



SAUGATUCK TOWNSHIP FIRE DISTRICT

Proudly serving : Douglas | Saugatuck | Saugatuck Township



3342 Blue Star Highway
Saugatuck, MI 49453
269 857-3000 / Fax: 269 857-1228
E-mail: info@saugatuckfire.org

FIRE DISTRICT “SPECIAL” BOARD MEETING

2:00pm – November 11th, 2024

AGENDA

1. Call to Order:
2. Pledge of Allegiance *(Stand if you are able):*
3. Roll Call:
4. Reminder: It is requested the board silences cell phones and put them away for the duration of the meeting.
5. Approval of Agenda *(additions / deletions):*
6. Public Comment on Agenda Items Only: *(The Fire Board requests that speakers respect the three-minute time limit for individual comments and the five-minute time limit for an individual speaking on behalf of a group. This is not a question-and-answer session, it is an opportunity to voice your thoughts with the Fire Board.)*
7. Unfinished Business:
 - A. **Letter of Agreement with Local 5291 Regarding Health Insurance *(Roll Call Vote)***
8. New Business:
 - A. **Collective Bargaining Agreement with Local 5291 – 1st Reading**
 1. **To be distributed at the meeting for a proposed vote on Monday 11/18/2024.**
9. Correspondence:
 - A. **None**
10. Public Comments: *(The Fire Board requests that speakers respect the three-minute time limit for individual comments and the five-minute time limit for an individual speaking on behalf of a group. This is not a question-and-answer session, it is an opportunity to voice your thoughts with the Fire Board.)*
11. Fire Board Comments:
12. Adjournment:

Posted 11/8/2024 –1:15pm

NOTICE

Request for accommodations or interpretive services must be made 48 hours prior to this meeting.
Please contact Saugatuck Township Fire District at 269-857-3000 for further information.

STFD Health-Care Costs under the Collective Bargaining Agreement

Under the collective-bargaining agreement (which affects 8 of our professional firefighters), the health insurance-related costs absorbed by the STFD fall into two component “buckets:” (1) STFD-paid health insurance coverage, and (2) STFD-paid contributions into the covered individuals’ Health Savings Accounts (HSA). Changes to these two benefit buckets for the agreement under discussion are presented and explained below.

(1) STFD-paid health-insurance-related costs

Since 2021, employee-paid health insurance deductibles have increased by 14%. At the same time, the insurance plan coverage (Priority Health) has dropped from 90% (after deductible) to 85% (and if that policy is renewed will drop to 80%).

Since 2021, the STFD-paid contributions to the union-employees’ HSA accounts have not been increased and stand at \$1,400/year for an individual and \$2,500 for families.

The STFD also currently reimburses up to \$2,500 annually per union employee for dental and vision expenses.

Union employees are proposing to change from the Priority Health plan to one offered by Blue Cross’ Blue Care Network. This plan will increase the deductible from \$1,600/\$3,200 (individual/family) to \$2,500/\$5,000, but the coverage after deductible is 100%.

Under this change, the STFD’s annual cost for this component would decrease by \$575 (from \$7,671 for the renewal cost increase of the Priority Health current plan to \$7,096 for the Blue Care Network plan).

(2) The STFD-paid health-savings account costs

Since 2021, the STFD’s payments into the HSA accounts have remained unchanged at \$1,400/\$2,500 (individual/family). The union is proposing increasing this to \$2,184/\$3,900. Under this proposal, STFD’s HSA-account total annual payments would be \$26,052 versus the current level of \$16,700, an increase of \$9,352, or 56%. In addition, any future increase in the deductible will be represented in an equivalent increase to the HSA.

To offset the HSA increase, the union is proposing to decrease Dental & Vision reimbursements from \$2,500 per covered employee to \$1,500, a net annual cost reduction to the STFD of \$8,000.

The net/net financial consequences to the STFD from the changes proposed and outlined here would be an annual increase of \$777 or 5%.

