COLLECTIVE BARGAINING AGREEMENT

between

THE COUNTY OF MACOMB

and

ADMINISTRATIVE AND TECHNICAL EMPLOYEES ASSOCIATION (ADTECH)

January 1, 2023
through
December 31, 2025

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ARTICLE 1

INTRODUCTION

1.1 This Agreement is effective January 1, 2023, between the COUNTY OF MACOMB, hereinafter referred to as "EMPLOYER" and the ADMINISTRATIVE AND TECHNICAL EMPLOYEES ASSOCIATION, inclusive of Units 1, 2, 3, 4 and 5, hereinafter independently referred to as "ASSOCIATION". It is understood that the headings used in this Agreement, including exhibits, are for reference only and are not meant to detract from the meaning.

ARTICLE 2

PURPOSE AND INTENT

2.1 The general purpose of this Agreement is to set forth terms and conditions of employment and promote orderly and peaceful labor relations for the mutual interest of EMPLOYER, the employees and ASSOCIATION. To that end, there shall be no discrimination against any employee because of ASSOCIATION activity, membership in the ASSOCIATION, or because of acting as an officer or in any other capacity on behalf of the ASSOCIATION. The EMPLOYER and the ASSOCIATION shall not discriminate against any employee because of age, sex, race, and nationality, religious or political beliefs. This provision shall in no way diminish the ASSOCIATION officer's duty to responsibly administrate the provisions herein. Where appropriate in this Agreement, the specification of the masculine gender applies to the feminine, and the specification of the singular applies to the plural and vice versa. The parties recognize that the interest of the community and the job security of the employees depend upon the EMPLOYER'S success in establishing a proper service to the community.

2.2 The ASSOCIATION officers together with the EMPLOYER shall administer the provision herein, with the membership's pledge to promote productive and efficient standards of service to the EMPLOYER and the public. The ASSOCIATION and its membership will encourage safety for the protection of the employees, and together with the EMPLOYER, eliminate waste and maximize efficiency in the interest of the public.

2.3 To these ends, the EMPLOYER and the ASSOCIATION shall encourage to the fullest degree friendly and cooperative relations between the respective representatives at all levels and among all employees under the terms of this Agreement.

ARTICLE 3

RECOGNITION OF BARGAINING UNIT

3.1 Pursuant to and in accordance with all applicable provisions of Act 336 of the Public Acts of 1947, as amended, the EMPLOYER recognizes the ASSOCIATION as the exclusive collective bargaining representative for all employees included within Units 1, 2, 3, 4 and 5 with respect to rates of pay, wages, hours of employment and other terms and conditions of employment.

ARTICLE 4

AID TO OTHER UNIONS

4.1 The EMPLOYER will not aid, promote or finance any labor group or organization which purports to engage in collective bargaining nor make any agreement with such group or organization for the purpose of undermining the ASSOCIATION.

ARTICLE 5

REPRESENTATION AND FEES AND DUES

To the extent that the laws of the State of Michigan permit, it is agreed that:

5.1 Employees will be represented by the bargaining unit and may authorize the Employer to deduct appropriate fees or dues to remit to the Union. If Public Act 349 of 2012 is either declared invalid, repealed or modified to make union security, including any form thereof lawful, the Union Security provisions contained in the 2011-2013 Labor Agreement will again be in force and effect to the fullest extent permitted by law.

5.2 Upon written authorization from an employee, the Employer shall deduct from the wages, all fees and dues as are prescribed by the Union and/or this Agreement. Such employee and the Union hereby authorize the Employer to rely upon and to honor written certification by the Union President or Treasurer of the Union of the amounts to be deducted. Such deduction under all properly executed authorizations shall become effective at the time application is signed by the employee. The Employer shall make such deductions the first pay period of the month following such authorization. The Employer shall transmit such deductions, together with a list of the employees paying same, to the Secretary/Treasurer of ASSOCIATION as soon as possible after the deduction.

5.3 The Employer agrees to provide this service without charge to the Union. It is understood and agreed, that the provision for deduction of the dues is for the benefit of the employees requesting same, and the Employer is under no obligation to demand or request that employees authorize such deductions as a condition of employment.

5.4 The Employer shall send written confirmation of all new hires, transfers out of the bargaining unit and terminations every month to the Union President.

5.5 The Employer shall not be liable to the Union by reason of the requirements of this Agreement for the remittance or payment of any sum other than that constituting actual deductions made from wages earned by employees.

5.6 The Union will, indemnify and save harmless the Employer from any and all claims, demands, suits and other liability by reason of action taken or not taken by the Employer for the purpose of complying with this Article.

ARTICLE 6

STEWARDS AND ALTERNATE STEWARDS

6.1 An employee shall be represented by one (1) Steward. In the absence of the Steward or in matters involving the Steward, an alternative representative of the Unit shall be designated.

6.2 Following a request to the Supervisor and pursuant to the terms of this Agreement, the Unit Steward or alternate representative, including the Association President, may investigate and present grievances and attend to the administration of the contract during working hours and without loss of pay. The Supervisor shall grant permission as soon as possible, but in no event later than the next regularly scheduled working day. The privilege of Stewards or Union representatives leaving their work during working hours without loss of time or pay is subject to the understanding that the time will be devoted to proper handling of grievances and administration of the contract and not abused.

ARTICLE 7

GRIEVANCE AND GRIEVANCE PROCEDURE

7.1 The Parties intend that the grievance procedure as set forth herein shall serve as a means for a peaceful settlement of all disputes 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.

7.2 Any employee having a grievance in connection with their employment MUST present it to the Employer within fifteen (15) days after occurrence of alleged grievance as follows:

STEP 1: The employee must first discuss the specific grievance with their immediate Supervisor or designee. A Steward 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 and their Steward.

STEP 2: WRITTEN -DEPARTMENT HEAD: If the grievance is not settled at the verbal step, a written grievance may be filed by the Union President or Steward 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, address, position and department of the grievant, a clear and concise statement of the grievance, the issue involved, the relief sought, the date the incident or violation took place, the specific section(s) of the Agreement alleged to have been Violated, the Signature of the grievant, the signature of one of the following: the Union President or Steward 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 Union President or Steward.

STEP 3: DIRECTOR, HUMAN RESOURCES AND LABOR RELATIONS: If the grievance is not settled at Step 2, such grievance may be submitted by the Union President to the Director, Human Resources and Labor Relations, 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.

The Union President, or designee, must make a request in writing to conduct a Step 3 grievance meeting and the Parties shall conduct a Step 3 meeting within fifteen (15) days of the receipt of the Union President's or Steward's written request. The Union President, or designee, and Administrative and Technical Employees Association Representative shall meet with the Director, Human Resources and Labor Relations, or designee, as scheduled for Step 3 grievance meetings. Dates and times shall be mutually agreed upon. The Union representatives at said meeting may include, at the Union's discretion, The Union President or designee, the grievant, the Steward. 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 or designee within ten (10) days of the completion of the Step 3 meeting.

STEP 4: ARBITRATION:

A. If the grievance is not resolved at Step 3, the Union President has thirty (30) days from the receipt of the Step 3 answer to file a Notice of Intent to Arbitrate, by sending a letter to the Director, Human Resources and Labor Relations. If the Union President fails to request arbitration within this time limit, the grievance shall be deemed not eligible to go to arbitration.

7.3 SELECTION OF THE ARBITRATOR:

A. Within thirty (30) days of the receipt of the written Notice of Intent to Arbitrate the Union shall notify one of the arbitrators from the permanent panel of arbitrators who are listed in a Letter of Understanding which is attached to this Agreement. Selection shall be made on a rotation basis with the arbitrator listed first as the one who will hear the first case. The next arbitrator on the list will hear the second case and so on until each arbitrator shall have heard a case. Once the list has been exhausted, the Parties will go back to the beginning of the list and start the selection process over with the first name on the list.

B. The Parties recognize that, through no fault of either, an arbitrator may not be available for an extended period of time, to hear a case (extended period of time shall mean three (3) months or longer). The Parties may then move to the next arbitrator listed.

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

D. An arbitrator may be removed from the list by written consent of both parties during the life of the Agreement. Upon such removal, no further cases will be assigned to that arbitrator, but the arbitrator will hear and decide any cases already assigned to him/her. Within thirty (30) days after such removal, the Parties shall meet and mutually agree upon another arbitrator to replace the arbitrator removed. The newly-selected arbitrator will be placed on the list in the numbered position of the arbitrator he/she replaces. An arbitrator may remove himself/herself from the list at any time.

E. If the Parties agree, in a particular case, not to use the list of arbitrators, they may agree in writing to use the American Arbitration Association selection procedure.

7.4 AUTHORITY OF THE ARBITRATOR:

A. All arbitration hearings shall be governed by the rules of the American Arbitration Association.

B. 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 within 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.

C. 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.

D. 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.

E. 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.

F. In matters concerning discipline imposed, the arbitrator shall have the authority to sustain, overrule or mitigate the disciplinary action.

G. 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.

H. The fees and approved expenses of an arbitrator will be paid by the Parties equally.

7.5 GENERAL CONDITIONS:

A. Withdrawal Of Grievances: A grievance may be withdrawn and, if so withdrawn, all financial liability shall be cancelled. If the grievance is reinstated, the financial responsibility shall date only from the date of reinstatement. If the grievance is not reinstated within fifteen (15) days from the date of withdrawal, the grievance shall not be reinstated.

B. Computation Of Back Wages: All claims for back wages shall be limited to the straight time wages less any unemployment compensation.

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 in writing 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. Nothing contained herein shall be deemed to abrogate or limit the rights guaranteed by existing statutes or court decisions.

E. Time limits may be extended or shortened by mutual written consent of the Parties.

F. 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. 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 the affected employee has authorized in writing the release of said information.

