AGREEMENT

BETWEEN

MIDLAND COUNTY BOARD OF COMMISSIONERS

AND THE

TECHNICAL, PROFESSIONAL AND OFFICEWORKERS
ASSOCIATION OF MICHIGAN (TPOAM)

OCTOBER 15, 2019 – DECEMBER 31, 2021

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AGREEMENT

WHEREAS, this Agreement is made and entered into effective October 15, 2019 by and between the Midland County Board of Commissioners (“Employer”), and the Technical, Professional and Officeworkers Association of Michigan ("Union").

WHEREAS, it is agreed by the Union that the County Board of Commissioners and the Health and Human Services Board (“HHSB”) respectively retain and reserve unto themselves, without limitation, all powers, rights, authority and duties conferred upon them by the laws and the Constitution of the State of Michigan, except as expressly limited by the terms of this Agreement. There shall be no implied dilution of the powers conferred upon the County’s Board of Commissioners or the HHSB;

WHEREAS, the Employer is a public employer and is engaged in furnishing essential public services vital to the people of Midland County;

WHEREAS, the Employer and its employees have a high degree of responsibility to the public to assure orderly and uninterrupted operations and functions of government;

WHEREAS, the parties hereto, in recognition of their respective responsibilities, enter into this Agreement with the intention and desire to foster and promote sound, stable and peaceful labor relations between the Employer and its employees, and to that end the parties have reached an understanding governing the conditions of employment of the employees covered by this Agreement;

WHEREAS, it is the further intent and desire of the parties hereto to establish an orderly relationship between the Employer and its employees so that grievances may be settled quickly and to the satisfaction of both parties, and so that service to the public will not be disrupted;

NOW, THEREFORE, in consideration of the mutual promises and obligations herein assumed, the parties agree as follows:

ARTICLE 1 – PURPOSE AND INTENT

The purpose of this Agreement is to set forth the wages, hours, terms and conditions of employment of the employees covered by this Agreement, and to promote orderly and peaceful labor relations between, and in the mutual interest of, the employees, the Union, and the Employer. The Employer and the Union encourage to the fullest degree, friendly and cooperative relations between their respective representatives at all levels and among all employees.

The terms of this Agreement are to be interpreted strictly and are not to be expanded for any purpose or reason other than as specified by this Agreement's express terms.

ARTICLE 2 - RECOGNITION

The Employer recognizes the Union as the sole and exclusive representative for the purpose of collective bargaining with respect to rates of pay, hours of work and other conditions of

employment for all full-time and part-time Resident Associates of Pinecrest Farms, excluding supervisors, temporary and on-call employees, and all other employees of the Employer. This section is limited strictly to recognition of the Union as required by the provisions of the Michigan Public Employment Relations Act and shall not be interpreted or expanded for any purpose.

For purposes of this Agreement, the following terms shall be defined as follows:

a. "Employee" when used hereinafter in this Agreement shall refer to all employees represented by the Union in the bargaining unit as above defined. References to employees of the masculine or feminine gender shall refer to both.

b. Regular “full-time employee” shall mean a person who is regularly scheduled to work sixty-five (65) or more hours per biweekly pay period. This shall not constitute a guarantee of pay or work.

c. Regular “part-time employee” shall mean a person who is regularly scheduled to work less than sixty-five (65) hours per biweekly pay period. Except as otherwise expressly provided in this Agreement, part-time employees shall not be entitled to leaves of absence, insurance benefits, retirement benefits and other benefits provided under this Agreement.

d. “On-call” or “temporary” employee shall mean a person who is employed by the employer for a period of limited duration. An on-call or temporary employee is not subject to the terms of this Agreement.

e. Unless otherwise indicated, the term “day(s)” means calendar day(s).

Headings used in the Agreement are for informational purposes only.

ARTICLE 3 – WORK BY NON-BARGAINING UNIT EMPLOYEES

The Union recognizes that competent professionals in the social services field have in the past prescribed therapy for residents of the Pinecrest Farms. This therapy has included the assignment to such residents of certain duties or work normally performed by employees in the bargaining unit. It is expressly agreed by the parties that this practice may continue.

The Union further agrees that supervisors, on-call and temporary employees, and other non-bargaining unit personnel have in the past and may continue to perform many of those tasks normally performed by employees in the bargaining unit as interrelated parts of their jobs.

It is also agreed that supervisors, on call and temporary employees, and other non-bargaining unit personnel may be used to supplement the work force and assist in cases when employees are not immediately available, where unsafe conditions exist, or when an unforeseen circumstance or a combination of circumstances call for immediate action.

ARTICLE 4 - NONDISCRIMINATION

The Employer and the Union agree that employees shall not be discriminated against because of race, color, religion, national origin, disability, age, sex, veteran status, or any other characteristic protected under applicable state or federal law.

The Union agrees to exert every effort on its part to cause the employees, individually and collectively, to perform and render legal and efficient work and service on behalf of the Employer and that neither its members nor representatives will intimidate, coerce, interfere with, or discriminate against any employee in any manner at any time.

ARTICLE 5 – UNION ACCESS

Authorized representatives of the Union shall be permitted access to the facilities of the Pinecrest Farms during working hours to talk with employees and/or representatives of the Employer concerning matters covered by this Agreement. Such representatives shall not interfere with the performance of the employees' duties and, further, shall first make arrangements with the Pinecrest Administrator prior to gaining such access.

ARTICLE 6 – RIGHT TO WORK

6.1 Membership in the Union is not compulsory. Regular employees have the right to join, not join, maintain, or drop their membership in the Union, as they see fit. Neither party shall exert any pressure on or discriminate against an employee as regards such matters.

Further, the Union agrees that its members and representatives will not abuse or threaten any employee in an effort to persuade him or her to join, or to remain a member of the Union.

The Employer agrees that it will not interfere with the free choice of any employee regarding the decision to join, not join, or to continue or discontinue as a member of the Union, and further agrees that it will in no way discriminate in favor of or against any employee because of his/her status or membership in the Union.

6.2 The Union is required under this Agreement to represent all of the employees in the bargaining unit fairly and equally without regard to whether or not an employee is a member of the Union. The terms of this Agreement have been made for all employees in the bargaining unit and not only for members in the Union.

6.3 During the life of this Agreement, the Employer will honor written voluntary individual membership dues deduction requests of unit employees who have executed and presented to the Employer the Membership Dues Deduction Authorization Form attached to this Agreement as Appendix D. Each dues deduction authorization will be limited to deduction of regular monthly basic dues and will remain in effect (1) for a specified time in accordance with law, or (2) until the Employer receives written notification that the employee has cancelled the authorization, or (3) until active employment in a covered classification is terminated. However no deduction of Union dues will be made for the first thirty (30) days of an individual's employment. It is understood that such dues deduction authorization shall not compel any

employee to join or remain a member of the Union and that such authorizations will be provided to the Employer at least thirty (30) days before the first deduction is to be made. Should this Agreement be terminated for any reason, the dues deduction authorization forms will be automatically cancelled. The Union shall certify to the Employer in writing the amount of each member's regularly monthly dues and designate the proper Union official to whom remittance of all dues deducted should be made. After deductions have been made, the Employer will send one payment for all dues deductions to the Union, along with a list of the employees from whom the deductions were made and the amount of the deduction from each employee.

6.4 The Union shall protect, save harmless and indemnify the Employer from any and all claims, demands, costs, suits, fees, judgments, and other forms of liability by reason of action taken or not taken by the Employer for the purpose of complying with this Article.

ARTICLE 7 – MANAGEMENT RIGHTS

The Union recognizes that nothing in this Agreement shall restrict, interfere with or abridge any rights, powers, authority, duties or responsibilities conferred upon or vested in the Employer or the HHSB, or any of their elected or appointed officials, by the laws and Constitution of the State of Michigan or of the United States of America.

In addition to all rights conferred by law, the Employer and the HHSB reserve the right to manage, operate, administer, direct and conduct their affairs efficiently and economically, without restriction or limitation, including, by way of illustration but not by way of limitation, the right to determine:

- the number and locations of buildings and work areas within buildings;
- the services to be provided;
- the scheduling and means of providing its services;
- the amount of supervision necessary;
- the methods of operations;
- the work to be performed within the bargaining unit;
- the hours and schedules of work;
- the qualifications of employees and standards of workmanship;
- the process, forms, criteria and frequency by which employees are to have their performance of required job duties evaluated;
- to study and/or introduce new or improved methods or facilities;

- the selection, procurement, design, engineering and control of tools, equipment and materials;
- the discontinuance of any services, materials or methods of operation;
- the work, processes or services to be purchased from others;
- the work to be subcontracted;
- the quantity and quality of service;
- the employees to hire, layoff, discipline, suspend or discharge;
- all matters related to the starting and quitting times, work schedules and number of hours to be worked;
- all matters related to vacancies, assignments, promotions, and transfers of employees;
- all matters related to the employment of all non-bargaining unit personnel, including, but not limited to, on-call and temporary employees;
- the amount of overtime, if any, to be worked;
- to maintain order and efficiency in all their operations;
- to relieve employees from duty because of lack of work or for other legitimate reasons;
- all matters related to direction of the work force, the assignment of work and the number of employees assigned to each job classification;
- the right to establish, change, combine or discontinue job classifications and prescribe and assign job duties; and
- the right to adopt, revise and enforce working rules and regulations.