		Priority Health		Blue Care Network		
		Current Plan	Renewal Plan	Alternate Plan D	Alternate Plan E	Alternate Plan F
		HMO HSA Gold - 85% \$500/\$3,000 deductible	HMO HSA Gold - 80% \$1,600/\$3,200 deductible	BCN HSA Gold Option 1	BCN HSA Gold Option 2	BCN HSA Gold Option 3
HSA/HRA Required Employer Contribution		No Restrictions	No Restrictions	No Restrictions	No Restrictions	No Restrictions
In-Network Coverage						
	Deductible	\$1,500/\$3,000 (Aggregate)	\$1,600/\$3,200 (Aggregate)	\$1,600/\$3,200 (Aggregate)	\$2,500/\$5,000 (Aggregate)	\$3,200/\$6,400 (Embedded)
	Embedded Coinsurance Maximum	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	True Out-Of-Pocket Maximum (TROOP includes deductible, coinsurance, copays and Rx)	\$4,000/\$8,000 (Embedded)	\$4,000/\$8,000 (Embedded)	\$4,500/\$9,000 (Aggregate)	\$4,500/\$9,000 (Aggregate)	\$3,200/\$6,400 (Embedded)
	PCP Office Visit	85% after deductible	80% after deductible	80% after deductible	100% after deductible	100% after deductible
	Specialist Office Visit	85% after deductible	80% after deductible	80% after deductible	100% after deductible	100% after deductible
	Virtual Visits	\$10 copay after deductible	\$10 copay after deductible	80% after deductible	100% after deductible	100% after deductible
	Preventive Health Care Services	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
	Urgent Care Center	85% after deductible	80% after deductible	80% after deductible	100% after deductible	100% after deductible
	Emergency Room	85% after deductible	80% after deductible	80% after deductible	100% after deductible	100% after deductible
	Ambulance	85% after deductible	80% after deductible	80% after deductible	100% after deductible	100% after deductible
	Outpatient Services (i.e., diagnostic lab, x-ray, surgery, etc.)	85% after deductible	80% after deductible	80% after deductible	100% after deductible	100% after deductible
	Advanced Diagnostic Imaging	85% after deductible	80% after deductible	80% after deductible	100% after deductible	100% after deductible
	Inpatient & Outpatient Hospital	85% after deductible	80% after deductible	80% after deductible	100% after deductible	100% after deductible
	Prescription Drug Copay	AFTER DEDUCTIBLE:	AFTER DEDUCTIBLE:	AFTER DEDUCTIBLE:	AFTER DEDUCTIBLE:	AFTER DEDUCTIBLE:
	Tier 1	\$5/\$30	\$5/\$35	1A - \$10 / 1B - \$30	1A - \$15 / 1B - \$40	100%
	Tier 2	\$65	\$65	\$60	\$80	100%
	Tier 3	\$85	\$85	\$80	\$100	100%
	Tier 4	20% (Max \$250)	20% (Max \$250)	20% (Max \$200)	20% (Max \$200)	100%
	Tier 5	20% (Max \$450)	20% (Max \$450)	20% (Max \$300)	20% (Max \$300)	100%
	(A) Pediatric Dental & (B) Pediatric Vision	(A) Not Included / (B) Included	(A) Not Included / (B) Included	(A) Included / (B) Included	(A) Included / (B) Included	(A) Included / (B) Included
	Out-of-Network Coverage	Not available unless referred by your Primary Care Provider and authorized by the carrier.	Not available unless referred by your Primary Care Provider and authorized by the carrier.	Not available unless referred by your Primary Care Provider and authorized by the carrier.	Not available unless referred by your Primary Care Provider and authorized by the carrier.	Not available unless referred by your Primary Care Provider and authorized by the carrier.
		Current Plan	Renewal Plan	Alternate Plan D	Alternate Plan E	Alternate Plan F
		MEMBER LEVEL RATES			MEMBER LEVEL RATES	
Single	4					
Double	0					
Family	4					
Avg Monthly Cost PMPM	8	\$853.35	\$933.27	\$916.21	\$927.27	\$898.62
Avg Monthly Cost PMPM	19	\$359.31	\$392.95	\$385.77	\$390.43	\$378.37
ESTIMATED MONTHLY PREMIUM		\$6,826.81	\$7,466.13	\$7,329.71	\$7,418.17	\$7,188.98
ESTIMATED ANNUAL PREMIUM		\$81,921.72	\$89,593.56	\$87,956.52	\$89,018.04	\$86,267.76
DIFFERENCE (EST. ANNUAL) % DIFFERENCE			\$7,671.84	\$6,034.80	\$7,096.32	\$4,346.04
			9.4%	7.4%	8.7%	5.3%

*NOTES: Includes Estimated taxes and fees. Blue Care Network rates include pediatric dental. Page 3 of 13

LETTER OF AGREEMENT

The Letter of Agreement (“LOA”) is made and entered into this __ day of _____, 2024, by and between the Saugatuck Township Fire District, County of Allegan, State of Michigan, a public entity (hereinafter, the “District”), and the Saugatuck Area Professional Fire Fighters Union, Local 5291, (hereinafter, the “Union”), who shall be collectively known as “the Parties.”

