

AGREEMENT

between

COUNTY OF MACOMB

and

TECHNICAL, PROFESSIONAL OFFICEWORKERS ASSOCIATION OF MICHIGAN

representing the

INFORMATION TECHNOLOGY EMPLOYEES ASSOCIATION

January 1, 2023
through
December 31, 2025

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AGREEMENT

This Agreement entered into on the first day of January, 2023, between the County of Macomb, hereinafter collectively referred to as the Employer, and the Technical, Professional Officeworkers Association of Michigan (TPOAM), hereinafter referred to as the Union, on behalf of employees set forth in Article 1, Recognition.

PURPOSE AND INTENT

The general purpose of this Agreement is to set forth terms and conditions of employment, and to promote orderly and peaceful labor relations for the mutual interests of the Employer, its employees and the Union.

The Parties recognize that the best interests of the community and the job security of the employees depend upon the Employer's success in establishing a proper service to the community.

To these ends, the Employer and the Union encourage to the fullest degree friendly and cooperative relations between the respective representatives at all levels and among all employees.

NON-DISCRIMINATION

The provisions of the Agreement shall apply equally to all employees regardless of religion, race, color, national origin, age, height, weight, familial status, marital status, sex, sexual orientation, gender identity, union affiliation or political affiliation.

ARTICLE 1

RECOGNITION

Pursuant to and in accordance with all applicable provisions of Act 379 of the Public Acts of 1965, as amended, the Employer does hereby recognize the Union as the sole and exclusive representative for the purpose of collective bargaining with respect to wages, hours and other terms and conditions of employment for the term of this Agreement for all classifications (full-time or part-time) of TPOAM-IT, provided it is agreed and understood that the County of Macomb does not, by entering into this Agreement, purport to assume control or exercise jurisdiction in those areas where statutory and constitutional powers have been exclusively vested in County or State elected and/or appointed officials.

ARTICLE 2

REPRESENTATION

- A. The Union shall notify the Employer in writing of the name(s) of the Officer and Steward for their bargaining unit. In the event there is a change in the Officer or Steward, the Union shall inform the Employer forty-eight (48) hours prior to such Union Officer or Steward taking over their duties.
- B. The Employer agrees to recognize one (1) Officer and one (1) Steward for the bargaining unit.
- C. The bargaining unit will be permitted a maximum of five (5) hours per calendar week during their working hours, without loss of time or pay, for the purpose of investigating and presenting grievances to the Employer. A greater period of time may be permitted by prior authorization from their immediate Supervisor or the Department.
- D. Bargaining Committee:
 - 1. The Bargaining Committee shall be comprised of three (3) local union members and a TPOAM representative.

2. The Bargaining Committee shall be released from regular duty and compensated for all time spent negotiating during the member's regular work schedule.

ARTICLE 3

STRIKES AND LOCKOUTS PROHIBITED

The Parties hereto recognize that it is essential for the health, safety and public welfare of the County that services to the public be without interruption and that the right to strike is forbidden by the Statutes of the State of Michigan. Any employee guilty of engaging in a slowdown, work stoppage, or strike, shall be subject to disciplinary action up to and including discharge.

The Employer agrees that it shall not lock out its employees.

ARTICLE 4

WAGE RATES FOR NEW CLASSIFICATIONS

When a new classification is established by the Macomb County Office of the County Executive that is to be placed in the bargaining unit, the Employer shall place the new classification in the Wage Schedule that is found in Appendix B of this Agreement. If the Union does not agree with the Wage Schedule that was assigned by the Employer, the Union may submit the assignment of the Wage Schedule to the Grievance Procedure at the Third Step.

ARTICLE 5

GRIEVANCE PROCEDURE

The Parties intend that the grievance procedure as set forth herein shall serve as a means for a peaceful settlement of all disputes, including but not limited to dismissals, suspensions, demotions and other disciplinary actions of any type that may arise between them concerning the interpretation or operation of this Agreement without any interruption or disturbance of the normal operation of the Employer's affairs. Any employee having a grievance in connection with their employment MUST present it to the Employer within fifteen (15) days after the occurrence of the alleged event causing the grievance in the following manner:

Step 1:

The employee must first discuss the specific grievance with their immediate Supervisor or designee. A Steward or Union President shall be present at this meeting; otherwise, the complaint shall not be considered a formal grievance, as outlined in this Article. The immediate Supervisor shall attempt to adjust the matter consistent with the terms of this Agreement as soon as possible, and shall, within five (5) days give a verbal answer to the employee.

Step 2:

If the grievance is not settled at the verbal step, a written grievance may be filed by the Steward or Union President with the employee's Department Head within ten (10) days after the immediate Supervisor's response at Step 1. When a grievance is reduced to writing, it shall contain the name, position and department of the grievant, a clear and concise statement of the grievance, the relief sought, the date the incident or violation took place, the specific section(s) of the Agreement, if any, alleged to have been violated, the signature of the Steward or Union President and the date the grievance is reduced to writing. Inadvertent omission of minor information will not prejudice the processing of the grievance.

A meeting shall be held between the Parties within ten (10) days, unless mutually waived in writing. Within five (5) days after the completion of the meeting, or the waiver thereof, the Department Head shall give a written answer to the Steward or Union President.

Step 3:

If the grievance is not settled at Step 2, such grievance may be submitted by the Steward or Union President to the Director, Human Resources and Labor Relations or their designee, with a courtesy copy to the Department Head, within ten (10) days after the Department Head's written response has been received by the Union President or Steward. A grievance number shall be assigned when the grievance is submitted to the Human Resources and Labor Relations Department.

The Union President or designee must make a request in writing to conduct a Step 3 grievance meeting. A Grievance Committee, composed of the Union President, the Steward, the Director, Human Resources and Labor Relations or their designee and the Department Head or their designee shall conduct a Step 3 meeting within fifteen (15) days of the receipt of the Union President's written request. An officer of P.O.A.M. may be present at the Step 3 meeting. In addition, a witness(es) may be in attendance if deemed necessary by both Parties.

The decision of the Director, Human Resources and Labor Relations or designee shall be given in writing to the Union President within ten (10) days of the completion of the Step 3 meeting.

GRIEVANCE MEDIATION: If the grievance is not resolved at Step 3 of the grievance procedure, either party may pursue the matter to Mediation by filing a request with the Michigan Employment Relations Commission (MERC) and notifying the other party concurrently within five (5) days of the grievance meeting. If the mediation process is unsuccessful, either party shall have the right to move the matter to arbitration.

Step 4:

If the grievance is not resolved at Step 3, or through grievance mediation, the Union President or designee has thirty (30) days from the Step 3 answer or the date of the decision issued by the mediator in the event of grievance mediation, to file a Notice of Intent to Arbitrate, by sending a letter to the Director, Human Resources and Labor Relations. If the Union President or designee fail to request arbitration within this time limit, the grievance shall be deemed not eligible to go to arbitration.

- A. Selection of the Arbitrator: Within thirty (30) days of the receipt of the written Notice of Intent to Arbitrate, the County and the Association shall attempt to mutually select an Arbitrator. In the event that the parties cannot agree upon an arbitrator, the Union will have an additional ten (10) days to request the Michigan Employment Relations Commission (MERC) provide a list of impartial arbitrators in accordance with its applicable rules and regulations. Any grievance not scheduled in accordance with this procedure is considered settled and not subject to further review.

Upon written agreement of the Parties, an arbitrator may hear more than one case.

- B. All arbitration hearings shall be governed by the rules of the Michigan Employment Relations Commission (MERC) to the extent that those rules are not inconsistent with this Agreement.
- C. Any arbitrator selected shall have only the functions and authority set forth herein. The scope and extent of the jurisdiction of the arbitrator shall be limited to those grievances arising out of and pertaining to the respective rights of the Parties within the terms of this Agreement. The arbitrator shall be without power or authority to make any decision contrary to or inconsistent with in any way, the terms of this Agreement or of applicable laws or rules or regulations having the force and effect of law. The arbitrator shall be without power to modify or vary in any way the terms of this Agreement.
- D. The arbitrator shall have no power to establish or modify job classifications, to establish wage rates, or to change any existing wage rate, work schedule, or assignment, except for grievances arising out of Article 4, Wage Rates For New Classifications.
- E. In the event a grievance is submitted to an arbitrator and the arbitrator finds that they have no jurisdiction to rule on such grievance, it shall be referred back to the Parties without an answer or recommendation on the merits of the grievance.

- F. To the extent that the laws of the State of Michigan permit, it is agreed that any arbitrator's decision shall be final and binding on the Union and its members, the employee or employees involved, and the Employer, and that there shall be no appeal from any such decision unless such decision shall extend beyond the limits of the powers and jurisdiction herein conferred upon such arbitrator.
- G. In matters concerning discipline imposed, the arbitrator shall have the authority to sustain, overrule or mitigate the disciplinary action.
- H. The decision of the arbitrator shall be in writing and due within thirty (30) days of the close of the hearing. This time limit may be waived by mutual written consent of the Parties.
- I. The parties will bear their own expenses individually. The fees and expenses of the arbitrator shall be paid equally by the Parties. Neither party shall be responsible for the expense of witnesses called by the other.

GENERAL CONDITIONS:

- A. Withdrawal Of Grievances: A grievance may be withdrawn. A withdrawn grievance may be reinstated within twenty (20) days from the date of withdrawal. If a grievance is not reinstated within twenty (20) days of the date of withdrawal it cannot be reinstated.
- B. Computation Of Back Wages: All claims for back wages shall be limited to the amount of straight time wages less any unemployment compensation, and/or wages earned from any other sources during the period in question.
- C. Time Of Appeals: Any grievance not appealed within the time specified in the particular step of the Grievance Procedure, shall be considered settled and not subject to further review. In the event that the Employer shall fail to supply the Union with its answer to the particular step within the specified time limits, the Union may appeal the grievance to the next step with the time limit for exercising said appeal, commencing with the expiration date of the Employer's period for answer.
- D. Legal Rights: Nothing contained herein shall be deemed to abrogate or limit the rights guaranteed by existing statutes or court decisions.
- E. Time Limits: Time limits may be extended or shortened by mutual written consent of the Parties.
- F. Days Defined: All references to days as they pertain to the Grievance Procedure shall mean "working days". They do not include Saturdays, Sundays and designated holidays.
- G. Access to Records: Records, reports and other information pertaining to a grievance which are requested by the Union shall be made available for inspection and copying by the Union, provided the proper representative of the Union makes a request for the specific document referenced above and, if applicable, the affected employee has authorized, in writing, the release of said information.

ARTICLE 6

PROBATIONARY PERIOD

- A. Probationary Period For New Full-time Employees: All full-time employees newly hired into this bargaining unit shall be required to successfully complete a probationary period; the length of said probationary period shall be the first six (6) months of employment from the date of hire. During the probationary period of a new employee, s/he may be terminated at any time without the right of appeal or a statement of cause.
- B. Probationary Period For New Part-time Employees: All part-time employees newly hired into this bargaining unit shall be required to successfully complete a probationary period; the length of said probationary period shall be the first nine (9) months of employment from the date of hire. During the probationary period of a new employee, s/he may be terminated at any time without the right of appeal or a statement of cause.

- C. Probationary Period For Employees Who Have Had a Change in Classification: Employees in this bargaining unit who have had a change in classification (promotion, demotion, lateral transfer, bump or recall) shall serve a probationary period of four (4) months from the date of change in classification. Employees who have had a change in classification shall have the opportunity to return to their prior classification within one (1) month from the date of change in classification. During the probationary period of an employee who has had a change in classification, the employee may be returned to his/her former classification at any time without the right of appeal or statement of cause. Such decision shall be within the sole discretion of the Employer.

ARTICLE 7

EMPLOYEE DEFINED

- A. Regular Full-Time Employee: A "Regular Full-Time Employee" is an individual employed in a full-time budgeted position and regularly scheduled to work thirty (30) hours or more per week for six (6) consecutive months. Regular full-time employees are entitled to benefits as specifically outlined in this Labor Agreement.
- B. Regular Part-Time Employee: A "Regular Part-Time Employee" is an individual employed in a part-time budgeted position and regularly scheduled to work less than thirty (30) hours per week for six (6) consecutive months. Regular part-time employees shall not be entitled to any benefits pursuant to this Labor Agreement.

ARTICLE 8

WAGE AND INCREMENT SCHEDULE

- A. Bargaining Unit Wage and Increment Schedules are attached in Appendix B of this Agreement.
- B. INCREMENTS: After employment commences, an employee will be eligible to receive one (1) normal wage increment after each thirteen (13) biweekly pay periods of continuous employment until the employee reaches the maximum of his/her wage range. Such increments are found in Appendix B. All increments are to be approved or disapproved by the respective Department Head. If the increment has been disapproved, the employee and the Director, Human Resources and Labor Relations shall be notified in writing by the Department Head of the reason(s) for such disapproval.

ARTICLE 9

TEMPORARY ASSIGNMENT

Temporary assignments are made at the discretion of the Employer in order to ensure orderly performance and continuity of services. A regular employee temporarily assigned to a higher job classification for a period in excess of five (5) consecutive working days will receive the minimum rate of the higher classification or one increment added to their current salary, whichever is greater. The employee temporarily assigned must have the current ability to do the available work and meet the minimum qualifications of the higher classification.

The employee temporarily assigned shall be eligible for increments until the maximum salary for the temporary assignment is reached. Payment for such temporary assignment must be authorized in writing by the Department Head and approved by the Director, Human Resources and Labor Relations before the salary adjustment is made.

The procedure set forth in Article 8, Wage and Increment Schedule, shall be utilized to approve or disapprove increments pursuant to this provision.

ARTICLE 10

OVERTIME AND SPECIAL COMPENSATION

- A. Flexible Scheduling and Overtime: Scheduling and payment for overtime shall be managed as follows:

1. Flexible scheduling is to be limited by the need to provide adequate service in each of the work areas during the business hours of 7:00 a.m. to 6:00 p.m. Work areas are defined as Network/Operating Systems Services, Client Support Services, Database Administration and Applications Development.
2. Full-time employees shall receive compensation at the rate of 1 1/2 times their regular hourly rate for all hours scheduled and authorized over and above their regular work week. Compensation as used in this Article shall mean either cash payment or compensatory time. The Employer has the right to offer overtime compensation either in the form of cash payment or compensatory time. An employee has the right to refuse overtime if it is offered as compensatory time; however, the Employer may then offer the overtime, in the form of compensatory time, to other employees. There shall be no accrual of compensatory time in excess of 40 hours.
3. Temporary and Probationary employees are not eligible to work overtime until all regular qualified employees within their NIOG group have been offered to work the overtime first, unless such employees do not have the necessary skill-set to do the work.
4. Employees may request to be paid for unused compensatory time and the County shall, within thirty (30) days of such request, pay the employee for unused compensatory time.

B. Compensation for Required Availability Status and Call-In Pay:

1. Required Availability Status: Information Technology employees, on a periodic basis to be determined by management, with as much advance notice as possible, employees may be placed on required availability status. Any assignment of required availability status of 14 consecutive calendar days or more, will require at least 10 working days of advance notice by the employer.

Any employee placed on required availability status will be furnished with an electronic device and will be expected to be available to respond to a request for assistance at any location served by Macomb County Information Technology. Employees on required availability status shall be compensated as follows:

Employees placed on required availability status shall be paid \$40.00 per day for each day this status is imposed or \$50.00 per weekend day or holiday this status is imposed.

2. Call-In Pay: Any employees who are contacted during non-working time shall be compensated as follows:
 - a. Those employees that are able to resolve the contact by telephone, on-line or some other method that does not require an appearance at a work location, shall be paid one hour of pay at one and one half times their regular hourly rate or the time actually spent responding, whichever is greater.
 - b. Employees who are actually contacted and required to report to a work location shall be compensated with two hours of pay at one and one-half times their regular hourly rate or time actually spent responding, whichever is greater.

