

COLLECTIVE BARGAINING AGREEMENT

BETWEEN THE

CITY OF WESTLAND

AND THE

WESTLAND LIEUTENANTS AND SERGEANTS ASSOCIATION

FOR THE PERIOD OF

JANUARY 1, 2015 TO DECEMBER 31, 2019

**WESTLAND LIEUTENANTS & SERGEANTS ASSOCIATION
COLLECTIVE BARGAINING AGREEMENT 2015 - 2019
TABLE OF CONTENTS**

<u>Topic</u>	<u>PAGE</u>
Association Activities.....	5
Association Dues.....	5
Association Security.....	4
City's Rights & Responsibilities.....	24
Copies of Contract.....	24
Coverage.....	2
Deputy Chief Classification.....	31
Detective Bureau.....	32
Drug Policy.....	32
Duration of Agreement.....	24
Employee Injuries.....	9
Employee's Rights.....	19
Police Professional Liability Insurance.....	20
Fair Practices.....	2
Fringe Benefits	
Bereavement.....	15
Clothing Allowance.....	11
Dental Coverage.....	19
Holiday Pay.....	17
Life Insurance.....	19
Retirees Life Insurance.....	19
Medical & Hospital Insurance.....	17
Mutual Gains Program.....	18
Optical Program.....	19
Pension.....	26
Duty Disability Pension.....	29
Personal Leave Days.....	16
Retiree Health Insurance.....	18
Senior Knowledge Bonus.....	7
Sick Leave.....	14
Special Assignment Compensatory Bank.....	8
Tuition Reimbursement & Educational Stipend.....	25
Vacations.....	12
Weapons Qualification.....	11
Grievance Procedure.....	21
Jury Duty Pay.....	21

Layoffs.....	13
Leaves of Absence & FMLA.....	16
Maintenance of Conditions.....	21
Modification.....	24
Promotions.....	30
Purpose & Intent.....	2
Recognition of Association.....	4
Rights of the Association.....	3
Rights of the Employer.....	3
Savings Clause.....	25
Seniority & Vacancies.....	14
Special Investigation Unit.....	32
Strikes & Lockouts.....	25
Wages.....	6
Extradition.....	9
Overtime.....	8
Shift Premium Pay.....	7
Stand By Status.....	9
Wage Differential.....	6
Work Hours.....	12
Appendix A – Benefits Plan Summaries	
Blue Cross PPO-1, PPO-2, Base, Value & Qualified Plans.....	36

This Agreement is entered into on this ____ day of _____, 2015, between the City of Westland, a Michigan Municipal Corporation (hereinafter referred to as the Employer or the City,) and the Westland Lieutenants and Sergeants Association (hereinafter referred to as the Association), and shall cover the period from January 1, 2015 to December 31, 2019.

**ARTICLE 1
PURPOSE AND INTENT**

1.1 WHEREAS, the general purpose of this agreement is to set forth terms and conditions of employment, and to promote orderly and peaceful labor relations for the mutual interest of the City of Westland in its capacity as an Employer, the Employees and the Association, and the people of the City of Westland, and

1.2 WHEREAS, the parties recognize that the interest of the community and the job security of the employee depend upon the Employer's success in establishing a proper service to the Community, and

1.3 WHEREAS, to these ends the Employer and the Association encourage to the fullest degree, friendly and cooperative relations between the respective representatives at all levels and among all employees, and

1.4 WHEREAS, it is agreed by the City and the Association that the City is legally obligated to provide equal opportunity, consideration and treatment of all members of the Association in all phases of the employment process; to this end, basic rights and equities of employees are established through the City Charter, Ordinances and Resolutions of the City Council, and Rules and Regulations of the Civil Service Commission, and

1.5 WHEREAS, it is further agreed by the City and the Association that the provisions of P.A. 78 of 1935, as amended, and P.A. 379 of 1965, as amended, are incorporated by reference into this agreement to the extent that said statutes do not conflict with other provisions of this agreement.

**ARTICLE 2
COVERAGE**

2.1 This agreement shall be applicable as to all employees of the Westland Police Department of the ranks of Sergeant, Lieutenant and Deputy Chief.

**ARTICLE 3
FAIR PRACTICES**

3.1 The Association agrees to maintain its eligibility to represent police officers by continuing to admit to membership without discrimination on the basis of race, creed, color, national origin, sex or marital status and to represent equally all employees without regard to membership or participation in, or association with the activities of, any employee organization.

3.2 The City agrees to continue its policy of not discriminating against any employee on the basis of race, creed, color, national origin, sex, marital status or membership or participation in or association with the activities of, any employee organization.

**ARTICLE 4
RIGHTS OF THE EMPLOYER**

4.1 There is reserved exclusively to the City all responsibilities, power, rights and authority vested in it by the laws and Constitution of Michigan and the United States or which have been heretofore properly exercised by it, excepting where expressly and in specific terms limited by the provisions of this Agreement.

It is further recognized that the responsibility of Management of the City, selection and direction of the working forces, including the right to hire, suspend or discharge for cause, assign, promote or transfer, to determine the hours of work, to relieve employees from duty because of lack of work are solely the responsibilities of the City. The City agrees that it shall exercise these rights in conformity with the terms of the Agreement as they pertain herein, and shall not exercise these rights in conflict with the terms of this Agreement. The City agrees to negotiate any changes in personnel policies related to wages, terms and conditions of employment of the members of the Association.

4.2 The City has the right to control and manage operations which includes the right to determine staffing levels in the WLSA. The 2010 LOU section regarding "Staffing Levels" (p. 5 of LOU) between the City of Westland and the WLSA is hereby terminated. This agreement is controlling over any provision of the 2010 LOU between the City and the Union which is in conflict.

**ARTICLE 5
RIGHTS OF THE ASSOCIATION**

5.1 Pursuant to Act 379 of the Public Acts of 1965, the City hereby agrees that every employee of the City engaged in law enforcement work in the ranks of Sergeant, Lieutenant and Deputy Chief shall have the right freely to organize, join and support the Association for the purpose of engaging in collective bargaining and other concerted activities for mutual aid and protection.