ARTICLE 8

SPECIAL CONFERENCES

8.1 Special Conferences will be arranged between the ASSOCIATION President or his/her designee and the EMPLOYER'S designated representative upon request of either party. Representatives of the ASSOCIATION, at any Special Conference, shall be limited to the President, or designee, the employee (when applicable), the steward or designee, and the ASSOCIATION attorney. Employees shall not lose time or pay for the time spent in Special Conferences. Such conferences shall be scheduled within seven (7) days of the request unless waived by the EMPLOYER and the ASSOCIATION. When a Special Conference is called regarding an issue germane to a specific unit, or an employee from a specific unit, the steward of the affected unit shall be permitted to attend the Special Conference.

ARTICLE 9

ASSOCIATION BULLETIN BOARDS

9.1 The EMPLOYER will provide a reasonable number of bulletin boards to be placed in those areas mutually agreed upon by the EMPLOYER and the ASSOCIATION to be used for posting notices of all ASSOCIATION and professional activities. Information posted shall be pertinent and in good taste.

9.2 The bulletin boards shall not be used for disseminating propaganda and shall not be used for posting or distributing pamphlets of a political nature. The ASSOCIATION shall have exclusive use of the bulletin boards.

ARTICLE 10

MANAGEMENT RIGHTS

10.1 The ASSOCIATION recognizes the Management of the EMPLOYER, the direction of the work and the execution of its various duties, functions and responsibilities, are vested exclusively in the EMPLOYER, except as limited by this Agreement or subsequent amendments through Memorandums of Understanding agreed to by the parties.

ARTICLE 11

CONTINUOUS WORK FOR REGULAR EMPLOYEES AND SUBCONTRACTING

11.1 The EMPLOYER shall do all within its authority to provide all regular employees continuous work throughout the year. Subcontracting of work, however, shall continue to be within the sole discretion of the EMPLOYER. If the EMPLOYER subcontracts, the basis of any subcontracting will be limited to the issue of responsible fiscal management and not intended as a means to decrease employment or employee benefits among the bargaining unit employees.

ARTICLE 12

TEMPORARY ASSIGNMENT

12.1 Employees represented by the ASSOCIATION shall be expected to temporarily work in either higher, comparable or lower classifications. An Employee assigned to a comparable or lower classification shall suffer no reduction in pay rate. Pay for assignment to a higher classification shall become effective immediately upon assignment to that classification at the current yearly wage level of the EMPLOYEE (i.e., Year 1 Wage Level EMPLOYEE will be paid at the Year 1 Wage Level in the higher classification). Substantial performance of the duties of the classification without official assignment shall be considered an assignment for purposes of pay. Further, temporary assignment will only be recognized for a minimum assignment of four (4) hours.

12.2 Temporary assignment of six (6) calendar weeks or less may be filled by assignment of a bargaining unit employee or a person outside of the ASSOCIATION without first having to bid the assignment. The EMPLOYER in its discretion may temporarily assign a bargaining unit Employee within the Employee's designated unit, regardless of seniority. This period may be extended by mutual agreement. The EMPLOYER retains the option of transferring the least senior employee for a period of six (6) weeks. If the temporary assignment exceeds six (6) weeks, the assignment shall be bid under paragraph 12.3. The parties, however, as part of any agreement to extend the period, may also agree to extend or postpone the bid process.

12.3 The EMPLOYER shall not create and/or approve successive assignments of six (6) weeks or less which shall have the effect of avoiding the obligation to bid temporary assignments of more than six (6) weeks. The EMPLOYER shall maintain a current roster of non-bargaining unit persons temporarily assigned under this Paragraph which list shall include the person's name, position and beginning and ending date of the assignment. This roster shall be kept current and made available to the ASSOCIATION upon request.

12.4 A temporary assignment to a higher, comparable or lower classification exceeding six (6) calendar weeks shall be bid and awarded to the most senior qualified bargaining unit Employee. Temporary assignments of twelve (12) weeks or less shall be allowed for leaves taken under the Family Medical Leave Act in

accordance with federal law. A temporary assignment shall not exceed a total of one hundred twenty (120) days within a calendar year without mutual consent of the EMPLOYER and the ASSOCIATION.

12.5 Bargaining unit employees wanting to fill temporary assignments of six (6) weeks or less as specified in paragraphs above, shall notify the Human Resources and Labor Relations Department in writing of their desire. Such notices shall expire every six (6) months unless renewed in writing by the employee. The EMPLOYER shall keep a current list of employees wishing to fill temporary assignments.

12.6 The granting of temporary assignments pursuant to paragraphs above shall require approval of the employee's immediate supervisor. Approval of the immediate supervisor shall not be withheld for unreasonable, arbitrary or discriminatory reasons.

12.7 Temporary assignments are those made at the discretion of the EMPLOYER in order to assure orderly performance and continuity of services. They may be occasioned by but not limited to death, retirement, resignation, discharge, vacation, Sick Leave, compensation leave, maternity leave, or other approved leaves of absences. Temporary assignments involving non-bargaining unit persons shall be permitted providing the use of such persons does not result in a lay-off or loss of regular full-time work or benefits for any bargaining unit member. Temporary assignments to non-bargaining unit persons shall not be permitted while any regular, full time bargaining unit member is on lay-off.

ARTICLE 13

NO STRIKE CLAUSE

13.1 The ASSOCIATION recognizes that strikes are illegal and contrary to public policy in Michigan and that strikes are detrimental to the public health, safety and welfare. The ASSOCIATION agrees that no strike of any kind shall be caused or sanctioned by the ASSOCIATION at any time during the life of this Agreement. The occurrence of any such acts or actions prohibited in this Article by the ASSOCIATION shall be deemed a violation of this Agreement. Any employee who commits any of the acts prohibited in this Article may be subject to discharge or other disciplinary action as determined by the EMPLOYER, subject to the Grievance Procedure.

ARTICLE 14

PROBATIONARY, TEMPORARY AND CO-OP EMPLOYEES

14.1 All new Full-time employees newly hired in this bargaining unit shall be considered probationary employees for the first six (6) months of employment from the date of hire.

14.2 There shall be no seniority among probationary employees. When an employee completes the probationary period, he/she shall be entered onto the seniority list of the unit and shall rank for seniority from the first day of employment.

14.3 The Union shall represent new hire probationary employees for the purposes of collective bargaining in respect to rates of pay, wages, hours and other conditions of employment as set forth in Article 3, Recognition of Bargaining Unit, except that at any time during this period the Employer may dismiss the employee and such employee shall not have recourse to the grievance procedure provided the dismissal is for other than union activities.

14.4 Unit seniority for employees shall commence after an employee successfully completes his/her probationary period in such Unit. Unit seniority will prevail for purposes of Paid Time Off and overtime preference and bumping rights, layoff and recall rights within the department.

14.5 Except as provided for under Article 30, Leave of Absence, date of entry into County employment will provide a seniority date that will prevail for purposes of Paid Time Off, Sick Leave eligibility and accumulation, longevity, retirement and Similar "fringe benefits" the Parties hereto may agree.

14.6 Any employees with the same seniority date shall be considered by the higher number in the last four numbers of their social security number for any situation requiring the need of determination by seniority.

14.7 An employee who moves to a classification that is not in the bargaining unit shall have his/her bargaining unit seniority frozen as of the date of said move; the employee shall not accumulate any bargaining unit seniority while working in the classification that is not in the bargaining unit.

An employee who returns to the bargaining unit shall retain his/her County seniority.

ARTICLE 15

OUTSIDE EMPLOYMENT

15.1 EMPLOYER shall permit employees to engage in outside employment provided, however, that said outside work shall not create a conflict of interest, which is defined as:

A conflict of interest is created by employees who engage in activities on EMPLOYER time, or use or allow the use of EMPLOYER facilities, materials, vehicles, supplies, information or equipment for their personal business, benefit or profit. In addition, a conflict of interest is created by employees who use EMPLOYER funds to any extent for personal business, benefit or profit. An employee may not divulge or release information obtained as a result of their employment with the EMPLOYER for the purpose of fostering personal financial gain or financial gain for another employee or a member of the employee's family. An employee may not engage in any business transaction or private arrangement for personal financial gain or financial gain for a member of the employee's family or for other EMPLOYER employees which accrues from or is based on the employee's position or on information gained by reason of the employee's position.

15.2 Employees of the EMPLOYER are provided pay and benefits in exchange for their dedicated service. As such, the EMPLOYER expects its employees to treat their positions with the EMPLOYER as their primary job, and give it exclusive focus while on EMPLOYER work time.

ARTICLE 16

SENIORITY

16.1 There shall be no seniority among probationary employees. When an employee completes the probationary period, he/she shall be entered onto the seniority list of the unit and shall rank for seniority from the first day of employment.

16.2 An employee who moves to a classification that is not in the bargaining unit shall have his/her bargaining unit seniority frozen as of the date of said move; the employee shall not accumulate any bargaining unit seniority while working in the classification that is not in the bargaining unit.

16.3 An employee who returns to the bargaining unit shall retain his/her County seniority. The Human Resources and Labor Relations Department will notify the Union of any movement by a member in or out of the bargaining unit.

16.4 Any employees with the same seniority date shall be considered by the higher number in the last four numbers of their social security number for any situation requiring the need of determination by seniority.

ARTICLE 17

LOSS OF SENIORITY

17.1 An employee shall forfeit seniority rights for the following reasons:

A. He/she resigns or terminates his/her employment with the Employer.

B. He/she is dismissed and not subsequently reinstated in accordance with appropriate provisions of the Agreement between the Parties.

C. He/she 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 notification to the employee at his/her last known address that he/she has lost his/her seniority and his/her 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.

D. He/she retires.

E. If the employee, except for participants in the Deferred Retirement Option Plan, withdraws his/her contributions from the Macomb County Employees' Retirement System.

F. If he/she does not return to work when recalled from layoff. The recall rights are spelled out in this Agreement between the Parties.

G. Return from Sick Leave and Leaves of Absence will be treated the same as 17.1.c above.

H. To the extent, that this Article conflicts with other provisions included in this agreement those sections will take precedence and will be controlling.