ARTICLE 11

JURY DUTY

In the event an employee is called for jury duty, the employee shall promptly provide a copy of the official notice to his/her immediate supervisor. The employee's schedule may be adjusted by the Employer, provided, however, no employee shall be required to work any number of hours, when added to the number of hours the person spends on jury duty, that exceeds the number of hours normally and customarily worked by the person during a

work day. An employee working second shift, whose schedule has not been adjusted, shall be released from the shift scheduled for the same date as the scheduled jury duty. An employee working third shift, whose schedule has not been adjusted, shall normally be released from the shift scheduled on the date prior to the scheduled jury duty, except, with approval of the Department, an employee may be released from the scheduled shift on the date after the scheduled jury duty.

Should any employee be released from jury duty prior to the end of that shift, the employee shall, when practicable, return to the department and work until the conclusion of that day's shift.

The employee shall be paid his/her normal daily wage for each day worked and/or assigned to jury duty. The employee shall pay to the Employer an amount equal to any payment received as a result of jury duty service. Expenses provided to employees as a result of jury duty service, such as mileage, parking or meal expenses, may be retained by the employee.

ARTICLE 12

HOLIDAY BENEFITS

A. The designated holidays are:

January 1 st (New Year's Day)	Martin Luther King, Jr. Day
Presidents Day	One-half (1/2) day Good Friday
Memorial Day	Independence Day
Labor Day	Columbus Day
November 11 th (Veterans' Day)	Thanksgiving Day
The day AFTER Thanksgiving	December 24 th (Christmas Eve)
December 25 th (Christmas Day)	December 31 st (New Year's Eve)
Juneteenth (June 19 th)	General Election Day in the EVEN numbered years

B. Employees covered by this Agreement who normally work a regularly scheduled five (5) day week, Monday through Friday, shall be granted time off with pay for the designated holidays.

1. The holiday designated must fall on the week days, that is, Monday through Friday.
2. Should the holiday fall on Saturday, the immediately preceding Friday shall be observed as the designated holiday for that year.
3. Should the holiday fall on Sunday (except for December 24th and December 31st, which are detailed in B.4 of this Article) the immediately succeeding Monday shall be observed as the designated holiday for that year.
4. December 24th and December 31st:
 - a. Should December 24th and December 31st on Friday, the preceding Thursdays will be observed as the designated holidays for that year.
 - b. Should December 24th and December 31st fall on Sunday, the preceding Fridays will be observed as the designated holidays for that year.
5. The foregoing shall not apply if January 1st falls on Saturday in any year which is subsequent to the year of expiration of this Agreement.
6. An employee shall receive holiday pay provided that they work the scheduled day before and the scheduled day after the holiday and the holiday, if scheduled, or is excused with pay for the entire day from work.

ARTICLE 13

SICK LEAVE

- A. Participants in the Deferred Retirement Option Plan are not subject to Article 13, Sick Leave, but shall receive Sick Leave in the manner described in Article 20, Deferred Retirement Option Plan.
- B. Regular full time employees shall accrue Sick Leave bank at the rate of up to 12 days per year. Sick Leave shall accumulate only on hours paid.

The paid leave provisions in this contract apply only to full time employees working 37.5 hours or more. All other employees accrue paid leave time in accordance with Michigan's paid leave act and that leave time will be administered according to the acts provisions (PA 338 of 2018 as amended).

- C. For Sick Leave usage only, the unused Sick Leave accumulation maximum that an employee can earn will be one hundred eighty (180) work days.

For accumulated Sick Leave payoff purposes the maximum Sick Leave accumulation will retain its cap of one hundred twenty-five (125) work days.

- D. An employee may utilize available Sick Leave for absences:
 - 1. Due to personal illness or physical incapacity caused by factors that the employee has no reasonable immediate control. Personal illness includes a woman's actual physical inability to work as a result of pregnancy, child birth, or related medical condition.
 - 2. Necessitated by exposure to contagious disease or condition in which the health of others would be endangered by attendance on duty.
 - 3. Due to illness of a member of their immediate family who requires their personal care and attention. The term "immediate family" as used in this section shall mean parent, current step parent, current mother-in-law, current father-in-law, current spouse, children, current daughter-in-law, current son-in-law, current step children, brother, sister, grandparent or grandchildren. It shall also include any person who is normally a member of the employee's household.
 - 4. To report to the Veterans' Administration for medical examinations or other purposes relating to eligibility for disability pension or medical treatment.

- E. Any employee absent for one of the reasons mentioned above shall inform their immediate Supervisor of such absence as soon as possible and failure to do so within the earliest reasonable time, may be the cause of denial of Sick Leave with pay for the period of absence.

- F. When an absence occurs as defined in this Article, and the Department Head or designee suspects abuse, a medical certificate may be required.

- G. An employee who is seriously ill for more than five (5) days while on Paid Time Off, may, upon application, have the duration of such illness charged against their Sick Leave bank rather than against Paid Time Off. Notice of such illness must be given immediately. Proof of such illness in the form of a physician's certificate shall be submitted by the employee.

- H. Sick Leave shall be available for use upon accrual.

- I. Accumulated Sick Leave Payoff (does not apply to employees hired after 1-1-16)

- 1. The maximum Accumulated Sick Leave available to be paid off is one hundred twenty-five (125) work days. Any accumulated sick leave above the one hundred twenty-five (125) work days will be considered excess sick leave.

2. **Retirement:** A regular employee, as defined in Article 7, Employee Defined, who leaves employment because of retirement and is eligible for and receives a pension under Macomb County Employees' Retirement Ordinance, shall be paid for fifty percent (50%) of their accumulated and unused Sick Leave at employee's then current rate of pay.
3. In case of death of a regular employee, as defined in Article 7, Employee Defined, payment of their accumulated and unused Sick Leave, at deceased employee's then current rate of pay, shall be made to the deceased employee's estate/trust.
4. Excess sick leave, up to a maximum of 440 hours, will be paid at the time of separation from the County to either those eligible to receive benefits under Macomb County Employees' Retirement Ordinance or to those who have participated in the DROP. The cash payment will be made in the payoff check with normal deductions. This payment will not be included in the Final Average Calculation (FAC).

J. Sick Leave payoff for employees in the Defined Contribution (401(a) Plan):

Upon separation of employment, an employee shall be compensated for a portion of their unused sick leave up to one hundred twenty-five (125) work days. The rate of pay will be based on the employee's hourly rate at the time of separation. The payoff will be based on a percentage in accordance with the following schedule:

Continuous years of Full Time Service	Percentage Payoff Amount
After 5 years	25% of a maximum of 125 work days
After 10 years	50% of a maximum of 125 work days

The cash payment will be made in the final payoff check with all normal payroll deductions.

ARTICLE 14

WORKER'S COMPENSATION

Macomb County will act in accordance with the Workers' Disability Compensation Act of Michigan.

ARTICLE 15

BEREAVEMENT LEAVE

Upon presentation of proof as required by the Employer, such as, but not limited to, newspaper death or obituary notices, the following shall apply:

- A. A full time employee may elect to take up to three (3) days off with pay due to a death in the Employee's family as follows: parent, current step parent, current mother-in-law, current father-in-law, current spouse, children, current daughter-in-law, current son-in-law, current step children, brother, sister, grandparent, or grandchildren. It shall also include any person who is normally a member of the employee's household.
- B. The Employee may elect to take up to three (3) bereavement leave days chargeable to Sick Leave or Paid Time Off due to the death of an Employee's friend or family member, other than those listed in section A of this article.
- C. Full-time employees are permitted to take up to four (4) hours of bereavement leave with pay to attend the funeral of an employee who worked within the same department, provided attendance is during the

employee's normally scheduled work hours and does not interfere with the operational needs of the Department/County.

Bereavement Leave requests made pursuant to sections B. or C. of this article are subject to prior approval by the Employer and shall not be unreasonably withheld or denied.

ARTICLE 16

PAID TIME OFF

- A. Participants in the Deferred Retirement Option Plan are not subject to Article 16, Paid Time Off, but shall receive Paid Time Off in the manner described in Article 20, Deferred Retirement Option Plan.
- B. The purpose of Paid Time Off (PTO) is to provide employees with flexible paid time off from work that shall be used for such employee needs as vacation, personal business and other activities, without disrupting the operations of the department. Paid Time Off (PTO) shall also be used for employee absences incurred from inclement weather.
- C. Full time employees, except for participants in the Deferred Retirement Option Plan (DROP), shall be entitled to accrue Paid Time Off (PTO) according to the following schedule. DROP participants shall receive Paid Time Off (PTO) in the manner outlined Article 20, Deferred Retirement Option Plan.

The paid leave provisions in this contract apply only to full time employees working 37.5 hours or more. All other employees accrue paid leave time in accordance with Michigan's paid leave act and that leave time will be administered according to the acts provisions (PA 338 of 2018 as amended).

<u>YEARS OF CONSECUTIVE FULL TIME SERVICE COMPLETED:</u>	<u>ANNUAL EQUIVALENT OF:</u>
less than 5	15 days
5	20 days
10	21 days
13	24 days
20	25 days
21	26 days
22	27 days
23	28 days
24	29 days
25	30 days

- D. Paid Time Off days may be accumulated to a maximum of thirty (30) work days.
- E. Paid Time Off shall be available for use upon accrual.

Full-time employees shall be entitled to accumulate Paid Time Off as above for each fully paid two (2) week pay period of service. Paid Time Off shall accumulate only on hours paid.

- F. Paid Time Off requests shall be reviewed by the Department Head/designee, and must have their approval. Such approval shall be at the Department Head/designee's discretion to ensure efficient operations.
- G. Full time employees may request Paid Time Off conversion to cash payment of up to forty (40) hours per conversion, maximum of eighty (80) hours per year. Employees requesting Paid Time Off conversion must have a minimum of one hundred twenty (120) hours of Paid Time Off to be eligible for the conversion. The requested Paid Time Off conversion(s) must be submitted by February with the cash payment to be made on the second pay in March and August with the cash payment to be made on the second pay in September in a regular paychecks with normal deductions.

- H. Upon termination of employment, an employee shall be compensated for their Paid Time Off at the rate of pay said employee received at the time of termination.

ARTICLE 17

LEAVE OF ABSENCE

- A. Full-time employees are eligible and may request a leave of absence in writing for any of the following reasons:

1. Personal Leave
2. Medical Leave for Employee and/or Family
3. Military

- B. Provisions:

1. Personal Leave:

- a. An employee may be eligible for a Personal Leave upon completion of 12 months of service from their date of hire.
- b. An employee absent from work for more than 15 consecutive working days shall be required to apply for and submit a request for Personal Leave in writing using forms required by Human Resources and Labor Relations.
- c. All requests for a Personal Leave must be submitted at least thirty (30) days prior to the effective date of the Personal Leave.
- d. While on an approved Personal Leave, an employee must exhaust paid time off and compensatory time.
- e. An approved personal leave shall not exceed six months.
- f. An employee approved for a Personal Leave shall not accrue credited service for retirement during the time which the employee is on said Personal Leave without pay.
- g. While on an unpaid Personal Leave, benefits will be cancelled at the end of the month from the point of unpaid status. Upon return from an unpaid Personal Leave of Absence, insurance benefits will be reinstated in accordance with the waiting periods as outlined in Article 18, Insurance Benefits.
- h. The Department Head/designee and the Director, Human Resources and Labor Relations/designee shall approve or disapprove all requests for Personal Leave.
- i. An employee that fails to report for duty upon expiration of a Personal Leave shall be subject to loss of seniority as outlined in Article 26, Seniority and termination of employment.

2. Medical Leave for Employee and/or Family:

- a. An employee may be eligible for a Medical Leave upon completion of 6 months of service from their date of hire.
- b. An eligible employee who is unable to work due to their own medical condition caused by an illness or injury or the medical condition of a family member caused by illness or injury may request a Medical Leave.

- c. A family member shall be defined as parent, current step parent, current spouse, children, current step children, brother, sister, grandparent or grandchild. It shall also include any person who is normally a member of the employee's household.
- d. An employee absent from work for more than 5 consecutive working days shall be required to apply for and submit a request for Medical Leave in writing using forms required by Human Resources and Labor Relations.
- e. All foreseeable requests for a Medical Leave must be submitted in writing to the Department Head or designee at least thirty (30) days prior to the effective date of the Medical Leave.
- f. An eligible employee must complete a request for Medical Leave of Absence and Certification of Health Care Provider form provided by the U.S. Department of Labor.
- g. Medical certification must be received in the Human Resources and Labor Relations Department within 15 days from the employee's last day worked.
- h. While on an approved Medical Leave, an employee must exhaust sick leave and compensatory time.
- i. Medical Leaves are approved for a period of no more than 6 months. Medical Leave requested beyond 6 months, may be approved for an extension, but not to exceed an aggregate total of no more than 12 months.
- j. Medical Leave extension requests must be submitted in writing at least 5 working days prior to the expiration of the current approved Medical Leave.
- k. An employee on an approved unpaid Medical Leave shall not accrue credited service for retirement during the time which the employee is on said Medical Leave without pay.
- l. While on an unpaid Medical Leave, benefits will be cancelled at the end of the month following six (6) months of unpaid status. Upon the return from the unpaid Medical Leave, benefits will be reinstated effective immediately.
- m. The Employer may exercise the right to have the employee examined by a physician selected by the Employer before approving and granting such request for Medical Leave and/or Medical Leave extension at the Employer's expense.
- n. The Department Head/designee and the Director, Human Resources and Labor Relations/designee shall approve or disapprove all requests for Medical Leave.
- o. In order to return from a Medical Leave, the employee must have the ability to perform the essential functions of the job with or without reasonable accommodation. At the Employer's sole discretion, a medical examination may be conducted at the Employer's expense.
- p. Failure to report for duty upon expiration of a Medical Leave shall be subject to loss of seniority as outlined in Article 26, Seniority and termination of employment.

3. Military:

- a. The Employer complies with the Uniform Services Employment and Reemployment Right Act (USERRA), 38 USC, Chapter 43 Employment and Reemployment Rights of Members of the Uniformed Services. An employee whose absence from employment is necessitated by reason of

duty in the uniformed services, shall notify the Elected Official/Department Head or designee of the upcoming military service requirements.

- b. Benefits provided for employees absent under this Article shall be provided consistent with the Uniform Services Employment and Reemployment Right Act (USERRA), 38 USC, Chapter 43 Employment and Reemployment Rights of Members of the Uniformed Services as determined by Human Resources and Labor Relations. Employees absent under USERRA should provide the County with a copy of their military orders.
 - c. Any employee on an approved USERRA Military Leave of Absence shall be eligible for the following benefits as a result of their Military Leave of Absence: differential pay, medical, prescription drug, dental and vision benefits, life insurance, Retirement eligibility or 401(a) vesting, Sick Leave, Paid Time Off (PTO) and Longevity as determined by Human Resources and Labor Relations.
4. Family And Medical Leave Act: The Employer shall comply with all aspects of the Family and Medical Leave Act (FMLA). Leaves will run concurrent with any FMLA eligible Leave.

ARTICLE 18

INSURANCE BENEFITS

A. Life Insurance:

1. Full-time Employees (including DROP Participants):

- a. The life insurance benefit provided by the Employer shall be \$50,000.

The Employer will provide a payroll deduction option for employees wishing to purchase additional \$25,000 increments of life insurance to a maximum of \$325,000. Rates and conditions shall be those established by the insurance carrier.

