

APPROVED

**COPPER COUNTRY I.S.D.- 31000-51
CORRECTION TO NEW- December 1, 1994
SELF-FUNDED DENTAL SERVICE CONTRACT**

An Agreement between SET, Inc. (hereinafter referred to as SET), and the COPPER COUNTRY I.S.D.(hereinafter referred to as the District.)

1. **Notification to Collective Bargaining Agents** (As Required by Law)

The District agrees to notify in writing all affected collective bargaining agents and all affected employees not less than 30 days prior to signing of this agreement of the following information:

- a. Benefits provided;
- b. Changes, if any, in benefits;
- c. Plan is not insured (or partially insured as the case may be)
- d. SET is providing claims administration only. There will be no guarantee of payment of any covered claims without receipt of District funds to adequately cover outstanding claims.
- e. SET will process claims for benefits in a reasonable period of time. Delays in processing do not afford eligible individuals greater rights or interests or other remedies against SET, Inc. than otherwise afforded by law.

THE ABOVE INFORMATION SHALL BE PROMINENTLY DISPLAYED AND SHALL BE COMMUNICATED TO ELIGIBLE INDIVIDUALS WITHIN 60 DAYS AFTER THEY BECOME ELIGIBLE FOR BENEFITS. THE ABOVE INFORMATION SHALL BE UPDATED AND COMMUNICATED NO LESS THAN ONCE EVERY FIVE (5) YEARS.

2. **Benefit and Plan Maximum Year Defined**

The above year shall be January 1 to December 31.

3. **Agreement Year**

This Year: December 1 through December 31.

Thereafter: January 1 through December 31.

4. **Claims Fund**

- a. The District shall deposit an initial claim fund. **This fund shall be in the amount of: ALREADY ESTABLISHED** (The claims fund shall be reviewed periodically, and adjusted as needed.)
- b. Subsequent months will be amount actually paid in claims the prior month.
- c. District will be billed by the 5th of each month.
- d. District will remit payment by the 20th of each month.

5. **Claims Reports** - to include (by participant & dependent number)

- a. Incurred Date
- b. Paid Date
- c. Total Charges
- d. Eligible Charges
- e. Total Amount paid
- f. Service Type
- g. Indication of C.O.B.

6. **Benefit Schedule**

7. **State & Federal Reports** (SET to produce 1099's and other necessary reports)

8. **Charges**

- a. SET will bill district **No Change From Current Amount** /per employee per month for claims administration services and for providing 1099's.
- b. SET reserves the right to renegotiate above rate at the end of each contract year.

9. **Miscellaneous Charges**

NONE

Attachments (benefit schedules & eligible participants)

Paul A Oillila _____ **PAUL G. OILLILA** _____ 2/23/01
 Authorized Signature and Title SUPERINTENDENT Date

COPPER COUNTRY I.S.D.
 Name of Employer

Mailing Address 602 Hecla Street _____ HANCOCK _____ MICHIGAN _____ 49930

Number of Eligible Employees _____
 Number of Eligible Employees to Participate _____

Name of Person Who Will Handle
 Administrative Procedures KENNETH A. MAKI, _____ BUSINESS MANAGER

Phone Number (906) 482-4250

FOR SET USE: Coburn R. P. Jensen _____ 5-17-01
 Group Benefits Administration Date

ELIGIBILITY

Eligible Classes: All persons of the Employer in the following benefit classes shall be eligible for these benefits:

ALL
**ADMINISTRATORS, ADMINISTRATIVE SECRETARIES, MESPA MEMBERS AND
INSTRUCTIONAL EMPLOYEES**

Employee's Date of Eligibility: Each employee within the eligible classes, who works the number of hours in the normal work week established by the Employer for the purposes of participating in these benefits, shall be eligible for these benefits on the day such work requirements are satisfied. **EFFECTIVE: Date of hire; no probationary period.**

GENERAL DEFINITIONS

The Employer: When the term "The Employer" is used, it means collectively all employers included under the Plan Document.

Active Work Requirement: A requirement that an Employee be actively at work on full-time at the business establishment of the Employer or at other locations to which the Employer's business requires the Employee to travel.

Eligible Individual Within This Benefit Plan: An Employee who is eligible for benefits; a qualified dependent with respect to whom an Employee is eligible for dependent benefits.