ARTICLE 18

LAY-OFF AND RECALL

Lay-off:

18.1 Lay-off shall be defined as a reduction in the work force resulting from a necessary decrease of work or lack of funds. The EMPLOYER agrees that a lay-off shall never take place for punitive purposes. The ASSOCIATION will be given the opportunity to discuss the circumstances with the EMPLOYER prior to the effective date of the lay-off. Where practicable, the EMPLOYER will attempt to reassign rather than layoff.

18.2 If a reduction in the work force becomes necessary, the following procedure shall be mandatory:

A. All temporary, part-time, co-op and probationary employees shall be terminated.

B. If a further reduction is necessary, the EMPLOYER shall determine and select the classification(s) from which further reduction shall occur. Such reduction in the case of seniority employees will be made in inverse order of seniority as defined in Article 16.

C. The EMPLOYER shall prepare a bump list of all Employees who might be affected together with the similar or lower classification(s) whether within or without the affected unit, to which each of those Employees may be eligible to bump. A copy of the official EMPLOYER bump list shall be provided the

ASSOCIATION President, or designate, simultaneous with its final preparation. In determining the classification(s) to which an Employee may be eligible to bump, the EMPLOYER will use the Employee's seniority and qualifications. "Qualified" for purposes of this Article is defined as the ability to perform the job. It shall be assumed that an Employee can perform the duties of the position he or she selects if able to do so within the period of no more than forty (40) working hours. The forty (40) working hours period may be extended an additional forty (40) working hours if agreed by the parties.

D. The EMPLOYER shall follow the same procedure described in Paragraph 18.2 aforementioned for all subsequent bumps. This process shall be continued until the seniority and classification(s) of the employees afford(s) no further bumping rights.

18.3 As soon as possible but in no event later than five (5) working days following notification to the ASSOCIATION that the bump list has been finally prepared, a meeting shall be convened between three (3) EMPLOYER representatives and three (3) ASSOCIATION representatives to discuss the proposed bumping sequence. If the ASSOCIATION disagrees with the bumping sequence as presented by the EMPLOYER, every effort will be made to resolve the dispute through negotiation. If no agreement can be reached, the ASSOCIATION may exercise its grievance rights beginning with Article 7, Step 2 independent of the bumping process. Exercise of the ASSOCIATION'S rights under the grievance procedure shall not operate as a stay of the lay-off/bumping procedure. Any employee in the bumping sequence who desires to accept a lay-off rather than bump, shall be considered to have completed the bump process. The EMPLOYER/ASSOCIATION meeting shall be final as to the bumping sequence, and no Employee will process any further bumping rights related to this lay-off other than those preserved through the grievance process as aforementioned.

18.4 Employees to be laid off shall receive at least ten (10) working days' notice of lay-off. Simultaneous with the lay-off notice, all employees changing job assignments/ classifications through the bumping process shall be given the effective date of their new job assignments/classifications.

18.5 At the time of lay-off, employees of the ASSOCIATION will be given first opportunity to apply for employment among other EMPLOYER bargaining units prior to outside hiring. Further, a laid-off employee shall be considered as employed for purposes of bidding on a posted vacancy as set forth in Article 19 of this Agreement.

Recall Procedure:

18.6 When the workforce is increased or a job opening occurs during the period employee(s) are on lay-off, employee(s) will be recalled according to their seniority.

18.7 A laid-off employee will remain on the recall list for a period of time equivalent to the length of his/her seniority. A laid off employee with more than two (2) years seniority will be removed from the call list at the end of the two (2) year period unless he/she notifies the EMPLOYER in writing within thirty (30) calendar days following expiration of the two (2) year period that he/she desires to remain on the recall list. Further, the employee shall continue to give the EMPLOYER written notice each year of his/her desire to remain on the recall list at least thirty (30) calendar days following each anniversary.

18.8 A laid-off employee will be responsible to register his/her address with the EMPLOYER and any subsequent change of address. Notice of recall shall be sent to the employee by registered or certified mail at the last address filed with the EMPLOYER. An employee shall be expected to report for work within fourteen (14) calendar days after delivery of notice of recall, and his/her failure to report or to make alternate arrangements with the EMPLOYER shall be considered a quit as set forth in Article 17.

ARTICLE 19

PROMOTION AND LATERAL TRANSFER

19.1 Except as otherwise provided below, promotional and transfer opportunities shall first be granted to the senior qualified members of the bargaining unit where the vacancy occurs. Vacancies not filled in the above manner shall be open for bid to employees from all bargaining units' party to this Agreement. Issues of qualifications shall be addressed below.

19.2 Except as noted below, promotion and transfer within the Bargaining Unit shall be given the senior qualified applicant.

19.3 Notwithstanding the above, vacancies in the classifications of Service Center Foreman, Sign Shop Foreman, Mechanic Foreman, Electrical Supervisor, and Assistant Foreman, shall be filled in the following manner:

A. The job of Stock and Inventory Foreman, will be offered to the applicants from Unit 2, Supervisors, who have the qualifications as outlined in the applicable job description. The successful candidate will be selected on the basis of job experience, interview results and seniority consideration. In the event that the job cannot be filled from the Supervisor's Unit, the EMPLOYER may consider employees from the remaining units based upon qualifications. If the vacancy cannot be filled by an employee from the remaining Units, the EMPLOYER may attempt to fill the position with a person from outside the Bargaining Units.

B. The jobs of Service Center Foreman, Sign Shop Foreman, Mechanic Foreman and Electrical Supervisor shall first be offered to those employees from Unit 2, Supervisors, who have qualifications as outlined in the applicable job description. The successful candidate shall be selected on the basis of job experience, interview results and seniority consideration. In the event that the job cannot be filled from the Supervisor's Unit, the job shall next be offered to employees holding the classification of Unit 1, Assistant Foreman. The EMPLOYER shall select a qualified applicant from the Assistant Foreman Unit without regard to seniority. If the vacancy remains unfilled, the job shall be offered to a qualified applicant from the remaining ASSOCIATION classifications without regard to seniority.

C. Lateral transfer to the position of Assistant Foreman shall continue to be granted to the senior qualified applicant. Thereafter, however, the jobs of Assistant Foreman and Electrical Assistant Foreman shall be open to all ASSOCIATION employees who have the qualifications as outlined in the respective job descriptions. The successful candidate shall be selected on the basis of job experience, interview results and seniority consideration.

D. The job of Engineering Aide III and Records Technician will be offered to the applicants from Unit 3 who have the qualifications as outlined in the applicable job description. The successful candidate will be selected on the basis of job experience, interview results and seniority consideration.

E. Qualified individuals hired from the outside for positions may be placed into a pay increment commensurate with their work and educational experience. Vacancies in these positions shall continue to first be offered to ASSOCIATION members. If rejected for lack of qualifications, ASSOCIATION employees may grieve under the grievance procedure. Qualified persons from the outside become eligible only if there are no qualified ASSOCIATION applicants.

F. Any posting for a job opening, vacancy or transfer for an ASSOCIATION position shall be limited to the applicable ASSOCIATION units until the bid procedure is completed.

19.4 Vacancies will be posted for a period of seven (7) calendar days on the bulletin board in each work area. The posting shall include the job classification, job location, rate of pay and current job description. The

job description shall contain any testing requirement for the position. The vacancy shall be bid by employees within the seven (7) day posting period. It is the sole responsibility of the employee to personally insure and verify that their bid has been received by Human Resources and Labor Relations by the deadline for submission of bids.

19.5 The successful employee shall be given a forty-five (45) calendar day trial period. The trial period may be extended by mutual agreement of the ASSOCIATION and EMPLOYER when it is deemed necessary to further evaluate the employee's desire to remain on the job and/or ability to perform the job. Vacancies shall not be considered filled until conclusion of the trial period or settlement of any dispute resulting from the application of Paragraphs 19.6 and 19.7 of this Article. The bid list shall remain in effect until the end of the trial period and the permanent placement of the successful candidate in the vacant position, or until the list is exhausted.

19.6 In instances where promotions and/or transfers involve the application of seniority and senior applicants are rejected, the department head or immediate supervisor will, if requested, state the reasons timely. If the reasons given are not satisfactory, the matter will be a proper subject of a Special Conference. Those to be present in the event that a Special Conference is held shall include the ASSOCIATION President or Designee, immediate supervisor, future supervisor, Steward of the Unit and at least one (1) designated EMPLOYER representative. If the reasons given are not representative of just cause, meaning fair and honest cause or reasons regulated by good faith, then the aggrieved employee shall have a right to the grievance procedure.

19.7 During the forty-five (45) calendar day trial period, the employee shall have the option to revert back to his/her former non-probationary position within ten (10) calendar days. If the employee performs unsatisfactorily in the new position, notice and reasons shall be submitted to the ASSOCIATION in writing by the EMPLOYER with a copy to the employee.

19.8 Employees who bid and accept a lateral transfer, or a transfer to a lower classification, shall be restricted from bidding subsequent lateral and/or lower classification transfers for a period of twelve (12) months from the effective date of the initial transfer. The twelve (12) month restriction does not apply to promotional opportunities that may arise during the twelve (12) month period.

19.9 The EMPLOYER shall furnish the Administrative and Technical Employees Association President upon request bids awards and bid lists.

ARTICLE 20

LEAVE FOR UNION BUSINESS

20.1 Upon notice of not less than forty-eight (48) hours and with approval of the immediate supervisor, ASSOCIATION officers or designees may be granted time off without pay and without loss of benefits for ASSOCIATION business not to exceed two (2) working days. Any such time which might exceed more than two (2) working days shall require the additional approval of the Director, Department of Roads.

ARTICLE 21

DAILY WORK PERIOD

21.1 All employees shall work a regular eight (8) hour shift, the starting time of which shall be between 7:00 a.m. and 8:30 a.m., as determined by the EMPLOYER. The employees will have a one (1) hour lunch period, the starting and ending time of which shall be determined by their immediate supervisor. One-half (1/2) hour of the lunch period shall be considered as part of the regular eight (8) hour work day.

21.2 For those employees whose job assignments require their work day to coincide with a construction or contractor's activity, the work day shall relate to that of the activity, unless directed otherwise by the immediate supervisor.