Based on the above language, an employee exercising their ability to purchase the maximum life insurance benefit of \$325,000 would then have a total life insurance benefit of \$375,000.

- 2. Retirees: The Employer will provide a life insurance benefit, in the amount of two thousand dollars (\$2,000), to employees covered by this Agreement who retire and are eligible for and receive a retirement allowance under the Macomb County Employees' Retirement Ordinance. Employees hired on or after January 1, 2016 will not be eligible for this life insurance benefit.

B. Insurance Benefits:

- 1. Only full-time employees (including DROP participants) and their eligible dependents will be eligible for Macomb County's Insurance Benefits which includes medical, prescription drug, dental and vision plans, effective their first day of employment with Macomb County.

2. Dependent Eligibility:

Full-time employees (including DROP participants) may elect to cover their current spouse on Macomb County's medical, prescription drug, dental and vision plans.

Full-time employees (including DROP participants) may elect to cover their eligible children up to the age of 26 on Macomb County's medical, prescription drug, dental and vision plans. Supporting documentation must be provided to the Human Resources and Labor Relations Department as necessary.

C. The Employer shall provide two medical plan options: a Preferred Provider Organization (PPO) and an Health Maintenance Organization (HMO) to all regular eligible full-time employees and their eligible dependents including prescription drug coverage, as outlined in Appendix C, Active Employee Benefits or its substantial equivalence. Full-time employees shall be required to comply with PA 152. Prior to the implementation of any deductions, the Employer will meet and confer on design, plan, or carrier changes to comply with PA 152.

1. Full-time employees who have a current spouse who is also employed full-time by Macomb County will be entitled to only one (1) medical, prescription drug, dental and vision plan for both employee and all eligible dependents. Such employee shall not be eligible for the insurance waiver.
2. Full-time employees who elect not to participate in Macomb County's medical and prescription drug plans and who has coverage elsewhere shall receive a monthly insurance waiver payment of \$167.00. The insurance waiver will be paid in the employee's regular paycheck.
 - a. Full-time employees shall establish proof of their eligibility to receive the insurance waiver.
 - b. Full-time employees participating in the insurance waiver who lose coverage shall be allowed to enroll in Macomb County's medical, prescription drug, dental and vision plans as soon as administratively possible and the insurance waiver payments shall cease as soon as administratively possible.

D. 1. Retirees: Full-time employees hired before January 1, 2006, the Employer will provide a fully paid medical and prescription drug plan to the employee and the employee's eligible spouse, as defined in D.1.a. after eight (8) years of actual service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.

Full-time employees hired on or after January 1, 2006, the Employer will provide a fully paid medical and prescription drug plan to the employee and the employee's eligible spouse, as defined in D.1.a. after fifteen (15) years of actual service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.

- a. Coverage shall be limited to the spouse of the retiree, at the time of retirement or DROP.
 - b. Coverage for the eligible spouse will terminate upon the death of the retiree unless the retiree elects to exercise a retirement option whereby the eligible spouse receives applicable retirement benefits following the death of the retiree.
2. Full-time employees hired on or after January 1, 2012 will not be eligible for Macomb County's medical, prescription drug, dental and vision plans for the employee's spouse in retirement.
 3. All employees who retire or DROP after November 1, 2013, will have the medical and prescription drug plan as outlined in Appendix D, Post November 1, 2013 Retirees, until they are Medicare eligible, subject to the limitations and provisions of D.2. and D.4. of this Article. This provision does not apply to employees who retire or DROP prior to November 1, 2013.
 4. Full-time employees hired into the County on or after January 1, 2016 will not be eligible for Employer provided retiree medical, prescription drug, dental or vision coverage and life insurance.
 5. Retired employees and/or their eligible spouse as defined in D.1.a., shall apply and participate in the Medicare Program, if eligible, at their expense as required by the Federal Insurance Contribution Act, a part of the Social Security Program. At that time the Employer's obligation shall be only to provide medical and prescription drug coverage that will coordinate or supplement with Medicare. Failure to participate in the aforementioned Medicare Program shall be cause for termination of Employer paid

coverage of applicable hospital-medical benefits, as outlined herein for employees who retire and/or their eligible spouse as defined in D.1.a.

6. Employees who retire under the provisions of the Macomb County Employees' Retirement Ordinance and eligible spouse as defined in D.1.a., shall, if eligible apply for and participate in ANY National Health Insurance program offered by the U.S. Government. Failure to participate, if eligible, shall be cause for termination of Employer paid hospital-medical benefits as outlined.
7. Retirees who are eligible for Macomb County's medical and prescription drug plan and elect not to participate and who has coverage provided elsewhere, shall receive a monthly insurance waiver payment of \$167.00. The insurance waiver will be paid in the retiree's regular retirement check.
 - a. Retirees shall establish proof of their eligibility to receive the insurance waiver.
 - b. Retirees participating in the insurance waiver who lose coverage shall be allowed to enroll in Macomb County's medical and prescription drug plans as soon as administratively possible and the insurance waiver payments shall cease as soon as administratively possible.

E. Dental Plan:

The Employer shall provide a dental plan to full-time employees (including DROP Participants) and their eligible dependents as outlined in Appendix E, Active Employees Dental Benefits, or its substantial equivalence.

F. Vision Plan:

The Employer shall provide a vision plan to full-time employees (including DROP Participants) and their eligible dependents as outlined in Appendix F, Active Employees Vision Benefits or its substantial equivalence.

- G. Liability Insurance: The County shall provide for each regular employee (including DROP Participants) Bodily Injury and Property Damage Liability Insurance while acting within the scope of their duties and Personal Injury Insurance including "false arrest" when also arising out of and in the line of duty and in the conduct of duly constituted Employer business. The cost of this insurance will be borne by the Employer.

- H. Long Term Disability: Full-time employees (including DROP Participants) covered by this Agreement will be provided a Long Term Disability program with benefits as currently provided by the present provider, or its substantial equivalence.

- I. The County shall provide, at its discretion, a Voluntary Benefit Program to include, but not limited to, supplemental life insurance, pet insurance, critical care insurance, short term disability and legal services. The Employer will provide a payroll deduction for employees (including DROP participants) wishing to purchase these voluntary benefits.

- J. Part-time employees shall not be eligible for Macomb County's medical, prescription drug, dental and vision plans, life insurance, Voluntary Benefit Program and long term disability during employment and/or upon retirement.

ARTICLE 19

RETIREMENT SYSTEM

- A. Retirement Benefits: The Employer shall continue the benefits as provided by the presently constituted Macomb County Employee's Retirement Ordinance, and the Employer and the employee shall abide by the terms and conditions thereof, provided, that the provisions thereof may be amended by the Retirement Board as provided by the statutes of the State of Michigan and provided further, that an annual statement of employee's contributions is available upon request.

B. Full-time employees hired into the County prior to January 1, 2016:

1. Employee Contribution: For any employee hired on or before December 31, 2001, or who is vested as of February 27, 2009, the employee's contribution to the retirement system is three and five tenths percent (3.5%) of the employee's compensation.

For employees hired on or after January 1, 2002 the employee's contribution to the retirement system is two and five tenths percent (2.5%) of the employee's compensation.

2. County Pension Maximum: For any employee hired on or before December 31, 2001, or who is vested as of February 27, 2009, the County pension shall not exceed sixty-five percent (65%) of annual average compensation.

For employees hired on or after January 1, 2002, the County pension shall not exceed sixty-six percent (66%) of an employee's final average compensation.

3. Pension Multiplier: For any employee hired on or before December 31, 2001, or who is vested as of February 27, 2009, the pension multiplier is two and four tenths percent (2.4%) for the first twenty-six (26) years of credited service and one percent (1%) for each year of credited service thereafter.

For employees hired on or after January 1, 2002, the pension multiplier is two and two tenths percent (2.2%) for all years of credited service.

4. Final Average Compensation Formula: For any employee hired on or before December 31, 2001, or who is vested as of February 27, 2009, the formula for computing final average compensation, used for calculating pension benefits for eligible bargaining unit members, shall be based on the average of an employee's one hundred and four (104) highest consecutive pay periods of compensation out of the last two hundred and sixty (260) pay periods.

For employees hired on or after January 1, 2002, the formula for computing final average compensation, used for calculating pension benefits for eligible bargaining unit members, shall be based on the average of an employee's one hundred and thirty (130) highest consecutive pay periods of compensation out of the last two hundred and sixty (260) pay periods.

Retroactive Effect: Notwithstanding the provisions of the Macomb County Employees' Retirement System Ordinance, when an employee's Final Average Compensation is calculated, any retroactive wages provided shall be counted as if the retroactive wages were paid to the employee when the wages were paid, not when they were earned by the employee.

5. Pension Calculation: For any employee hired on or before December 31, 2001, or who is vested as of February 27, 2009, the County pension, which when added to an employee pension, will provide a straight life retirement allowance equal to the number of years, and fraction of a year, of an employee's credited service multiplied by the sum of 2.4% of the employee's final average compensation for the first twenty-six (26) years of credited service and one percent (1%) for each year of credited service thereafter.

For employees hired after January 1, 2002, the County pension, which when added to an employee pension, will provide a straight life retirement allowance equal to the number of years, and fraction of a year, of an employee's credited service multiplied by the sum of 2.2% of the employee's final average compensation for all years of credited service.

Effective January 1, 2020 in no case shall the Straight Life pension benefit for a bargaining unit member under this contract exceed 100% of the employee's base salary at the time of retirement. Such limitation shall be applied to a bargaining unit member's straight life benefit calculation prior to an applicable actuarial adjustment, if any, for the member's selection of an optional form of benefit or the annuity withdrawal option and shall also apply to the member's DROP benefit.

6. Eligibility:

- a. For employees hired on or before December 31, 2001, or who is vested as of February 27, 2009, who meets the following criteria may retire upon the employee's written application filed with the Retirement Board:
 1. Attained age 60 years and has 8 or more years of credited service; or
 2. Attained the age of 50 with at least 8 years of credited service, if the employee's age, when added to the employee's years of credited service, equal the sum of 70 or more.
- b. For employees hired on or after January 1, 2002, any member who meets the following criteria may retire upon the employee's written application filed with the Retirement Board:
 1. Attained age 60 years and has 8 or more years of credited service; or
 2. Attained the age of 55 with 25 years of credited service.
- c. For employees hired into the County on or after January 1, 2012, any member who meets the following criteria may retire upon their written application filed with the Retirement Board:
 1. Attained age 60 years and has 15 or more years of credited service; or
 2. Attained the age of 55 with 25 years of credited service.

Upon the employee's retirement, the employee shall receive a retirement allowance as provided in the Retirement Ordinance.

- d. In the event a former member is re-employed by the County as a full-time employee within four (4) years from their last separation date, membership is reinstated.
 1. For employees who have multiple terms of employment as a member in Macomb County Employees' Retirement System, the following shall apply:
 - a. If an employee was vested during the first term of employment, the pension will be calculated per the terms of the original date of hire.
 - b. If an employee was not vested during the first term of employment, the pension will be calculated per the terms of the employee's rehire date.
- e. In the event a former member is re-employed by the County as a full-time employee and it has been four (4) or more years since their last separation date, their membership will not be reinstated, and they will enter the 401(a) Defined Contribution plan.

7. Annuity Withdrawal: Members of the Macomb County Employees' Retirement System may elect to take an Annuity Withdrawal, excluding non-duty disability retirement and non-duty death. The utilization of this option shall be governed by any applicable Annuity Withdrawal provisions of the Macomb County Employees' Retirement System Ordinance.

8. Purchase of Military Service Credits: A member who wishes to purchase military service credits as provided in the Macomb County Employees' Retirement Ordinance shall be allowed to purchase said credits through payroll deduction. If a member chooses the payroll deduction option, the cost to purchase military service credit shall be computed as provided in the aforementioned Ordinance.

9. Option D: A retirant shall have the option of selecting survivor's benefits in conjunction with the retirement option described in the Macomb County Employees' Retirement Ordinance commonly known as "Option D – Level Income Option". Said survivor's benefits shall correspond to those benefits

known as Option A – 100% Survivor Allowance, Option B – 50% Survivor Allowance and Option C – Allowance for 10 Years Certain and Life Thereafter, as described in the Ordinance.

10. Pop Up Option: A retirant may elect this option in combination with Option A or B of the Ordinance. Under this option, a reduced retirement allowance is payable during the joint lifetime of the retirant and their beneficiary nominated under Option A or B, whichever is elected. Upon the death of the retirant, their beneficiary will receive a retirement allowance for life equal to the percentage specified by Option A or B of the reduced retirement income payable during the joint lifetime of the retirant and their beneficiary. Upon the death of the beneficiary, the retirant will receive a retirement allowance equal to one hundred percent of the amount specified by the Macomb County Employees' Retirement Ordinance for the remaining lifetime of the retirant. The reduced retirement allowance payable during the joint lifetime of the retirant and their beneficiary together with the retirement allowance payable to one upon the death of the other will be actuarially equivalent to the retirement allowance provided by the Macomb County Employees' Retirement Ordinance as a single life annuity. This provision shall be without force or effect unless or until the retirant submits acceptable documentation of the death of their beneficiary to the Secretary of the Retirement Board.
11. Deferred Retirement Allowance Option: In the event a vested bargaining unit member, leaves the employ of the County prior to the date they have satisfied the age and service requirements for retirement provided in the Macomb County Employees' Retirement Ordinance, for any reason except their disability retirement or death, they shall be entitled to retire at the normal retirement age and be subject to the retirement formula in effect at the time they left County employment and as provided for in the Macomb County Employee's Retirement Ordinance, provided that they did not withdraw their accumulated contributions from the employees savings fund. Their retirement allowance under the plan in effect at the employee's termination of County employment shall begin the first day of the calendar month next following the date their application for same is filed with the Board after the employee would have become eligible for retirement under the plan had the employee's employment not been terminated.

A vested former member who withdraws accumulated member contributions and voluntarily forfeits credited service in the System thereby forfeits all rights in and to the portion of the pension attributable to the forfeited credited service.

There shall be no pension paid to an eligible vested former member until an application for retirement is submitted and approved. In the event an eligible vested member dies prior to applying for their pension, their beneficiary or estate/trust shall not be entitled to a pension. The vested member's beneficiary or estate/trust shall receive the contributions and interest earned as of the date of the vested member's death.

12. Non-Duty Death Before Retirement, Beneficiary Nominated: Any bargaining unit member who is vested may at any time prior to the effective date of their retirement elect Option A provided in the Macomb County Employees' Retirement System Ordinance in the same manner as if they were then retiring from county employment, and nominate a beneficiary whom the Retirement Board finds to be dependent upon the said member for at least 50 percent of their support due to lack of financial means. Prior to the effective date of their retirement a member may revoke their said election of Option A and nomination of beneficiary and they may again elect the said Option A and nominate a beneficiary as provided in this section. Upon the death of a member who has an Option A election in force their beneficiary, if living, shall immediately receive a retirement allowance computed in the same manner in all respects as if the said member had retired the day preceding the date of their death, notwithstanding that they might not have attained age 60 years. If a member has an Option A election in force at the time of their his/her retirement their said election of Option A and nomination of beneficiary shall thereafter continue in force; provided, that prior to the effective date of their retirement, they shall have the right to elect to receive their retirement allowance as a straight life retirement allowance or under Option B provided in the Ordinance. No retirement allowance shall be paid under this section on account of the death of a member if any benefits are paid or will become payable under the Ordinance on account of their death.

