay for covered services in a contract year. Your coinsurance cost share counts toward your out-of-pocket limit.*	Not applicable
Out-of-pocket limit *The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.*	$2,000 individual/$4,000 family
Office visits	
Primary care provider (PCP)	Covered in full after deductible
Specialists	Covered in full after deductible
Urgent care	Covered in full after deductible
Virtual visits *24/7 care for non-emergency conditions*	Covered in full after deductible
Allergy testing, serum and injections	Covered in full after deductible
Retail health clinic *Located in a retail center, like a supermarket or pharmacy and provides care for common illnesses and services (examples: ear aches, sore throats, flu shots)*	Covered in full after deductible
Mental and behavioral health	
Inpatient hospital	Covered in full after deductible
Outpatient office visits	Covered in full after deductible

continued	
Prescription drug coverage *Visit priorityhealth.com and search Optimized or Traditional in the **Approved Drug** list to see coverage and pricing information.*	
Formulary	Traditional
Generic	$10 copayment after deductible
Brand	$40 preferred copayment, $80 non-preferred copayment, after deductible
Mail Order	Generic: 2x Brand: 2x; after deductible
Specialty	20% preferred coinsurance, $100 max, 20% non-preferred coinsurance, $200 max, after deductible
Preventive care	
Preventive care, immunizations	Covered in full; includes women's preventative health care services, well-child visits, flu shots and routine physical exams. Get the most up-to-date list of all the care that's recommended in our Preventative Health Care Guidelines when you login to your online account at PriorityHealth.com
Laboratory and X-ray	
Radiology	Covered in full after deductible
Advanced imaging (CT/ PET/MRI)	Covered in full after deductible
Laboratory	Covered in full after deductible
Emergency services	
Emergency room	Covered in full after deductible
Emergency transportation/ ambulance services	Covered in full after deductible
Hospital care	
Inpatient hospital physician services	Covered in full after deductible
Surgery and/or facility fee	Covered in full after deductible; exceptions apply
Bariatric surgery	Covered in full after deductible; covered once per lifetime
Outpatient care	
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	Covered in full after deductible
In-home and hospice care	Covered in full after deductible
Rehabilitation services and devices	
Physical and occupational therapy	Covered in full after deductible Combined maximum 50 visits per member per contract year
Chiropractic care	Covered in full after deductible Maximum 24 visits per member per contract year
Speech therapy	Covered in full after deductible; Combined maximum 50 visits per member per contract year
Prosthetic and orthotic support	Covered in full after deductible
Durable medical equipment (DME)	Covered in full after deductible
Family planning and maternity care	
Family planning	50% coinsurance after deductible
Routine prenatal and postpartum care	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services
Maternity delivery and nursery care	Covered in full after deductible
Tubal ligation	Covered in full for physicians services and outpatient facility Note: Hospital inpatient charges are subject to deductible and coinsurance when in connection with delivery or other covered inpatient surgery
Vasectomy	Covered in full when performed in physician's office or in connection with other surgery after deductible

continued	
Riders	
Durable medical equipment	100% coverage
Prosthetics and orthotics	100% coverage
Minimum Abortion Rider	Adds in "abortion coverage in the event of rape or incest" that was removed from the standard medical policy due to the Abortion Opt Out Act
Hearing	One hearing test plus one hearing aid every 36 contract months; in network only.
Rehabilitative medicine	20 additional visits
Chiropractic visits	24 additional visits

Additional benefits:

Cost estimator: Calculates specific costs for hundreds of procedures, based on where you're at with your deductible, coinsurance, etc. If a selected procedure is above fair market price, the tool will provide a list of nearby facilities where it's offered at a lower cost.

Travel assistance: If you become ill or injured while traveling more than 100 miles from home, AssistAmerica® coverage is included in your plan. Receive help with medical care, coordinating prescriptions, assistance with lost luggage, and even arrange your travel back home.