It is specifically agreed that the management of the organization, in all its phases and details, shall remain solely vested in the Employer and the HHSB, and has not been relinquished in any way except as shall be specifically set forth by the express provisions of this Agreement.

ARTICLE 8 – POLICIES, WORK RULES, AND REGULATIONS

The Employer shall have the right to make, modify, rescind and enforce policies, rules, and regulations relating to employee conduct which, when published or posted, shall be regarded for all purposes as having been incorporated into and made an integral part of this Agreement. As an integral part of this Agreement, it is agreed Employer policies, rules, and regulations shall be

observed by all employees. Employees who fail to abide by such policies, rules, and regulations shall be subject to discipline, up to and including termination.

It is further agreed that neither the Union nor the employees shall challenge the reasonableness of said policies, rules and regulations, but may only challenge the application of same through the Grievance Procedure provided for in this Agreement.

ARTICLE 9 – GRIEVANCE PROCEDURE

9.1 Definition. As used in this Agreement, a grievance is defined as a formal dispute arising under and during the term of this Agreement alleging misinterpretation or misapplication of the express terms or conditions of this Agreement.

9.2 Settlement. All grievances arising under and during the term of this Agreement shall be settled in accordance with the procedure herein provided. Every effort shall be made to satisfactorily adjust grievances in an amicable manner between the Employer and the Union. Employees and their representatives involved in this grievance procedure shall be allowed a reasonable amount of time off, with pay, during working hours to meet with Employer representatives as herein provided. Time off shall be scheduled by supervision at times convenient to the operation.

9.3 Grievance Procedure. The Employer recognizes the right of the Union to select or appoint a Unit President and one Steward to assist employees in presenting grievances to representatives of management. Employees designated as a Unit President or Steward shall first attain seniority status with the Employer. (The names, phone numbers, and other appropriate contact information of the Unit President and Steward shall be given to the Employer, in writing, by the Union before the Unit President and Steward assume their duties.)

Time limits specified in the Grievance Procedure are of the essence. In the event a grievance is not appealed from a decision in any of the Steps in the Grievance Procedure to the next step in the Grievance Procedure within the time limits set forth in said Step, it shall be considered settled on the basis of the Employer's last written decision on the grievance. If the grievance is not answered by the Employer within the time limits, the grievance shall be automatically forwarded to the next step of the grievance procedure.

The time limits at any level of the Grievance Procedure may be extended by mutual written agreement of the parties.

Step 1. Within five (5) calendar days of the occurrence of the act or condition giving rise to the grievance, the aggrieved employee shall confer with the employee's immediate supervisor for the purpose of resolving the grievance. If the grievance is not brought to the immediate supervisor's attention within the above specified five (5) calendar days, further processing of the grievance shall be barred. Within five (5) calendar days after the Step 1 conference, the immediate supervisor shall give an answer to the grievance to the employee.

Step 2. If the grievance is not satisfactorily resolved, the Unit President (or Steward) shall, within ten (10) calendar days of the occurrence of the act or condition giving rise to the grievance, submit a written grievance to Pinecrest's Director of Nursing and its Administrator. The grievance shall be signed by the aggrieved employee and the Unit President (or Steward), state the facts underlying the grievance in clear and explicit terms, identify the specific provision(s) of the Agreement alleged to have been violated, and state the remedy sought. The Director of Nursing or Administrator will sign for receipt of the Grievance, note the date and time of receipt, and return a copy to the Unit President (or Steward). The Administrator shall then schedule a conference for the grievant and the Unit President (or Steward) to confer with the Administrator, the Director of Nursing, and such other parties as the Employer deems appropriate for the purpose of attempting to resolve the grievance. This Step 2 conference shall be scheduled as quickly as all the participants are available, but in no event later than 30 calendar days following the Administrator's receipt of the written grievance. Within five (5) calendar days after the Step 2 conference, the Administrator shall provide a written answer to the grievance to the Unit President (or Steward), with a copy to the grievant.

Step 3. If the grievance is not satisfactorily resolved at Step 2, the Union's Business Agent may, within ten (10) calendar days of the Unit President's (or Steward's) receipt of the Step 2 answer, serve written notice upon the Employer's Director of Human Resources and the Michigan Employment Relations Commission of its desire to mediate the grievance. All mediation conferences shall be private and at no charge to the parties. The mediator shall arrange a conference at which he or she will provide the parties with an opportunity to completely discuss the issues in dispute. The mediator may meet separately with each party to discuss the issues and explore areas of compromise. The mediator shall have no authority to impose a settlement or issue a directive on disputed issues.

Step 4. If the grievance is not satisfactorily resolved within 30 days of its referral to mediation, the Union's Business Agent shall notify the Employer's Director of Human Resources of his desire to submit the grievance to arbitration. In the event the Business Agent should fail to serve such written notice within said thirty (30) calendar days, the matter shall be considered as settled on the basis of the written disposition made at Step 2 of the Grievance Procedure and all further proceedings shall be barred. After the Director of Human Resources' receipt of a written notice of the Union's desire to arbitrate, the parties shall attempt to agree on an arbitrator. If the parties are unable to so agree within five (5) working days, the Business Agent shall, within ten (10) days of said notice of desire to arbitrate the grievance, refer the matter in writing to the American Arbitration Association (AAA) requesting that an arbitrator be selected under the rules of the AAA. Concurrent notification of such appeal shall be provided to the Employer's Human Resources Director. Notification to the Employer's Human Resources Director shall be subject to the same time limitations set forth for filing with the American Arbitration Association and shall include a copy of the Union's Demand

for Arbitration and identification of the grievance, the issue(s) and the provisions of the Agreement involved. If the grievance is not submitted to Arbitration in accordance with the procedure and time limits herein provided, the Step Two disposition of the grievance shall be final and all further proceedings shall be barred.

The Union shall be prohibited from inserting in such arbitration proceedings any issues which have not previously been set forth in the grievance procedure.

In fulfilling his duties under this Agreement, the arbitrator shall have authority to apply and interpret the express terms or conditions of this Agreement but shall not have the authority to add to, subtract from, or modify this Agreement or resolve any dispute under any section of this Agreement which is expressly excluded from arbitration, or imply a provision which is not otherwise specifically provided herein.

The parties understand and agree that in making this Agreement they have resolved for its term all bargaining issues which were or which could have been made the subject of discussion. The arbitral forum here established is intended to resolve disputes between the parties only over the interpretation or application of the matters which are specifically covered in this Agreement, and which are not excluded from arbitration.

Excluded from arbitration are grievances which question the exercise of the Employer's rights set forth in Article 7, Management Rights, and Article 8, Policies, Work Rules, and Regulations of this Agreement. Also expressly excluded are questions concerning the use or application of any right under which the Employer is given unilateral discretion in this Agreement, or any disciplinary matter other than the alleged suspension or discharge of a seniority employee without just cause.

No claim for back wages shall exceed the amount of wages the employee would otherwise have earned at his base rate as set forth in Appendix A, less any unemployment or other money including any compensation he may have received from any source of employment (not previously approved in writing as supplemental employment by the Employer) during the period in question.

If either party shall claim before the arbitrator that a particular grievance fails to meet the test of arbitrability as herein provided, the arbitrator shall proceed to decide such issue before proceeding to hear the case upon the merits. In any case the arbitrator determines is non-arbitrable, the arbitrator shall refer the case back to the parties without a recommendation on the merits.

If the arbitrator issues his decision within his jurisdiction, the decision of the arbitrator shall be final and binding upon the employee(s), the Union, and the Employer.

The arbitration hearing shall be governed by the Voluntary Labor Arbitration Rules of the American Arbitration Association in effect at the time the Union's Demand for Arbitration is filed with the Association. The arbitrator shall have the authority to issue a subpoena for a witness to attend the arbitration hearing. Grievances shall be arbitrated separately unless otherwise agreed in writing between the Employer and the Union.

The fees and approved expenses of the arbitrator shall be shared equally by the Union and the Employer. Each party shall be responsible for compensating its own representatives and witnesses. All hearings shall be held on the Employer's premises. Employee witnesses, except the grievant, Unit President (or Steward), who are scheduled to work on the day of an arbitration hearing, shall be excused from work only to testify and shall return to work immediately thereafter. The grievant(s) and the Unit President (or Steward) shall be excused from work to attend the entire arbitration hearing and shall return to work immediately thereafter.

Grievances processed to arbitration may be withdrawn only upon written agreement of the Employer and the Union.

ARTICLE 10 – NO STRIKE

The Union agrees to cooperate with the Employer in strict observance of all the terms, provisions and agreements herein contained so that the purposes and objectives of this Agreement may be fully attained. The Union recognizes that it has a joint responsibility with the Employer in maintaining good labor relations and the cooperative effort of the employees to the end that the Employer and the people of Midland County will receive from the employees' efficient and uninterrupted service.

At no time during the term of this Agreement or during any period of time that negotiations are in progress between the Union and the Employer for the continuance or renewal of this Agreement, will the Union cause or authorize or permit its members or any of them to cause, nor will any member of the bargaining unit take part in, any impeding of work or curtailment of or interference with any operation of the Employer or any building, office, grounds or facility of the Employer.

The Union further agrees that it shall not cause, authorize or permit its members at any time to violate the laws of the State of Michigan concerning the duty of public employees not to strike.

ARTICLE 11 – SENIORITY

11.1 Probationary Employees. Until a newly hired employee has been employed for one hundred eighty (180) calendar days in the bargaining unit, the employee shall be known as a "probationary employee". The Employer expressly reserves the right to discipline or discharge employees without recourse during their probationary period.