5.2 The City administration, as a duly elected body exercising Governmental power under Color of Law of the State of Michigan undertakes and agrees that it will not directly or indirectly discourage or deprive or coerce any police officer in the enjoyment of any rights conferred by Act 78 and Act 379 or other Laws of Michigan or the Constitutions of Michigan and the United States, that it will not discriminate against any police officer with respect to hours, wages or any terms or conditions of employment by reason of his membership in the Association, his participation in any activities of the Association or collective professional negotiations with the City Administration, or its designated representative(s), or his institution of any grievance, complaint or proceeding with respect to any terms or condition of employment under this agreement.

5.3 Nothing contained herein shall be construed to deny or to restrict any police officer's rights he or she may have under the Michigan Public Employee Laws, or other applicable laws.

5.4 The City specifically recognizes the right of its employees appropriately to invoke the assistance of the State Labor Mediation Board or a mediator from such public agency, or invoke arbitration proceedings whenever differences cannot be resolved in local negotiations pursuant to the provisions of this Agreement, as well as any other remedy provided for by Michigan Statutes.

5.5 The City specifically recognizes the right of its employees appropriately to invoke the assistance of the State of Michigan Mediation Board or a mediator from such public agency, or negotiations pursuant to the provisions of this Agreement, as well as any other remedy provided for by Michigan statutes.

ARTICLE 6 RECOGNITION OF ASSOCIATION

6.1 Pursuant to and in accordance with all applicable provisions of Acts 78 and 379 as referred to hereinabove, the Employer does hereby recognize the Association as the exclusive representative for the purpose of collective bargaining, with respect to hours, wages and all terms and conditions of employment for the term of this Agreement, of all employees of the Police Department of the City of Westland of the ranks of Sergeant, Lieutenant and Deputy Chief.

ARTICLE 7 ASSOCIATION SECURITY

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

7.2 Employees covered by this Agreement, at the time it becomes effective and who are members of the Association at the time, shall be considered active members, and the City will continue to honor the voluntary dues deduction authorization.

7.3 Employees who are members of the Association, or who subsequently become members, will be required as a condition of continued employment to pay dues for the duration of the Agreement.

7.4 An employee who shall tender the periodic dues uniformly required as a condition of acquiring or retaining membership shall be deemed to meet the conditions of this section.

7.5 Employees shall be deemed to be members of the Association within the meaning of this section if they are not more than sixty (60) days in arrears in payment of membership dues.

7.6 The employer shall be notified, in writing, by the Association of any member who is sixty (60) days in arrears in payment of dues and the member shall be discharged by the City.

**ARTICLE 8
ASSOCIATION DUES**

8.1 PAYMENT BY PAYROLL DEDUCTION – In accordance with the provisions of this Agreement relating to Association Security (see Article 7), those employees who desire to or are required to tender an initiation fee and membership dues shall be required to do so by signing a written authorization in this regard.

8.2 WHEN DEDUCTION BEGINS – Payroll deductions for the Association initiation fee and membership dues shall become effective at the time the written authorization is received by the City, and shall be deducted from the first pay of the month providing the authorization is received by the City on or before the 15th of the prior month and each month thereafter.

8.3 IF THE EMPLOYEE HAS NO PAY COMING FOR SUCH PAY PERIOD – such dues shall be deducted from his next subsequent pay.

8.4 REMITTANCE OF DUES TO FINANCIAL OFFICER – Such deductions, accompanied by a list of the Employees' names shall be forwarded to the Association treasurer within thirty (30) days after such collection has been made.

**ARTICLE 9
ASSOCIATION ACTIVITIES**

9.1 BULLETIN BOARDS – A bulletin board shall be used for the purpose of displaying the activities of the Association; the bulletin board shall be in the squad room and shall be supplied by the City; the Association shall designate person(s) to maintain the bulletin board. Bulletin boards used will be restricted to official organization materials.

A. Material shall not be posted without the authorization of a member of the Executive Board.

B. Political campaign material, material which reflects upon the city or any of its employees in a detrimental manner, or any material intended solely for the personal use of any employee shall not be posted.

9.2 ASSOCIATION MEETINGS – Meetings of the Officers of the Association may be conducted at any city building, insofar as these meetings shall not disrupt the other employees from their normal work. Forty-eight (48) hours prior notice will be given to the Chief or his designated representative when the use of a city building is needed.

9.3 REQUEST TO USE EQUIPMENT AND FACILITIES – Reasonable requests for use of existing equipment and facilities will be granted to the Association by the Chief of Police. The Association agrees to pay for all materials used for its purposes, and the Association agrees to reimburse the City for any damage to equipment entrusted to its use and care.

9.4 COMPENSATING UNION REPRESENTATIVES DURING WORKING HOURS – Officers of the Association shall have or be afforded reasonable time, as determined by the Chief or his representative during working hours without loss of time or money to fulfill their Association responsibilities, including negotiations with the City, processing grievances and administration and enforcement of this Agreement.

9.5 At no time will officers leave their shift without supervision.

9.6 COMPENSATING UNION REPRESENTATIVES IF OFF DUTY – All members of the Executive Board and/or Grievance Committee called back by the Chief or the Shift Commander from off duty for any grievance or Association business shall be compensated at the rate of time and one-half (1 ½) with a minimum of two (2) hours.

9.7 Any member of the Association who feels aggrieved will be afforded reasonable time, up to one (1) hour, during working hours, to file a grievance if the alleged grievance occurred during duty hours.

**ARTICLE 10
WAGES**

10.1 General Wage Scale: The general wage scale shall be as follows:

EFFECTIVE	SERGEANT < 1 YR	SERGEANT > 1 YR	LIEUTENANT	DEPUTY CHIEF
7/1/2014	\$75,823	\$80,017	\$87,219	\$95,068
7/1/2015	\$77,339	\$81,618	\$88,963	\$96,970
7/1/2016	\$78,886	\$83,250	\$90,742	\$98,909
7/1/2017	\$78,886	\$83,250	\$90,742	\$98,909
7/1/2018	\$78,886	\$83,250	\$90,742	\$98,909

7/1/19 –The differential stated in section 10.2 shall be maintained.

10.2 A twenty-four percent (24%) differential shall be maintained between a Sergeant, 1 year in rank, and the highest base wage rate in the non-supervisory police unit for all command officers promoted prior to ratification of this Agreement. For all officers promoted or otherwise hired into the Unit on or after ratification of this Agreement and with an original hire date that is on or after July 1, 2014, the wage differential between a Sergeant 1 year in rank and the highest base wage rate in the non-supervisory police unit for all command officers shall be 20%. The differential between a Sergeant, less than 1 year in rank and the highest base wage rate in the non-supervisory police unit shall be seventeen and one-half (17.5%) percent. A nine percent (9%) differential will be maintained between the rank of Sergeant and Lieutenant and between the rank of Lieutenant and Deputy Chief. These differentials are controlling over the wages contained in section 10.1.