Member perks: Earn up to 20% cash back when you purchase digital gift cards from hundreds of local and national retailers - from Amazon to Zappos. Redeem online or at checkout at the store.

Benefits summary:
HMO PriorityHSA

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Member cost-sharing	
Deductible *The amount you pay before we begin to pay.*	$3,000 individual/$6,000 family Deductible costs don't apply towards your coinsurance maximum. Out-of-network services not covered.
Coinsurance *Your share of the costs of a covered health care service.*	No cost for services after deductible is met, except where noted. Out-of-network services not covered.
Coinsurance maximum *The most coinsurance cost share you'll pay for covered services in a contract year. Your coinsurance cost share counts toward your out-of-pocket limit.*	Not applicable
Out-of-pocket limit *The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.*	$5,000 individual/$10,000 family
Office visits	
Primary care provider (PCP)	Covered in full after deductible
Specialists	Covered in full after deductible
Urgent care	Covered in full after deductible
Virtual visits *24/7 care for non-emergency conditions*	Covered in full after deductible
Allergy testing, serum and injections	Covered in full after deductible
Retail health clinic *Located in a retail center, like a supermarket or pharmacy and provides care for common illnesses and services (examples: ear aches, sore throats, flu shots)*	Covered in full after deductible
Mental and behavioral health	
Inpatient hospital	Covered in full after deductible
Outpatient office visits	Covered in full after deductible

continued	
Prescription drug coverage *Visit priorityhealth.com and search Optimized or Traditional in the **Approved Drug** list to see coverage and pricing information.*	
Formulary	Traditional
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Mail Order	Generic: 2x Brand: 2x; after deductible
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Vasectomy	Covered in full when performed in physician's office or in connection with other surgery after deductible

continued	
Riders	
Embedded deductible HSA	Includes embedded deductible and embedded TrOOP. The deductible/TrOOP paid by all members will be combined to satisfy the family deductible/TrOOP. One member cannot contribute more than the individual deductible/TrOOP. Deductible $3,000 per member, $6,000 per contract per calendar year TrOOP $5,000 per member, $10,000 per contract per calendar year
Durable medical equipment	100% coverage
Prosthetics and orthotics	100% coverage
Minimum Abortion Rider	Adds in "abortion coverage in the event of rape or incest" that was removed from the standard medical policy due to the Abortion Opt Out Act
Hearing	One hearing test plus one hearing aid every 36 contract months; in network only.
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Travel assistance: If you become ill or injured while traveling more than 100 miles from home, AssistAmerica® coverage is included in your plan. Receive help with medical care, coordinating prescriptions, assistance with lost luggage, and even arrange your travel back home.

Member perks: Earn up to 20% cash back when you purchase digital gift cards from hundreds of local and national retailers - from Amazon to Zappos. Redeem online or at checkout at the store.