21.3 It is acknowledged that professionalism and supervisory responsibilities require flexibility in the daily work schedule.

21.4 Breaks will be allowed for a period up to fifteen (15) minutes once each morning and once each afternoon.

21.5 Employees shall be allowed breaks for a period up to fifteen (15) minutes for each two (2) hours worked in excess of ten (10) continuous hours.

21.6 Employees shall be allowed a thirty (30) minute dinner break, paid for by the EMPLOYER, after twelve (12) continuous hours of work.

21.7 Any employee sent home for lack of work for any circumstance other than disciplinary action shall receive four (4) hours show up time.

21.8 No summer help, temporary or probationary employee shall work any overtime until all regular qualified employees have been asked to work the overtime first.

ARTICLE 22

RATES FOR NEW JOBS

22.1 When a new job is created and cannot be properly placed in an existing classification, the EMPLOYER will establish an applicable classification and rate structure. Upon the establishment of any such classification and rate structure, the EMPLOYER shall notify the ASSOCIATION and shall grant a Special Conference, if requested. In the event the ASSOCIATION does not agree that the description and rate are proper, the ASSOCIATION shall have the right to submit the matter to the grievance procedure at Step 2.

ARTICLE 23

DISCIPLINE AND DISCHARGE

23.1 No employee shall be discharged, demoted or otherwise disciplined except for just cause. The just cause standard, however, shall not apply to probationary employees. Disciplinary action shall consist of, but not necessarily be limited to, the following, nor shall the following be necessarily a listing of steps in which discipline may be imposed:

1 Verbal reprimand
2 Written reprimand
3 Suspension without pay
4 Discharge

23.2 If any seniority employee is subject to discipline or to disciplinary action involving time off, the employee, the steward and the ASSOCIATION President will be notified in writing immediately. Immediate shall reflect the quickest possible notice which can be given once said action is decided upon, but in any event, no later than the next scheduled work day. The disciplined employee will be allowed time to discuss their discharge or discipline with their steward and ASSOCIATION President or their designated representative on the same day they received said notice. The EMPLOYER will make available time for such discussion.

23.3 If any seniority employee is subject to disciplinary action not involving time off, the employee, the steward and the ASSOCIATION President will all receive written notice as soon as possible, but in any event within the next regularly scheduled working day. They will be allowed time to discuss the disciplinary action. The EMPLOYER will make available time for such discussion.

23.4 Unless otherwise agreed to, employees shall not be permitted to use Paid Time Off or Sick Leave for disciplinary time off.

23.5 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 from 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 employer 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 24

RETIREMENT SYSTEM

24.1 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.

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

1. Employee Contribution: For any employee hired on or before July 31, 2007 or who is vested as of January 29, 2015, 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 August 1, 2007 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 July 31, 2007 or who is vested as of January 29, 2015, the County pension shall not exceed sixty-five percent (65%) of an employee's final average compensation.

   For employees hired on or after August 1, 2007, 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 July 31, 2007 or who is vested as of January 29, 2015, 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 August 1, 2007, 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 July 31, 2007 or who is vested as of January 29, 2015, 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 August 1, 2007, 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 July 31, 2007 or who is vested as of January 29, 2015, 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 on or after August 1, 2007, 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 July 31, 2007 or who is vested as of January 29, 2015, 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 August 1, 2007, 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 December 17, 2013, 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 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 pension 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 re-instated, 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 his/her 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 Employees' 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 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 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 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: Unless specified in the Macomb County Employees' Retirement System Ordinance, 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. The Deferred Retirement Option Plan: The Memorandum of Understanding executed in 2007 regarding the Deferred Retirement Option Plan (DROP) incorporated by reference herein as Article 25, Deferred Option Retirement Plan. Vesting for the purposes of DROP excludes service time under Reciprocal Act 88.

24.3 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 who meets the Employer contribution vesting requirements as outlined in Article 24 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 24.3.1.

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 completion of 5 years of actual service with the Employer, employees shall be eligible to elect to increase their contribution by 1% of the employee's base pay. Per IRS regulations, the additional 1% contribution is a post-tax contribution. If such election is made by the employee, the Employer shall increase its contribution from 6% to 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.

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 25

DEFERRED RETIREMENT OPTION PLAN

25.1 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: Any current employee who is a member of the Macomb County Employees' Retirement System may voluntarily elect to participate in the DROP with a minimum of a thirty (30) day notice, at any time after attaining the minimum age and service requirements for a normal service retirement. Vesting for the purpose of DROP excludes service time under the Reciprocal Act 88.

B. Participation: The maximum period for DROP payments credited to the account is five (5) years (the "Participation Period"). An employee may elect to DROP at any time of year. There is no minimum time period for participation. Employees may continue to work beyond the 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 suspension 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 effective date of the DROP shall be on the first day of an EMPLOYER payroll period. 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: The employee's DROP Account shall be the regular monthly pension 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: 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 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 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

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.

STEP	CONTINUOUS YEARS OF FULL-TIME SERVICE ON OR BEFORE OCTOBER 31st OF EACH YEAR	AMOUNT
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:

YEARS OF CONSECUTIVE FULL-TIME SERVICE COMPLETED:	ANNUAL EQUIVALENT OF:
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

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 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 of March and August with the cash payment to be made in the second pay of 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 a DROP participant by December 31st of a calendar year shall be forfeited.

g) There shall be no compensation for Paid Time Off remaining in the DROP participants 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.

1. Sick Leave

   a) DROP participants shall be entitled to Sick Leave calculated in the following manner:

      i. DROP participants shall be provided with six (6) days of Sick Leave on January 1st of each year the employee participates in the DROP.

      ii. 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.

      iii. 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 during 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.

      iv. 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 i, above shall receive a pay out of up to three (3) of the unused sick leave days. Payment will be made the following January.

      v. There shall be no compensation for any Sick Leave time remaining in the DROP participant's bank upon separation from employment.

   b) DROP participants 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.

v. 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.

vi. When an absence occurs as defined in this Article, and the Department Head or designee suspect's abuse, a medical certificate may be required.

vii. 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 26

PREMIUM PAY, CALL-OUT PAY. SHIFT DIFFERENTIAL AND OVERTIME

26.1 Premium pay at double the hourly salary rate shall be paid for actual hours worked on Thanksgiving Day, Christmas Eve Day, Christmas Day, New Year's Eve Day, New Year's Day and Easter. Premium pay at one and one-half (1-1/2) the hourly salary rate shall be paid for all work performed on Saturday and holidays as set forth in Article 29. There shall be no payment for unauthorized overtime. Employees will be compensated at two (2) times their hourly rate of pay only for hours worked on Sundays.

26.2 Overtime assignments shall first be offered to the full-time permanent employee who by virtue of his/her classification is regularly assigned the work. In the event two (2) or more employees are regularly assigned the work, seniority shall prevail. The EMPLOYER, however, may offer the overtime to the less senior employee regularly assigned the work where the work is a continuation of specific duties being performed by the less senior employee and it would be impracticable to offer the overtime to another employee. If the employee regularly assigned the work declines or is unavailable for the overtime assignment the overtime assignment shall then be offered to the most senior employee within the unit who is capable of performing the work. If, on account of unavailability and/or lack of volunteers, the work cannot be assigned to any employee within the unit, the EMPLOYER may assign the work to temporary employees or full-time employees from another unit.

26.3 When called out after normal working hours, employees shall receive four (4) hours call-out pay at time and one-half (1-1/2). In the event the call-out time (4 hours) overlaps the start of the shift, the employee shall only be paid time and one-half (1-1/2) for the hours worked prior to the start of that shift. However, if a call out occurs on a Sunday, double time will be paid only for actual hours worked.

26.4 The use of compensatory time shall be governed by the parties' 1991 Letter of Understanding as set forth in full in the Memorandums of Understanding to this Agreement.

26.5 Bargaining Unit Members may accumulate compensatory time to a maximum of forty (40) hours.

ARTICLE 27

INSURANCE BENEFITS

27.1 Life Insurance:

1. Full-time Employees (including DROP Participants)

   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.

27.2 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.

27.3 The Employer shall provide two medical plan options: A Preferred Provider Organization (PPO) and a Health Maintenance Organization (HMO) to all regular eligible full-time employees and their eligible dependents including prescription drug coverage, as outlined in Appendix B, 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 employees 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.

27.4 1. Retirees: Full-time employees hired before June 15, 2010, 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.

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 June 15, 2010, the Employer will provide a fully paid medical and prescription drug plan to the employee only, 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.

3. All employees who retire or DROP on or after June 15, 2010, will have the medical and prescription drug plan as outlined in Appendix C, 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.

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.

27.5 Dental Plan:

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

27.6 Vision Plan:

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

27.7 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.

27.8 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.

27.9 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.

27.10 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 28

WORKERS' COMPENSATION AND LIABILITY INSURANCE

28.1 EMPLOYER shall provide Worker's Compensation and Liability Insurance and shall be responsible for premiums thereon. For a period not to exceed one (1) year, and provided the employee remains disabled and eligible for Worker's Compensation benefits, the benefits received by the employee shall be supplemented by payment of an amount which represents the difference between the worker's compensation and the employee's base pay. At no time shall the supplemental pay result in the employee receiving compensation in excess of base payer an amount which is less than the limits prescribed by law. In the event of a disputed Worker's Compensation claim, the EMPLOYER will pay the difference between Worker's Compensation and base pay for the period, not to exceed one (1) year that the claim is settled or determined to be compensable as a matter of law.

28.2 If at the end of any such one (1) year period the employee is still not able to return to work, the employee may elect to use his/her unused Sick Leave to supplement Worker's Compensation payments. If disability exists at the end of any such one (1) year period, employee, at his/her option, may seek to become eligible for coverage under the appropriate disability provision of the Retirement Ordinance and/or continue applicable Worker's Compensation benefits. Employees receiving disability compensation hereunder shall continue to accrue Sick Leave days on the same basis as employees on the active roll.