10.3 Shift premium shall be paid to Association members assigned to shifts as follows:

1. Members assigned to shifts starting from 11 a.m. up to 7 p.m. are to be paid \$250.00 every four (4) months (shift cycle).
2. Members assigned to shifts starting from 6 p.m. up to 5 a.m. are to be paid \$300.00 every four (4) months (shift cycle).
- c. Supervisors will be assigned to the same shift system as those Police Officers they supervise.
- d. Payments for shift premiums shall be paid within thirty days of the expiration of each four-month shift period.

10.4 Senior Knowledge Bonus

A. Employees who have completed two years in the Association, or eight years of departmental service, as of March 31st of the current calendar year will be eligible to take a senior command knowledge test. Employees must register to take the test by January 20th of that year. The test shall be administered in February of each year. If the test is not administered in February of that calendar year, all eligible registered employees will have their certification extended one additional year. The categories of the test shall be as follows:

1. Local ordinances
2. State law
3. Rules and regulations of the police department
4. Policies/procedures
5. Supervisory principles
6. Municipal government issues

B. The form of the test shall be multiple choice and true/false. A score of 70% is considered passing. An employee must pass this test at least once in the previous five (5) years to be eligible for the senior payment. An employee may take the test at any testing period and upon passing the test the employee will not be required to pass for an additional five (5) years from the period that the employee last passed the test.

C. The Chief and his Cadre will be responsible for the development of these written tests. The Union will be allowed input into the test to assure that the test requirements are job-related and fair.

D. Effective January 1, 2016, all employees with a hire date prior to July 1, 2014 shall receive an annual \$4,500 Senior Knowledge Bonus. In the event an employee retires prior to the completion of the year ending March 31, employee shall not have any pro rata deductions of the Senior Knowledge Bonus deducted from their final pay (for unearned monthly credits). For

employees with a City of Westland hire date on or after July 1, 2014, there shall be no senior knowledge bonus.

ARTICLE 11 OVERTIME

11.1 If an employee is called back while off duty for appearance in Circuit Court, Liquor Control Commission in Lincoln Park or Lansing, License Appeal Board or for testifying in any legal matter outside the City of Westland, he shall receive a minimum of four (4) hours paid compensatory time for any A.M. session and an additional minimum of four (4) hours paid in compensatory time for P.M. session, or in the alternative, the employee shall be paid at the rate of time and one-half (1 ½), whichever is greater. Time shall be computed from when the employee checks into the station upon arrival and when he checks back upon return. In the event that the officer is required to use his own motor vehicle because of the unavailability of a city vehicle in any of the above situations, he shall be reimbursed at the rate of twenty (\$.20) cents a mile, plus parking expenses.

11.2 When an employee is called back for an 18th District Court appearance, he/she shall be paid for a minimum of three (3) hours if called for a morning session, and an additional three (3) hours if called for an afternoon session, and an additional three (3) hours for evening sessions, or in the alternative, the employee shall be paid at the rate of time and one-half (1 ½), whichever is greater. However, any employee appearing in Court immediately preceding his normal shift by one hour or less, shall be paid one (1) hour at time and one-half (1 ½), and any employee appearing during regular duty hours shall be paid at the rate of time and one-half (1 ½), if required to stay beyond his regular shift.

11.3 A. Any employee, exchanging compensatory time for cash payment, at the prevailing hourly rate, shall do so in writing to the Chief of Police. Said cash payment shall be made to the employee no later than two full pay periods from the date of the employee's request. For officers with a City hire date prior to July 1, 2014, the maximum compensatory time accumulation limit shall be one-hundred sixty (160) hours. Officers hired by the City on or after July 1, 2014 may accumulate up to one hundred twenty-five (125) hours of compensatory time. Any employee who has accumulated in excess of the limit shall be paid at the prevailing hourly rate in effect within two full pay periods for all compensatory time exceeding the 160-hour/125-hour maximums. All requests for payment shall be made in increments of ten hours.

11.3 B. Special Assignment Compensatory Bank. For special operations, all employees may work in lieu of regular payment or regular compensatory for special compensatory time. This special compensatory time shall be earned at the rate of 1.5 times the number of hours actually worked. This special overtime shall not exceed a bank of 100 hours at the end of any four month shift period. Special compensatory time shall be taken off on an hour-for-hour basis. Any special compensatory time in excess of 100 hours at the end of any pay cycle will be transferred to the employee's regular comp time bank. For hours at assigned training, employees shall receive time and one half in time owed.

11.4 In the event an employee dies, retires, or resigns, or is discharged, he or his beneficiaries or heirs shall receive compensation in the sum equivalent of his accumulated compensatory time at his/her prevailing hourly rate.

11.5 STAND-BY-STATUS – All employees placed on a stand-by status while off duty will be compensated at a rate of one (1) hour in compensatory time for each three (3) hour period or less, with a minimum of two (2) hours.

11.6 When an employee is called back for any reason to correct improperly completed reports, a mutual aid incident, or to turn in City equipment, he shall receive time and one-half with a minimum of three hours; provided that a SWAT assignment shall be at a minimum of two hours. If an employee works beyond his normal shift, he shall be compensated at the rate of time and one-half for all time over the regular shift hours. Employees called back while off duty to work a mutual aid incident shall be compensated at a double time rate for all hours assigned to work the mutual aid incident, and shall be paid for a minimum of three hours. Time shall be compensated when the employee checks into the station upon arrival until dismissal from such assignment.

11.7 In the event an employee is required to attend any departmental school on his scheduled day off he shall change his assigned leave days; provided the employee is notified seven (7) days in advance. The employee shall receive compensatory time at the regular hourly rate of pay for travel to and from the assigned school. In the event an employee is required to attend any departmental school or training on a leave day, he or she shall be compensated at the rate of time and one half (1-1/2) for each hour of school or training, and for travel to and from the assigned school.

11.8 EXTRADITION – In the event an officer is required to pick up a prisoner who has been extradited to the State of Michigan, the officer shall be paid at the rate of straight time plus a minimum of two (2) hours compensatory time per day for each day that the officer is away.