11.2 Computation of Seniority. Upon successful completion of a one hundred eight (180) day probationary period, each full-time employee shall acquire seniority status and be assigned a seniority date retroactive to the employee's most recent date of hire into the bargaining unit. Such employee's name shall also be added to the Unit seniority list.

When employees have the same seniority date, the employee with the lowest social security number will be given preference.

11.3 Loss of Seniority. An employee's seniority and employment rights shall terminate and she shall be removed from the Employer's payroll upon the occurrence of any of the following:

a. Voluntary quit or failure to return from leave of absence.

b. Discharge.

c. Fails to comply with leave of absence provisions such as, but not limited to, overstaying a leave of absence or giving a false reason for request for leave.

d. Absence due to illness or injury for a period exceeding twenty-four (24) months.

e. Retirement.

f. Acceptance of a position with the Employer that is not in the bargaining unit.

g. Failure to report for duty or call-in her absence within 24 hours of the start of the shift.

h. Failure to report within five (5) calendar days of receipt of notice of recall, said notice having been in writing by certified mail, return receipt requested, addressed to the employee's last address of record.

i. Layoff exceeding one (1) year or her length of seniority, whichever is less.

j. The employee is absent from work for three (3) consecutive working days without providing the Employer a reason, that is acceptable to the Employer, for such absence.

k. The Employee has entered into a settlement agreement with the Employer related to a continuing disability.

l. The Employee has provided false information to the Employer on her employment application, time record or any other matter related to her employment.

m. The Employee underperforms in the completion of required job functions.

11.4 Unit List. The Employer shall keep a record of each full-time employee's service in the bargaining unit and shall furnish to the Unit President an up-to-date copy of the unit seniority list.

In addition, the Employer shall furnish an up to date copy of part-time employees' length of service and shall provide such information to the Union President upon her reasonable request.

11.5 Temporary Position Vacancies

a. The provisions of Section 11.6, Regular Position Vacancies, shall apply to the assignment of temporary vacancies expected to be in excess of 30 days duration.

b. Temporary vacancies created by a full-time or part-time employee's absence shall be assigned at the discretion of the Employer. The employee assigned the temporary job shall remain on said job for the duration of said absence. When the employee who created the temporary job returns to work, the employee filling the position temporarily will be returned to her regular job and all employees awarded subsequent jobs will revert to their former position.

11.6 Regular Position Vacancies. When a regular job is to be filled, the Employer will post a notice on the bulletin board giving all employees an opportunity to make application for the job by filing the appropriate application form. Said notice shall be posted for a period of three (3) calendar days. The job posting notice will show the shift, classification, and necessary qualifications for the job vacancy. All posted vacancies shall be filled within three (3) calendar days of the close of the job posting period. During the bidding period the Employer may make a temporary assignment to fill the posted vacancy. If such employee fails to adequately perform the job, he shall be returned to his previous position without loss of seniority rights, if any.

No employee shall sign a job posting unless he is willing to assume the duties of the posted position.

To apply for a regular position vacancy, the applicant must meet the position's minimum qualifications. The most qualified applicant shall be awarded the job.

11.7 Work Force Reduction. In the event of a reduction in the work force, the Employer will give the affected employees at least fourteen (14) calendar days advance notice.

Should it become necessary for the Employer to reduce the work force, such reduction shall begin with the employee with the lowest seniority within the classification being reduced. No reduction of employees with seniority will take place until all probationary, temporary and part-time employees are released, provided the employees with seniority are willing and capable of performing the available work.

The names of laid off employees shall be placed on the recall list in the order of their seniority.

ARTICLE 12 – DISCIPLINE

12.1 Notice of Suspension or Discharge. No seniority employee shall be suspended or discharged without just cause. Notice of suspension or discharge of a seniority employee shall be by written notice to the employee, stating the reasons(s) therefore, with a copy to the Unit President (or Steward).

12.2 Presence of the Unit President (or Steward) in Investigatory Meetings and Interviews. An employee may request the presence of the Unit President (or Steward) at any investigatory meeting or interview which the employee reasonably believes will result in disciplinary action against the employee.

12.3 Time Limits to Grieve Suspension or Discharge. In all cases of suspension or discharge of a seniority employee, a grievance, if any, must be filed at Step 2 of the Grievance Procedure in writing within ten (10) calendar days of the employee's receipt of said notice of suspension or discharge.

12.4 Limitations On Progressive Discipline. It is specifically agreed that no progressive discipline need be given to any employee before he is suspended or discharged if the cause of such suspension or discharge is dishonesty, drunkenness, recklessness, negligence, insubordination, drinking intoxicating beverages on duty, the possession, use, sale or distribution of drugs that are illegal under state or federal law, or the violation of the Employer's posted rules allowing discharge without notice.

ARTICLE 13 – COMPENSATION

13.1 Pay Periods. Employees will be paid every other Friday. One (1) week of wages is withheld to provide the necessary time to prepare the payroll. Payment shall be made through direct deposit. The employee shall also be provided an itemized statement of his earnings and all deductions made for any purpose.

13.2 Job Evaluation Plan. During calendar year 2016, the Employer engaged the services of Municipal Consulting Services LLC ("MCS") to conduct a classification and compensation study for selected employees of Midland County. After careful review of the results of the study, the parties have agreed upon attached Appendices A and B setting forth employee pay grades, job classifications, and wage schedules. The Employer and the Union agree upon and accept the job classifications and job descriptions as the basis for the payment of wages as provided herein.

The parties have also reviewed MCS's job descriptions, Job Analysis Questionnaire, and Job Evaluation Plan. The Employer and the Union agree that the job descriptions accurately reflect the duties and responsibilities performed by employees. It is also agreed that MCS's Job Evaluation Plan provides a fair and accurate assessment of each job classification subject to the Study.

Effective January 1, 2017, all employees in the bargaining unit who were on the Employer's payroll as of December 20, 2016, had their annual Step Advancement date changed to January 1.

All employees who commence employment with the Employer after December 20, 2016, shall initially be placed at the minimum step for their pay grade and classification as provided in Appendix B, and, if their overall performance has been satisfactory or above during the preceding period, advance annually thereafter on the anniversary of their initial date of

employment until they reach the maximum of the pay schedule for their classification and pay grade.

13.3 Weekend Premium. Employees whose posted odd schedule includes Saturday and/or Sunday shall receive an additional $1.00 per hour premium for each hour worked on the Saturday and/or Sunday.

13.4 Shift Premium. There will be a $0.35 per hour shift premium for employees whose regular work shift falls between the hours of 6:00 p.m. - 6:00 a.m. and for employees called in to work such a shift.

13.5 Fill-In Nurse/Medication Technician/Supervisor Premium. Employees accepting opportunities to fill in for the nurse/supervisor will be paid a $2.00 per hour premium for all hours worked in said position.

13.6 Call-In Pay. In case of emergencies, employees called in will be assured of a minimum of four (4) hours work or pay.

13.7 Longevity Pay. Employees hired after January 1, 1996 shall not be eligible for longevity pay.

All full-time employees covered by this Agreement who have completed either 5, 10, 15 or 20 years of continuous service in a regular full-time capacity and who have performed nine (9) months of actual work in their anniversary year, shall, on the first payroll period following their anniversary date of hire, receive an annual longevity payment based on the following schedule:

(a) Upon completion of 5 years of continuous service, 1% of their annual base salary.

(b) Upon completion of 10 years of continuous service, 3% of their annual base salary.

(c) Upon completion of 15 years of continuous service, 5% of their annual base salary.

(d) Upon completion of 20 years of continuous service, 7% of their annual base salary.

For all purposes hereunder, “annual base salary” shall mean the employee’s base salary in effect on the first salary payroll period following his anniversary hire date.

Article 14 – JOB CLASSIFICATIONS AND DESCRIPTION

14.1 General. The Employer will maintain job descriptions for all jobs covered by this Agreement, which shall be subject to periodic review and revision as the Employer deems appropriate. Job descriptions will be made available to the Unit President or affected employees upon their reasonable request.

14.2 New or Revised Job Classifications and/or Descriptions. In the event the Employer creates a new job classification or revises an existing job description in the bargaining unit after January 1, 2017, the Employer shall provide the Union a copy of the new or revised job classification or job description and its pay grade prior to posting. If requested within ten (10) calendar days after such notification, the Human Resources Director and the Pinecrest Administrator shall meet with the Unit President and Business Agent to discuss the pay grade of the new or revised job classification and/or description. If, following such discussion, there is a dispute as to the pay grade for the new or revised job classification and/or description, such dispute shall be an appropriate matter for a grievance initiated at Step Two of the grievance procedure. If a grievance is subsequently referred to arbitration, the arbitrator shall use as the basis for his discussion, the terms of this Agreement, the former and proposed job classification and/or description, and MCS's 2016 Job Analysis Questionnaire, Job Evaluation Plan and Point Factor Evaluation.

14.3 No Limitation on Employer Rights. Nothing contained in this Agreement, the MCS's 2016 Classification and Compensation Study, or employee job classifications or descriptions shall in any way be interpreted to restrict the Employer's management rights as set forth in Article 7.