ARTICLE 29

PAID HOLIDAYS

29.1 The designated holidays are:

January 1st (New Year's Day)
Presidents Day
Memorial Day
Independence Day
Columbus Day
Thanksgiving Day
December 24th (Christmas Eve)
December 31st (New Year's Eve)
Martin Luther King, Jr. Day
Good Friday
June 19th (Juneteenth)
Labor Day
November 11th (Veterans' Day)
The day AFTER Thanksgiving
December 25th (Christmas Day)

29.2 When one (1) of the above listed paid holidays falls on a Saturday, the preceding Friday shall be considered the holiday. When the paid holiday falls on a Sunday, the following Monday shall be considered the holiday.

29.3 An employee will not receive holiday pay for a designated holiday if absent without leave on the scheduled work day preceding or following the holiday.

ARTICLE 30

LEAVE OF ABSENCE

30.1 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

30.2 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 annual leave/paid time off and compensatory time.

e. An approved Personal Leave shall not exceed 6 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 27, 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 16, 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 16, 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). Leave will run concurrent with any FMLA eligible Leave.

ARTICLE 31

PAID TIME OFF (PTO)

31.1 Participants in the Deferred Retirement Option Plan are not subject to Article 31, Paid Time Off, but shall receive Paid Time Off in the manner described in Article 25, Deferred Retirement Option Plan.

31.2 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.

31.3 Full time employees, shall be entitled to accrue Paid Time Off (PTO) according to the following schedule.

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).

YEARS OF CONSECUTIVE FULL TIME SERVICE COMPLETED:		ANNUAL EQUIVALENT OF:
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

31.4 Paid Time Off days may be accumulated to a maximum of thirty (30) work days.

31.5 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.

31.6 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.

31.7 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 conversions 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 regular paychecks with normal deductions.

31.8 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 32

SICK LEAVE

32.1 Participants in the Deferred Retirement Option Plan are not subject to Article 32, Sick Leave, but shall receive Sick Leave in the manner described in Article 25, Deferred Retirement Option Plan.

32.2 Regular full time employees shall accrue a Sick Leave bank at the rate of up to twelve (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).

32.3 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.

32.4 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.

32.5 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 a period of absence.

32.6 When an absence occurs as defined in this Article, and the Department Head or designee suspect's abuse, a medical certificate may be required.

32.7 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.

32.8 Sick Leave shall be available for use upon accrual.

32.9 <u>Accumulated Sick Leave Payoff</u> (does not apply to employees hired after January 1, 2016)

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. <u>Retirement</u>: A regular employee 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, 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 by either those eligible to receive benefits under Macomb County Employees' Retirement Ordinance or by 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).

32.10 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 33

LONGEVITY

33.1 Participants in the Deferred Option Plan are not subject to Article 33, Longevity, but shall receive Longevity in the manner described in Article 25, Deferred Option Retirement Plan.

33.2 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.

33.3 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 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 follows:

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

33.4 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.

33.5 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.

33.6 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.

33.7 Employees hired into the County after January 1, 2012 will not be eligible for Longevity.

ARTICLE 34

BEREAVEMENT LEAVE

34.1 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. and C. of this article are subject to prior approval by the Employer and shall not be unreasonably withheld or denied.

ARTICLE 35

JURY DUTY

35.1 In the event a full-time 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.

35.2 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.

35.3 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 36

SEMINARS AND EDUCATIONAL TRAINING

36.1 The employees recognize that seminars and training programs may be required to promote efficiency and job skills in their respective classifications, and that they may be required to attend such programs. All such training will be subject to review and approval of EMPLOYER prior to attendance. The employee shall be reimbursed any personal costs for travel and expenses while attending authorized seminars and/or training programs in accordance with the County Policy, as amended.

ARTICLE 37

PROFESSIONAL REGISTRATIONS AND CERTIFICATIONS

37.1 Upon approval of management and the EMPLOYER and in accordance with job requirements, expenses associated with professional registration and certification renewals shall be reimbursed to permanent employees.

ARTICLE 38

MEMBERSHIP FEES -PROFESSIONAL AND TECHNICAL ORGANIZATIONS (APPLICABLE TO UNIT 5 AND THE ENGINEERING AIDE II -REGISTERED LAND SURVEYOR FROM UNIT 3)

38.1 The EMPLOYER recognizes that membership in professional and technical organization is beneficial to both the employee and the EMPLOYER. When financial conditions permit and upon immediate supervisor and EMPLOYER approval, EMPLOYER shall reimburse employees for membership fees to such organizations.

ARTICLE 39

LEGAL SERVICE

39.1 EMPLOYER agrees to provide legal services and hold employees harmless from any monetary recovery assessed against them as parties to litigation arising from actions or activities involving professional service to EMPLOYER projects or assignments.

ARTICLE 40

SAFETY EQUIPMENT, CLOTHING AND TOOLS

40.1 Safety equipment, safety clothing, gloves and rain gear (excluding shoes) shall be provided by the EMPLOYER when the job so requires. Any disagreement as to interpretation and/or application of this Article shall be resolved by Special Conference rather than through the grievance procedure.

ARTICLE 41

REPLACEMENT OF PERSONAL BELONGINGS

41.1 When an employee suffers accidental damage to personal belongings through no fault of the employee, consideration shall be given to replacement in kind. Replacement shall be based upon an investigation, a written review and a recommendation by the immediate supervisor to the Human Resources and Labor Relations Department. The Human Resources and Labor Relations Department will have final say on consideration of replacement after reviewing the immediate supervisor's recommendation.

ARTICLE 42

RATIFICATION

42.1 The ASSOCIATION agrees to submit the final Agreement for ratification to the members of the bargaining unit pursuant to the ASSOCIATION's Constitution and By-Laws.

ARTICLE 43

EFFECTIVE DATE

43.1 This Agreement shall become effective 1st day of January 2023.

ARTICLE 44

SUPPLEMENTAL AGREEMENTS

44.1 All supplemental agreements shall be subject to the approval of the EMPLOYER and the ASSOCIATION. They shall be approved in writing or rejected in writing within a period of thirty (30) days following submission of a final draft.

ARTICLE 45

TERMINATION AND MODIFICATION

45.1 This Agreement shall continue in full force and effect from the date of ratification by both parties through the termination date of December 31, 2025.

45.2 If either party desires to terminate this Agreement, it shall, ninety (90) days prior to the termination date, give written notice of termination. If neither party gives notice of termination as provided in this paragraph or notice of amendment as hereinafter provided, this Agreement shall continue in effect from year to year subject to notice of termination by either party upon ninety (90) days' written notice prior to the current year's termination date.

45.3 If either party desires to modify or change this Agreement, it shall, ninety (90) days prior to the termination date or any subsequent termination date, give written notice of amendment in which event the notice of amendment shall set forth the nature of the amendment(s) desired. Any amendments that may be agreed upon shall become a part of this Agreement without modifying or changing any of the other terms of this Agreement.

45.4 Notice of termination or modification shall be in writing and mailed by regular mail to the Union at: 10 South Main Street, Suite 405 Mt. Clemens, MI 48043 and mailed to the EMPLOYER at: Human Resources and Labor Relations, 1 South Main Street, 6th Floor, Mt. Clemens, MI 48043 or to any such address as the Union or EMPLOYER may designate in writing.

45.5 Negotiations shall commence within ninety (90) days prior to the expiration of the contract.

ARTICLE 46

CHANGE OF NAME/ADDRESS

It is the Employee's responsibility to notify the County of any change of name/address.

Upon request, the County will furnish the Names and Addresses of all Employees covered by this Agreement to the Local Union. The Local Union shall appoint one Local Officer authorized to make the request. Requests are limited to one request per calendar quarter.

ARTICLE 47

CLOTHING ALLOWANCE

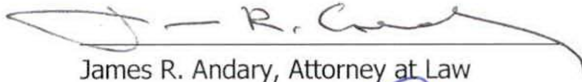
A. Employees will be provided a credited amount of $300.00 on even numbered years towards work-related clothing with a vendor as determined by the Employer.

B. Any purchase in excess of the $300.00 will be the paid by the employee.

C. Eligible employees who qualify for clothing allowance must have past his/her probationary period.

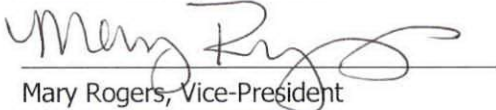
IN WITNESS WHEREOF, the County of Macomb and its Office of the County Executive, by its Director, Human Resources and Labor Relations, and representatives of the Administrative and Technical Employees Association, on behalf of its represented employees, hereby cause this Agreement to be executed.

FOR THE UNION:

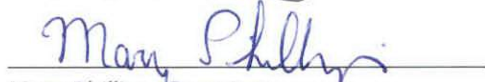


James R. Andary, Attorney at Law

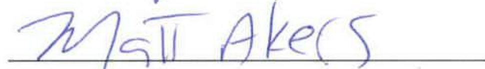
Andrew Pisarcik, President



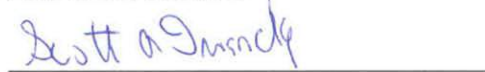
Mary Rogers, Vice-President



Mary Phillips, Secretary



Matt Akers, Steward



Scott Drwencke, Steward

Adam Newton, Steward

FOR THE EMPLOYER:

Karlyn Semlow, Director
Human Resources and Labor Relations

DATED: March 31, 2023

LETTER OF UNDERSTANDING

between

THE COUNTY OF MACOMB

and

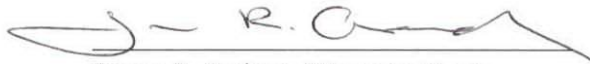
ADMINISTRATIVE AND TECHNICAL EMPLOYEES ASSOCIATION

RE: PANEL OF ARBITRATORS

The Parties agree that the following arbitrators shall serve on the panel of grievance arbitrators as per Article 7 - Grievance and Grievance Procedure:

1. David Kotzian
2. Patrick McDonald
3. Tom Gravelle

FOR THE UNION:



James R. Andary, Attorney at Law

Andrew Pisarcik, President

FOR THE EMPLOYER:

Karlyn Semlow, Director
Human Resources and Labor Relations

DATED: March 31, 23

LETTER OF AGREEMENT

Between

THE COUNTY OF MACOMB

and

ADMINISTRATIVE AND TECHNICAL EMPLOYEES ASSOCIATION

RE: ARTICLE 31 – PAID TIME OFF (PTO)

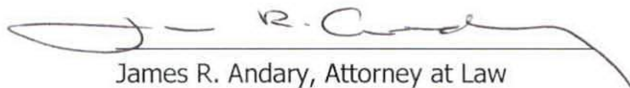
In reference to Article 31 – Paid Time Off (PTO) item F: Employees who are eligible for a Paid Time Off (PTO) conversion to cash may choose to transfer PTO hours to their sick leave bank in lieu of a cash payment.