11.9 Upon completion of an overtime assignment employees shall receive a rest period of six hours commencing with the completion of the overtime assignment. In the event the rest period overlaps the employee's next regularly scheduled work day, the employee shall suffer no loss of straight time pay normally earned.

ARTICLE 12 EMPLOYEE INJURIES

12.1 If an employee is unable to perform his/her regular duties as the result of an accident and/or illness as the result of an on-the-job event or while off duty and acting in the capacity of his oath of office, the employee shall be provided with such police duties as he is capable of performing within the police department, upon the recommendation of the City designated doctor, provided that if the employee is presently not capable of performing any duties within the police department or the police department does not have available any duties for which the employee is capable of performing, upon the recommendation of the City designated doctor. The

employee shall continue to receive an amount equal to the base salary, however, effective 1/1/93 said amount shall be recalculated as necessary to continue to provide eight-five percent (85%) of the base salary of the classification. Effective 3/17/2008, said 85% supplemental pay shall be in effect for only the first two years that the employee is off with the injury, and it shall thereafter be discontinued. In the event the Internal Revenue Code is hereafter amended to adversely affect the taxability of Workers' Compensation benefits, to the extent that it does, then this provision shall be adjusted proportionately from the eighty-five percent (85%) to one hundred percent (100%).

12.2 A. The City is not obligated to provide duties, other than an officer's regular duties, if an officer is injured while off duty or incapacitated from injury or illness that is not job related.

B. Employees who are on light duty due to being injured on the job, according to the City Doctor's restrictions, may be assigned to another shift to expedite visits for medical treatments providing the employee has been given 48 hours notice of such a change. When treatments end the employee will resume their normal shift.

12.3 If an employee retires under the duty disability provisions of Act 345, he shall receive a pension equal to the base salary he received as an active member of the department. Said pension shall be recalculated as necessary to continue to provide a retired member eighty-five percent (85%) of the base pay of the classification from which he retired until he meets what would have been his normal age and service requirements necessary to receive a normal retirement. In the event the Internal Revenue Code is hereafter amended to adversely affect the taxability of Workers' Compensation benefits, to the extent that it does, then this provision shall be adjusted proportionately from the eighty-five percent (85%) to one hundred percent (100%).

At the time the employee reaches what would have been his normal age and service requirements, his pension shall be recalculated according to the provisions of Act 345, and based on the actual base salary of the classification that the employee would have received each year had the employee continued to work and its value factored into the average final compensation.

Said disability retirement shall include the continuance of the medical and life insurance plan of this and future contracts until the recalculations to normal retirement as described above or death, whichever comes first, providing the employee does not earn more than fifty percent (50%) of his base pay in other employment. In the event the employee earns more than fifty percent (50%) of his base pay, there will be a dollar-for-dollar offset for all earnings over fifty percent (50%).

One hundred percent (100%) of the cost of the pension, including all related medical expenses for employees retiring as a result of a duty disability described above, shall be the obligation of the Act 345 pension system.

12.4 In the event that the employee shall disagree with the findings of any city doctor as to his medical condition, he can elect to obtain a medical opinion from some other doctor at his own expense. A doctor shall be defined as an M.D. or D.O.

12.5 In the event that an employee is killed in the line of duty, his designated beneficiaries shall receive one (1) full year's benefits that are herein provided. Benefits shall include total salary, weapons qualification, clothing allowance, longevity and holiday pay. Payment is to be made to the beneficiary on regular pay days for twelve (12) months from the date of the employee's death.

**ARTICLE 13
CLOTHING ALLOWANCE**

13.1 Each officer with a City hire date prior to July 1, 2014 shall receive the sum of one thousand five hundred dollars (\$1,500) on the first payday of October by separate check for the refurbishing care, and maintenance of their clothing. For officers hired by the City on or after July 1, 2014, the amount of clothing allowance shall be one thousand (\$1,000) dollars. This amount will cover loss or damage to all personal clothing or personal property. The amount will increase as provided to POAM members.

13.2 Clothing allowance will be paid for the previous twelve (12) months service, and shall be computed at the rate of one-twelfth (1/12) of the annual amount for each month of service.

13.3 All payments under this Article shall be made by separate checks, paid on the first payday in October of each year.

**ARTICLE 14
WEAPONS QUALIFICATION**

14.1 Payable on the first pay in September, all officers shall receive a Weapons Qualification Allowance providing the employees qualifies twice a year; qualifications may include qualifying on an inside range and an outdoor combat range or both qualifications may be held on an inside range as circumstances dictate. Qualifications shall not be scheduled on weekends or holidays. The indoor range shall be made reasonably accessible to all officers. If an officer is required to qualify while off duty, the officer shall be compensated at the rate of time and one half for any hours beyond the eighty (80) hours scheduled in the pay period.

Command officers hired prior to July 1, 2014, shall receive \$1,250
Command officers hired on or after July 1, 2014, shall receive \$750
The amount will increase as provided to POAM members.

14.2 The City shall replace service weapons that are deemed unserviceable by the senior range officer and shall be maintained in perfect operating condition, at the City's expense.

14.3 The department issued weapon shall be as determined by the Police Chief and as approved through the City's budget process. The City may change to a 40 caliber weapon. Exception can be made for officers on assignment who could be issued other departmental authorized weapons, or officers could carry their personal authorized weapons. The City shall purchase all ammunition for qualification and duty use.

**ARTICLE 15
WORK HOURS**

15.1 All days or shifts shall be eight (8) straight hours or twelve (12) straight hours, not a split shift.

15.2 Hours assigned for the pay period (paid every two [2] weeks) shall be assigned in such a manner so as not to conflict with allowing an employee one hundred and four (104) leave days per year. The work schedule shall be prepared at the Department's discretion.

15.3 Trading of Assignments – Employees shall be permitted, by the approval of their respective Command Officers, to voluntarily trade work shifts or leave days on a day for day basis.

15.4 Command Officers assigned to the two uniform shifts and overlap shifts will be assigned to permanent shifts for a period not to exceed four (4) months. The cycles shall commence on February 1st, June 1st, and October 1st. Permanent shifts shall be determined based on seniority within the WLSA with each officer being permitted to bid from the first through the seventh day in the month preceding shift change. All bid sheets shall be turned in to the Chief's office on the 8th day of said month. The shift schedule shall be posted on the 15th day of said month. If a WLSA member is going to be absent (vacation, illness, etc.) during the shift selection period, it shall be his/her responsibility to make his/her immediate Supervisor aware of his/her shift preference. Failure to do so will result in the WLSA member being assigned at the Chief's discretion.