ARTICLE 15 – HOURS OF WORK AND OVERTIME

15.1 Hours of Work. Employee work schedules will be posted on the bulletin board not less than two (2) weeks ahead of the time the employee is scheduled to work. Except as otherwise provided by this Agreement, regular full-time employees are expected to work eight (8) hours a day and forty (40) hours per week. Schedules will be established so that regular full-time employees will share weekends off.

15.2 Overtime Pay. One and one-half (1-½) times the employee's regular hourly rate shall be paid for all hours worked in excess of:

a. Eight (8) hours in any work day.

b. Eight (8) consecutive hours.

c. Eighty (80) hours in any pay period.

Compensatory time off may, by mutual consent of the employee and Employer, be granted in lieu of overtime pay.

For the purpose of computing overtime, paid leave time off shall not count as time worked.

15.3 Lunch Periods & Rest Periods. Each employee who works a minimum of five (5) hours will be provided a one-half (1/2) hour paid lunch period. Lunch periods will normally be scheduled by supervision after four (4) hours work.

Employees will be allowed a fifteen (15) minute paid rest period approximately half way between the start of their work day and their lunch period as scheduled by supervision.

Employees will be allowed an additional paid rest period of fifteen (15) minutes approximately half way between the lunch period and the end of their work day. Lunch and rest periods will be scheduled by supervision so there is no interruption of necessary operations.

Except in emergency situations, each rest and lunch period shall be continuous and uninterrupted. A suitable employees lounge will be provided and maintained for the exclusive use of employees. Employees may not leave the premises during work hours.

15.4 Overtime Assignments. Employees will be provided personal notice of overtime requirements as soon as practical.

Mandatory stay over to the next shift while awaiting a replacement, will be done by starting with the most senior person on that shift on a voluntary basis. If the position is not filled, the person last hired in the bargaining unit on that shift will be required to fill the position. Failure to stay over will result in discipline up to and including termination.

15.5 Posting and Award of Two-Week Work Schedules.

Two-week work schedules will be posted up to four (4) weeks in advance.

Employees must submit vacation or personal day requests thirty (30) days in advance so that other staff members may sign up to work the posted shifts. Postings will be dated and remain on the sign up board for fourteen (14) calendar days. Employees may not sign up for more than sixty (60) days in advance. If an employee signs up to work another shift, he cannot change his mind at a later date without approval of the Pinecrest Administrator or designee.

The two-week work schedule will be awarded in the following order:

1. All bargaining unit employees will be awarded their regular full and regular part-time shifts.

2. If there are any shifts open after filling the work schedules as provided in paragraph a. above, the available shift(s) will be awarded first to regular part-time employees. (An employee once having turned down or not signed for the shift, may not change his/her mind and make a claim for said shift, or make a claim for overtime.)

3. On-call employees will be awarded any remaining vacant shifts.

4. Regular full-time employees on the opposite shifts will be awarded any remaining open shifts.

5. Any remaining full-time employees.

15.6 Posting Of Annual Leave After The Two-Week Schedule Has Been Posted.

Employees may post annual leave requests so that other staff members may sign up to work the open shifts. Postings may not be removed thereafter without the approval of management. Open shifts will be awarded in the following order:

1. Regular part-time union employees up to the point where an employee would be eligible for overtime.

2. On-call employees up to the point where an employee would be eligible for overtime.

3. Regular full-time employees.

If no employees sign up for the posting, then on-call employees will be called first in an attempt to fill requests for non-scheduled annual leave or personal day requests.

15.7 Call-Ins – Emergency Absence. In the case where an employee calls in to report his or her absence before the start of their shift, preference for awarding the shift is as follows:

1. Regular part-time employees up to the point where overtime criteria is met.

2. On-call employees up to the point where overtime criteria is met.

3. Regular full-time employees.

Employees will be called at their home telephone number of record. If an employee is not reached during the first attempt to call at the telephone number of record, then the next employee on the list will be called until the open shift is filled.

ARTICLE 16 – ANNUAL LEAVE

All regular full-time employees covered by this Agreement and hired prior to January 1, 1996 shall be credited with an annual leave allowance on January 1st of each new year as follows:

After 1 year	200 hours
After 5 years	232 hours
After 10 years	256 hours
After 15 years	264 hours

All regular full-time employees hired after January 1, 1996, who have completed one year or more of service on December 31st of each year shall be credited with an annual leave allowance on January 1 of each new year as follows:

Eight Hour Shift

After 1 year	144 hours

After 5 years 176 hours
After 10 years 200 hours
After 15 years 208 hours
After 20 years 216 hours

Full time new hires will accrue annual leave on the first day of each month for the first twelve months of employment. The amount of annual leave accrued will be 8 hours each month multiplied by the Board-Approved position FTE.

Part time employee who have worked more than 90 days as a new employee and those current employees who work an average of 25 hours per week will accrue 1 hour of paid leave for every 35 hours that they work, not to exceed 40 hours of paid leave in a calendar year. Paid medical leave may be taken in one hour increments and will be paid at the employee's regular hourly rate of pay. Unused accrued leave will carry over from year to year, but an employee will be limited to the use of 40 hours of Paid Medical Leave per calendar year. These provisions are in accordance with the Michigan Paid Medical Leave Act of 2019 and are subject to change if amended by the Michigan Legislature.

Annual leave front-loads for full-time employees will be effective January 1 of each calendar year except for employees who have not completed the first 12 months of employment. Upon the employee's one-year anniversary, the front-load will be pro-rated based on the number of months remaining in the calendar year. (The term "front load" means annual leave hours for the calendar year will be credited to the employee's annual leave bank January 1 of each year for use throughout the calendar year.)

An employee on a temporary assignment in a position with a higher Board Approved Budgeted FTE will continue to earn annual leave hours at the rate of their regularly assigned FTE and not at the higher rate of the temporary assigned position.

Employees are allowed to carryover up to 80 hours of annual leave from one calendar year to the next. Any hours in excess of 80 hours shall be forfeited with no compensation.

Employees hired prior to January 1, 2019,[1] who retire or resign with a minimum of 10 days' notice shall be compensated for the remaining balance of hours in the annual leave bank upon termination of employment plus the subsequent year's annual leave, pro-rated based on when the employee retires or reassigns. Employees who retire/resign as of October 1 shall receive the entire subsequent year's annual leave without pro-ration. (Example: Jim elects to retire on July 1. His annual leave balance as of July 1 is 56 hours. Jim has been employed for 16 years. Jim will also be compensated for 208 hours, pro-rated for 6 of the 12 months he worked in the year of his retirement. Jim's total annual leave compensation will be 160 hours.)

1 Employees hired after January 1, 2019 will need to meet retirement eligibility requirements to receive any portion of the subsequent year's annual leave allowance upon separation of employment.

Employees who are laid off may elect to be paid for the remaining balance of hours in their annual leave bank or have such time carried in their leave bank during the period of their layoff.

In the event of death, the remaining balance of hours in an employee's annual leave bank shall be paid to the employee's estate.

Employees who are discharged from employment or retire/resign with less than 10 days' notice shall not receive compensation for the remaining balance of hours in the annual leave bank.

Employees who voluntarily leave employment and are hired back as regular full-time employees shall have their annual leave front-loaded to their bank consistent with the total sum of years employed and pro-rated based on the number of months remaining in the calendar year.

Employees may not use annual leave in advance of it being earned. If an employee has insufficient annual leave credits to cover a period of absence, no allowance for annual leave shall be posted in advance or in anticipation of future leave credits. In the absence of applicable leave credits, payroll deductions for the time lost shall be made for the work period in which the absence occurred upon approval of the Department Head and Human Resources.

An employee may elect to cash out up to two (2) days of unused annual leave days, not to exceed 16 hours per full-time employee. The payment for cash out of unused leave days shall occur in the month of December of each year. Letters to request the payment for unused annual leave time shall be received by the Finance office by November 15 each year.

Planned annual leave for the equivalent of three (3) or more sequential days shall be scheduled between the Pinecrest Administrator and the employees involved in order to maintain continuity and efficiency of operations. The Pinecrest Administrator shall, in all planned annual leave cases, make the final decision involving annual leave allocation, both as to the number of employees who may be off at any one time and the dates of leave permitted for each employee. In meeting staffing requirements, the senior employee(s) shall be entitled to the preference.

An employee may use leave in increments of one (1) hour; however, this provision may not be abused.

Annual leave requests which have been made with thirty (30) or more days advance notice, will either be denied or granted within fourteen (14) days. Once an advance notice request has been granted, the Pinecrest Administrator will not rescind that decision, unless the employee does not have sufficient accrued annual leave.

ARTICLE 17 – LEAVES OF ABSENCE

17.1 Military Leave. Employees who enter the armed services shall be granted an unpaid military leave of absence in accordance with applicable state and federal law. Employees on such leave shall receive credited time for purposes of seniority and placement on the applicable salary schedule upon their return to regular employment with the Employer.

17.2 Personal Leave. An unpaid leave of absence for a bona-fide reason (which shall not include employment for another employer) may, upon proper written request, be granted to employees for periods not to exceed thirty (30) calendar days. Such leave shall not involve loss of seniority, if it has been approved in writing by the Pinecrest Administrator and the Employer's Human Resources Director. Such leaves may be extended for up to ninety (90) day periods upon written approval of the Pinecrest Administration and Human Resources Director.

17.3 Family/Medical Leave Act. The Employer agrees that it shall maintain a policy providing for employee family and medical leaves under the federal Family and Medical Leave Act (FMLA). Employees shall be governed by the provisions of that policy; however, to the extent the Employer's policy provides less benefits than those provided by the FMLA, the provisions of the FMLA shall control.