WHEREAS, the Parties wish to amend Article 19 (Insurance) and Appendix E: Benefits Summary, of the Parties’ Collective Bargaining Agreement (“CBA”) in effect from September 20, 2021, through June 30, 2024;

WHEREAS, the Parties are currently in contract negotiations and recognize the eminent deadline to complete changes to the health insurance program during the open enrollment period no later than November 15th, 2024. The parties recognize the balance of the CBA will be finalized and adopted at a future date.

NOW THEREFORE, the Parties agree to the following:

1. The previous version of Section 19.1 of the CBA shall be deleted in full, and shall be replaced by an amended version of Section 19.1 of the CBA, which is deemed incorporated into the CBA, and reads as follows:

Section 19.1. Health Insurance. The Employer will provide, under the same conditions currently in place, a group health insurance plan (“plan”) covering certain hospitalization, surgical, and medical expenses for participating employees and their eligible dependents. Participation in this plan shall be on a voluntary basis for all full-time employees who elect to participate. The current Blue Cross Blue Shield BCN HSA Gold Option 2 plan provides the coverage options outlined in Appendix E. The specific coverage provisions, terms, and conditions are identified in the plan policy issued by the carrier. The employer will make the following annual contributions into the employee’s HSA account: \$2,184.00 for single coverage and \$3,900.00 for double or family coverage. The HSA contribution will increase matching the equivalent percentage of the deductible increase on an as the health plan changes. The District shall consult with the Union prior to making changes to the health insurance plan.

2. The previous version of Appendix E: Benefits Summary of the CBA shall be deleted in full, and shall be replaced by an amended version of Appendix E: Benefits Summary of the CBA, which is deemed incorporated into the CBA, and reads as follows:

Appendix E: Benefits Summary



Benefits-at-a-Glance 2024 BCN HSA Gold Option 2 Saugatuck Township Fire District Effective Date: 12/01/2024

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. Services must be provided or arranged by the member's primary care physician or health plan.

Preauthorization for Select Services - Services listed in this summary are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at <https://bcbsm.com/priorauth>.

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

Benefits	
Deductible Note: The Deductible will apply to all services except preventive services	\$2,500 per member/\$5,000 per family per calendar year (no 4th quarter carry-over)
The deductible is combined for both medical and prescription drug coverage.	The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract None
Coinsurance Note: Coinsurance applies once the deductible has been met	50% for select services as noted below
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$4,500 per member/\$9,000 per family per calendar year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening - laboratory services only - laboratory services only	100%
Routine Colonoscopy	100%
Mammography Screening	100%

Appendix E: Benefits Summary (Continued)

Preventive services (continued)	
Benefits	
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services	
Benefits	
PCP Office Visits Note: Applicable cost sharing applies when other services are received in the office	100% after deductible
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor Note: Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	100% after deductible
Referral Physician Visits - when referred	100% after deductible

Emergency medical care	
Benefits	
Hospital Emergency Room	100% after deductible
Urgent Care Center	100% after deductible
Retail Health Clinic	100% after deductible
Ambulance Services - medically necessary	100% after deductible

Diagnostic services	
Benefits	
Laboratory and Pathology Tests	100% after deductible
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% after deductible

Maternity services provided by a physician	
Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care	100% after deductible

Hospital care	
Benefits	
General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery - see member certificate for specific surgical coinsurance	100% after deductible

Appendix E: Benefits Summary (Continued)

Alternatives to hospital care	
Benefits	
Skilled Nursing Care	100% after deductible Up to 45 days per calendar year
Hospice Care	100% after deductible
Home Health Care	100% after deductible

Surgical services	
Benefits	
Surgery - includes all related surgical services and anesthesia.	100% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	50% after deductible
Elective Abortion (One procedure per two-year period of membership)	Not Covered
Human Organ Transplants (subject to medical criteria)	100% after deductible
Reduction Mammoplasty (subject to medical criteria)	50% after deductible
Male Mastectomy (subject to medical criteria)	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	50% after deductible

Behavioral health services (mental health and substance use disorder treatment)	
Benefits	
Inpatient Mental Health Care	100% after deductible
Residential Substance Use Disorder	100% after deductible
Outpatient Mental Health Care includes online and telemedicine visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	100% after deductible
Outpatient Substance Use Disorder	100% after deductible

Autism spectrum disorders, diagnoses and treatment	
Benefits	
Applied behavioral analysis (ABA) treatment Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC)	100% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	100% after deductible
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health, medical office visit and preventive benefit.