At no time may a sick leave bank exceed the maximum accumulation of one hundred and eighty (180) work days.

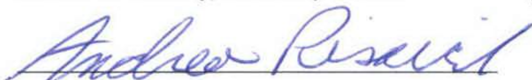
At no time may an employee transfer or return converted hours to their Paid Time Off (PTO) banks.

This Letter of Agreement will be in effect only through the life of the 2023-2025 Collective Bargaining Agreement.

FOR THE UNION:

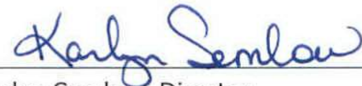


James R. Andary, Attorney at Law



Andrew Pisarcik, President

FOR THE EMPLOYER:



Karlyn Semlow, Director
Human Resources and Labor Relations

DATED: March 31, 23

Appendix A

Wage and Increment Schedules

APPENDIX A

PAY GRADES AND ASSIGNED CLASSIFICATIONS

ADTECH	
Classification	PTA Grade
*Traffic Engineer	K
Civil Engineer 3	K
*Traffic Supervisor	J
Right of Way Agent	J
Mechanic Foreman	J
Electrical Supervisor	J
Stock and Inventory Foreman	I
Sign Shop Foreman	I
Service Center Foreman	I
Mechanic Assistant Foreman	I
Information Systems Coordinator	I
Electrical Assistant Foreman	I
Design Technician	I
Civil Engineer 2	I
Traffic Technician, Senior	H
Systems Technician	H
Right-of-Way Technician	H
Records Technician	H
Engineering Aide III	H
Electrical Technician	H
Assistant Foreman	H
Account Specialist III	H
Traffic Technician	F
Facilities and Maintenance Coordinator	F
Engineering Aide II	F
Civil Engineer I	F
Buyer	F
Account Specialist II	F
Engineering Aide I	E
Department Secretary	E
Account Specialist I	E
**Stock Clerk	C
Inventory Delivery Clerk	C
Department Clerk	C
Office Assistant	B

*The classifications of Traffic Supervisor and Traffic Engineer shall receive an annual stipend of $3,000 (to be broken down into two (2) payments of $1,500 in January and July).

**Provided that the currently "red-circled" employee remains in the classification of Stock Clerk (pay grade C), they will receive a one-time lump sum payment of $3,000.00 per year for the term of this contract. Payments will be made on the second pay period of January.

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 $14.46	$30,952.79 $14.88	$31,850.42 $15.31	$32,774.09 $15.76	$33,724.53 $16.21	$34,702.55 $16.68	$35,708.92 $17.17	$36,744.48 $17.67	$37,810.07 $18.18	$38,906.56 $18.71
B	$33,088.51 $15.91	$34,048.07 $16.37	$35,035.47 $16.84	$36,051.49 $17.33	$37,096.99 $17.84	$38,172.80 $18.35	$39,279.81 $18.88	$40,418.93 $19.43	$41,591.08 $20.00	$42,797.22 $20.58
C	$36,397.36 $17.50	$37,452.88 $18.01	$38,539.01 $18.53	$39,656.64 $19.07	$40,806.69 $19.62	$41,990.08 $20.19	$43,207.79 $20.77	$44,460.82 $21.38	$45,750.18 $22.00	$47,076.94 $22.63
D	$40,037.09 $19.25	$41,198.17 $19.81	$42,392.91 $20.38	$43,622.31 $20.97	$44,887.36 $21.58	$46,189.09 $22.21	$47,528.57 $22.85	$48,906.90 $23.51	$50,325.20 $24.19	$51,784.63 $24.90
E	$44,040.80 $21.17	$45,317.98 $21.79	$46,632.21 $22.42	$47,984.54 $23.07	$49,376.09 $23.74	$50,808.00 $24.43	$52,281.43 $25.14	$53,797.59 $25.86	$55,357.72 $26.61	$56,963.10 $27.39
F	$48,444.88 $23.29	$49,849.78 $23.97	$51,295.43 $24.66	$52,782.99 $25.38	$54,313.70 $26.11	$55,888.80 $26.87	$57,509.57 $27.65	$59,177.35 $28.45	$60,893.49 $29.28	$62,659.40 $30.12
G	$53,289.37 $25.62	$54,834.76 $26.36	$56,424.97 $27.13	$58,061.29 $27.91	$59,745.07 $28.72	$61,477.68 $29.56	$63,260.53 $30.41	$65,095.09 $31.30	$66,982.84 $32.20	$68,925.35 $33.14
H	$58,618.31 $28.18	$60,318.24 $29.00	$62,067.47 $29.84	$63,867.42 $30.71	$65,719.58 $31.60	$67,625.44 $32.51	$69,586.58 $33.46	$71,604.59 $34.43	$73,681.13 $35.42	$75,817.88 $36.45
I	$64,480.14 $31.00	$66,350.06 $31.90	$68,274.21 $32.82	$70,254.16 $33.78	$72,291.53 $34.76	$74,387.99 $35.76	$76,545.24 $36.80	$78,765.05 $37.87	$81,049.24 $38.97	$83,399.67 $40.10
J	$70,928.15 $34.10	$72,985.07 $35.09	$75,101.63 $36.11	$77,279.58 $37.15	$79,520.69 $38.23	$81,826.79 $39.34	$84,199.77 $40.48	$86,641.56 $41.65	$89,154.16 $42.86	$91,739.63 $44.11
K	$78,020.96 $37.51	$80,283.57 $38.60	$82,611.80 $39.72	$85,007.54 $40.87	$87,472.76 $42.05	$90,009.47 $43.27	$92,619.74 $44.53	$95,305.71 $45.82	$98,069.58 $47.15	$100,913.60 $48.52
L	$85,823.06 $41.26	$88,311.93 $42.46	$90,872.98 $43.69	$93,508.29 $44.96	$96,220.03 $46.26	$99,010.41 $47.60	$101,881.72 $48.98	$104,836.29 $50.40	$107,876.54 $51.86	$111,004.96 $53.37
M	$94,405.37 $45.39	$97,143.12 $46.70	$99,960.27 $48.06	$102,859.12 $49.45	$105,842.04 $50.89	$108,911.46 $52.36	$112,069.89 $53.88	$115,319.91 $55.44	$118,664.19 $57.05	$122,105.45 $58.70
N	$103,845.90 $49.93	$106,857.44 $51.37	$109,956.30 $52.86	$113,145.03 $54.40	$116,426.24 $55.97	$119,802.60 $57.60	$123,276.88 $59.27	$126,851.91 $60.99	$130,530.61 $62.76	$134,316.00 $64.57
O	$114,230.49 $54.92	$117,543.18 $56.51	$120,951.93 $58.15	$124,459.54 $59.84	$128,068.86 $61.57	$131,782.86 $63.36	$135,604.56 $65.19	$139,537.10 $67.09	$143,583.67 $69.03	$147,747.60 $71.03

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 $15.329	$32,809.96 $15.774	$33,761.45 $16.231	$34,740.54 $16.702	$35,748.00 $17.187	$36,784.70 $17.685	$37,851.46 $18.198	$38,949.15 $18.726	$40,078.67 $19.269	$41,240.95 $19.827
B	$35,073.82 $16.862	$36,090.95 $17.351	$37,137.60 $17.855	$38,214.58 $18.372	$39,322.81 $18.905	$40,463.17 $19.453	$41,636.60 $20.018	$42,844.07 $20.598	$44,086.54 $21.195	$45,365.05 $21.810
C	$38,581.20 $18.549	$39,700.05 $19.087	$40,851.35 $19.640	$42,036.04 $20.210	$43,255.09 $20.796	$44,509.48 $21.399	$45,800.26 $22.019	$47,128.47 $22.658	$48,495.19 $23.315	$49,901.56 $23.991
D	$42,439.32 $20.404	$43,670.06 $20.995	$44,936.48 $21.604	$46,239.65 $22.231	$47,580.60 $22.875	$48,960.44 $23.539	$50,380.28 $24.221	$51,841.31 $24.924	$53,344.71 $25.646	$54,891.71 $26.390
E	$46,683.25 $22.444	$48,037.06 $23.095	$49,430.14 $23.764	$50,863.61 $24.454	$52,338.66 $25.163	$53,856.48 $25.893	$55,418.32 $26.643	$57,025.45 $27.416	$58,679.18 $28.211	$60,380.89 $29.029
F	$51,351.57 $24.688	$52,840.77 $25.404	$54,373.16 $26.141	$55,949.97 $26.899	$57,572.52 $27.679	$59,242.13 $28.482	$60,960.14 $29.308	$62,727.99 $30.158	$64,547.10 $31.032	$66,418.96 $31.932
G	$56,486.73 $27.157	$58,124.85 $27.945	$59,810.47 $28.755	$61,544.97 $29.589	$63,329.77 $30.447	$65,166.34 $31.330	$67,056.16 $32.239	$69,000.80 $33.173	$71,001.81 $34.135	$73,060.87 $35.125
H	$62,135.41 $29.873	$63,937.33 $30.739	$65,791.52 $31.631	$67,699.47 $32.548	$69,662.75 $33.492	$71,682.97 $34.463	$73,761.77 $35.462	$75,900.87 $36.491	$78,102.00 $37.549	$80,366.95 $38.638
I	$68,348.95 $32.860	$70,331.06 $33.813	$72,370.66 $34.794	$74,469.41 $35.803	$76,629.02 $36.841	$78,851.27 $37.909	$81,137.95 $39.009	$83,490.95 $40.140	$85,912.19 $41.304	$88,403.65 $42.502
J	$75,183.84 $36.146	$77,364.17 $37.194	$79,607.73 $38.273	$81,916.35 $39.383	$84,291.93 $40.525	$86,736.40 $41.700	$89,251.76 $42.909	$91,840.05 $44.154	$94,503.41 $45.434	$97,244.01 $46.752
K	$82,702.22 $39.761	$85,100.58 $40.914	$87,568.51 $42.100	$90,107.99 $43.321	$92,721.13 $44.577	$95,410.04 $45.870	$98,176.92 $47.200	$101,024.05 $48.569	$103,953.75 $49.978	$106,968.42 $51.427
L	$90,972.44 $43.737	$93,610.65 $45.005	$96,325.36 $46.310	$99,118.79 $47.653	$101,993.23 $49.035	$104,951.03 $50.457	$107,994.62 $51.920	$111,126.47 $53.426	$114,349.13 $54.976	$117,665.26 $56.570
M	$100,069.69 $48.110	$102,971.71 $49.506	$105,957.89 $50.941	$109,030.67 $52.419	$112,192.56 $53.939	$115,446.15 $55.503	$118,794.08 $57.113	$122,239.10 $58.769	$125,784.04 $60.473	$129,431.78 $62.227
N	$110,076.65 $52.921	$113,268.89 $54.456	$116,553.68 $56.035	$119,933.73 $57.660	$123,411.81 $59.333	$126,990.76 $61.053	$130,673.49 $62.824	$134,463.02 $64.646	$138,362.45 $66.520	$142,374.96 $68.450
O	$121,084.32 $58.214	$124,595.77 $59.902	$128,209.05 $61.639	$131,927.11 $63.426	$135,752.99 $65.266	$139,689.83 $67.159	$143,740.83 $69.106	$147,909.33 $71.110	$152,198.69 $73.172	$156,612.46 $75.294