13. Non-Duty Death Before Retirement, Non-spousal Beneficiary Nominated: In the event of a non-duty death of a vested member prior to retirement, a non-spousal beneficiary shall receive only contributions and interest.
14. Non-Duty Death Retirement Allowance, Automatic Provisions: Any vested bargaining unit member who continues County employment and (1) dies while in County employment and (2) leaves a spouse, the spouse shall immediately receive a retirement allowance computed in the same manner in all respects as if the member had (1) retired the day preceding the date of the member's death, notwithstanding that the member might not have attained age 60 years, (2) elected Option A in the Macomb County Employees' Retirement Ordinance.
15. Deferred Retirement Option Plan (DROP): The Memorandum of Understanding regarding the Deferred Retirement Option Plan (DROP) is incorporated herein as Article 20, Deferred Retirement Option Plan. Vesting for the purposes of DROP excludes service time under Reciprocal Act 88.

C. Full-time employees hired into the County on or after January 1, 2016:

1. Will be eligible to receive a one-time fixed payment of \$1000 from the Macomb County Employees' Retirement System. This payment will be made to an employee after separation from employment and who meets the Employer contribution vesting requirements as outlined in Section C.5 and after the completion of five (5) years of service.
2. Will not be eligible for or participate in the Macomb County Employees' Retirement System for any other benefit, including DROP, other than for the fixed payment as outlined in Section C.1.
3. Will participate in a Defined Contribution Retirement Plan. Employees shall contribute 3% of the employee's base pay and the Employer shall contribute 6% of the employee's base pay. Upon the completion of five (5) years of actual service with the Employer, employees shall be eligible to elect to increase their contribution by one percent (1%) of the employee's base pay. Per IRS regulations, the additional one percent (1%) contribution is a post-tax contribution. If such election is made by the employee, the Employer shall increase its contribution from six percent (6%) to eight percent (8%) of the employee's base pay.
4. Will not be eligible for Employer provided retiree medical, prescription drug, dental or vision coverage and life insurance. The eligible employee, however, shall receive \$100 per pay period, deposited by the County, into the Defined Contribution Retirement Plan, not to exceed \$2600 per year.
5. Employees shall have the following schedule as it relates to vesting for the Employer contributions:

Completion of 1 year of service	20%
Completion of 2 years of service	40%
Completion of 3 years of service	60%
Completion of 4 years of service	80%
Completion of 5 years of service	100%

ARTICLE 20

DEFERRED RETIREMENT OPTION PLAN (DROP)

Eligible employees may elect to participate in the Deferred Retirement Option Plan (DROP). Eligibility, terms, and conditions of DROP participation are set forth below, including the payment of certain fringe benefits to DROP participants, Longevity, Paid Time Off and Sick Leave.

- A. Eligibility: An employee who is a member of the Macomb County Employees Retirement System may voluntarily elect to participate in the DROP at any time with a minimum of a thirty (30) day notice, after attaining the minimum age and service requirements for a normal service retirement. Vesting for the purposes of DROP excludes time under Reciprocal Act 88.
- B. Participation: The maximum period for DROP payments credited to the account is five (5) years (the "Participation Period"). There is no minimum time period for participation. Employees may continue to work beyond five (5) years, but DROP payments will cease at the end of the participation period.
- C. DROP Payment: Upon termination of employment, the retiree shall receive the monthly pension previously credited to their DROP account. Failure to terminate employment at the expiration of the DROP Participation Period shall result in forfeiture of the employee's monthly pension otherwise payable to the DROP account. Interest on the DROP account will continue to accrue during such a forfeiture.
- D. Election to Participate: Participation in the DROP is irrevocable once an employee begins participation. An employee who wishes to participate in the DROP shall be eligible to begin at the start of a pay period and must complete and sign such application form. Such application shall be reviewed by the Human Resources and Labor Relations Department within a reasonable time period and a determination shall be made as to the member's eligibility for participation in the DROP. On the date upon which the member's participation in the DROP shall be effective, they shall be considered to be a DROP participant and shall cease to be an active member of the Macomb County Employees Retirement System. The amount of credited service, multiplier and final average compensation shall be fixed as of the employee's DROP date. When an employee's Final Average Compensation is calculated, any retroactive wages provided shall be counted as if the retroactive wages were paid to the employee when the wages were paid, not when they were earned by the employee. Increases or decreases in compensation during DROP participation will not be factored into retirement benefits of active or former DROP participants. DROP participants accrue no service time credit for retirement purposes pursuant to the Macomb County Employees Retirement System.
- E. DROP Account Benefit: The employee's DROP Account shall be the regular monthly pension with interest to which the employee would have been entitled if they had actually retired on the DROP date. The payment shall be credited monthly to the employee's individual DROP account. At the time an employee elects to participate in the DROP, their optional form of retirement allowance as set forth in the Macomb County Employee Retirement Ordinance shall be irrevocable. All individual DROP accounts shall be maintained for the benefit of each employee participating in the DROP and will be managed by the Retirement System in the same manner as the primary retirement fund. DROP interest for each employee who participates in the DROP shall be at a fixed rate of 3.5% per annum, calculated in the same manner as the interest in the employee savings accounts in the Macomb County Employees Retirement System.
- F. Annuity Withdrawal: An employee who elects to participate in the DROP may elect the Annuity Withdrawal option provided by the retirement ordinance at the time of electing DROP participation. Such election shall be made commensurate with the employee's DROP election, but not thereafter. Such annuity withdrawal will be utilized to compute the actuarial reduction of the member's DROP benefit, as well as the member's monthly pension from the Macomb County Employees Retirement System, after termination of employment.

The annuity withdrawal amount (accumulated contributions and interest) will be disbursed from the Macomb County Employees Retirement System within sixty (60) days from the first pension check. All withdrawal provisions and options under the Retirement Ordinance, which are available to Retirement System members shall be available to the employee participating in the DROP at such time that they elect to participate in the DROP.

G. Contributions: The employee's contributions to the Macomb County Employees Retirement System shall cease as of the date that the employee begins participation in the DROP.

H. Distribution of DROP Account Funds: The employee participating in the DROP must choose one, or a non-inconsistent combination of, the following distribution methods to receive payment(s) from their individual DROP account:

- 1) A lump sum distribution to the employee; AND/OR
- 2) A lump sum direct rollover to another qualified plan to the extent allowed by federal law and in accordance with any procedures established by the Retirement System for such rollovers.

Failure to elect one of the above options and receive such distribution within 60 days of termination of employment shall result in a lump sum distribution to the employee.

I. Death During DROP Participation: If an employee participating in the DROP dies either: (1) before full retirement, that is before termination of employment with the County, or (2) during full retirement (that is, after termination of employment with the County but before the DROP account balance has been fully paid), the employee's designated beneficiary(ies) shall receive the remaining balance in the employee's DROP account in the manner in which they elect from the previously mentioned distribution methods (above). If there is no such beneficiary, the account balance shall be paid in a lump sum to the estate/trust of the employee. Benefits payable from the Macomb County Employees Retirement System shall be determined as though the employee participating in the DROP had separated from service on the day prior to the employee's date of death.

J. Disability During DROP Participation: In the event an employee participating in the DROP becomes totally and permanently disabled from further service in the employment of Macomb County, the employee's participation in the DROP shall cease, and the employee shall receive such benefits as if the employee had retired and terminated employment during the participation period.

K. Internal Revenue Code Compliance: The DROP is intended to operate in accordance with Section 415 and other applicable laws and regulations contained within the Internal Revenue Code of the United States. Any provision of the DROP, or portion thereof, that is in conflict with an applicable provision of the Internal Revenue Code of the United States is hereby null and void and of no force and effect.

L. Other Provisions: The Macomb County Employees Retirement System is a defined benefit plan. Should that plan be modified to include a defined contribution plan, this DROP account established is only part of a defined benefit plan. It is intended that this DROP be a "forward" DROP only and contains no DROP "back" provision, which would allow members to retire retroactively.

M. Paid Time Off and Sick Leave in Final Average Calculation: The collective bargaining agreement may provide for the crediting of both Paid Time Off and Sick Leave banks for inclusion in determining an employee's final average compensation for purposes of computing an employee's pension.

At the effective date of an employee's participation in the DROP, an employee's Paid Time Off and Sick Leave bank shall be "credited" and/or paid as provided for in the collective bargaining agreement or the Macomb County Employees Retirement Ordinance.

After the effective date of an employee's participation in the DROP, the employee's Paid Time Off and Sick Leave shall be determined as set forth in the collective bargaining agreement.

N. Longevity, Paid Time Off and Sick Leave: After the effective date of an employee's participation in the DROP, the employee's Longevity, Paid Time Off and Sick Leave shall be determined as set forth below.

1. Longevity for DROP Participants:

- a. At the time an employee elects to participate in the DROP they shall receive, as part of their payoff, a prorated amount of longevity compensation. Payment for the balance of the DROP years' longevity payment and subsequent longevity payments shall be made in December of each year as described below.
- b. For DROP participants, the amount of longevity compensation paid in subsequent years shall be determined by the step level achieved by the employee at the time they elected to DROP. Step levels are listed below.

CONTINUOUS YEARS OF FULL TIME SERVICE ON OR BEFORE OCTOBER 31ST		
<u>STEP</u>	<u>OF EACH YEAR</u>	<u>AMOUNT</u>
1	15 through 19	\$600
2	20 through 24	\$800
3	25 and thereafter	\$1,000

- c. Longevity compensation shall be added to the regular payroll check, when due, for eligible DROP participants. It shall be considered a part of the regular compensation and, as such subject to Federal and State withholding tax, social security, regulations and ordinances of the County of Macomb and other applicable statutes.
- d. Payments to eligible DROP participants as of October 31st of any year shall be included in the first regular payroll check of December. The annual period covered in computation of longevity shall be from November 1 of each year through and including October 31st of the following year.
- e. DROP participants who terminate employment shall be entitled to and receive a longevity payment upon a pro-rated basis for that portion of the year employed.

2. Paid Time Off for DROP Participants:

- a. The purpose of Paid Time Off (PTO) is to provide employees with flexible paid time off from work that shall be used for such employee needs as vacation, personal business and other activities, without disrupting the operations of the department. Paid Time Off (PTO) shall also be used for employee absences incurred from inclement weather.
- b. Employees who are participants in the Deferred Retirement Option Plan (DROP) shall receive Paid Time Off in the following manner.

DROP participants shall receive, on January 1st of each year of DROP participation, a number of hours of Paid Time Off equal to the number of hours of Paid Time Off earned based upon their years of service at the commencement of DROP participation according to the following schedule:

<u>YEARS OF CONSECUTIVE FULL-TIME SERVICE COMPLETED:</u>	<u>ANNUAL EQUIVALENT OF:</u>
less than 5	15 days
5	20 days
10	21 days
13	24 days
20	25 days
21	26 days
22	27 days
23	28 days

24
25

29 days
30 days

- c. Paid Time Off requests shall be reviewed by the Department Head/designee, and must have their approval. Such approval shall be at the Department Head/designee's discretion to ensure efficient operations.
- d. DROP participants may request Paid Time Off conversion to cash payment of up to forty (40) hours per conversion, maximum of eighty (80) hours per year. Employees requesting Paid Time Off conversion must have a minimum of one hundred twenty (120) hours of Paid Time Off to be eligible for the conversion. The requested Paid Time Off conversion(s) must be submitted by February with the cash payment to be made in the second pay in March and August with the cash payment to be made in the second pay in September in a regular paycheck with normal deductions.
- e. Employees whose DROP participation begins at a time of year other than January 1st, shall receive a pro-rata share of Paid Time Off for the balance of the calendar year computed in the same manner as paragraph b, above.
- f. Paid Time Off not utilized by an employee by December 31st of a calendar year shall be forfeited.
- g. There shall be no compensation for Paid Time Off remaining in the DROP participant's Paid Time Off bank upon separation from employment.
- h. DROP participants who utilize Paid Time Off in an amount in excess of a proportionate share prior to voluntarily or involuntarily discontinuing employment shall be obligated to compensate the Employer for all Paid Time Off time used in excess of such proportionate share. This provision shall not apply to a DROP participant whose involuntary discontinuance of employment is caused by duty related death or disability.

3. Sick Leave for DROP Participants

- a. DROP participants shall be provided with six (6) days of Sick Leave on January 1st of each year the employee participates in the DROP.
- b. Employees who begin DROP participation at a time other than January 1st, shall receive a pro-rata share of six (6) Sick Leave days for the balance of the calendar year.
- c. After the exhaustion of the six (6) Sick Leave days provided for in paragraph a, above, DROP participants may utilize that Excess Sick Leave, accrued the period of employment prior to the effective date of DROP participation, for which the employee was not compensated at the time of entry into the DROP.
- d. DROP participants who are employed on December 31st of each year and have not exhausted the six (6) sick leave days provided for in paragraph a, above, shall receive a pay out of up to three (3) of the unused sick leave days. Payment will be made the following January.
- e. There shall be no compensation for any Sick Leave time remaining in the DROP participant's Sick Leave bank upon separation from employment.
- f. An employee may utilize available Sick Leave for absences:
 - i. Due to personal illness or physical incapacity caused by factors that the employee has no reasonable immediate control. Personal illness includes a woman's actual

physical inability to work as a result of pregnancy, child birth, or related medical condition.

- ii. Necessitated by exposure to contagious disease or condition in which the health of others would be endangered by attendance on duty.
 - iii. Due to illness of a member of their immediate family who requires their personal care and attention. The term "immediate family" as used in this section shall mean parent, current step parent, current mother-in-law, current father-in-law, current spouse, children, current daughter-in-law, current son-in-law, current step children, brother, sister, grandparent or grandchildren. It shall also include any person who is normally a member of the employee's household.
 - iv. To report to the Veterans' Administration for medical examinations or other purposes relating to eligibility for disability pension or medical treatment.
- g. DROP participants absent for one of the reasons mentioned above shall inform their immediate Supervisor of such absence as soon as possible and failure to do so within the earliest reasonable time, may be the cause of denial of Sick Leave with pay for the period of absence.
 - h. When an absence occurs as defined in this Article, and the Department Head or designee suspects abuse, a medical certificate may be required.
 - i. A DROP participant who is seriously ill for more than five (5) days while on Paid Time Off, may, upon application, have the duration of such illness charged against their Sick Leave bank rather than against Paid Time Off. Notice of such illness must be given immediately. Proof of such illness in the form of a physician's certificate shall be submitted by the employee.

ARTICLE 21

LONGEVITY

- A. Participants in the Deferred Retirement Option Plan are not subject to Article 21, Longevity, but shall receive Longevity in the manner described in Article 20, Deferred Retirement Option Plan.
- B. The Parties recognize employees who have a record of long continued employment and service with the County of Macomb and value the experience gained through such length of service.
- C. The basis of longevity compensation is as follows:
 - 1. Eligibility of a full-time employee shall commence when such employee shall have completed fifteen (15) years of continuous full-time employment on or before October 31st of any year.
 - 2. Continuous employment shall not be considered interrupted when absences arise as paid vacations, paid Sick Leave, approved Leave of Absence and/or paid Worker's Compensation period not to exceed one year.
 - 3. The following schedule shall be used as a basis for longevity payments, paid to such employees as of October 31st, provided said employees qualify as to length of service, as per Paragraph C.1 of this Article, as follows:

<u>STEP</u>	<u>CONTINUOUS YEARS OF FULL TIME SERVICE ON OR BEFORE OCTOBER 31ST OF EACH YEAR</u>		<u>AMOUNT</u>
	1	15 through 19	
2	20 through 24		\$800
3	25 and thereafter		\$1,000

- D. Longevity compensation shall be added to the regular payroll check, when due, for eligible employees. It shall be considered a part of the regular compensation and, as such subject to Federal and State withholding tax, social security, retirement deductions, regulations and ordinances of the County of Macomb and other applicable statutes.
- E. Payments to employees eligible as of October 31st of any year shall be included in the first regular payroll check of December. The annual period covered in computation of longevity shall be from November 1 of each year through and including October 31st of the following year.
- F. Employees leaving the employ of the County by reason of retirement and receiving benefits under the Macomb County Employees' Retirement Ordinance, or by reason of death from any cause shall be entitled to and receive a longevity payment upon a pro-rated basis for that portion of the year employed.
- G. Employees hired into the County after January 1, 2012 will not be eligible for Longevity.