In the event vacancies occur in the bargaining unit due to promotion, discharge, illness, or other reason, the employer shall be authorized to fill the vacancies by assignment of existing bargaining unit members to such vacancies. No more than one person per vacancy shall be moved from an existing position during a bid cycle. The moving of any employee from an existing position during a bid cycle shall not be deemed to create a vacancy in such position. The employer may move additional personnel, provided that the personnel are moved to shifts of greater preference under the existing shift bid.

15.5 Notwithstanding the provisions of Section 15.4, the Association agrees to work rotating shifts on the same basis and in the same manner as may be hereafter agreed to during the term of the Agreement, whether arrived at by negotiated settlement or compulsory arbitration, between the City and the non-supervisory-police unit.

**ARTICLE 16
VACATIONS**

16.1 Eligibility and Amount -- For the purpose of computing vacation eligibility and amount, current vacation shall be earned in the preceding calendar year of January 1 through December 31, inclusive. Employees shall be allowed to carry over vacation days to the next calendar year; carrying a maximum of not more than two-hundred forty (240) hours, subject to section 16.6 herein. Annual Vacation time shall be earned in accordance with the following schedule:

<u>Years of Service</u>	<u>Hire Date Prior to July 1, 2014</u>	<u>Hire Date On or after July 1, 2014</u>
Less than seven (7) years	160 hours	132 hours
7 – 10 years	192 hours	168 hours
More than ten (10) years	288 hours*	192 hours

*Effective January 1, 2015, employees with a hire date prior to July 1, 2014 and with ten (10) or more years of seniority shall receive 272 hours in vacation pay.

Effective January 1, 2016, and for the remaining years of the CBA, employees with a hire date prior to July 1, 2014 and with ten (10) or more years seniority shall receive 288 hours in vacation pay.

The above vacation schedule shall apply to all members of the bargaining unit.

16.2 Employee’s preferences as to time off for vacation will be considered subject only to the Department’s ability to maintain the highest standard of protection of the City’s welfare. Employees shall be entitled to preference, first on seniority in rank, then by, on seniority in the Department.

16.3 The anniversary date of service shall be the date of appointment to the present police department providing the employee has not of his own volition terminated employment and returned since his original anniversary date. If such be the case, the anniversary date shall be such date as determined by the Civil Service Commission at the time of rehiring.

16.4 Upon separation from service, for any reason, an employee shall be paid within thirty (30) days for earned vacation. In the event of death, the employee’s dependents or heirs if designated, or his estate shall be paid the vacation pay.

16.5 There will be two vacation periods, one from April 1 through September 30, and one from October 1 through March 31. In each period an officer may take no more than half the time he has accumulated on January 1.

16.6 The vacation bank shall be limited to two-hundred forty (240) hours. On the second pay in January of each year all vacation hours over the 240 hour limit that have accrued as of December 31, of the preceding year, will be paid off at the prevailing hourly rate. Effective upon ratification of this agreement, said payment shall be made on the first pay of February.

**ARTICLE 17
LAYOFFS**

17.1 Layoffs in the bargaining unit shall be made in conformity with the principle of seniority, i.e., the last one hired being the first one laid off, and the first one laid off being the last one

recalled. No employee in the bargaining unit shall be laid off unless and until all employees in the police department with less department seniority are laid off first.

ARTICLE 18 SENIORITY AND VACANCIES

- 18.1 Seniority – Seniority shall be determined as date of hire of an employee.
- 18.2 Vacancies – Vacancies in the Police Department shall be filed in accordance with Act 78.
- 18.3 Seniority shall first be determined by rank.
- 18.4 Seniority in rank shall be determined by date of promotion. In the event the date of promotion is the same, the seniority in rank shall be determined by position on the eligibility list as established by the Civil Service Commission.
- 18.5 Seniority in rank shall be the determining criteria for any and all circumstances in which seniority is a factor.
- 18.6 Departmental seniority shall be determined as the date of hire of an employee.
- 18.7 Department seniority shall have no bearing on seniority in rank.

ARTICLE 19 SICK LEAVE

- 19.1 Effective January 1, 2016, any employee with an original hire date with the City that is prior to July 1, 2014 shall accumulate eighteen (18) hours per month sick leave, credited on the first day of each month. Any employee with an original date of hire with the City that is on or after July 1, 2014, shall accumulate eight (8) hours per month of sick leave. In the event that an employee is off work on sick leave on a given day, the employee shall be off work for the balance of the employee's scheduled shift. Each officer shall accumulate no more than the limit of sixteen hundred (1600) hours in their sick bank. On the first pay in February each year, any hours in excess of the sixteen hundred hour limit, as calculated as of January 1, shall be paid to the employee at the prevailing hourly rate at one hundred (100%) percent of his pay as of payment date.
- 19.2 Accumulated Sick Days – In the event an employee dies, retires or resigns, he or his beneficiaries or heirs shall receive compensation within thirty (30) days in the sum equivalent of his accumulated sick leave credits at his prevailing hourly rate.
- 19.3 Employees, at their discretion, may donate either sick days or compensatory days (in increments of eight (8) hours) to another employee in this bargaining group, provided: 1) the employee receiving donated time must have 56 or less hours in his/her sick bank; 2) time is being donated to an employee for whom an illness has been verified and supported by medical

documentation; 3) the donated sick or compensatory days are not included in any calculations of average final compensation used to determine retirement or pension benefits; and 4) the employee donating time retains a minimum of fifty-six (56) hours sick leave for their own use.

19.4 Pay off of sick leave hours is at one hundred (100%) percent of hourly rate if the employee retires, dies, is laid off, or terminated for any reason. This payment is payable upon termination by the employee.

19.5 Sick Time Sell Back – An employee having an excess of four hundred (400) hours of accumulated sick time, may sell back, at his or her option, accumulated sick time, up to a maximum of one-hundred sixty (160) hours as long as he/she declared that intention by November 1. Those accumulated sick days sold back to the City shall be paid the first pay in December, at the then prevailing hourly rate.