17.4 Funeral Leave. In the event of a death in the employee's immediate family (spouse, child, stepchild, parent, step-parent, brother, step-brother, sister, step-sister, mother-in-law or father-in-law, grandchild), an employee shall be excused without loss of pay on the dates which he has been scheduled to work during the period from the day of death to the day of the funeral, both inclusive, but not to exceed a total of three (3) working days for such absence as is required to discharge specific obligations placed upon him by the death.

The employee shall be excused without loss of pay on the day of the funeral in the case of the death of the employee's grandparents, son-in-law, daughter-in-law, brother-in-law and sister-in-law.

In case of extenuating circumstances, the Pinecrest Administrator or his designee may make special arrangements with the employee for funeral leave.

ARTICLE 18 – JURY DUTY & COURT ATTENDANCE

Employees shall be granted a leave of absence with pay when they are required to report for jury duty.

Employees shall be paid their regular wages (not exceeding base pay) for time necessarily spent in jury service after endorsing all checks and otherwise turning over to the Employer all payments received from the Court. Seniority will continue to accrue while on jury duty.

Employees required, whether by the County of Midland or any public agency, to appear before a court or agency on any matters related to their work for Midland County and in which they are personally involved, shall be granted a leave of absence with pay for the period during which they are so required to be absent from work. Such employees shall be paid their regular wages (not exceeding base pay) for time necessarily spent on such appearances after endorsing all checks and otherwise turning over to the Employer payments received from the court or agency.

ARTICLE 19 - HOLIDAYS

The Employer recognizes the following paid holidays for under this Agreement:

- New Year's Day
- Presidents Day
- Good Friday
- Memorial Day
- Fourth of July
- Labor Day
- Veteran's Day
- Thanksgiving Day
- Christmas Eve Day
- Christmas Day
- Three (3) personal holidays

A holiday period is defined as 6:00 a.m. - 6:00 a.m. starting the day of the holiday. Employees must work their assigned shift(s) before and after the specified holiday to receive holiday pay.

Full-time employees covered by this Agreement may be required to work on the designated holidays. Full-time employees who may be required to perform necessary work on one of the above holidays shall receive one and one-half (1-1/2) times their regular straight time hourly rate for all hours worked, in addition to their regular wages covering the holiday.

Part-time employees who are scheduled or called in to work on one of the above designated holidays shall receive one and one-half (1-1/2) times their regular straight time hourly rate for all hours worked on the holiday.

The three (3) personal holidays will be paid according to the employee's regularly scheduled work day (8 hours or 12 hours). Personal holidays shall be scheduled with the employee's supervisor.

ARTICLE 20 – INSURANCE

20.1 Enrollment for Insurance Benefits. To qualify for the insurance benefits provided in Sections 21.2 -21.6 below, each regular full-time employee must individually enroll and make proper application for such benefits in the Employer's Human Resources Office within thirty (30) calendar days of the commencement of employment with the Employer. An employee who fails to enroll and make proper application as herein provided is specifically an expressly excluded from participating in such benefit programs until such time as she enrolls and makes proper application during an open enrollment period. Coverage commences the first day of the month

following the month in which the employee completes the first thirty (30) days of regular employment with the Employer.

20.2 **Term Life & Accidental Death & Dismemberment**. Upon proper application, the Employer will provide and maintain at no cost to each regular full-time employee life insurance benefits in an amount equal to the employee's annual salary rounded to the nearest $1,000 increment, but not less than $15,000 or in excess of $25,000, and accidental death and dismemberment insurance benefits in an equal amount.

20.3 **Medical**. For regular full-time employees hired on or before January 20, 2004, the Employer shall provide, at no cost to the employee, Blue Cross-Blue Shield PPO4 for the employee and family as defined by Blue Cross-Blue Shield (rev. effective January 1, 2018; Appendix C-1).

For regular full-time employees hired after January 20, 2004, the Employer shall provide, at no cost to the employee, Blue Cross-Blue Shield PPO8 for the employee and family as defined by Blue Cross-Blue Shield (rev. effective January 1, 2018; Appendix C-2).

Employees hired after January 20, 2004 shall have the option of purchasing alternate insurance Blue Cross-Blue Shield PPO4 Plan. The amount to be charged employees for the cost of such optional coverage will be determined annually and adjusted on January 1 of each subsequent year of the contract. The cost for such purchase during the year will be the difference in rates between the PPO8 Plan (rev. effective January 1, 2018; Appendix C-2) and the PPO4 Plan (rev. effective January 1, 2018; Appendix C-1).

In addition to any other costs for which the employee may be responsible as herein provided, he shall also pay the difference between the Employer's maximum contribution under Section 3 of Publicly Funded Health Insurance Contribution Act, Act 152 of the Michigan Public Acts of 2011 and the illustrated premium costs of the plan selected. Employee contributions shall be deducted once a month through automatic payroll deductions.

The terms, conditions, exclusions and limitations specified in the Employer's policy with its insurance carrier shall govern all conditions of eligibility for and payment of benefits.

To qualify for the medical benefits as above described, each employee must individually enroll and make proper application for such benefits at the Employer's Human Resources Office within thirty (30) calendar days of the commencement of his regular employment. An employee who fails to complete, sign and return the required application forms is specifically and expressly excluded from such benefits plan until such time as he enrolls and makes proper application during an open enrollment period, unless the employee presents verifiable proof of having lost alternate coverage through another source. Subject to carrier approval, employees who have lost medical coverage through another source shall be permitted to immediately enroll in the Employer's medical plan.

Except as otherwise expressly provided in this Agreement, when on an authorized unpaid leave of absence the employee will be responsible for his benefit costs for the period he is not on the

active payroll. Employees electing to continue such benefits shall pay the full cost of such continued benefits. Proper application and arrangements for the payment of such continued benefits must be made at the Employer's Human Resources Office prior to the commencement of the leave. If such application and arrangements are not made as herein described, an employee's group medical benefits shall automatically terminate on the last day of the current month after the effective date of the unpaid leave of absence.

Except as otherwise provided under COBRA or this Agreement, an employee's group medical benefits coverage shall terminate on the last day of the month the employee goes on leave of absence, terminates, retires, the group medical benefits plan terminates, or on the 30th day following the date that the employee is laid off. Upon return from a leave of absence or layoff, an employee's group medical benefits coverage shall be reinstated commencing with the billing month following such return.

An employee who is on layoff or leave of absence or who terminates may elect under COBRA to continue at his own expense the coverage herein provided.

The Employer reserves the right to change the carrier and/or the manner in which it provides the above coverage, provided that the benefits are generally equivalent to or better than the benefits outlined above.

To be eligible for health insurance coverage as provided above, an employee must document all coverage available to him under his spouse's medical plan and cooperate in the coordination of coverage to limit the Employer's expense.

The Employer's responsibility to pay for any of the foregoing group medical benefits shall terminate as of the expiration date of this Agreement.

20.4 Opt Out Insurance. Employees who are eligible for but otherwise elect to opt out of the Employer's health insurance coverage shall receive payments of $150.00 per month if they can provide evidence of health insurance elsewhere.

20.5 Disability Insurance. The Employer will provide disability insurance for all regular full-time employees covered by this Agreement. The terms and provisions of such coverage shall be made available to the Union.

Short-Term Disability Plan:

Waiting Period - 7 calendar days
Percent of Pay - 66-2/3 percent of base pay
Maximum - $4,000.00 Per Month
Maximum Time - 6 months

Long-Term Disability Plan:

Waiting Period - 6 months
Percent of Pay - 66-2/3 percent of base pay

Maximum - $4,000.00 Per Month
Maximum Time - 2 years

The terms, conditions, exclusions, and limitations specified in the Employer's policy with its insurance carrier shall govern all conditions of eligibility for and payment of benefits.

Any employee whose personal disability extends beyond the period compensated and who is not able to assume the responsibilities of his position, shall lose his seniority and be terminated.

20.6 Dental and Vision. Upon proper application, the Employer will provide and maintain dental and vision insurance benefits (Appendices C-1 and C-2) under its Blue Cross-Blue Shield plan, for each regular full-time employee.

Except as otherwise provided under COBRA or this Agreement, an employee's dental and vision care benefits coverage shall terminate on the last day of the month the employee is laid off, goes on leave of absence, terminates, retires or the dental and vision care benefits coverage terminates. Upon return from a leave of absence or layoff, an employee's dental and vision care benefits coverage shall be reinstated commencing with the billing month following such return.

An employee who is on layoff or leave of absence or who terminates may elect under COBRA to continue at his own expense the coverage herein provided.

The Employer reserves the right to change the carrier and/or the manner in which it provides the above coverage, provided that the benefits are generally equivalent to or better than the benefits outlined above.

The Employer's responsibility to pay for any of the foregoing dental and vision care benefits shall terminate as of the expiration date of this Agreement.

20.7 Termination of Coverage. Full-time employee's term life, accidental death and dismemberment, medical, short-term disability, and dental insurance benefits shall terminate, at the end of the month the employee is laid off, retires, goes on an unpaid leave of absence or the individual benefit plan terminates.

In the event it becomes necessary to reduce the work force, full-time employees laid off will have their term life and AD & D, medical and dental benefits continued in full force and effect throughout the month in which their layoff commences. Employees on authorized paid disability leave will have their insurance benefits continued for such period as they are on disability leave or one (1) year, whichever is lesser.