ARTICLE 22

UNION BULLETIN BOARDS

- A. The Employer will provide bulletin boards in the respective departments and locations, which may be used by the Union for posting notices of the following topics:
 - 1. Notices of Union Meetings.
 - 2. Notices of Union Elections and results of said Elections
 - 3. Notices of recreational, educational and social events.
- B. The bulletin board shall not be used by the Union for disseminating propaganda and among other things, shall not be used by the Union for posting or distributing pamphlets pertaining to political matters.

ARTICLE 23

MANAGEMENT RIGHTS

- A. The Employer retains and shall have the sole and exclusive right and authority to manage and operate its affairs, including all of its operations and activities; to decide the number of employees; to establish the overall operation, policies and procedures of the Employer; to assign employees to shifts in order to adequately staff shifts with appropriate personnel; to schedule the shifts of all employees; to direct its working force of employees; to determine the methods, procedures and services to be provided; to comply with P.A. 390, as amended, known as the State's Emergency Management Act and the County's Emergency Management resolution as well as all related plans, policies and procedures covered by these statutes. All of such rights are vested exclusively in the Employer.
- B. The Employer, in addition to the rights set forth in Section A above, shall have the right to hire, promote, demote, assign, transfer, suspend, discipline, discharge, layoff, recall; to establish schedules of work for employees; to establish work rules and rules of conduct, and to fix and determine penalties for the violation of such rules; to maintain discipline and efficiency among the employees, provided that such rights shall not be exercised by the Employer in violation of any of the express terms and provisions of this Agreement.

- C. The Employer retains and shall have the sole and exclusive right to administer, without limitation, implied or otherwise, all matters not specifically and expressly covered by the provisions of Paragraph A and B of this Article, or accepted by the provisions of any other Article of this Agreement.
- D. The Employer retains and shall have the sole and exclusive right and authority to convert full time vacant positions to part time.

ARTICLE 24

EMERGENCY MANAGER

The Parties agree that this Collective Bargaining Agreement is applicable to an emergency manager as defined in Public Act 4 of 2011. The Union's agreement to this provision was not by negotiation, rather, this provision is required by Public Act 9 and accordingly is a prohibited subject of bargaining.

ARTICLE 25

DISCIPLINE AND DISCHARGE

A. Discipline:

1. Should circumstances warrant, an employee may be disciplined for just cause. Disciplinary actions or measures may include, but are not limited to, the following: oral reprimand, written reprimand, suspension or discharge.
2. Employees in the bargaining unit shall be entitled to their right to representation at an interview or meeting that the employee reasonably believes could result in disciplinary action or discharge.
3. Any disciplinary action or measures imposed upon an employee may be processed as a grievance through the regular grievance procedure or through the special conference provisions as provided for in this Agreement.
4. If the Employer has reason to reprimand an employee, it shall be done in a manner that will not embarrass the employee before other employees or the public.

B. Suspension And Discharge:

1. If the Employer feels there is just cause for suspension or discharge, the employee and his/her steward will be notified in writing that the employee has been so disciplined. Such notification shall contain the charge(s) against the employee.
2. The Union shall have the sole right to take a suspension and/or discharge as a grievance at the 3rd Step of the Grievance Procedure, and the matter shall be handled in accordance with this procedure.

C. Records in Personnel Files:

1. Where disciplinary action has been put in writing, a copy shall become part of the employee's personnel file.
2. Any record of disciplinary action shall remain in the employee's personnel file. If after two (2) years of the date of discipline there have been no further incidents of a similar nature, the employee may request in writing for the Employer to remove the discipline from the personnel file. If the employee has not violated paragraph 3 below, the employee will remove such discipline from the employee's personnel file. When such request has been granted, the discipline shall be kept by the Employer in a separate file and shall be maintained for record keeping purposes only and will not be used in progressive discipline.

3. If, prior to the end of the above two (2) years, the employee is disciplined for a similar incident, the record of the first disciplinary action shall be maintained in the employee's file for an additional two (2) years, or a total of four (4) years. Record(s) of any similar incident(s) which causes subsequent disciplinary action to be imposed shall remain in the employee's personnel file until the previous similar discipline is authorized to be removed pursuant to paragraph 2, above.
4. If a record of discipline is not subject to paragraph 3 above and is older than two (2) years, it will not be relied upon for the purposes of progressive discipline.
5. It is the responsibility of the Employee or the Association to petition the Employer for removal of discipline records. Employees are encouraged to exercise their right to review their personnel files in accordance with the provisions of this collective bargaining agreement and/or human resources policies.

ARTICLE 26

SENIORITY

Seniority shall be by Non-Interchangeable Occupational Groups (NIOG) which are:

1. **APPLICATIONS DEVELOPMENT**
 - Business Systems Analyst
 - Programmer Analyst
 - Web Developer
 - Junior Business Systems Analyst
 2. **DATA ADMINISTRATION**
 - Database Administrator
 3. **NETWORK/OPERATING SYSTEMS SERVICES**
 - Enterprise Solutions Architect
 - Infrastructure Solutions Specialist
 - Infrastructure Technician
 4. **CLIENT SUPPORT SERVICES**
 - Systems Technician
 - Client Support Technician
 5. **CIRCUIT COURT**
 - Programmer Analyst
 6. **SHERIFF**
 - Criminal Justice Technology Specialist
- B. 1. "Benefit Seniority" is the accumulated time from the date of entry into County employment and will be the seniority that will prevail for purposes of accumulation and eligibility for Paid Time Off, Sick Leave, longevity, retirement and similar "fringe benefits" the Parties hereto may have agreed to. Benefit seniority may be adjusted pursuant to Article 17, Leave of Absence, Sections B(1)(f) and B(2)(k).

2. "Department Seniority" is the accumulated time from the date of entry into the Union and in the respective Department. An employee hired, transferred or promoted into the Department shall enter the Department with date of entry seniority.
 3. "NIOG Seniority" is the accumulated time from the date of entry into a NIOG. An employee transferred, or promoted, from one NIOG to another NIOG shall enter the new NIOG with date of entry seniority.
 4. "Classification Seniority" is the accumulated time from the date of entry into a classification. An employee transferred, or promoted, from one classification to another classification shall enter the new classification with date of entry seniority.
- C. Seniority rights shall be forfeited if the employee:
1. Resigns or terminates employment.
 2. Is discharged and not subsequently reinstated in accordance with appropriate provisions of the Agreement.
 3. Is absent without leave for a period of three (3) consecutive working days without notifying the Employer. After such absence, the Employer will send written certified notification to the employee at their last known address that they have lost seniority, and that employment has been terminated. If the disposition made of any such case is not satisfactory, the matter may be referred to the Grievance Procedure. In proper cases, exceptions shall be made by the Employer.
 4. Retires.
 5. Withdraws their contributions from the Macomb County Employees' Retirement Fund, except for participants in the Deferred Retirement Option Plan.
 6. Does not return to work when recalled from layoff.
 7. Fails to return from Sick Leave or Leave of Absence when scheduled. This shall be treated the same as 3 above.
- D. DROP Participants: DROP participants shall continue to accrue seniority in the same manner as Active Employees, except as otherwise provided in this Agreement.
- E. Membership Lists: The employer will report incoming and/or outgoing members in classifications reflected in the agreement between the Parties on a monthly basis, except in July, when seniority reports are distributed.

ARTICLE 27

LAYOFF AND RECALL

LAYOFF DEFINED: Except as otherwise provided for in this Agreement, Layoff and Recall is defined as follows:

- A. The word "layoff" means a reduction in the working force.
- B. If a layoff becomes necessary the following procedures will be mandatory:
 1. Layoffs, as required, shall be made within the affected Non-Interchangeable Occupational Groups (NIOG's) within the affected department.
 2. Such reduction will be made in the first instance by terminating probationary and temporary

- employees in the affected groups.
3. If a further reduction in force is required, such reduction, in the case of seniority employees, will be made in reverse order of NIOG seniority within the affected group within the affected department.
- C. When an employee is laid off, due to a reduction in the work force, he/she shall be permitted to exercise his/her seniority rights to "bump" or replace an employee with less department seniority in classifications covered by this Agreement in the affected department only. Such employee may "bump" an employee in an equal or lower job classification under the following conditions:
1. He/she shall have seniority as required and as defined in Article 26, Seniority.
 2. He/she shall have current ability to do the available work, meet the qualifications and perform the duties of the job without a trial or training period.
 3. An employee who qualifies for rights as set forth above, shall have the right to exercise such right or to accept layoff, by so notifying his/her Department Supervisor in writing. Failure of the affected employee to exercise such "bumping rights" at the time of layoff will result in forfeiture of "bumping rights" during the term of such layoff.
- D. Employees to be laid off for an indefinite period of time will have at least seven (7) calendar days notice of such layoff. The Unit Chairperson shall receive a list from the Employer of the employees being laid off on the same date the notices are issued to the employees.
- E. **RECALL PROCEDURE:** When the working force is increased after a layoff, employees will be recalled according to NIOG seniority as defined in Article 26, Seniority. Notice of recall shall be sent to the employee at his/her last known address, as listed in his/her personnel file, located in the Human Resources and Labor Relations Department, and sent by Certified Mail. If the employee fails to report for work within ten (10) working days from date of mailing of notice of recall, his/her employment shall be considered terminated. Extension will be granted solely by the Employer, in proper cases.
- F. Recall rights for laid off employees who have completed their probationary period will be limited to length of the employee's seniority, up to a maximum of five (5) years. Upon expiration of this period, the Employer shall be under no further obligation to recall the laid off employee and such employee shall forfeit his/her seniority.

ARTICLE 28

JOB POSTINGS

- A. Postings shall be made for a minimum of five (5) working days. Posting periods may be shortened or eliminated by agreement of the Parties.
- B. The posting will include the following information: The job classification, department, salary range, hours, starting time, qualifications and any testing requirements.
- C. Any employee interested in a position must apply through the Human Resources and Labor Relations established application process within the posting period. The employee must meet the minimum qualifications before the closing date of the posting, unless otherwise specified by Human Resources and Labor Relations or this collective bargaining agreement.
- D. If necessary, a temporary appointment may be made by the Department Head.

ARTICLE 29

PROMOTIONS

Promotions to a higher classification within the bargaining unit will be based on qualifications. The Employer shall offer the promotion to the bargaining unit employee, or other interested person, who has the best abilities and qualifications. After the interview, if the employer in its sole discretion has determined employees to be equal in all other ways, the employee with the greatest amount of departmental seniority will be offered the promotion.

ARTICLE 30

SPECIAL CONFERENCES

- A. Special Conferences mutually agreed upon will be arranged between the Union President and the Director, Human Resources and Labor Relations, or designated representative, for purposes of discussion of important matters. Such meetings shall be between up to three (3) representatives of the Employer and up to three (3) representatives of the Union, unless the Parties mutually agree to include additional persons.
- B. Arrangements for such Special Conferences shall be made in advance, in writing, and an agenda of the matters to be taken up at the meeting shall be presented at the time the conference is requested and agreed upon. Matters taken up in Special Conferences shall be confined to those included in the Agenda.
- C. The members of the Union shall not lose pay for time spent in such Special Conferences.

ARTICLE 31

MILEAGE

Mileage reimbursement will be made for employees required to use their personal vehicles while performing assigned County business. The mileage reimbursement rate will be established in accordance with the Internal Revenue Service mileage reimbursement formula. Mileage reimbursement will be paid based on the rate in effect at the time the mileage was incurred.

Mileage reimbursement must be authorized in advance by the Department Head or designee and in accordance with County and Department Policy.

ARTICLE 32

SAVINGS CLAUSE

Should any part of this Agreement be rendered or declared illegal or invalid by legislation, decree of a court of competent jurisdiction, Michigan Employment Relations Commission or other established or to be established governmental administrative tribunal, such invalidation shall not affect the remaining portions of this Agreement. Should a provision(s) be declared invalid, the Union and the County may agree on a replacement for the affected provision(s).

ARTICLE 33

REIMBURSEMENT ACCOUNT PROGRAM

The Employer shall offer a pre-tax Reimbursement Account Program, as authorized by Section 125 of the Internal Revenue Service Code. The Reimbursement Account Program shall be limited to the Health Care and Dependent Care provisions of the IRS Code. Employees shall have the option of participating in the Health Care and/or Dependent Care program. The Employer supports the establishment of a Premium Only Plan (POP) based upon the limitations of the Internal Revenue Service code and the vendor administering the program.

ARTICLE 34

TERMINATION OR MODIFICATION

- A. This Agreement shall continue in full force and effect until December 31, 2025.
- B. If either party wishes to terminate or modify this Agreement, said party shall provide written notice to the other party to that effect. Said notice shall be made no later than one hundred twenty (120) days prior to the termination date in Paragraph A., above. If neither party gives a notice of termination or modification, or if each party giving notice of termination or modification withdraws said notice prior to the termination date in Paragraph A., above, this Agreement shall continue in full force and effect from year to year thereafter, subject to timely notice of termination or modification by either party in subsequent year(s) of an extended Agreement.
- C. Notice of termination or modification shall be made in writing and shall be sent by Certified Mail. If said notice is made to the Union, it shall be sent to TPOAM, 27056 Joy Road, Redford, MI 48239-1949; if said notice is made to the County, it shall be sent to the Macomb County Director, Human Resources and Labor Relations, 6th Floor, 1 South Main Street, Mount Clemens, Michigan, 48043; address changes shall be made available to the other party, where applicable.
- D. It is agreed and understood that the provisions contained herein shall remain in full force and effect so long as they are not in violation of applicable Statutes or Ordinances and remain within the jurisdiction of the County of Macomb.
- E. The foregoing Agreement shall not be construed or utilized in any manner that may impede or prevent any elected or appointed Macomb County official from fulfilling or carrying out the Statutory or Constitutional duties of his/her office.

IN WITNESS WHEREOF, the Employer and its Office of the County Executive, by its Director, Human Resources and Labor Relations, and representatives of The Technical, Professional Officeworkers Association of Michigan (TPOAM), on behalf of the Information Technology Employees Association, hereby cause this Agreement and Appendices to be executed.