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 $15.789	$33,794.26 $16.247	$34,774.29 $16.718	$35,782.76 $17.203	$36,820.44 $17.702	$37,888.24 $18.216	$38,987.00 $18.744	$40,117.62 $19.287	$41,281.03 $19.847	$42,478.18 $20.422
B	$36,126.03 $17.368	$37,173.68 $17.872	$38,251.73 $18.390	$39,361.02 $18.924	$40,502.49 $19.472	$41,677.07 $20.037	$42,885.70 $20.618	$44,129.39 $21.216	$45,409.14 $21.831	$46,726.00 $22.464
C	$39,738.64 $19.105	$40,891.05 $19.659	$42,076.89 $20.229	$43,297.12 $20.816	$44,552.74 $21.420	$45,844.76 $22.041	$47,174.27 $22.680	$48,542.32 $23.338	$49,950.05 $24.014	$51,398.61 $24.711
D	$43,712.50 $21.016	$44,980.16 $21.625	$46,284.57 $22.252	$47,626.84 $22.898	$49,008.02 $23.562	$50,429.25 $24.245	$51,891.69 $24.948	$53,396.55 $25.671	$54,945.05 $26.416	$56,538.46 $27.182
E	$48,083.75 $23.117	$49,478.17 $23.788	$50,913.04 $24.477	$52,389.52 $25.187	$53,908.82 $25.918	$55,472.17 $26.669	$57,080.87 $27.443	$58,736.21 $28.239	$60,439.56 $29.057	$62,192.32 $29.900
F	$52,892.12 $25.429	$54,425.99 $26.166	$56,004.35 $26.925	$57,628.47 $27.706	$59,299.70 $28.509	$61,019.39 $29.336	$62,788.94 $30.187	$64,609.83 $31.062	$66,483.51 $31.963	$68,411.53 $32.890
G	$58,181.33 $27.972	$59,868.60 $28.783	$61,604.78 $29.618	$63,391.32 $30.477	$65,229.66 $31.360	$67,121.33 $32.270	$69,067.84 $33.206	$71,070.82 $34.169	$73,131.86 $35.160	$75,252.70 $36.179
H	$63,999.47 $30.769	$65,855.45 $31.661	$67,765.27 $32.579	$69,730.45 $33.524	$71,752.63 $34.496	$73,833.46 $35.497	$75,974.62 $36.526	$78,177.90 $37.586	$80,445.06 $38.676	$82,777.96 $39.797
I	$70,399.42 $33.846	$72,440.99 $34.827	$74,541.78 $35.837	$76,703.49 $36.877	$78,927.89 $37.946	$81,216.81 $39.047	$83,572.09 $40.179	$85,995.68 $41.344	$88,489.56 $42.543	$91,055.76 $43.777
J	$77,439.36 $37.230	$79,685.10 $38.310	$81,995.96 $39.421	$84,373.84 $40.564	$86,820.69 $41.741	$89,338.49 $42.951	$91,929.31 $44.197	$94,595.25 $45.478	$97,338.51 $46.797	$100,161.33 $48.154
K	$85,183.29 $40.954	$87,653.60 $42.141	$90,195.57 $43.363	$92,811.23 $44.621	$95,502.76 $45.915	$98,272.34 $47.246	$101,122.23 $48.616	$104,054.77 $50.026	$107,072.36 $51.477	$110,177.47 $52.970
L	$93,701.61 $45.049	$96,418.97 $46.355	$99,215.12 $47.700	$102,092.35 $49.083	$105,053.03 $50.506	$108,099.56 $51.971	$111,234.46 $53.478	$114,460.26 $55.029	$117,779.60 $56.625	$121,195.22 $58.267
M	$103,071.78 $49.554	$106,060.86 $50.991	$109,136.63 $52.470	$112,301.59 $53.991	$115,558.34 $55.557	$118,909.53 $57.168	$122,357.90 $58.826	$125,906.27 $60.532	$129,557.56 $62.287	$133,314.73 $64.094
N	$113,378.95 $54.509	$116,666.96 $56.090	$120,050.29 $57.716	$123,531.74 $59.390	$127,114.16 $61.113	$130,800.48 $62.885	$134,593.69 $64.709	$138,496.91 $66.585	$142,513.32 $68.516	$146,646.21 $70.503
O	$124,716.85 $59.960	$128,333.64 $61.699	$132,055.32 $63.488	$135,884.92 $65.329	$139,825.58 $67.224	$143,880.52 $69.173	$148,053.05 $71.179	$152,346.61 $73.244	$156,764.65 $75.368	$161,310.83 $77.553

Appendix B

Active Employee Benefits

Blue Cross Blue Shield

Community Blue PPO ASC

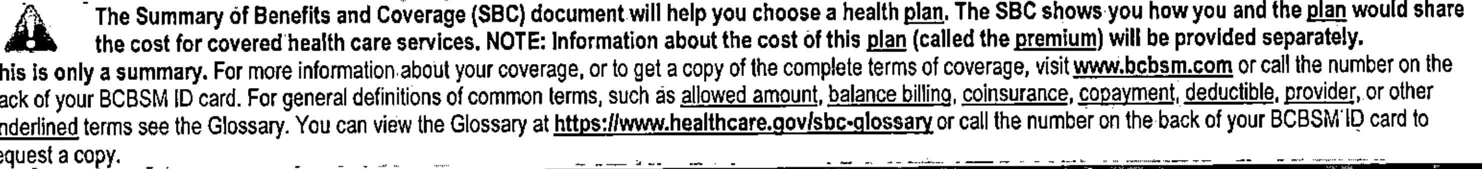
As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of 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.

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

MACOMB COUNTY EMPLOYEES

Community Blue PPO℠ ASC

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **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 deductible?	$1,500 Individual/ $3,000 Family	$3,000 Individual/ $6,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$6,350 Individual/ $12,700 Family	$12,700 Individual/ $25,400 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 limits 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, any pharmacy penalty and health care this plan doesn't 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.bcbsm.com or call the number on the back of your BCBSM ID card 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?	No.		You can see the specialist you choose without a referral.

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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/office visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$40 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	$7 copay/prescription for retail 30-day supply; $14 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network.
	Preferred brand-name drugs	$35 copay/prescription for retail 30-day supply; $70 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Non preferred brand-name drugs	$70 copay/prescription for retail 30-day supply; $140 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible 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% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit; deductible does not apply	$250 copay/visit; deductible does not apply	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply
	Urgent care	$40 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization may be required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	20% coinsurance	20% coinsurance	Your cost share may be different for services performed in an office setting
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	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 In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Habilitation services	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
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% coinsurance	20% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	Preauthorization 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 • Cosmetic surgery • Dental care (Adult)	• Hearing aids • 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 • 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** $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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$100
Coinsurance	$1,700
What isn't covered	
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$900
Coinsurance	$70
What isn't covered	
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**

In this example, Mia would pay:

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

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 تساعده بحاجة لمساعدة، 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 مشتركا 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。

[illegible] 877-469-2583 TTY:711 [illegible]

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 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 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

Simply Blue PPO HSA ASC with Rx

(High Deductible Health Plan)

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

MACOMB COUNTY EMPLOYEES

Simply Blue PPO HSA℠ ASC with Rx

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

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

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 deductible?	$2,000 Individual/ $4,000 Family	$4,000 Individual/ $8,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$3,000 Individual/ $6,000 Family	$6,000 Individual/ $12,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't 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.bcbsm.com or call the number on the back of your BCBSM ID card 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?	No.		You can see the specialist you choose without a referral.