ARTICLE 21 – RETIREMENT

21.1 Defined Benefit Plan (Employees hired on or before October 21, 2008). Regular full-time employees hired on or before October 21, 2008 are covered under the Midland County Employees' Retirement System, subject to such terms and conditions in effect on the date this

Agreement takes full force and effect. The Union shall be furnished a copy of the Plan and any changes which the Employer may institute from time to time.

Each regular full-time employee covered by this Agreement shall contribute 3% of his gross earnings to the County Retirement System.

Age and Service Requirement: Employees shall be allowed to receive retirement benefits at age 60 or older after completing 10 or more years of service at age 65 with eight or more years of service.

Employees may also elect early retirement at age 55 with reduced benefits. If their age + years of service = 85, the employee will qualify for full retirement with full benefits.

Retirement Multiplier: A retirement multiplier factor of 2.25% (.0225) shall be multiplied by the final average compensation and years of service in determining the employees annual retirement allowance.

Final Average Compensation: Final average compensation shall mean the highest average annual compensation received by a member during a period of five consecutive years of service contained within the ten years of service immediately preceding retirement. Compensation of members, in determining amounts subject to deduction for payment to the retirement system and for determination of "final average compensation" shall consist of all payments received by a member for base salary, longevity pay, and overtime and any lump sum payment in lieu of annual leave.

21.2 Defined Contribution Plan (Employees Hired After October 21, 2008). Regular full-time employees hired after October 21, 2008, shall be required to participate in a County sponsored defined contribution plan. Both the County and employees shall be required to contribute to the Plan. The County's contribution on behalf of employees shall be 5.0% of wages in calendar years 2019 and 2020, and 6% of wages commencing January 1, 2021. Employees shall be required to contribute 4% and 5% of wages in calendar years 2019 and 2020, respectively, and 6% of wages commencing January 1, 2021.

The employee shall be 100% vested in all employee contributions. The Employer contributions shall be subject to the following vesting schedule:

Years of Service Completed	Vesting
Zero	0%
One	25%
Two	50%
Three	75%
Four	100%

21.3 Retiree Health Care Plan. Full-time employees hired after October 21, 2008 shall not be eligible to participate in the Midland County Retiree Health Care Plan. Those regular full-time employees eligible to participate in the Retiree Health Care Plan (hired on or before October 21, 2008) and not otherwise eligible for Medicare will be eligible for the same health, dental, and vision benefits under the same terms and conditions as the Employer provides for its active employees for the retiree only. At age 65, the retiree must enroll in part B Medicare Program at his or her own expense. The Employer will thereafter pay the cost of Blue Cross and Blue Shield Master Medical Complimentary Coverage Option-1 or its equivalent coverage.

Employee contributions shall be 3% of bi-weekly base pay.

The Employer shall also allow the retiree to include in its group coverage the retiree's spouse in accordance with the following provisions:

a. The Employer shall establish a "Retiree Health Care Fund" to be used for the purpose of paying Retiree Health Care Premiums. The Employer shall annually budget sufficient funds, as a contribution to the Retiree Health Care Plan in accordance with GASB (Governmental Accounting Standards Board). If the employee dies prior to becoming eligible for retirement and/or retiree health care benefits, the employee's contribution will go to his estate. If the employee quits or leaves Employer employment for any reason prior to becoming eligible for retirement benefits and/or retiree health care benefits, the employee shall be refunded the amount the employee has contributed to the Retiree Health Care Fund along with accumulated interest thereon as determined by the Employer.

b. A retiree's spouse who is covered by health care benefits from the spouse's employer, shall not be allowed to participate in the Employer sponsored retiree health care program.

c. A retiree and spouse shall be allowed to participate in the retiree health care program benefit provided they meet the following requirements;

    1. The recipient must be an active retiree of the Employer and must be receiving monthly retirement benefits pursuant to the County Retirement Plan.

    2. Beneficiaries of retirees shall be allowed to continue to receive health care benefits as long as the named beneficiary is covered by the retiree's health care plan at the time of the retiree's death and continues to receive the deceased retiree's retirement allowance. If a deceased retiree's spouse remarries, health care benefits shall not be available to the new spouse.

    3. Dependent children of the retiree are eligible for continued health care coverage after the retiree's death, provided the dependent children were enrolled in the retiree's health care plan at the time of the retiree's death

and continue as dependents under the surviving spouse who is the named beneficiary of the retiree who is receiving the deceased retiree's retirement allowance. In the event a dependent child is the named beneficiary and continues to receive the deceased retiree's retirement allowance, and is also enrolled in the retiree's health care plan at the time of the retiree's death, the dependent child shall continue to receive health care coverage through the end of the year in which the dependent child reaches age 26.

4. An employee who is eligible for retirement, regardless of age or years of service, shall be entitled to Retiree Health Care Benefits for the employee and their spouse. The Employer shall pay 100% of the health care premiums for the retiree and 50% of the premium for retiree spouses and eligible sponsored dependents and the employee shall pay 50% of the difference.

5. The Employer shall pay an additional 5% of the retiree spouses and eligible sponsored dependent's health care premiums for each year of service in excess of 10 years of service for Retiree Health Care.

ARTICLE 22 – MISCELLANEOUS

22.1 Supplemental Employment. The Employer will not limit an employee engaging in supplemental employment as long as such employment does not interfere with the employee's regular duties under this contract. However, in no case shall Employer telephones, addresses or property be used to operate a non-Employer business nor shall an employee use Employer work time to conduct such business.

22.2 Safety & Health. The Employer shall provide a place of employment that is reasonably free of physical and health hazards.

22.3 Worker's Compensation Pay. In the event an employee sustains an occupational injury, he or she shall receive such benefit entitlements as may be available under Michigan's Worker's Compensation statutes.

22.4 Transportation. Members of the bargaining unit may be required to transport residents, but will not be expected to use their own vehicle to transport residents.

22.5 Mandatory Meeting or Training. All employees shall report for mandatory meetings except as otherwise excused in advance by the Pinecrest Administrator or his designee. Management will post notice of mandatory meetings or training sessions at least one (1) week prior to said meeting. Employees who report to the facility or offsite for mandatory meetings and/or training will be paid for all time spent in said meetings or training.

22.6 Posting of Union Notices.

(a) The Employer agrees to provide bulletin board space which may be used by the Union for posting the following notices:

(1) Notices of Union recreational and social affairs.

(2) Notices of Union elections.

(3) Notices of Union appointments and the results of Union elections.

(4) Notices of the date, time, and place of Union meetings.

(5) Other notices concerning Union affairs which are not political or controversial in nature.

(b) The Union agrees that in no instance shall any notice be derogatory or critical of the Employer or the Social Services Board, or the Employer's or Board's commissioners, board members, officers, agents, supervisors, or employees, nor shall such notices be derogatory or critical of the services, policies, techniques or methods of the Employer.

(c) All notices shall be approved by and bear the signature of the President of the Local Union or the Union. Notices approved by the Local Union President or Steward shall be submitted to and must also be approved by the Pinecrest Administrator, or his designee, prior to being posted.

(d) There shall be no posting by employees, of pamphlets, advertising or political matter, notices, or any other kind of literature upon the Employer's property other than as herein provided.

22.7 Physical Examinations. All persons who have been given a conditional offer of employment shall, at the Employer's request, submit to a physical examination by a doctor designated and paid for by the Employer. Such individuals shall also complete a medical data form as provided by the Employer. Refusal to submit to said physical examination, or the making of a false statement of material fact upon such medical data form, shall constitute cause for the withdrawal of the offer of employment or, if discovered after the individual's commencement of employment, discharge.

If the Employer has reason to suspect that an employee has a physical condition which may endanger the employee's health or interfere with the work of such employee or other employees, the Employer may require such employee to be examined at any time by a doctor designated and paid for by the Employer.

22.8 Copies of Agreement. The Employer shall provide an electronic version and/or access to retrieve an electronic version of the Agreement to all employees, including new hires.

22.9 Name, Address, and Telephone Changes. The Employer shall be entitled to rely upon an employee's last name, address, and telephone number shown on its records for all purposes

involving the employee's employment and this Agreement. The employees shall promptly notify the Employer of any change of name, address, and telephone number.

22.10 Smoke-Free Environment. The Employer's buildings, vehicles, and grounds are smoke-free. Smoking by employees in such facilities or vehicles or on its grounds is strictly prohibited. Violations of this rule will result in disciplinary action, up to and including termination.

ARTICLE 23 – SCOPE OF AGREEMENT

A. This Agreement, including all Appendices and letters of understanding attached hereto, represents the entire agreement between the Employer, the Union, and the Employer's employees which the Union represents. This Agreement supersedes, cancels, and renders null and void, all previous agreements, oral or written, or based on an alleged past or Employer practice either established by the Employer or between the Employer, the Union, or employees and constitutes the entire agreement between the parties. Any agreement or agreements which supplement this Agreement shall not be binding or effective for any purpose whatsoever unless reduced to writing and signed by the Employer and the Union.