Appendix E: Benefits Summary (Continued)

Other services	
Benefits	
Allergy Testing and Therapy	100% after deductible
Allergy Injections	100% after deductible
Chiropractic Spinal Manipulation - when referred	100% after deductible Limited to 30 visits per calendar year
Rehabilitative Services -subject to meaningful improvement within 90 days	100% after deductible Rehabilitative outpatient physical and occupational therapy - limited to a combined benefit maximum of 30 visits per calendar year. Rehabilitative outpatient speech therapy - limited to 30 visits per calendar year.
Habilitative Services	100% after deductible Habilitative outpatient physical and occupational therapy - limited to a combined benefit maximum of 30 visits per calendar year Habilitative outpatient speech therapy - limited to 30 visits per calendar year
Outpatient Cardiac and Pulmonary Rehabilitation	100% after deductible Cardiac and pulmonary rehab limited to 30 visits combined per calendar year
Infertility Counseling and Treatment	50% after deductible (excludes in-vitro fertilization)
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies	100% after deductible
Note: Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	
Pediatric Vision - Eye exam and prescription glasses (chosen from a select collection) limited to once per calendar year through the last day of the year in which an individual turns 19.	100%
Hearing Aid	Not Covered
Prescription drugs	
Benefits	
Preferred Generic Tier	\$15 copay after deductible
Nonpreferred Generic Tier	\$40 copay after deductible
Preferred Brand Tier	\$80 copay after deductible
Nonpreferred Brand Tier	\$100 copay after deductible
Preferred Specialty Tier	20% coinsurance (max \$200) after deductible
Nonpreferred Specialty Tier	20% coinsurance (max \$300) after deductible
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic- Copayment/Coinsurance above applies after deductible, Preferred Brand -Copayment/Coinsurance above applies after deductible, Non-Preferred Brand - Copayment/Coinsurance above applies after deductible
Drugs for the Treatment of Sexual Dysfunction, Weight Loss, Cough & Cold	Not covered

Appendix E: Benefits Summary (Continued)

Prescription drugs (continued)	
Benefits	
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay/coinsurance, 31-90 day supply - 3x's the 30 day copay/coinsurance minus \$10 after deductible
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
Custom Select Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Select Drug List require prior authorization and/or step therapy by BCN before they are covered. The Custom Select Drug List may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only
Benefits Selected - HDHPSM : 2500HD,450MHD,90D3X,P1548D,PVSN,RXVAR

Appendix E: Benefits Summary (Continued)



**Saugatuck Township Fire District
AOA-0000253595
Dental Coverage (Pediatric)
Effective Date: On or after December 2024
Benefits-at-a-glance**

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

Note: Pediatric members are members who are 18 years of age or younger on the group's renewal date. They will receive pediatric dental benefits up to the group's renewal date after they turn age 19.

Dentist information

With Blue Dental PPO, you can choose any licensed dentist anywhere. However, you'll get the best coverage and save the most money when you choose a Tier 1 PPO (in-network) dentist.

You have outstanding access to thousands of Tier 1 PPO dentists across the country through the Blue Dental PPO network. Tier 1 PPO dentists agree to accept our PPO approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 1 PPO dentist near you, log into your member account at bcbsm.com or call **1-888-826-8152**.

If you go to a non-PPO dentist, you can still save money by choosing a Tier 2 participating non-PPO (out-of-network) dentist. Tier 2 dentists participate with us on a "per claim" basis through our Blue Par Select (BPS) arrangement. They accept our BPS approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 2 participating non-PPO dentist near you, log into your member account at bcbsm.com. You should ask your dentist if they participate with BCBSM before every treatment.

Note: If you go to a nonparticipating dentist, you are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, coinsurance and dollar maximums)	
Benefits	Coverage
Deductibles	\$25 per member, \$50 for two members, \$75 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services)	20%
• Class I services	
• Class II services	50%
• Class III services	50%
• Class IV services	Not covered
Dollar maximums	None
• Annual maximum for Class I, II and III services	
• Lifetime maximum for Class IV services	Not applicable

BD-PEDS;BDPED OPM\$400;BDPPO60/50/50

Appendix E: Benefits Summary (Continued)

Benefits	Coverage
Out-of-pocket maximum <ul style="list-style-type: none"> The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum does not apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, or non-covered services. 	\$400 for one pediatric member or \$800 for two or more pediatric members per calendar year. Note: This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).
Plan's responsibility The plan's responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.	