FOR THE UNION:



Michael Gerald, TPOAM Business Agent



Robin Chagnon, TPOAM Unit Chair

FOR THE EMPLOYER:



Karlyn Semlow, Director
Human Resources and Labor Relations

Dated: April 17, 2023

APPENDIX A

CLASSIFICATIONS

TPOAM – INFORMATION TECHNOLOGY EMPLOYEES ASSOCIATION

	<u>CLASSIFICATION</u>	<u>PAY GRADE</u>
	Business Systems Analyst	J
	Client Support Technician	D
	Criminal Justice Technology	I
	Database Administrator	L
	Enterprise Solutions Architect	L
	Infrastructure Solutions Specialist	K
	Infrastructure Technician	H
	Junior Business System Analyst	H
	Programmer Analyst	I
	Systems Technician	G
	Web Developer	H

APPENDIX B – WAGE AND INCREMENT SCHEDULES

2023 Pay Grades										
	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9	Step 10
A	\$30,080.46	\$30,952.79	\$31,850.42	\$32,774.09	\$33,724.53	\$34,702.55	\$35,708.92	\$36,744.48	\$37,810.07	\$38,906.56
B	\$33,088.51	\$34,048.07	\$35,035.47	\$36,051.49	\$37,096.99	\$38,172.80	\$39,279.81	\$40,418.93	\$41,591.08	\$42,797.22
C	\$36,397.36	\$37,452.88	\$38,539.01	\$39,656.64	\$40,806.69	\$41,990.08	\$43,207.79	\$44,460.82	\$45,750.18	\$47,076.94
D	\$40,037.09	\$41,198.17	\$42,392.91	\$43,622.31	\$44,887.36	\$46,189.09	\$47,528.57	\$48,906.90	\$50,325.20	\$51,784.63
E	\$44,040.80	\$45,317.98	\$46,632.21	\$47,984.54	\$49,376.09	\$50,808.00	\$52,281.43	\$53,797.59	\$55,357.72	\$56,963.10
F	\$48,444.88	\$49,849.78	\$51,295.43	\$52,782.99	\$54,313.70	\$55,888.80	\$57,509.57	\$59,177.35	\$60,893.49	\$62,659.40
G	\$53,289.37	\$54,834.76	\$56,424.97	\$58,061.29	\$59,745.07	\$61,477.68	\$63,260.53	\$65,095.09	\$66,982.84	\$68,925.35
H	\$58,618.31	\$60,318.24	\$62,067.47	\$63,867.42	\$65,719.58	\$67,625.44	\$69,586.58	\$71,604.59	\$73,681.13	\$75,817.88
I	\$64,480.14	\$66,350.06	\$68,274.21	\$70,254.16	\$72,291.53	\$74,387.99	\$76,545.24	\$78,765.05	\$81,049.24	\$83,399.67
J	\$70,928.15	\$72,985.07	\$75,101.63	\$77,279.58	\$79,520.69	\$81,826.79	\$84,199.77	\$86,641.56	\$89,154.16	\$91,739.63
K	\$78,020.96	\$80,283.57	\$82,611.80	\$85,007.54	\$87,472.76	\$90,009.47	\$92,619.74	\$95,305.71	\$98,069.58	\$100,913.60
L	\$85,823.06	\$88,311.93	\$90,872.98	\$93,508.29	\$96,220.03	\$99,010.41	\$101,881.72	\$104,836.29	\$107,876.54	\$111,004.96
M	\$94,405.37	\$97,143.12	\$99,960.27	\$102,859.12	\$105,842.04	\$108,911.46	\$112,069.89	\$115,319.91	\$118,664.19	\$122,105.45
N	\$103,845.90	\$106,857.44	\$109,956.30	\$113,145.03	\$116,426.24	\$119,802.60	\$123,276.88	\$126,851.91	\$130,530.61	\$134,316.00
O	\$114,230.49	\$117,543.18	\$120,951.93	\$124,459.54	\$128,068.86	\$131,782.86	\$135,604.56	\$139,537.10	\$143,583.67	\$147,747.60

2024 PAY GRADES (6% Increase from 2023)

	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9	Step 10
A	\$31,885.29	\$32,809.96	\$33,761.45	\$34,740.54	\$35,748.00	\$36,784.70	\$37,851.46	\$38,949.15	\$40,078.67	\$41,240.95
B	\$35,073.82	\$36,090.95	\$37,137.60	\$38,214.58	\$39,322.81	\$40,463.17	\$41,636.60	\$42,844.07	\$44,086.54	\$45,365.05
C	\$38,581.20	\$39,700.05	\$40,851.35	\$42,036.04	\$43,255.09	\$44,509.48	\$45,800.26	\$47,128.47	\$48,495.19	\$49,901.56
D	\$42,439.32	\$43,670.06	\$44,936.48	\$46,239.65	\$47,580.60	\$48,960.44	\$50,380.28	\$51,841.31	\$53,344.71	\$54,891.71
E	\$46,683.25	\$48,037.06	\$49,430.14	\$50,863.61	\$52,338.66	\$53,856.48	\$55,418.32	\$57,025.45	\$58,679.18	\$60,380.89
F	\$51,351.57	\$52,840.77	\$54,373.16	\$55,949.97	\$57,572.52	\$59,242.13	\$60,960.14	\$62,727.99	\$64,547.10	\$66,418.96
G	\$56,486.73	\$58,124.85	\$59,810.47	\$61,544.97	\$63,329.77	\$65,166.34	\$67,056.16	\$69,000.80	\$71,001.81	\$73,060.87
H	\$62,135.41	\$63,937.33	\$65,791.52	\$67,699.47	\$69,662.75	\$71,682.97	\$73,761.77	\$75,900.87	\$78,102.00	\$80,366.95
I	\$68,348.95	\$70,331.06	\$72,370.66	\$74,469.41	\$76,629.02	\$78,851.27	\$81,137.95	\$83,490.95	\$85,912.19	\$88,403.65
J	\$75,183.84	\$77,364.17	\$79,607.73	\$81,916.35	\$84,291.93	\$86,736.40	\$89,251.76	\$91,840.05	\$94,503.41	\$97,244.01
K	\$82,702.22	\$85,100.58	\$87,568.51	\$90,107.99	\$92,721.13	\$95,410.04	\$98,176.92	\$101,024.05	\$103,953.75	\$106,968.42
L	\$90,972.44	\$93,610.65	\$96,325.36	\$99,118.79	\$101,993.23	\$104,951.03	\$107,994.62	\$111,126.47	\$114,349.13	\$117,665.26
M	\$100,069.69	\$102,971.71	\$105,957.89	\$109,030.67	\$112,192.56	\$115,446.15	\$118,794.08	\$122,239.10	\$125,784.04	\$129,431.78
N	\$110,076.65	\$113,268.89	\$116,553.68	\$119,933.73	\$123,411.81	\$126,990.76	\$130,673.49	\$134,463.02	\$138,362.45	\$142,374.96
O	\$121,084.32	\$124,595.77	\$128,209.05	\$131,927.11	\$135,752.99	\$139,689.83	\$143,740.83	\$147,909.33	\$152,198.69	\$156,612.46

2025 PAY GRADES (3% Increase from 2024)

	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9	Step 10
A	\$32,841.85	\$33,794.26	\$34,774.29	\$35,782.76	\$36,820.44	\$37,888.24	\$38,987.00	\$40,117.62	\$41,281.03	\$42,478.18
B	\$36,126.03	\$37,173.68	\$38,251.73	\$39,361.02	\$40,502.49	\$41,677.07	\$42,885.70	\$44,129.39	\$45,409.14	\$46,726.00
C	\$39,738.64	\$40,891.05	\$42,076.89	\$43,297.12	\$44,552.74	\$45,844.76	\$47,174.27	\$48,542.32	\$49,950.05	\$51,398.61
D	\$43,712.50	\$44,980.16	\$46,284.57	\$47,626.84	\$49,008.02	\$50,429.25	\$51,891.69	\$53,396.55	\$54,945.05	\$56,538.46
E	\$48,083.75	\$49,478.17	\$50,913.04	\$52,389.52	\$53,908.82	\$55,472.17	\$57,080.87	\$58,736.21	\$60,439.56	\$62,192.32
F	\$52,892.12	\$54,425.99	\$56,004.35	\$57,628.47	\$59,299.70	\$61,019.39	\$62,788.94	\$64,609.83	\$66,483.51	\$68,411.53
G	\$58,181.33	\$59,868.60	\$61,604.78	\$63,391.32	\$65,229.66	\$67,121.33	\$69,067.84	\$71,070.82	\$73,131.86	\$75,252.70
H	\$63,999.47	\$65,855.45	\$67,765.27	\$69,730.45	\$71,752.63	\$73,833.46	\$75,974.62	\$78,177.90	\$80,445.06	\$82,777.96
I	\$70,399.42	\$72,440.99	\$74,541.78	\$76,703.49	\$78,927.89	\$81,216.81	\$83,572.09	\$85,995.68	\$88,489.56	\$91,055.76
J	\$77,439.36	\$79,685.10	\$81,995.96	\$84,373.84	\$86,820.69	\$89,338.49	\$91,929.31	\$94,595.25	\$97,338.51	\$100,161.33
K	\$85,183.29	\$87,653.60	\$90,195.57	\$92,811.23	\$95,502.76	\$98,272.34	\$101,122.23	\$104,054.77	\$107,072.36	\$110,177.47
L	\$93,701.61	\$96,418.97	\$99,215.12	\$102,092.35	\$105,053.03	\$108,099.56	\$111,234.46	\$114,460.26	\$117,779.60	\$121,195.22
M	\$103,071.78	\$106,060.86	\$109,136.63	\$112,301.59	\$115,558.34	\$118,909.53	\$122,357.90	\$125,906.27	\$129,557.56	\$133,314.73
N	\$113,378.95	\$116,666.96	\$120,050.29	\$123,531.74	\$127,114.16	\$130,800.48	\$134,593.69	\$138,496.91	\$142,513.32	\$146,646.21
O	\$124,716.85	\$128,333.64	\$132,055.32	\$135,884.92	\$139,825.58	\$143,880.52	\$148,053.05	\$152,346.61	\$156,764.65	\$161,310.83

DISCLAIMERS:

- Pending ratification from TPOAM – Information Technology Employees Association and the approval of the Board of Commissioners, this agreement will become effective, January 1, 2023.
- Employees in classifications currently on the Professional, Technical and Administrative (PTA) Schedule will receive the agreed upon PTA Schedule rates effective on the first pay of 2023 and the first pay of each year thereafter for the remainder of the contract. This agreement and all other provisions of the January 1, 2023 agreement shall remain in effect until December 31, 2025.

Appendix C

Active Employee Benefits

Blue Care Network

BCN HMO Active Employees

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCN does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCN administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCN disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCN, or whether the coverage provides minimum essential coverage.

CLSSLG

Macomb Co Employees - Hard Cap-Active/COBRA

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Plan Types

Plan Type: TPA

BCN HMO Active Employees



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call 800-662-6667 .

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 800-662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$6,350/\$12,700	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance billed charges and health care this plan does not cover	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsm.com or call the phone number on the back of your ID card for a list of <u>network providers</u> . 800-662-6667 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	Not covered	\$20 <u>copay</u> for online visits.
	<u>Specialist visit</u>	\$30 <u>copay</u> /visit	Not covered	Requires <u>referral</u> . No charge for allergy injections, allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	May require <u>preauthorization</u> / No charge for lab services
	<u>Imaging</u> (CT/PET scans, MRIs)	No charge	Not covered	Requires <u>preauthorization</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsm.com/customdruglist	Tier 1 - Mostly Generics	\$10 <u>copay</u> /30 days	Not covered	<u>Preauthorization</u> & step-therapy apply to select drugs. 50% <u>coinsurance</u> for sexual dysfunction drugs. Effective 1/1/2013 Tier 1 contraceptives are covered in full 90 day mail order and retail <u>copays</u> are 2x the standard retail <u>copays</u> .
	Tier 2 - Preferred Brand	\$25 <u>copay</u> /30 days	Not covered	
	Tier 3 - Non-Preferred Brand	\$50 <u>copay</u> /30 days	Not covered	
	<u>Specialty drugs</u>	Tiered <u>copays</u> listed above apply	Not covered	Limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	May require <u>preauthorization</u> /50% <u>coinsurance</u> for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgéon fees	No charge	Not covered	See "Outpatient surgery facility fee"

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	<u>Copay</u> waived if admitted
	<u>Emergency medical transportation</u>	No charge	No charge	Non-emergent transport is covered when preauthorized
	<u>Urgent care</u>	\$30 <u>copay</u> /visit	\$30 <u>copay</u> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	<u>Preauthorization</u> is required. 50% <u>coinsurance</u> for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fee	No charge	Not covered	See "Hospital Stay surgery facility fee"
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No Charge	Not covered	<u>Preauthorization</u> is required
	Inpatient services	No Charge	Not covered	<u>Preauthorization</u> is required
If you are pregnant	Office visits	No charge	Not covered	Postnatal and non-routine prenatal office visits-\$20 <u>copay</u>
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	\$30 <u>copay</u> /visit	Not covered	Requires <u>preauthorization</u> . Custodial care not covered.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit	Not covered	Requires <u>preauthorization</u> / One period of treatment for any combination of therapies within 60 consecutive days per medical episode. Subject to meaningful improvement within 60 days.
	<u>Habilitation services</u>	ABA - \$20 <u>copay</u> per visit. \$30 <u>copay</u> per visit for PT/OT/ST	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires <u>preauthorization</u> .
	<u>Skilled nursing care</u>	No charge	Not covered	Requires <u>preauthorization</u> /Limited to 730 days
	<u>Durable medical equipment</u>	No charge	Not covered	Requires <u>preauthorization</u> and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered in full

BCN HMO Active Employees

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	Not covered	Inpatient care requires <u>preauthorization</u> . Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's glasses	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's dental check-up	Not covered	Not covered	Contact benefit administrator for coverage.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|---|--|----------------------------|
| • Acupuncture (if prescribed for rehabilitation purposes) | • Long-term care | • Routine eye care (Adult) |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Dental Care (Adult) | • Private-duty nursing | • Weight loss programs |
| • Elective Abortion | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | |
|---------------------|-------------------------|
| • Bariatric surgery | • Infertility treatment |
| • Chiropractic care | • Hearing Aid |

Macomb County Blue Care Network Plans generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Care Network Plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Macomb County at (586) 469-5280.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Care Network or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Macomb County HRLR Department at (586) 469-5280.

BCN HMO Active Employees

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact : Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284, Southfield, MI 48086 or fax, 1-866-522-7345. For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, <http://www.michigan.gov/difs>; call 1-877-999-6442 or fax: 517-284-8838.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444- EBSA (3272) or www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, <http://www.michigan.gov/difs> or difs-HICAP@michigan.gov

Does this Plan Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Plan Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example, prescription drugs, through another carrier.)

Translation available

To get help reading in your language call the customer service number on the back of your ID card

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$0
- **Specialist copayment** \$30
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$130

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$0
- **Specialist copayment** \$30
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$860

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$0
- **Specialist copayment** \$30
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$200

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعد على المساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711 إذا لم تكن مشتركاً بالمثل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

بمساعدة، في حين أنك بحاجة للمساعدة، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711 إذا لم تكن مشتركاً بالمثل.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তালম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujesz pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の方の身の方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号（メンバーでない方は 877-469-2583, TTY: 711）までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomazete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at Impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Blue Cross Blue Shield

Community Blue PPO ASC

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCBSM, or whether the coverage provides minimum essential coverage. If you have an ASC Plan Modification, it may be defined here in only a limited way.