Michigan Manufacturers Association

Dental Benefit Summary for **Child Development Services of Ottawa County**

Preferred *PLUS* 2.0 Plan GCert2000

Coverage Type **Dental Expense Period: Jan 1 – Dec 31**	**In Network -** % of PDP Fee	**Out of Network –** % of R&C Fee (90th)
Type A – **Preventive**	**100%**	**100%**
Type B – **Basic Restorative**	**80%**	**80%**
Type C – **Major Restorative**	**50%**	**50%**
Orthodontia	**50%**	**50%**
Deductible – B & C services only	**$50 / 3x per Family**	
Annual Maximum - per Individual	**$1,750**	
Orthodontia Maximum - Lifetime	**$1,000**	
Type A – Preventive	**How Many / How Often**	
Prophylaxis – Cleanings	Once every 6 months	
Oral Examinations (including problem-focused exams)	Once every 6 months	
Topical Fluoride Applications	Once in 12 months for children under age 14	
Space Maintainers	For children under age 14	
Sealants	1 per 60 months on permanent 1st and 2nd molars up to age 14	
Bitewing X-rays (Adult / Child)	1 set every 12 months	
Full Mouth X-rays	1 set every 60 months	
Other X-rays		
Type B – Basic Restorative	**How Many / How Often** **We recommend a pre-treatment estimate for any service over $300.**	
Fillings – Amalgam & Composite	1 per tooth in 24 months	
Extractions		
Oral Surgery		
Endodontic – Root Canal	1 in 24 months for the same tooth	
Periodontal Maintenance	4 in 1 calendar year, includes preventive cleanings	
Periodontics	Once per quadrant in 24 months	
Periodontal Surgery	Once per quadrant in 36 months	
Emergency Palliative		
Type C – Major Restorative	**How Many / How Often** **We recommend a pre-treatment estimate for any service over $300.**	
General Anesthesia		
Crowns / Dentures */ Bridges *	10 year replacement	
Implants *	10 year replacement	
Occlusal Guards /Bruxism Appliances		
	** In order to be covered, dental coverage must be in effect with the same employer at the time natural teeth are lost.*	
Type D - Orthodontia		
Diagnostics & Treatment	Children under age 19	

For a List of **Participating Network Dentists (PDP PLUS Network) - www.metlife.com/dental**

MetLife Dental Claims : **P.O. Box 981282, El Paso, TX 79998-1282** **800-275-4638, Fax: 859-389-6505**

This summary is for informational purposes only.

(For complete benefit details including exclusions and limitations, please refer to the certificate of insurance. In the event of a conflict between this summary and your certificate of insurance, the certificate of insurance governs.) Rvsd: 1016

Child Development Services

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-866-804-0982**.
- For Lasik providers, call 1-877-5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Co-pay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay; $130 allowance; 20% off balance over $130	Up to $91
Standard Plastic Lenses		
Single Vision	$25 Co-pay	Up to $30
Bifocal	$25 Co-pay	Up to $50
Trifocal	$25 Co-pay	Up to $70
Standard Progressive Lens	$90 Co-pay	Up to $50
Premium Progressive Lens△	$110 Co-pay - $135 Co-pay	
Tier 1	$110 Co-pay	Up to $50
Tier 2	$120 Co-pay	Up to $50
Tier 3	$135 Co-pay	Up to $50
Tier 4	$90 Co-pay, 80% of charge less $120 allowance	Up to $50
Lenticular	$25 Co-pay	Up to $70
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Polycarbonate - Kids under 19	$0	Up to $32
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating△	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Contact Lenses		
Conventional	$0 Co-pay; $130 allowance; 15% off balance over $130	Up to $130
Disposable	$0 Co-pay; $130 allowance; plus balance over $130	Up to $130
Medically Necessary	$0 Co-pay, Paid-in-Full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

△Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.

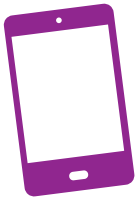
Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	**$10 Co-pay**	Up to $40
Frames (Once every 12 months)	**$0 Co-pay; $130 allowance; 20% off balance over $130**	Up to $91
Single Vision Lenses (Once every 12 months) Or **Contacts** (Once every 12 months)	**$25 Co-pay** / **$0 Co-pay; $130 allowance; plus balance over $130**	Up to $30 / Up to $130

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

77% SAVINGS with us*

With EyeMed	Without Insurance**
Exam $10 Co-pay	Exam $106
Frame $163 **-$130 allowance** **$33** **-$6.60 (20% discount off balance)** **$26.40**	Frame $163
Lens $25 Co-pay **$15 UV treatment add-on** **+$15 Scratch coating add-on** **$55**	Lens $78 $23 UV treatment add-on +$25 Scratch coating add-on $126
Total $91.40	Total $395



Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.

EyeMed | Independent Provider Network + LensCrafters | Pearle Vision | Optical | Sears Optical | JCPenney optical

*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.