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

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

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$30
Coinsurance	$0
What isn't covered	
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$700
Coinsurance	$0
What isn't covered	
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**

In this example, Mia would pay:

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

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 تساعده بحاجة لمساعدة، 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 مشتركا 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。

[illegible] 877-469-2583 TTY:711 [illegible]

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 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 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 Care Network

BCN HMO Active Employees

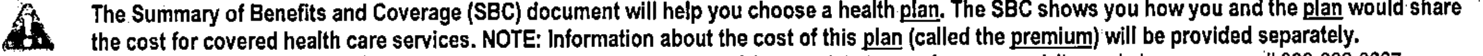
As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCN does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of 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



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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 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.
What is the out–of–pocket limit for this plan?	$6,350/$12,700	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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan does not cover	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 limits until the overall family out-of-pocket limit has been met.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the phone number on the back of your ID card for a list of network providers. 800-662-6667 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	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

BCN HMO Active Employees

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 copay/visit	Not covered	$20 copay for online visits.
	Specialist visit	$30 copay/visit	Not covered	Requires referral. No charge for allergy injections, allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	May require preauthorization / No charge for lab services
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Requires preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/customdruglist	Tier 1 - Mostly Generics	$10 copay/30 days	Not covered	Preauthorization & step-therapy apply to select drugs. 50% coinsurance for sexual dysfunction drugs. Effective 1/1/2013 Tier 1 contraceptives are covered in full 90 day mail order and retail copays are 2x the standard retail copays.
	Tier 2 - Preferred Brand	$25 copay/30 days	Not covered	
	Tier 3 - Non-Preferred Brand	$50 copay/30 days	Not covered	
	Specialty drugs	Tiered copays 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 preauthorization/50% coinsurance for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fees	No charge	Not covered	See "Outpatient surgery facility fee"

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)	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay waived if admitted
	Emergency medical transportation	No charge	No charge	Non-emergent transport is covered when preauthorized
	Urgent care	$30 copay/visit	$30 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required. 50% coinsurance 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	Preauthorization is required
	Inpatient services	No Charge	Not covered	Preauthorization is required
If you are pregnant	Office visits	No charge	Not covered	Postnatal and non-routine prenatal office visits-$20 copay
	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	Home health care	$30 copay/visit	Not covered	Requires preauthorization. Custodial care not covered.
	Rehabilitation services	$30 copay/visit	Not covered	Requires preauthorization/ One period of treatment for any combination of therapies within 60 consecutive days per medical episode. Subject to meaningful improvement within 60 days.
	Habilitation services	ABA - $20 copay per visit. $30 copay per visit for PT/OT/ST	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires preauthorization.
	Skilled nursing care	No charge	Not covered	Requires preauthorization/Limited to 730 days
	Durable medical equipment	No charge	Not covered	Requires preauthorization 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 preauthorization. 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.

BCN HMO Active Employees

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) • Cosmetic surgery • Dental Care (Adult) • Elective Abortion	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• 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	• Infertility treatment • 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:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
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:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
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:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
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 تساعده بحاجة لمساعدة، 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 مشتركا 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。

[illegible] 877-469-2583 TTY:711 [illegible]

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 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 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*.

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

Health Care Services	In-Network	Out-of-Network	Limitations
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		
Non-Preferred Brand Drugs	$50 Copay 30 day supply, $100 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.
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 C

Post November 1, 2013 Retiree Benefits

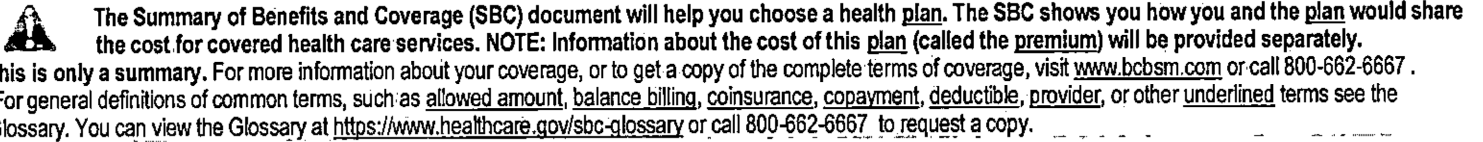
Blue Care Network

(Post November 1, 2013 Retirees)

CLSSLG

Macomb Co Employees - Hard Cap-Retired
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2020
Coverage for: All Plan Types **Plan Type:** TPA



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 deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,350/$12,700	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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges and health care this plan does not cover	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 limits until the overall family out-of-pocket limit has been met.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the phone number on the back of your ID card 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	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 copay/visit	Not covered	$20 copay for online visits.
	Specialist visit	$30 copay/visit	Not covered	Requires referral. No charge for allergy injections, allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	May require preauthorization / No charge for lab services
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Requires preauthorization
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com/customdruglist	Tier 1 - Mostly Generics	$10 copay/30 days	Not covered	Preauthorization & step-therapy apply to select drugs. 50% coinsurance for sexual dysfunction drugs. Effective 1/1/2013 Tier 1 contraceptives are covered in full 90 day mail order and retail copays are 2x the standard retail copays.
	Tier 2 - Preferred Brand	$25 copay/30 days	Not covered	
	Tier 3 - Non-Preferred Brand	$50 copay/30 days	Not covered	
	Specialty drugs	Tiered copays 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 preauthorization/50% coinsurance 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	Emergency room care	$100 copay/visit	$100 copay/visit	Copay waived if admitted
	Emergency medical transportation	No charge	No charge	Non-emergent transport is covered when preauthorized
	Urgent care	$30 copay/visit	$30 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required. 50% coinsurance 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	Preauthorization is required
	Inpatient services	No Charge	Not covered	Preauthorization is required
If you are pregnant	Office visits	No charge	Not covered	Postnatal and non-routine prenatal office visits-$20 copay
	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	Home health care	$30 copay/visit	Not covered	Requires preauthorization. Custodial care not covered.
	Rehabilitation services	$30 copay/visit	Not covered	Requires preauthorization/ One period of treatment for any combination of therapies within 60 consecutive days per medical episode. Subject to meaningful improvement within 60 days.
	Habilitation services	ABA - $20 copay per visit. $30 copay per visit for PT/OT/ST	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires preauthorization.
	Skilled nursing care	No charge	Not covered	Requires preauthorization/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)	
	Durable medical equipment	No charge	Not covered	Requires preauthorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered in full
	Hospice services	No charge	Not covered	Inpatient care requires preauthorization. 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) • Cosmetic surgery • Dental Care (Adult) • Elective Abortion	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult)	• 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 plan document.)	
• Bariatric surgery • Chiropractic care	• 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

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
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:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
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:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
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 تساعده بحاجة لمساعدة، 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 مشتركا 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。

[illegible] 877-469-2583 TTY:711 [illegible]

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 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 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

(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.

Coverage Period: Beginning on or after 01/01/2021

MACOMB COUNTY EMPLOYEES

Community Blue PPO℠ 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 deductible?	$1,500 Individual/ $3,000 Family	$3,000 Individual/ $6,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$6,350 Individual/ $12,700 Family	$12,700 Individual/ $25,400 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 limits 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, any pharmacy penalty and health care this plan doesn't 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.bcbsm.com or call the number on the back of your BCBSM ID card 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?	No.		You can see the specialist you choose without a referral.

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 In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/office visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$40 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	$7 copay/prescription for retail 30-day supply; $14 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive 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 copay/prescription for retail 30-day supply; $70 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Nonpreferred brand-name drugs	$70 copay/prescription for retail 30-day supply; $140 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	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% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit; deductible does not apply	$250 copay/visit; deductible does not apply	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply
	Urgent care	$40 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% coinsurance	20% coinsurance for mental health; 40% coinsurance for substance use disorder	Your cost share may be different for services performed in an office setting
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Physician certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	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)	
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% coinsurance	20% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible 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 • Cosmetic surgery • Dental care (Adult)	• Hearing aids • 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 • 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

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**

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**

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**

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.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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 تساعده بحاجة لمساعدة، 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 مشتركا 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。

[illegible] 877-469-2583 TTY:711 [illegible]

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 mermi 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 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 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*.

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not Covered	Visits are face-to-face, telephonic, or through secure electronic portal
	Specialist visit	$30 copay per visit	Not Covered	——None——
	Other practitioner office visit	$20 PCP Other Practitioner copay per visit/ $30 Specialist Other Practitioner copay 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 preventive services. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require preauthorization.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Services require preauthorization.
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 copay/prescription (retail) Non-Preferred $15 copay/prescription (retail)	Not Covered	Retail: 30 day supply for non-maintenance drugs at 1 copay; 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 copay/prescription (retail)	Not Covered	
	Non-preferred brand drugs	$50 copay/prescription (retail)	Not Covered	
	Specialty drugs	Preferred $50 copay/prescription (retail) Non-Preferred $50 copay/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 preauthorization.
	Physician/surgeon fees	No Charge	Not Covered	——None——

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	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
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care (Only when meets plan guidelines)
- Vision Hardware (Unless additional rider purchased)

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

- Bariatric Surgery
- Infertility Treatment (Only when meets plan guidelines)
- Routine Eye Care (Adult)
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue coverage after it ends. For more information on you 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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$610
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$670

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,075
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,130

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$90

The plan would be responsible for the other costs of these EXAMPLE covered services.

hap

Language Access Services

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

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم 4641-422 (800) أو خدمة الهاتف النصي: 711.

নজর দিন: আপনি বাংলা ভাষায় কথা বললে, ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ।

(800) 422-4641 বা

TTY: 711 নম্বরে কল করুন।

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 Sprachassistenzdienste 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 연락해주십시오.

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.

[illegible]

)800(4641-422 .TTY: 711

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 D

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, 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 bicuspids 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.

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.

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 form the point of banding due to lack of patient cooperation. For cased 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 E

Active Employees Vision Benefits

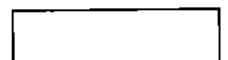
Certificate of Coverage

Macomb County

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



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.

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	

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. • Standard Progressive Lenses - Covered when rendered by a VSP network doctor	100% of approved amount One pair of lenses, with or without frames, in any period of 12 **consecutive** months	Reimbursement up to approved amount based on lens type (member responsible for any difference)

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

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) Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$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)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	

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

HAP

Please refer to the HAP Medical Benefits Summary