Qualified Dependent:

- (1) An Employee's spouse while not divorced or legally separated from the Employee;
- (2) Each of the Employee's unmarried children who is a dependent within the meaning of the Internal Revenue code of the United States until the January 1st next following such child's twenty-fifth birthday; provided, however, that a divorced or otherwise legally separated spouse shall be considered a qualified dependent as long as the Employee is compelled by an order, ruling or other form of decision of a court of competent jurisdiction to provide dental expense benefits for such spouse. An Employee's children shall include stepchildren, legally adopted children, and any other children residing with and being supported by the Employee pursuant to an order, ruling or other form of decision of a court of competent jurisdiction.

If a dependent child is or becomes incapacitated due to physical handicap or mental retardation while eligible for benefits. Such child's incapacity must be submitted to SET within 30 days following the end of the year in which the child would otherwise cease to qualify as a dependent child. Proof must be submitted to SET once each year thereafter of the continuation of said incapacity, to continue with the eligible dependent benefits.

BENEFIT SCHEDULE
(The pages, which follow, refer to this Schedule)

EMPLOYER: COPPER COUNTRY I.S.D.- NEW December 1, 1994- 31000
DEN1B-105553 DEN2B-2050701 COMP-3100000

Dental Expense Benefit - Employee and Dependents Benefit (Assignable)

Benefit Year - A Calendar Year (January 1 through December 31)

List of Dental Services - See List of Dental Services

DENTAL EXPENSE BENEFITS

Basic Benefits:

Percentage	80%
Lifetime Deductible Amount	\$0
Incentive Plan Increments*	10% each succeeding benefit year, not to exceed a Basic Benefits of 100% (OPTION M ONLY)

Additional Benefits (Major Services):

Percentage	80%
Annual Deductible Amount	\$0
(Maximum Two Per Family)	

Maximum Annual Dental Benefit Each Eligible Individual (**Basic & Major Services**). **\$1,000.00**

ORTHODONTIC EXPENSE BENEFIT

Percentage	80%
Deductible Amount.	\$0
Lifetime Maximum Benefit	\$1,500.00

SPECIAL PROVISIONS (as described in the Benefit Schedule Supplement)

(a) Missing Tooth Waiver	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included
(b) Five Year Denture Waiver	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included
List of Dental Services		
(c) Basic Services Modification	<input type="checkbox"/> Included	<input checked="" type="checkbox"/> Not Included
(d) Major Services Modification	<input type="checkbox"/> Included	<input checked="" type="checkbox"/> Not Included
(e) Basic Benefits Percentage Modification	<input type="checkbox"/> Included	<input checked="" type="checkbox"/> Not Included
Orthodontic Services:		
(f) Pre-Existing Exclusion Waiver	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included
(g) Age Restriction Waiver	<input type="checkbox"/> Included	<input checked="" type="checkbox"/> Not Included
(h) Extension of Benefits Waiver	<input type="checkbox"/> Included	<input checked="" type="checkbox"/> Not Included
(I) External Coordination of Benefits Only	<input type="checkbox"/> Included	<input checked="" type="checkbox"/> Not Included
(m) Incentive Plan Modification M	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included
(n) Incentive Plan Modification N	<input type="checkbox"/> Included	<input checked="" type="checkbox"/> Not Included

**COPPER COUNTRY I.S.D.
CORRECTION TO NEW DECEMBER 1, 1994
31000-51 DEN1B-1055553
DEN2B-2050701COMP-3100000**

Benefit Schedule (cont'd)

Alternate Procedures of Treatment: If alternate procedures, services or courses of treatment may be performed to properly correct a dental condition, the maximum eligible dental charge which will be considered shall be for the least expensive procedure, as determined by the standards established within the Dental industry, producing a satisfactory professional result

***Basic Benefits Incentive Plan Increment Provision:** The Basic Benefits Percentage applicable to an Eligible Individual under this Plan Document for a benefit year will be increased as indicated, provided the Eligible Individual visited a Dentist for periodic examination and diagnosis at least once during the preceding Benefit Year, and all Basic Services, indicated in the list of Dental Services as a result of the first of such visits, were completed during that Benefit Year. Otherwise, the original Basic Benefits Percentage will again apply for the current Benefit Year, and future incentive plan increments will be determined as described on the Benefit Schedule.

****Additional Benefits Annual Deductible Amount Provision:** For the purposes of calculating benefits for charges incurred in connection with any one Treatment Plan, charges used toward the satisfaction of the Additional Benefits Annual Deductible for a Benefit Year will include any charges in connection with the Treatment Plan which were used toward the satisfaction of the Additional Benefit for a previous Benefit Year. If any Benefit has become payable under this Benefit Plan in connection with a charge, that charge shall in no event be considered in the satisfaction of the Additional Benefit Annual Deductible for any Benefit Year.