MACOMB COUNTY EMPLOYEES

Community Blue PPOSM ASC

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual/Family | Plan Type: PPO

Note to ASC groups: Before completing this template, please reference the disclaimer on the attached cover page.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$1,500 Individual/ \$3,000 Family	\$3,000 Individual/ \$6,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$6,350 Individual/ \$12,700 Family	\$12,700 Individual/ \$25,400 Family	The <u>out-of-pocket</u> limit is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket</u> limits until the overall family <u>out-of-pocket</u> limit has been met.
What is not included in the <u>out-of-pocket</u> limit?	<u>Premiums</u> , <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Will you pay less if you use a <u>network</u> provider?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of <u>network</u> providers.		This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network</u> <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network</u> <u>provider</u> might use an <u>out-of-network</u> <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /office visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	May require <u>preauthorization</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	\$7 <u>copay</u> /prescription for retail 30-day supply; \$14 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	<u>Preauthorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. 90-day supply not covered out of network.
	Preferred brand-name drugs	\$35 <u>copay</u> /prescription for retail 30-day supply; \$70 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	
	Non preferred brand-name drugs	\$70 <u>copay</u> /prescription for retail 30-day supply; \$140 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$250 <u>copay/visit</u> ; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted or for an accidental injury.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Mileage limits apply
	<u>Urgent care</u>	\$40 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required
	Physician/surgeon fee	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Your cost share may be different for services performed in an office setting
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	Prenatal: No Charge; <u>deductible</u> does not apply Postnatal: No Charge; <u>deductible</u> does not apply	Prenatal: 40% <u>coinsurance</u> Postnatal: 40% <u>coinsurance</u>	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. <u>Cost sharing</u> does not apply to certain maternity services considered to be <u>preventive</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	Not covered for Applied Behavioral Analysis; Not covered for Physical, Speech and Occupational Therapy	Not covered for Applied Behavioral Analysis; Not covered for Physical, Speech and Occupational Therapy	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	<u>Preauthorization</u> is required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-------------------------|-------------------------|----------------------------|
| • Acupuncture treatment | • Hearing aids | • Routine eye care (Adult) |
| • Cosmetic surgery | • Infertility treatment | • Routine foot care |
| • Dental care (Adult) | • Long term care | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---------------------|---|---|
| • Bariatric surgery | • Coverage provided outside the United States.
See http://provider.bcbs.com | • Non-emergency care when traveling outside the U.S |
| • Chiropractic care | • If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses - like the deductible, co-payments, or co-insurance, or benefits not otherwise covered | • Private-duty nursing |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$100
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$900
Coinsurance	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,530

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583; TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تحتاجه لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. لتتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY: 711 إذا لم تكن مشتركاً بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話：如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ማከላከያ ለማድረግ ወይንም ለማረጋገጥ የሚያስፈልጉ ጥያቄዎችን ወይንም ለማረጋገጥ የሚያስፈልጉ መረጃዎችን ለማግኘት እርስዎን ወይንም ሌላ ሰውን ወይንም ሌላ ሰውን ለማረጋገጥ የሚያስፈልጉ ጥያቄዎችን ወይንም ለማረጋገጥ የሚያስፈልጉ መረጃዎችን ለማግኘት 877-469-2583 TTY: 711 ይደውሉ።

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 용역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号(メンバーでない方は 877-469-2583, TTY: 711)までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulongan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filling a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ociportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Blue Cross Blue Shield

Simply Blue PPO HSA ASC with Rx

(High Deductible Health Plan)

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCBSM, or whether the coverage provides minimum essential coverage. If you have an ASC Plan Modification, it may be defined here in only a limited way.

MACOMB COUNTY EMPLOYEES

Simply Blue PPO HSASM ASC with Rx

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Note to ASC groups: Before completing this template, please reference the disclaimer on the attached cover page.

Coverage for: Individual/Family | **Plan Type:** PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$2,000 Individual/ \$4,000 Family	\$4,000 Individual/ \$8,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$3,000 Individual/ \$6,000 Family	\$6,000 Individual/ \$12,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of <u>network providers</u> .		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care or Online visit to treat an injury or illness	No Charge	20% <u>coinsurance</u>	None
	Specialist visit	No Charge	20% <u>coinsurance</u>	None
	Preventive care/ screening/ immunization	No Charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% <u>coinsurance</u>	May require <u>preauthorization</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	\$10 <u>copay</u> /prescription for retail 30-day supply; \$20 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 20% <u>coinsurance</u> of the approved amount	Preauthorization, step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. 90-day supply not covered out of network.
	Preferred brand-name drugs	\$40 <u>copay</u> /prescription for retail 30-day supply; \$80 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 20% of the approved amount	
	Non preferred brand-name drugs	\$80 <u>copay</u> /prescription for retail 30-day supply; \$160 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 20% of the approved amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <u>coinsurance</u>	None
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u>	None
	Emergency room care	No Charge	No Charge	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency medical transportation</u>	No Charge	No Charge	Mileage limits apply
	<u>Urgent care</u>	No Charge	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> is required
	Physician/surgeon fee	No Charge	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No Charge	No Charge	None
	Inpatient services	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	Prenatal: No Charge; <u>deductible</u> does not apply Postnatal: No Charge	Prenatal: 20% <u>coinsurance</u> Postnatal: 20% <u>coinsurance</u>	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. <u>Cost sharing</u> does not apply to certain maternity services considered to be <u>preventive</u> .
	Childbirth/delivery professional services	No Charge	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No Charge	20% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	No Charge	<u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	No Charge	20% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.
	<u>Habilitation services</u>	Not covered	Not covered	None
	<u>Skilled nursing care</u>	No Charge	No Charge	<u>Preauthorization</u> is required. Limited to 90 days per member per calendar year
	<u>Durable medical equipment</u>	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge	No Charge	<u>Preauthorization</u> is required. Visit limits apply.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
For more information on pediatric vision or dental, contact your plan administrator	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture treatment
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See <http://provider.bcbs.com>
- Hearing aids
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses - like the deductible, co-payments, or co-insurance, or benefits not otherwise covered
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$2,000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$30
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,090

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,760

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic tests (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعد بحاجة لمساعدة، فليك الحق في الحصول على المساعدة والمعلومات الضرورية بلسانك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711 إذا لم تكن مشتركاً بالخدمة.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話：如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

بمجرد أن تكون قد طلبت المساعدة، فأنت لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلسانك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711 إذا لم تكن مشتركاً بالخدمة.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객센터 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigen, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号（メンバーでない方は 877-469-2583, TTY: 711）までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filling a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Health Alliance Plan



Administered by Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company (Alliance)
Self-Funded Health Maintenance Organization (HMO) Plan
Summary of Benefits

AS000096 / XR002356 / XW000712

2023 Summary Self-Funded HMO

AS000096 / XR002356 / XW000712

Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	\$0 Individual; \$0 Family	N/A	
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	\$6,600 Individual; \$13,200 Family	N/A	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered	N/A	
Related Laboratory and Radiology Services	Covered	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered	N/A	
Immunizations	Covered	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	\$20 Copay	N/A	
Telehealth Visit	\$20 Copay	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	\$30 Copay	N/A	
Routine Audiology Exam	Covered	N/A	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered	N/A	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	Not Covered	N/A	
Allergy Treatment	Covered	N/A	
Allergy Injections	Covered	N/A	
Laboratory & Pathology	Covered	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered	N/A	Services require preauthorization.
Radiology (X-ray)	Covered	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered	N/A	
Dialysis	Covered	N/A	
Outpatient Medical Drugs	Covered	N/A	
Outpatient Surgical Services			
Outpatient Surgery	Covered	N/A	
Ambulatory Surgical Center	Covered	N/A	
Professional Surgical and Related Services	Covered	N/A	
Emergency/Urgent Care			
Urgent Care	\$30 Copay		
Emergency Room Care	\$150 Copay		Copay will be waived if admitted
Emergency Medical Transportation	Covered		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	Covered	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	N/A	
Bariatric Surgery and Related Services	\$1,000 Copay	N/A	One procedure per lifetime

Maternity Services			
Prenatal Office Visits	Covered	N/A	Covered under Preventive Services
Postnatal Office Visits	\$30 Copay	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	\$20 Copay	N/A	
Other Services			
Home Health Care	Covered	N/A	Does not include Rehabilitation Services. Unlimited.
Hospice Care	Covered	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	Covered	N/A	Covered for authorized services. Up to 730 days. Maximum benefit renews after 60 days of nonconfinement.
Durable Medical Equipment; Prosthetics & Orthotics	Covered	N/A	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered	N/A	May be rendered at home. Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	Covered	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	\$20 Copay	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy.
Infertility Services	Covered	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	Covered	N/A	One attempt per lifetime.
Temporomandibular Joint Disorder	Covered	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	\$15 Copay 30 day supply, \$30 Copay 90 day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply.
Non-Preferred Generic Drugs	\$15 Copay 30 day supply, \$30 Copay 90 day supply		
Preferred Brand Drugs	\$30 Copay 30 day supply, \$60 Copay 90 day supply		Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Non-Preferred Brand Drugs	\$50 Copay 30 day supply, \$100 Copay 90 day supply		
Preferred Specialty Drugs	\$50 Copay 30 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	\$50 Copay 30 day supply at specialty pharmacy only		

Template Rev 01/2020

- In case of conflict between this summary and your Self-Funded HMO Benefit Guide, the terms and conditions of the Self-Funded HMO Benefit Guide will govern.
- Elective hospital admissions require that Alliance be notified prior to the admission. Alliance must be notified within 48 hours after an emergency hospital admission. Failure to notify Alliance could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.
- Students away at school are covered for acute illness and injury related services according to Alliance criteria.
- Self-Funded HMO plans are administered by Alliance Health and Life Insurance Company, a wholly owned subsidiary of Health Alliance Plan.

Appendix D
Post November 1, 2013
Retirees

Blue Care Network
(Post November 1, 2013 Retirees)



CLSSLG

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Macomb Co Employees - Hard Cap-Retired

Coverage Period: Beginning on or after 1/1/2020

Coverage for: All Plan Types

Plan Type: TPA

Summary of Benefits and Coverage: What this Plan Covers & What it Costs



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call 800-662-6667 .

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 800-662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$6,350/\$12,700	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance billed charges and health care this plan does not cover	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsm.com or call the phone number on the back of your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care or Online visit to treat an injury or illness	\$20 <u>copay</u> /visit	Not covered	\$20 <u>copay</u> for online visits.
	<u>Specialist visit</u>	\$30 <u>copay</u> /visit	Not covered	Requires <u>referral</u> . No charge for allergy injections, allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	May require <u>preauthorization</u> / No charge for lab services
	<u>Imaging</u> (CT/PET scans, MRIs)	No charge	Not covered	Requires <u>preauthorization</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsm.com/customdruglist	Tier 1 - Mostly Generics	\$10 <u>copay</u> /30 days	Not covered	<u>Preauthorization</u> & step-therapy apply to select drugs. 50% <u>coinsurance</u> for sexual dysfunction drugs. Effective 1/1/2013 Tier 1 contraceptives are covered in full 90 day mail order and retail <u>copays</u> are 2x the standard retail <u>copays</u> .
	Tier 2 - Preferred Brand	\$25 <u>copay</u> /30 days	Not covered	
	Tier 3 - Non-Preferred Brand	\$50 <u>copay</u> /30 days	Not covered	
	<u>Specialty drugs</u>	Tiered <u>copays</u> listed above apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	May require <u>preauthorization</u> /50% <u>coinsurance</u> for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fees	No charge	Not covered	See "Outpatient surgery facility fee"

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	<u>Copay</u> waived if admitted
	<u>Emergency medical transportation</u>	No charge	No charge	Non-emergent transport is covered when preauthorized
	<u>Urgent care</u>	\$30 <u>copay</u> /visit	\$30 <u>copay</u> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	<u>Preauthorization</u> is required. 50% <u>coinsurance</u> for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fee	No charge	Not covered	See "Hospital Stay facility fee"
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No Charge	Not covered	<u>Preauthorization</u> is required
	Inpatient services	No Charge	Not covered	<u>Preauthorization</u> is required
If you are pregnant	Office visits	No charge	Not covered	Postnatal and non-routine prenatal office visits-\$20 <u>copay</u>
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	\$30 <u>copay</u> /visit	Not covered	Requires <u>preauthorization</u> . Custodial care not covered.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit	Not covered	Requires <u>preauthorization</u> / One period of treatment for any combination of therapies within 60 consecutive days per medical episode. Subject to meaningful improvement within 60 days.
	<u>Habilitation services</u>	ABA - \$20 <u>copay</u> per visit. \$30 <u>copay</u> per visit for PT/OT/ST	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires <u>preauthorization</u> .
	<u>Skilled nursing care</u>	No charge	Not covered	Requires <u>preauthorization</u> /Limited to 730 days

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	No charge	Not covered	Requires <u>preauthorization</u> and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered in full
	<u>Hospice services</u>	No charge	Not covered	Inpatient care requires <u>preauthorization</u> . Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's glasses	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's dental check-up	Not covered	Not covered	Contact benefit administrator for coverage.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none">• Acupuncture (if prescribed for rehabilitation purposes)• Cosmetic surgery• Dental Care (Adult)• Elective Abortion	<ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing• Routine eye care (Adult)	<ul style="list-style-type: none">• Routine foot care• Weight loss programs• Hearing Aids
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none">• Bariatric surgery• Chiropractic care	<ul style="list-style-type: none">• Infertility treatment	

Macomb County Blue Care Network Plans generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Care Network designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Macomb County at (586) 469-5280.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Care Network Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Macomb County HRLR Department at (586) 469-5280.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact : Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284, Southfield, MI 48086 or fax. 1-866-522-7345. For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, <http://www.michigan.gov/difs>; call 1-877-999-6442 or fax: 517-284-8838.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444- EBSA (3272) or www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, <http://www.michigan.gov/difs> or difs-HICAP@michigan.gov

Does this Plan Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Plan Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example, prescription drugs, through another carrier.)

Translation available

To get help reading in your language call the customer service number on the back of your ID card

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$130

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$860

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$200

Blue Cross Blue Shield
Community Blue PPO ASC
(Post November 1, 2013 Retirees)

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCBSM, or whether the coverage provides minimum essential coverage. If you have an ASC Plan Modification, it may be defined here in only a limited way.

MACOMB COUNTY EMPLOYEES

Community Blue PPOSM ASC

Note to ASC groups: Before completing this template, please reference the disclaimer on the attached cover page.

Coverage for: Individual/Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$1,500 Individual/ \$3,000 Family	\$3,000 Individual/ \$6,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan? (May include a <u>coinsurance</u> maximum)	\$6,350 Individual/ \$12,700 Family	\$12,700 Individual/ \$25,400 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of <u>network providers</u> .		This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /office visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	May require <u>preauthorization</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	\$7 <u>copay</u> /prescription for retail 30-day supply; \$14 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.
	Preferred brand-name drugs	\$35 <u>copay</u> /prescription for retail 30-day supply; \$70 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	
	Nonpreferred brand-name drugs	\$70 <u>copay</u> /prescription for retail 30-day supply; \$140 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	\$250 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$250 <u>copay/visit</u> ; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted or for an accidental injury.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Mileage limits apply
	Urgent care	\$40 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required
	Physician/surgeon fee	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> for mental health; 40% <u>coinsurance</u> for substance use disorder	Your cost share may be different for services performed in an office setting
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	Prenatal: No Charge; <u>deductible</u> does not apply Postnatal: No Charge; <u>deductible</u> does not apply	Prenatal: 40% <u>coinsurance</u> Postnatal: 40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for preventive services.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required.
	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	Not covered for Applied Behavior Analysis; Not covered for Physical, Speech and Occupational Therapy	Not covered for Applied Behavior Analysis; Not covered for Physical, Speech and Occupational Therapy	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Physician certification required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture treatment
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Dental care (Adult)
- Long term care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Coverage provided outside the United States.
See <http://provider.bcbs.com>
- Private-duty nursing
- Chiropractic care
- Non-emergency care when traveling outside the U.S

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing

Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$1,700

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$3,270

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$900
Copayments	\$800
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic tests (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing

Deductibles	\$1,500
Copayments	\$90
Coinsurance	\$70

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$1,660

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

Health Alliance Plan
(Post November 1, 2013 Retirees)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: As of 01/01/2020