19.6 Employees with an original date of hire with the City that is prior to July 1, 2014 and who use 48 hours or less of sick leave in a calendar year (January 1 through December 31) shall be credited with an additional 48 hours of vacation time, which will be added to their vacation bank on January 1st of the following calendar year. Any employee with an original date of hire with the City that is on or after July 1, 2014, and who uses 24 hours or less of sick leave in a calendar year shall be credited with an additional 24 hours of vacation time. For purposes of this section, donations pursuant to section 19.3 and "sell back" pursuant to section 19.5 shall not be considered the "use" of sick time.

**ARTICLE 20
BEREAVEMENT**

20.1 Upon notification to the Chief or his designee, each employee shall be granted time off with pay to attend, make plans, arrangements and travel to a funeral in accordance with the following procedure:

a. In the event of a death in the immediate family, the employee shall be granted sixty (60) working hours off with pay. Immediate family shall be defined as spouse, children, stepchildren, parents, stepparents, parents-in-law and grandchildren.

b. An employee shall be granted forty (40) working hours off with pay in the event of a death of brother, sister, or grandparent of the employee or their spouse.

c. An employee with a hire date prior to July 1, 2014 shall be granted twenty-four (24) working hours with pay to attend the funeral of any uncle, aunt, niece, nephew, brother-in-law or sister-in-law. Employees hired on or after July 1, 2014 shall be granted twenty-four (24) working hours off to attend the funeral of any uncle, aunt, niece, nephew, brother-in-law or sister-in-law. However, in order to be paid for this time off, the employee must use accumulated leave time in his/her bank(s).

**ARTICLE 21
PERSONAL LEAVE DAYS**

21.1 Effective January 1, 2015, all officers hired prior to July 1, 2014 shall receive seventy-two (72) hours of non-cumulative personal leave with pay per year and all officers hired on or after July 1, 2014 shall receive forty-eight (48) hours of non-cumulative personal leave with pay per year for personal business.

21.2 An employee shall be granted pay for personal business, with the following restrictions:

- A. These personal leave hours shall not be used as an extension of vacation days.
- B. Personal leave shall be granted by the Department subject to department's ability to maintain the highest standard of protection of the City welfare.
- C. Personal leave days shall not be taken in less than four (4) hour increments.

**ARTICLE 22
LEAVES OF ABSENCE & FAMILY MEDICAL LEAVE ACT**

The City will comply with the federal Family Medical Leave Act currently in effect and as it may be amended from time to time.

22.1 Requesting Leave of Absence – Upon application to the Chief of the Department, a leave of absence may be granted, without pay, to employees for thirty (30) work days. Request for more than thirty (30) work days may be granted by the Chief of the Department, but must be approved by the Personnel Department and Chief Executive of the City. Employees shall not accrue seniority or accrue benefits, (gun, clothing, holiday, longevity) while on leaves of absence.

22.2 Reasons for Leave – Leaves will be granted for the following reasons which are not all inclusive:

- A. Employees who are reinstated in accordance with the Universal Military Training Act, as amended and applicable legislation, may attend a recognized University, Trade school or Technical school for a period not to exceed their seniority. Written proof of school attendance must be submitted at the expiration of each semester.
- B. Sick Leave. Any employee known to be ill, supported by satisfactory evidence, will be granted sick leave automatically for the period equal to their seniority or two years, whichever is lesser. Upon returning from sick leave the employee must submit medical evidence of his/her ability to return to work.
- C. For National Guard duty, Army Encampments, Naval Reserve Cruises.

22.3 Returning from Leave of Absence – When returning from any leave of absence, it shall be the obligation of the employee to notify the Personnel Department that he is returning ready, willing and able to work, three (3) working days before his return to work.

22.4 Extension of Leave of Absence – Application for extension of leave of absence must be made fifteen (15) calendar days prior to the termination of the original leave of absence for extension thereof. The employer agrees to give his answer, granting or denying the request for extension five (5) calendar days before the original leave of absence expires and the answer must be in writing.

22.5 Copies of Leave of Absence – The Union will be given copies of leaves of absences when granted.

**ARTICLE 23
HOLIDAY PAY**

23.1 Holiday pay shall be paid by separate check to all employees at their current rate of pay on the last payday in November. Holidays are defined as follows and shall constitute twelve (12) hours pay for each Holiday:

- | | |
|--------------------------------|--------------------------------|
| 1. New Year's Day | 8. Patriot Day |
| 2. Martin Luther King, Jr. Day | 9. Thanksgiving Day |
| 3. Good Friday | 10. Day after Thanksgiving Day |
| 4. Easter Sunday | 11. Christmas Eve Day |
| 5. Memorial Day | 12. Christmas Day |
| 6. Independence Day | 13. New Year's Eve Day |
| 7. Labor Day | |

Employees in the rank of Lieutenant or higher are only expected to work on Independence Day, unless otherwise scheduled to be off duty.

**ARTICLE 24
MEDICAL AND HOSPITAL INSURANCE**

24.1 ACTIVE EMPLOYEES HEALTH INSURANCE

- A. The City will provide employees, eligible spouses and eligible dependents healthcare. All active employees will be required to share in the cost of their healthcare through the City in accordance with P.A. 152 as that Act is implemented by the City. In the event P.A. 152 is repealed, the cost-sharing in place at the time the Act is repealed shall remain in effect.

- B. The City will provide active employees the ability to select coverage under one of the following Blue Cross Blue Shield of Michigan (BCBSM) plans: PPO-1, PPO-2,

Base Plan PPO, Value Plan PPO and Qualified High Deductible Health Plan (QHDHP). Each plan is summarized in the Appendix to this Agreement.

- C. The City may substitute health plans if doing so provides substantially similar coverage and a premium range from which the employee may select.