Class I services	
Benefits	Coverage
Most diagnostic and preventive services: <ul style="list-style-type: none"> Routine oral examinations/evaluations - twice per calendar year Prophylaxes (cleanings) - three times per calendar year Fluoride treatments or topical fluoride varnishes- twice every calendar year for members to the end of the month of their 19th birthday Sealants - once per fully erupted first and second permanent molar every 36 months for members to the end of the month of their 16th birthday 	80% of approved amount
Bitewing X-rays-one set (up to four films) per calendar year	80% of approved amount
Oral brush biopsy sample collection -twice per calendar year	80% of approved amount

Class II services	
Benefits	Coverage
Other diagnostic and preventive services: <ul style="list-style-type: none"> Diagnostic tests and laboratory examinations Space maintainers - for missing posterior primary teeth for members to the end of the month of their 15th birthday 	50% of approved amount after deductible
Panoramic or full-mouth X-rays -once per 60 months	50% of approved amount after deductible
Emergency palliative treatment	50% of approved amount after deductible
Minor restorative services: <ul style="list-style-type: none"> Amalgam and resin-based composite fillings and fillings of similar materials - once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth Recementation or repair of posts, crowns, veneers, inlays and onlays - three times per tooth per calendar year 	50% of approved amount after deductible
Simple and surgical extractions of non-impacted teeth	50% of approved amount after deductible
Non-surgical endodontic services: <ul style="list-style-type: none"> Root canal treatments - once per tooth per lifetime (retreatment of a root canal is payable once per tooth per lifetime) Therapeutic pulpotomies or pulpal debridement Vital pulpotomies on primary teeth Apexification 	50% of approved amount after deductible
Non-surgical periodontic services: <ul style="list-style-type: none"> Periodontal maintenance - three times per calendar year in place of routine dental prophylaxis Periodontal scaling and root planing - once per quadrant per 24 months 	50% of approved amount after deductible
Adjustments, repairs, relines, rebases and tissue conditioning for removable prosthetic appliances: <ul style="list-style-type: none"> Relines or rebases of partial dentures or complete dentures - once per 36 month per arch Tissue conditioning - once per 36 months per arch 	50% of approved amount after deductible

BD-PEDS;BDPED OPMS400;BDPPO00/50/50

Appendix E: Benefits Summary (Continued)

Benefits	Coverage
Adjunctive general services:	50% of approved amount after deductible
• General anesthesia or IV sedation	
• Office visits after regularly scheduled hours	50% of approved amount after deductible

Class III services

Benefits	Coverage
Major restorative services:	50% of approved amount after deductible
• Onlays, crowns and veneers - once per permanent tooth per 60 months	
• Substructures, including cores and posts	50% of approved amount after deductible
Oral surgery services:	50% of approved amount after deductible
• Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after deductible
• Incision and drainage of cellulitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after deductible
• Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after deductible
• Excision of hyperplastic tissue per arch	50% of approved amount after deductible
• Soft tissue biopsies	50% of approved amount after deductible
• Frenulectomies	50% of approved amount after deductible
Surgical endodontic services:	50% of approved amount after deductible
• Apical surgery on permanent teeth	50% of approved amount after deductible
• Hemisections - once per tooth per lifetime	50% of approved amount after deductible
Surgical periodontic services:	50% of approved amount after deductible
• Gingivectomy and gingivoplasty	50% of approved amount after deductible
• Clinical crown lengthening - hard tissue	50% of approved amount after deductible
• Gingival flap procedures	50% of approved amount after deductible
• Soft tissue grafts	50% of approved amount after deductible
Prosthodontic services:	50% of approved amount after deductible
• Complete dentures - once per 84 months	
• Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics - once per 84 months for members age 16 and older only	50% of approved amount after deductible
• Recementation and repairs of bridges	50% of approved amount after deductible
• Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after deductible

Class IV services

Benefits	Coverage
Orthodontics and related services	Not covered

BD-PEDS;BDPED OPM\$400;BDPPO80/50/50

3. This LOA shall only become effective upon ratification by the Fire Board for the District. The Parties agree that this LOA shall supersede and amend the current CBA. All other Articles and Sections of the CBA not otherwise amended by this LOA remain in effect and are hereby affirmed by the Parties. This LOA shall remain in full force and effect through the current term of the Parties' CBA, and shall be deemed incorporated therein.

SAUGATUCK TOWNSHIP FIRE
DISTRICT

SAUGATUCK AREA PROFESSIONAL
FIRE FIGHTERS UNION, LOCAL 5291,

Gregory Janik, Fire Chief

Michael Betts, President

Jane Verplank, Fire Board Chairperson

Christopher Mantels, Secretary/Treasurer