Administered by Alliance Health and Life Insurance Company

Coverage for: Individual+Family | Plan Type: ASO HMO

! The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-766-4709 or visit www.hap.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-866-766-4709 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
What is the out-of-pocket limit for this plan?	\$6,600 person / \$13,200 family	The out of pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out of pocket limit until the overall family out of pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Balance billing Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out of pocket limit.
Will you pay less if you use a network provider?	Yes. See www.hap.org or call 1-866-766-4709 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out of network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out of network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> per visit	Not Covered	Visits are face-to-face, telephonic, or through secure electronic portal
	Specialist visit	\$30 <u>copay</u> per visit	Not Covered	None
	Other practitioner office visit	\$20 PCP Other Practitioner <u>copay</u> per visit/ \$30 Specialist Other Practitioner <u>copay</u> per visit	Not Covered	Chiropractic Care and Acupuncture Not Covered
	Preventive care/ screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org . You may have to pay for services that aren't <u>preventive services</u> . Ask your <u>provider</u> if the services needed are <u>preventive services</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require <u>preauthorization</u> .
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Services require <u>preauthorization</u> .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org	Generic drugs	Preferred \$15 <u>copay</u> /prescription (retail) Non-Preferred \$15 <u>copay</u> /prescription (retail)	Not Covered	Retail: 30 day supply for non-maintenance drugs at 1 <u>copay</u> ; 90 day supply for eligible maintenance drugs at 2 copays; Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 copays.
	Preferred brand drugs	\$30 <u>copay</u> /prescription (retail)	Not Covered	
	Non-preferred brand drugs	\$50 <u>copay</u> /prescription (retail)	Not Covered	
	Specialty drugs	Preferred \$50 <u>copay</u> /prescription (retail) Non-Preferred \$50 <u>copay</u> /prescription (retail)	Not Covered	Specialty drugs not available at 90 day or mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require <u>preauthorization</u> .
	Physician/surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention:	Emergency room care	\$150 copay per visit	\$150 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency medical transportation Only
	Urgent care	\$30 copay per visit	\$30 copay per visit	None
If you have a hospital stay:	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services:	Outpatient services	\$20 copay per visit	Not Covered	* Services can be accessed by calling 1-800-444-5755
	Inpatient services	No Charge	Not Covered	** Services can be accessed by calling 1-800-444-5755
If you are pregnant:	Office visits	\$30 copay per visit	Not Covered	No Charge for Prenatal care
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	**Some services require preauthorization.
If you need help recovering or have other special health needs:	Home health care	No Charge	Not Covered	None
	Rehabilitation services	No Charge	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require preauthorization. *See outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services- Up to 730 days, renewable after 60 days
	Durable medical equipment	No Charge	Not Covered	Coverage provided for approved equipment based on HAP's guidelines. Some services require preauthorization.
	Hospice services	No Charge	Not Covered	Up to 210 days per lifetime

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eyecare:	Children's eye exam	\$30 copay per visit	Not Covered	No Charge for one routine eye exam
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Hearing Aids	• Private-Duty Nursing
• Chiropractic Care	• Long-Term Care	• Routine Foot Care (Only when meets plan guidelines)
• Cosmetic Surgery	• Non-Emergency Care When Traveling Outside the U.S.	• Vision Hardware (Unless additional rider purchased)
• Dental Care (Adult)		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery	• Routine Eye Care (Adult)	• Weight Loss Programs
• Infertility Treatment (Only when meets plan guidelines)		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-866-766-4709; you may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.Healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the plan at 1-800-422-4641; you may also contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P.O. Box 30220, Lansing, MI 48909-7720, <http://michigan.gov/difs>; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Financial and Insurance Regulation, P.O. Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: <http://michigan.gov/difs> or e-mail difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum essential coverage for a month, you'll have to pay when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum value standards, you may be eligible for premium tax credits to help you pay for a plan through the Marketplace.

Language Access Services:

Please see a full list of Language Access Services following the Coverage Examples at the end of the Summary of Benefits of Coverage.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

Macomb County Health Alliance Plans generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Health Alliance Plan may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Macomb County at (586) 469-5280.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Health Alliance Plan Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Macomb County HRLR Department at (586) 469-5280.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$0
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$610
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Peg would pay is	\$670
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Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$0
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,075
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$55

The total Joe would pay is	\$1,130
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Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$0
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$90
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$90
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The plan would be responsible for the other costs of these EXAMPLE covered services.



Language Access Services

VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Telefononi numrin (800) 422-4641 ose TTY: 711.

تنبه: إذا كنت نتحدث اللغة العربية، فإتانا نوفر لك خدمات المساعدة اللغوية مجاناً. اتصل بالرقم (800) 422-4641 أو خدمة الهاتف النصي: 711.

নজর দিন: আপনিন বাংলা ভাষায় কথা বললে, ভাষা সহায়তার পিরেববা িবনামেলে আপনোর জন্ uপলb। (800) 422-4641 বা

TTY: 711 নমের কল ক ন।

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 (800) 422-4641 或 TTY 用戶請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzenzdienste zur Verfügung. Rufnummer: (800) 422-4641 oder TTY: 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 422-4641 (TTY: 711).

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。(800) 422-4641 まで、お電話にてご連絡ください。TTY ユーザーは 711 までご連絡ください。

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-422-4641 번 또는 TTY: 711 번으로 연락해 주십시오.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641, los usuarios TTY deben llamar al 711.

ৱাংলা ভাষায় কথা বললে, আপনোর জন্ uপলb। (800) 422-4641 বা TTY: 711 নমের কল ক ন।

ৱাংলা ভাষায় কথা বললে, আপনোর জন্ uপলb। (800) 422-4641 বা TTY: 711 নমের কল ক ন।

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.

Appendix E

Active Employees Dental Benefits

Delta Dental

Delta Dental of Michigan
Dental Benefit Highlights for
Macomb County Active and Retiree Dental Plan



Delta Dental PPO (Point-of-Service)	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non- participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	75%	75%
Endodontic Services - root canals	80%	75%	75%
Periodontic Services - to treat gum disease	80%	75%	75%
Oral Surgery Services - extractions and dental surgery	80%	75%	75%
Major Restorative Services - crowns	80%	75%	75%
Other Basic Services - misc. services	80%	75%	75%
Relines and Repairs - to bridges, implants, and dentures	80%	75%	75%
Major Services			
Prosthodontic Services - bridges, implants, and dentures	50%	50%	50%

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

Maximum Payment – \$1,000 per person total per Benefit Year on all services.

Deductible – None.

Note - This document is only intended to provide a brief description of your benefits. Please refer to your Certificate and summary for a complete description of benefits, exclusions, and limitations.

Welcome to Michigan's largest dental benefits family!

As a member of Delta Dental of Michigan, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier.

- It's easy to find a dentist! Four out of five dentists nationwide participate in our network.
- You have superior access to care and fee savings because of our agreements with participating dentists.
- Our dentists cannot balance bill you, which means more money in your pocket!
- No troublesome paperwork! Network dentists will fill out and file your claims.
- Pay only your copayments and/or deductibles when you receive care from network dentists – there are no hidden fees.
- You can still visit nonparticipating dentists, but you may be billed the full amount at the time of service and then have to wait to be reimbursed.

Quality Dental Program

With our quick and accurate claims processing, we pay more than 90% of claims in 10 days or less. Delta Dental also offers world-class customer service from our Certified Center of Excellence call center, as awarded by Benchmark Portal.

Online Access

Our online Consumer Toolkit lets you access your dental plan securely over the Internet. You can find a dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more – all at your own convenience.

A Healthy Smile

Keep your smile healthy with dental benefits from Delta Dental. Your smile is a good indicator of your health. Did you know that your dentist can detect up to 120 different diseases, including diabetes and heart disease? Early detection is one of the best ways to prevent further complications.

Questions?

If you have questions, please call our Customer Service team at 800-524-0149 (TTY users call 711) or look online at www.DeltaDentalMI.com.

Golden Dental



Golden Dental Plans

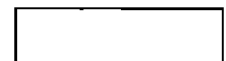
Certificate of Coverage

Macomb County

<u>OFFICE VISIT CO-PAY</u>	\$5.00
<u>CLASS I</u>	
Diagnostic and Preventive: Exams, Radiographs, Prophylaxis, Fluoride Treatment (up to age 19), Sealants (1 st and 2 nd Molars only – once in lifetime up to age 18), Space Maintainers (Primary Teeth only up to age 19)	100%
<u>CLASS II</u>	
Restorative: Fillings, Root Canals and Routine Extractions performed by General Provider	90%
<u>CLASS III</u>	
Prosthetic: Crowns, Bridges, Partial and Complete Dentures	75%
<u>CLASS IV</u>	
Specialty Care: Oral Surgery (including General Anesthesia) Endodontics Periodontics Pedodontics	75%
<u>ORTHODONTICS:</u>	
Dependents up to age 19 (Lifetime Maximum)	\$2,200
Member & Spouse (Lifetime Maximum)	\$1,800
Annual Maximum (per member per year):	Unlimited
Annual Renewal:	01/01
Membership Card Reads:	MACOMB

Dependents are covered up to the age of 26 for CLASS I – IV only.

29377 Hoover Road – Warren, MI 48093
 Phone: 1-800-451-5918 * Fax: 586-573-8720
 website: www.goldendentalplans.com



GOLDEN DENTAL PLANS, INC.
EXCLUSIONS, LIMITATIONS, AND EXCEPTIONS

I. General Exclusions, Limitations, and Exceptions

NOTE: No benefits will be paid under this Policy for the following treatments, services and care, unless otherwise indicated.

1	Dental services not appearing on the Schedule of Benefits.
2	Dental treatment for cosmetic purposes, unless specifically indicated on a specific plan.
3	Dental treatment performed in a hospital and/or any related hospital-fee.
4	Treatment of cleft palate, anodontia and mandibular prognathism.
5	Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained.
6	The cost of services secured from physicians, Dentists or Dental Surgeons, other than authorized GDP Providers, will not be paid for unless expressly authorized in writing by the Primary Care Dentist as cited under Emergency Coverage and Out-of-Area Emergency Coverage provisions.
7	Treatment for any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement under any Workmen's Compensation or Occupational Disease Law, even though You or Your Covered Dependent fails to claim the right of such benefits, provided that this exclusion will only apply to the extent that such benefits are payable through other plans.
8	Treatment for any disease, condition or injuries sustained, as a result of war, declared or undeclared, or any illness or injury occurring after the effective date of the Policy and caused by atomic explosion or exposure, whether or not the result of war.
9	Care of treatment obtained from or for which payment is made by any Federal, State, or County Municipal, or other governmental agency, including any foreign government.
10	Dental implants or transplants.
11	No Covered Person will be denied dental coverage due to trauma. However, dental care coverage under this Policy may not cover the Covered Person for certain traumatic events that may occur if those procedures are specifically excluded in this Policy. A Covered Person who requires dental care due to a serious trauma will not be covered for dental care in those areas that are specifically described as excluded.
12	A nominal administrative fee (i.e., sterilization, office visit, etc.) charged by selected dental offices.
13	Services or appliances started before a Covered Person became eligible under this Policy (i.e., teeth prepared for crowns or root canals in progress).
14	Prescription drugs.
15	Nitrous oxide analgesia.
16	Preventative control programs, including home care items.
17	Services started after termination of coverage.
18	Charges for failure to keep a scheduled visits with the Dentist.
19	Lost, missing, or stolen appliances (i.e., retainers, Occlusal guards, partial or complete dentures, or flippers).

GOLDEN DENTAL PLANS, INC.
EXCLUSIONS, LIMITATIONS, AND EXCEPTIONS

I. General Exclusions, Limitations, and Exceptions, *continued*

20	Duplicate full or partial dentures.
21	Inlays, unless listed as a Covered Service in the Schedule of Benefits.
22	Porcelain, porcelain substrate, and cast restorations on primary (baby) teeth.
23	Cysts and malignancies.
24	Removal of impacted teeth that exhibit no symptoms or pathology.
25	Consultations or examinations/evaluations for non-covered services.
26	Services or appliances performed by a Dentist whose practice is limited to prosthodontics
27	Behavior management fees for covered persons requiring additional or unusual efforts to complete a dental procedure.
28	Soft tissue management (i.e., irrigation, infusion, or special toothbrush).
29	Restorative work caused by orthodontic treatment.
30	Composite resin restorations on occlusal surfaces of bicuspid and molars.
31	Biopsy or Brush Biopsy to detect cancer.
32	Claims submitted due to auto accident, which should be submitted to automobile insurance carrier.
33	Claims reported as accident on school grounds, which should be submitted to school's primary insurance.
34	General anesthesia and the services of a special anesthesiologist unless authorized by employer group.
35	Treatment of fractures and dislocations.
36	Any service that is not specifically listed.
37	Congenital malformation.
38	Dispensing of drugs not normally supplied in a dental office.
39	Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.
40	Prophylactic removal of impactions (asymptomatic nonpathological).
41	Specialist consultations for noncovered benefits.
42	Dental expenses incurred with any dental procedure started prior to the enrollee's eligibility.
43	Services rendered by a dentist beyond the scope of his/her license.
44	Services rendered by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
45	Charges for duplication of radiographs.
46	Charges for temporary appliances.
47	Charges for experimental or investigational services or supplies.

**GOLDEN DENTAL PLANS, INC.
EXCLUSIONS, LIMITATIONS, AND EXCEPTIONS**

48	Services that the dentist feels, in his or her professional judgement, should not be provided.
49	Instructions in dental hygiene, dietary planning or plaque control.

50	Missed appointments or completion of claim forms. Infection control, including sterilization of supplies and equipment.
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II. Orthodontic Exclusions, Limitations, and Exceptions

1	Retreatment of prior Orthodontic problems, unless provided under this policy or any extension or renewal of this Policy
2	Patients with severe disabilities that may prevent satisfactory Orthodontic results
3	Any charge made by the Orthodontist for the cost of replacement and/or repair of an appliance furnished to the patient, which is lost or broken through no fault of the Orthodontist
4	Interceptive Orthodontic Treatment is not a covered benefit
5	Surgical procedures incidental to orthodontic treatment
6	Myofunctional therapy
7	Supplemental appliances not routinely used in typical orthodontic cases (i.e., Invisalign)
8	Active treatment extending more than 24 months from the point of banding due to lack of patient cooperation. For cases extending past 24 months, the Covered Person will be charged a monthly fee that is prorated at the Orthodontist's Submitted Fees.
9	Treatment started before the Covered Person became eligible under this policy
10	Transfer to another Dentist after banding has been initiated
11	Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and are subject to additional charges.
12	Orthodontic Benefit is once in a lifetime benefit per member.

Appendix F

Active Employees Vision Benefits

BCBSM Vision Benefits



MACOMB COUNTY EMPLOYEES
0070004480075 - 08BG2
Effective Date: 01/01/2023

Vision Coverage

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.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call 1-800-877-7195 or log on to the VSP Web site at vsp.com.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance *plus* savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None (member responsible for difference between approved amount and provider's charge)
Medically necessary contact lenses	None	None (member responsible for difference between approved amount and provider's charge)
Contact lens suitability examination (fitting and evaluation)	Up to \$60 copay	None (member responsible for difference between approved amount and provider's charge)

Note: No copay is required for prescribed contact lenses that are not medically necessary.

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to \$58 less \$5 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
<ul style="list-style-type: none"> Standard Progressive Lenses - Covered when rendered by a VSP network doctor 	One pair of lenses, with or without frames, in any period of 12 consecutive months	

ADM PLAN YR JAN; ASCMOD 9778 VIS; BLUE VISION; BV SPL; BV-CLSE; BVC; BVFL; BVPP CHOICE NET

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Benefits	VSP network doctor	Non-VSP provider
Standard frames	\$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less	Reimbursement up to \$65 less \$10 copay (member responsible for any difference)
Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.		One frame in any period of 12 consecutive months

Contact Lenses		
Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to \$210 (member responsible for any difference)
		Contact lenses up to the allowance in any period of 12 consecutive months
Contact lens suitability examination (fitting and evaluation)	\$120 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)		
		Contact lenses up to the allowance in any period of 12 consecutive months

HAP
Please refer to the HAP Medical Benefits Summary