24.2 RETIREE HEALTH INSURANCE

- D. Retirees on duty disability pension shall receive 100% medical insurance premium coverage.
- E. For employees hired prior to July 1, 2014, the healthcare plan(s) and related cost-sharing of active employees shall be the same for the pre-Medicare retiree and/or eligible spouse and dependents upon retirement. The pre-Medicare retiree is subject to changes in the future with respect to healthcare plans and/or cost-sharing as those changes may occur with active employees. Once a retired employee or spouse is eligible for Medicare, the City will then provide a Health Reimbursement Account (HRA) in lieu of medical insurance. Each year the City shall fund the Health Reimbursement Account for the retiree and/or spouse at \$2,000 for single and \$4,000 for two people. Any increases in this amount shall be tied to the federal Medical C.P.I. and will take effect during annual open enrollment. It will be the responsibility of the retired employee and/or spouse to secure supplemental insurance. The medical coverage of a deceased retiree shall be continued for the spouse in the same manner as described above. The medical coverage for the spouse shall continue as previously stated until the spouse becomes eligible for medical coverage through his/her own employer. In order to receive any retiree healthcare benefits, the employee or spouse must be receiving an Act 345 pension as noted under Articles 44 "Retirement Plan" in this Agreement.
- F. Employees who are hired on or after July 1, 2014 shall be enrolled in a Health Care Savings Program (HCSP) for their retirement healthcare. The City shall contribute \$2,000 per year into the employee's HCSP. The employee shall be eligible for the City's contributions to the HCSP upon ten (10) years of uninterrupted service with the City. The employee may make contributions to his/her HCSP on a post-tax basis, through payroll deduction, with the employee's contributions immediately vested and available to the employee upon separation of employment. In accordance with I.R.S. regulations, HCSP funds may be used for healthcare premium expenses, co-pays and deductibles and other out of pocket expenses as governed by applicable statute.
- G. Mutual Gains Program – employees who are able to obtain health insurance through a spouse or as a dependent of another may participate in the City's 2013 Mutual Gains Program as set forth in the plan on file in the City's Personnel Office. The City retains the right to amend or eliminate the MGP in the future.

24.3. OTHER COVERAGES

- H. Dental coverage will provide each active employee with the Delta Dental Plan – 80/20 on Class I, II, III benefits with an annual \$1,000 benefit cap and a \$1,000 per person lifetime maximum for orthodontic benefits.
- I. The City shall provide active employees 100% of the cost of the Blue Cross Basic Optical Program. The City shall pay for such optical coverage at the rate of 4% per complete year of service actually provided the City of Westland for retirees hired prior to July 1, 2014.
- J. Physicals: The City will reimburse employees up to two hundred dollars (\$200) for a standard personal physical once every two years. This physical exam is not mandatory, and the results of such exam are confidential.

ARTICLE 25 LIFE INSURANCE

25.1 The City agrees to pay full cost of the premium for each employee for a life and accident policy. The policy shall contain standard terms and conditions, and shall be in the amount of \$83,000 with double indemnity for each officer. The City shall provide each employee a copy of the insurance certificate. Each employee shall provide the City the name of beneficiary, and any changes of beneficiary.

25.2 Life Insurance – Retirees: The City shall provide a \$5,000 life insurance benefit for retired employees payable to a beneficiary designated by the retired employee or to his estate if no beneficiary is designated.

25.3 Employee/Retiree Paid Life Insurance: The City shall provide an opportunity for employees to purchase life insurance that can be carried into retirement through the City's life insurance carrier on a payroll deduction plan.

ARTICLE 26 EMPLOYEE'S RIGHTS

26.1 At no time shall any employee be required to answer to any allegation(s) of misconduct unless said allegation(s) has been reduced to writing and the member shall be provided with a copy of the allegation(s) and an opportunity to read same before answering any questions or making any statements regarding the allegation(s). Further, at his request, the member and/or a member of the Grievance Committee, or an attorney of his choice, shall be present during the time any answers are given or statements made. At no time shall any member of the Westland Lieutenants and Sergeants Association be required to take a polygraph test to prove or disprove any allegation(s) made against him/her, unless he/she so desires.

26.2 The private and personal life of any employee is not within the appropriate concern or attention of the City, as long as it is consistent with the high standards which the profession and the Association have set. No restriction, other than the approval of the Chief of Police is placed upon the freedom of employees to use their own time for gainful employment, or other activities insofar as it does not interfere with the satisfactory performance of their police duties.

26.3 The City recognizes its responsibility to continue to give reasonable support and assistance to all employees with respect to the performance of and the carrying out of their respective duties as police officers.

26.4 Each employee shall be covered by the applicable Worker's Compensation Law. The City further agrees that an employee being eligible for Worker's Compensation income shall receive benefits in accordance with Article 12.3.

26.5 Each employee shall have the right upon request to review the contents of his own personnel file maintained at either the Administration building or Police headquarters. All communications, including evaluations by supervisory personnel, and validated complaints directed toward the employee which are included in the personnel file shall be called to the employee's attention at the time of such inclusion.

26.6 Within a two-year period following the insertion of a letter of reprimand in the personnel file of the officer, he may ask that review be made, and unless there is substantial reason otherwise, the letter will be removed and the record of it expunged.

26.7 No vacancy shall be filled by the City in case of an emergency on a temporary basis without the City fully complying with the provisions of Act 78, Public Acts of Michigan, 1935, as amended.

26.8 The Police Professional Liability Insurance provided by the employer shall provide coverage as follows:

Each Person	\$ 500,000
Each Incident	\$1,000,000
Total	\$1,500,000

This coverage shall be maintained for the duration of the contract.

26.9 An employee who works out of classification for more than two hours on any given day shall be compensated at the higher rate for all hours worked.

26.10 Any discussion or conversations occurring between the Association Officer and any member who has been charged with a violation of the Rules and Regulations of the Westland Police Department or charged with any contract violation, shall be privileged to the extent that the Association Officer shall not be called to testify as to said conversations in any arbitration or civil service hearing.

26.11 All supplemental reports requested by the Administration from any employee shall be deemed to have been given by the employee under all the applicable provisions of Garrity vs. New Jersey, 385 U.S. 493 (1967).

26.12 No employee of the bargaining unit shall be discharged or otherwise disciplined except for just cause.

26.13 An employee that is discharged or otherwise disciplined may file a grievance pursuant to Article 28 beginning at Step 3, or appeal to the Police & Fire Civil Service Commission, but he or she may not do both.

26.14 For each day an employee is called for and serves on jury duty, such employee shall be compensated at his regular rate of pay. If an employee serves less than four (4) hours, he or she shall return to work or report for his or her regularly scheduled shift.

**ARTICLE 27
MAINTENANCE OF CONDITIONS**

27.1 Wages, benefits, and working conditions of employment in effect at the execution of this Agreement shall be maintained during the term of this Agreement.

27.2 The City will make no unilateral changes in wages, benefits and working conditions during the term of this Agreement.

27.3 This Agreement shall supersede any existing rules and regulations inconsistent herewith. Rules and regulations not in direct conflict with this contract shall remain the right of the Chief of Police.