B. The Employer and Union acknowledge that during the negotiations which resulted in this Agreement, each had the unlimited right and opportunity to make demands and proposals with respect to any subject or matter not removed by law from the area of collective bargaining, and that the understandings and agreements arrived at by the parties after the exercise of the right and opportunity are contained in this Agreement. Therefore, the Employer and the Union, for the life of this Agreement, each voluntarily and unqualifiedly waives the right, and agrees that the other shall not be obligated, to bargain collectively with respect to any subject or matter referred to or covered in this Agreement, with respect to any subject or matter which was raised in negotiations but as to which no agreement was reached, or with respect to any subject or matter not specifically referred to or covered by this Agreement, even though such subject or matter may not have been within the knowledge or contemplation of either or both of the parties at the time that they negotiated or signed this Agreement.

C. Any agreement reached between the Employer and the Union is binding upon all employees in the bargaining unit who are affected by such agreement and may not be changed by any individual employee.

D. Should any part or provision of this Agreement be rendered or declared illegal or invalid by any decree of a court of competent jurisdiction or by decision of any authorized government agency, the remaining, unaffected part(s) or provisions(s) of this Agreement shall not be affected thereby. However, in such a contingency, the parties shall meet promptly and negotiate with respect to substitute provisions for those parts or provisions rendered or declared illegal or invalid.

ARTICLE 24 – DURATION OF AGREEMENT

This Agreement shall be in full force and effect from October 15, 2019 to and including December 31, 2021 and shall continue in full force and effect from year to year thereafter unless

written notice of desire to cancel or terminate the Agreement is served by either party upon the other at least sixty (60) days prior to date of expiration.

IN WITNESS WHEREOF, the County of Midland and the Technical, Professional and Officeworkers Association of Michigan, by their duly authorized representatives, have hereunto signed their names this day 10-15-19.

COUNTY OF MIDLAND

Mark C. Bone, Chairman
Board of Commissioners

Gaye Terwillegar
County Commissioner

Joseph Blewett
Administrator
Pinecrest Farms

TECHNICAL, PROFESSIONAL AND OFFICEWORKERS ASSOCIATION OF MICHIGAN

Dan Kuhn
Business Agent

Charlotte Kobel
Unit President

Dena Fritz
Steward

Ronda Cunningham
Director of Nursing

Suzanne V. Ault
Human Resources Director

APPENDIX A

PAY GRADES AND JOB CLASSIFICATIONS

Pay Grade	Job Classification
2	Resident Associate

APPENDIX B
WAGE SCHEDULES
OCTOBER 15, 2019 THROUGH DECEMBER 31, 2019

2% OVER PREVIOUS YEAR

	Minimum			Midpoint			Maximum
Grade	**Step 1**	**Step 2**	**Step 3**	**Step 4**	**Step 5**	**Step 6**	**Step 7**
1	13.34	14.00	14.67	15.33	16.00	16.67	17.33
2	14.00	14.70	15.40	16.11	16.80	17.50	18.21
3	15.06	15.80	16.55	17.31	18.06	18.81	19.57
4	16.55	17.38	18.22	19.04	19.87	20.70	21.52
5	17.80	18.69	19.58	20.46	21.36	22.25	23.13
6	20.03	21.02	22.02	23.02	24.03	25.03	26.03
7	21.52	22.59	23.68	24.76	25.84	26.91	27.99
8	22.59	23.74	24.87	25.99	27.12	28.25	29.38
9	23.74	24.92	26.10	27.29	28.48	29.66	30.84
10	24.92	26.16	27.42	28.65	29.90	31.15	32.40
11	26.16	27.48	28.77	30.09	31.40	32.71	34.01
12	29.44	30.91	32.37	33.85	35.32	36.80	38.27
13	32.37	34.00	35.61	37.24	38.86	40.47	42.10
14	34.81	36.55	38.29	40.02	41.77	43.51	45.25
15	37.41	39.29	41.16	43.03	44.90	46.78	48.64
16	40.22	42.24	44.25	46.26	48.27	50.29	52.30
17	52.30	54.91	57.53	60.14	62.75	65.37	67.98

APPENDIX B
WAGE SCHEDULES
JANUARY 1, 2020 THROUGH DECEMBER 31, 2020

2% OVER PREVIOUS YEAR

	Minimum			Midpoint			Maximum
Grade	**Step 1**	**Step 2**	**Step 3**	**Step 4**	**Step 5**	**Step 6**	**Step 7**
1	13.61	14.28	14.96	15.64	16.32	17.00	17.68
2	14.28	14.99	15.71	16.43	17.14	17.85	18.57
3	15.36	16.12	16.88	17.66	18.42	19.19	19.96
4	16.88	17.73	18.58	19.42	20.27	21.11	21.95
5	18.16	19.06	19.97	20.87	21.79	22.70	23.59
6	20.43	21.44	22.46	23.48	24.51	25.53	26.55
7	21.95	23.04	24.15	25.26	26.36	27.45	28.55
8	23.04	24.21	25.37	26.51	27.66	28.82	29.97
9	24.21	25.42	26.62	27.84	29.05	30.25	31.46
10	25.42	26.68	27.97	29.22	30.50	31.77	33.05
11	26.68	28.03	29.35	30.69	32.03	33.36	34.69
12	30.03	31.53	33.02	34.53	36.03	37.54	39.04
13	33.02	34.68	36.32	37.98	39.64	41.28	42.94
14	35.51	37.28	39.06	40.82	42.61	44.38	46.16
15	38.16	40.08	41.98	43.89	45.80	47.72	49.61
16	41.02	43.08	45.14	47.19	49.24	51.30	53.35
17	53.35	56.01	58.68	61.34	64.01	66.68	69.34

APPENDIX B
WAGE SCHEDULES
JANUARY 1, 2021 THROUGH DECEMBER 31, 2021

2% OVER PREVIOUS YEAR

	Minimum			Midpoint			Maximum
Grade	**Step 1**	**Step 2**	**Step 3**	**Step 4**	**Step 5**	**Step 6**	**Step 7**
1	13.88	14.57	15.26	15.95	16.65	17.34	18.03
2	14.57	15.29	16.02	16.76	17.48	18.21	18.94
3	15.67	16.44	17.22	18.01	18.79	19.57	20.36
4	17.22	18.08	18.95	19.81	20.68	21.53	22.39
5	18.52	19.44	20.37	21.29	22.23	23.15	24.06
6	20.84	21.87	22.91	23.95	25.00	26.04	27.08
7	22.39	23.50	24.63	25.77	26.89	28.00	29.12
8	23.50	24.69	25.88	27.04	28.21	29.40	30.57
9	24.69	25.93	27.15	28.40	29.63	30.86	32.09
10	25.93	27.21	28.53	29.80	31.11	32.41	33.71
11	27.21	28.59	29.94	31.30	32.67	34.03	35.38
12	30.63	32.16	33.68	35.22	36.75	38.29	39.82
13	33.68	35.37	37.05	38.74	40.43	42.11	43.80
14	36.22	38.03	39.84	41.64	43.46	45.27	47.08
15	38.92	40.88	42.82	44.77	46.72	48.67	50.60
16	41.84	43.94	46.04	48.13	50.22	52.33	54.42
17	54.42	57.13	59.85	62.57	65.29	68.01	70.73

COUNTY OF MIDLAND
0070004730019 - 06N2F
Effective Date: 01/01/2018

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.

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

Note: A list of services that require approval before they are provided is available online at bcbsm.com/importantinfo. Select Approving covered services.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Eligibility Information

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

Members	Eligibility Criteria
Dependents	- Subscriber's legal spouse - Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26

Benefits	In-network	Out-of-network
Deductible	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over) Note: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $30 copay for office visits and office consultations • $30 copay for chiropractic and osteopathic manipulative therapy • $100 copay for emergency room visits • $30 copay for urgent care visits	• $100 copay for emergency room visits
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$1,500 for one member, $3,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost- sharing amounts for prescription drugs, if applicable	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.

One per member per calendar year

Benefits	In-network	Out-of-network
Colonoscopy- routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
One per member per calendar year		

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$30 copay per office visit	60% after out-of-network deductible
Online visits - by physician or BCBSM selected vendor must be medically necessary	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	$30 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	$30 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$100 copay per visit (copay waived if admitted or for an accidental injury)	$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessa	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
Note: Nonemergency services must be rendered in a participating hospital.	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facili	80% after in-network deductible	80% after in-network deductible
Limited to a maximum of 120 days per member per calendar year		
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		
Home health care: • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males Note: For voluntary sterilizations for females, see "Preventive care services."	80% after in-network deductible	60% after out-of-network deductible
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only

Benefits	In-network	Out-of-network
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials Note: BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance use disorder treatment

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment Unlimited days	80% after in-network deductible	60% after out-of-network deductible
Residential psychiatric treatment facility: • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities only
• Online visits - by physician or BCBSM selected vendor must be medically necessary	$30 copay per online visit	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$30 copay per visit	60% after out-of-network deductible
	Limited to a combined 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy- provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a combined 60-visit maximum per member per calendar year	
Durable medical equipment Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

BCBSM Preferred RX Program

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/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs - The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the same annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay $7 copay	You pay $7 copay	You pay $7 copay	You pay $7 copay plus an additional 25% of BCBSM approved amount for the drug
31 to 83-day period		No coverage	You pay $14 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	84 to 90-day period	You pay $14 copay	You pay $14 copay	No coverage	No coverage
	1 to 30-day period	You pay $35 copay	You pay $35 copay	You pay $35 copay	You pay $35 copay plus an additional 25% of BCBSM approved amount for the drug
31 to 83-day period		No coverage	You pay $70 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	84 to 90-day period	You pay $70 copay	You pay $70 copay	No coverage	No coverage
	1 to 30-day period	You pay $70 copay	You pay $70 copay	You pay $70 copay	You pay $70 copay plus an additional 25% of BCBSM approved amount for the drug
31 to 83-day period		No coverage	You pay $140 copay	No coverage	No coverage
84 to 90-day period		You pay $140 copay	You pay $140 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs. * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. Tier 1 (generic) - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. Tier 2 (preferred brand) - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. Tier 3 (nonpreferred brand) - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. Step Therapy, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy.
Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Elective lifestyle drugs	Benefits are excluded for elective lifestyle drugs. Note: Elective lifestyle drugs are lifestyle drugs that treat sexual impotency or infertility, or help in weight loss. They are not designed to treat acute or chronic illnesses. These medications are prescribed for medical conditions that have no demonstrable physical harm if not treated. (Smoking cessation drugs are not considered an elective lifestyle drug and are a payable benefit.) BCBSM determines when a drug is an elective drug.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Dental Coverage

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Network access information
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152.

[1]Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
[2]A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit mibluedentist.com.

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	- Subscriber's legal spouse - Unmarried dependent children: related to you by birth, marriage, legal adoption or legal guardianship, eligible for dental coverage through the last day of the month the dependent turns age 26, provided all eligibility requirements are met

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) Class I services	25%
Class II services	50%
Class III services	50%
Class IV services	Not covered
Dollar maximums Annual maximum for Class I, II and III services	$1,200 per member
Lifetime maximum for Class IV services	Not applicable

Class I services

Benefits	Coverage
Oral exams	75% of approved amount Note: Twice per calendar year
A set (up to 4 films) of bitewing x-rays	75% of approved amount Note: Twice per calendar year
Panoramic or full-mouth x-rays	75% of approved amount Note: Once every 60 months

Benefits	Coverage
Dental prophylaxis (teeth cleaning)	75% of approved amount Note: Twice per calendar year
Pit and fissure sealants - for members age 19 and younger	75% of approved amount Note: Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	75% of approved amount
Fluoride treatments	75% of approved amount Note: Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	75% of approved amount Note: Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	50% of approved amount Note: Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	50% of approved amount Note: Replacement fillings covered after 12 months or more after initial filling
Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	50% of approved amount Note: Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	50% of approved amount Note: Three times per tooth per calendar year after six months from original restoration
Oral surgery	50% of approved amount
Root canal treatment	50% of approved amount Note: Once every 12 months
Scaling and root planing	50% of approved amount Note: Once every 24 months per quadrant
Limited occlusal adjustments	50% of approved amount Note: Limited occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	50% of approved amount Note: Once every 12 months
General anesthesia or IV sedation	50% of approved amount Note: When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	50% of approved amount Note: Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	50% of approved amount Note: Once per arch in any 36 consecutive months
Tissue conditioning	50% of approved amount Note: Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount Note: Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount Note: Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount Note: Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination before treatment begins.

Vision Coverage

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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

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined $7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay
Medically necessary contact lenses Note: No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

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. One eye exam in any period of 12 consecutive months	$5 copay	Reimbursement up to $50 less $5 copay (member responsible for any difference)

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.	$7.50 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 consecutive months	
Standard frames 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	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $7.50 copay (one copay applies to both frames and lenses)	Reimbursement up to $70 less $7.50 copay (member responsible for any difference)

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)	$7.50 copay	Reimbursement up to $210 less $7.50 copay (member responsible for any difference)
	Contact lenses up to the allowance in any period of 12 consecutive months	

Benefits	VSP network doctor	Non-VSP provider
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	$130 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

COUNTY OF MIDLAND
0070004730021 - 06N1Z
Effective Date: 01/01/2018

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

Note: A list of services that require approval before they are provided is available online at bcbsm.com/importantinfo. Select Approving covered services.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.
Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Eligibility Information

Members	Eligibility Criteria
Dependents	- Subscriber's legal spouse - Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26

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

Benefits	In-network	Out-of-network
Deductible	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over) Note: Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over) Note: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $30 copay for office visits and office consultations • $30 copay for chiropractic and osteopathic manipulative therapy • $100 copay for emergency room visits • $30 copay for urgent care visits	• $100 copay for emergency room visits
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$2,500 for one member, $5,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost- sharing amounts for prescription drugs, if applicable	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	

Benefits	In-network	Out-of-network
Colonoscopy- routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$30 copay per office visit	60% after out-of-network deductible
Online visits - by physician or BCBSM selected vendor must be medically necessary	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	$30 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	$30 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$100 copay per visit (copay waived if admitted or for an accidental injury)	$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessa	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
Note: Nonemergency services must be rendered in a participating hospital.	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facili	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery- includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males Note: For voluntary sterilizations for females, see "Preventive care services."	80% after in-network deductible	60% after out-of-network deductible
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only

Benefits	In-network	Out-of-network
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials Note: BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance use disorder treatment

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities only
• Online visits - by physician or BCBSM selected vendor must be medically necessary	$30 copay per online visit	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$30 copay per visit	60% after out-of-network deductible
	Limited to a combined 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy- provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a combined 60-visit maximum per member per calendar year	
Durable medical equipment Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

BCBSM Preferred RX Program

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Specialty Pharmaceutical Drugs - The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the same annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay $7 copay	You pay $7 copay	You pay $7 copay	You pay $7 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $14 copay	No coverage	No coverage
	84 to 90-day period	You pay $14 copay	You pay $14 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $35 copay	You pay $35 copay	You pay $35 copay	You pay $35 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $70 copay	No coverage	No coverage
	84 to 90-day period	You pay $70 copay	You pay $70 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $70 copay	You pay $70 copay	You pay $70 copay	You pay $70 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $140 copay	No coverage	No coverage
	84 to 90-day period	You pay $140 copay	You pay $140 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs. * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. Tier 1 (generic) - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. Tier 2 (preferred brand) - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. Tier 3 (nonpreferred brand) - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. Step Therapy, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy.
Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Elective lifestyle drugs	Benefits are excluded for elective lifestyle drugs. Note: Elective lifestyle drugs are lifestyle drugs that treat sexual impotency or infertility, or help in weight loss. They are not designed to treat acute or chronic illnesses. These medications are prescribed for medical conditions that have no demonstrable physical harm if not treated. (Smoking cessation drugs are not considered an elective lifestyle drug and are a payable benefit.) BCBSM determines when a drug is an elective drug.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Dental 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.

Network access information
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152. [1]Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
[2]A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit mibluedentist.com.

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	- Subscriber's legal spouse - Unmarried dependent children: related to you by birth, marriage, legal adoption or legal guardianship, eligible for dental coverage through the last day of the month the dependent turns age 26, provided all eligibility requirements are met

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) Class I services	25%
Class II services	50%
Class III services	50%
Class IV services	Not covered
Dollar maximums Annual maximum for Class I, II and III services	$1,200 per member
Lifetime maximum for Class IV services	Not applicable

Class I services

Benefits	Coverage
Oral exams	75% of approved amount Note: Twice per calendar year
A set (up to 4 films) of bitewing x-rays	75% of approved amount Note: Twice per calendar year
Panoramic or full-mouth x-rays	75% of approved amount Note: Once every 60 months

Benefits	Coverage
Dental prophylaxis (teeth cleaning)	75% of approved amount Note: Twice per calendar year
Pit and fissure sealants - for members age 19 and younger	75% of approved amount Note: Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	75% of approved amount
Fluoride treatments	75% of approved amount Note: Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	75% of approved amount Note: Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	50% of approved amount Note: Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	50% of approved amount Note: Replacement fillings covered after 12 months or more after initial filling
Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	50% of approved amount Note: Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	50% of approved amount Note: Three times per tooth per calendar year after six months from original restoration
Oral surgery	50% of approved amount
Root canal treatment	50% of approved amount Note: Once every 12 months
Scaling and root planing	50% of approved amount Note: Once every 24 months per quadrant
Limited occlusal adjustments	50% of approved amount Note: Limited occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	50% of approved amount Note: Once every 12 months
General anesthesia or IV sedation	50% of approved amount Note: When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	50% of approved amount Note: Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	50% of approved amount Note: Once per arch in any 36 consecutive months
Tissue conditioning	50% of approved amount Note: Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount Note: Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount Note: Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount Note: Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination before treatment begins.

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

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined $7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay
Medically necessary contact lenses Note: No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

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.	$5 copay	Reimbursement up to $50 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.	$7.50 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 consecutive months	
Standard frames Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $7.50 copay (one copay applies to both frames and lenses)	Reimbursement up to $70 less $7.50 copay (member responsible for any difference)
	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)	$7.50 copay	Reimbursement up to $210 less $7.50 copay (member responsible for any difference)
	Contact lenses up to the allowance in any period of 12 consecutive months	

Benefits	VSP network doctor	Non-VSP provider
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	$130 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	

APPENDIX D

MEMBERSHIP DUES DEDUCTION AUTHORIZATION FORM

I authorize the Payroll Department of the County of Midland ("County") to deduct my regular Technical, Professional and Officeworkers Association of Michigan ("TPOAM") membership dues from my pay. I agree that such deductions shall be consecutive and in such amounts as certified to the County in writing, and that all dues deducted shall be remitted to the person designated by TPOAM in writing.

I further understand and agree that this authorization shall remain in effect until I serve written notification of cancelation upon the Payroll Department or until my separation or retirement from the County of Midland, whichever occurs first.

Name	Date