**ARTICLE 28
GRIEVANCE PROCEDURES**

28.1 PURPOSE: The primary purpose of this procedure is to secure, at the lowest level possible, equitable solutions to the problems of the parties. Both parties agree that these proceedings shall be kept as confidential as may be appropriate at each level of the procedure. Nothing contained herein shall be construed as limiting the right of any police officer with a grievance to discuss the matter informally with any appropriate member of the Administration. All grievances must be filed within thirty (30) days of the alleged infraction.

28.2 DEFINITIONS:

a. A "grievance" is a claim based upon an event or condition which affects the conditions or circumstances under which a police officer works, allegedly caused by a violation of a provision or term of this Agreement or existing law.

b. The term "employee" includes any individual or group who is a member of the bargaining unit covered by the contract.

28.3 PRESENTATION OF GRIEVANCE – STEP 1: Any employee having a grievance shall have the opportunity to take up the grievance with the Shift Commander who shall attempt to adjust same. The employee presenting the grievance shall have the right to summon one member of his choosing from the Executive Board and/or one member of his choosing from the grievance committee.

28.4 STEP 2: If the grievance is not adjusted by the Shift Commander on duty, it shall be reduced to writing, at that time, on the Association grievance forms, signed by the aggrieved employee. The original shall be filed with the Shift Commander who shall date and sign for its receipt.

28.5 Within five (5) working days after the grievance is filed with the Shift Commander, they shall meet with the Grievance Committee Chair and attempt to settle the grievance. The Shift Commander's disposition shall be made known to the grievant, the Executive Board, and Grievance Committee, in writing, within five (5) days after the meeting with the Shift Commander.

28.6 STEP 3: The Executive Board shall then review the grievance and it shall, within fifteen (15) days of this review abandon the grievance or it shall be appealed to the Chief of Police; if appealed to the Chief of Police, a meeting will be arranged with the President of the Executive Board and Chair of the Grievance Committee, within five (5) days and the Chief's written disposition shall be given to the Grievant, his written disposition shall set forth reasons therefor.

28.7 STEP 4: If the grievance is still unsettled the President of the Association may appeal the grievance to the Personnel Director within five (5) calendar days of receipt of the Department Chief's answer. The Personnel Director or designated representative shall within fifteen (15) calendar days of such appeal, meet with the grievance committee member or his designated representative shall give their written, dated and signed disposition of the grievance within fifteen (15) calendar days after such a meeting to the President of the Association.

28.8 STEP 5 – ARBITRATION: If after reviewing the grievance, the Association feels the disposition is still not satisfactory, it may within twenty (20) days after the answer is due, and by written notice to the other party, request either arbitration, or at the option of the Association, appeal to the Police & Fire Civil Service Commission. If arbitration is chosen, any right of the employee or the union to appeal the matter to the Police & Fire Civil Service Commission is waived. Conversely, if an appeal to the Police & Fire Civil Service Commission is chosen, any right of the employee or the union to request arbitration of the matter is waived. If arbitration is chosen, within five (5) days following the notice of arbitration, both parties will attempt to select an arbitrator on an ad hoc basis. In the event the parties cannot agree upon an arbitrator within five (5) days, the Association will make a request to the Michigan Employment Relations Commission (MERC). The parties will be bound by the rules and procedures of MERC for the selection of the Arbitrator. The arbitrator so elected will hear the matter promptly and will issue his decision no later than thirty (30) days from the date of the close of the hearings.

The Arbitrator's decision will be in writing and will set forth his findings of facts, reasoning and conclusions on the issues submitted.

28.9 The power of the arbitrator stems from this Agreement and his function is to interpret and apply this Agreement and to pass upon alleged violations thereof. He shall have no power to add to, subtract from, or modify any terms of this Agreement, nor shall he have any power or authority to make any decision which requires the commission of an act prohibited by law or which is violative of the terms of this Agreement. The decision of the arbitrator shall be final and binding upon the employer, the Association and the Grievant.

28.10 The costs of the arbitrator's services, including his expenses, shall be borne equally by the parties. Each party shall pay for its own expenses.

28.11 APPEAL TO POLICE & FIRE CIVIL SERVICE COMMISSION – STEP 1: If the grievance is not adjusted at the fourth step and the employee feels that he has grounds for appeal, the employee shall have the right to appeal to the Westland Fire and Police Civil Service Commission only those issues concerning disciplinary actions and promotions, and only if the employee waives his and the union's right to request arbitration. All other items of dispute must proceed through the other steps of the grievance procedure as provided in Article 28. If appeal to the Police & Fire Civil Service Commission is chosen, members shall give the Commission written notice, with a copy to the City Personnel Director, of the unadjusted grievance, on forms supplied by the Association.

28.12 STEP 2: This appeal shall take place within thirty (30) days after the member has been furnished with the written decision of the City's representative on the pre-arbitration panel.

28.13 STEP 3: In the event the Police & Fire Civil Service Commission does not make an adjustment of the grievance satisfactory to the member, he shall have the immediate right of appeal to the Circuit Court for Wayne County as provided under Act 78 above.

28.14 MISCELLANEOUS: No grievance, verbal or written, withdrawn or dropped by the member or Association or granted by the City, prior to the final step of the grievance procedure, will have any precedent value. The sentence above applies only to grievances resolved after the effective date of this contract.

28.15 The Association shall have the right, through its Executive Board, to file a grievance directly with the Chief of Police at Step 3 of the Grievance Procedure if the Executive Board and/or the Association believe that the alleged violation affects the members of the entire bargaining unit. In such a case, the Association shall be deemed to be the grievant.

28.16 During the pendency of any proceedings, and until a final determination has been reached, all proceedings shall be private and any preliminary disposition will not be made public without the agreement of all parties.

28.17 There shall be no reprisals of any kind by the administrative personnel taken against the grievant, any party in interest or his Association representative, any member of the Grievance

Committee, or any other participant in the procedure set forth herein by reason of such participation.

28.18 All documents, communications and records dealing with the processing of a grievance shall be filed separately from the personnel files of the participants.

28.19 Time limits between the various steps may be waived and/or extended by mutual written agreement.

28.20 In the event that the Police & Fire Civil Service Commission should rule that it has no jurisdiction to hear the grievance, the Grievant may elect to appeal that ruling to the Wayne County Circuit Court in accordance with Act 78 or in the alternative, proceed through arbitration procedure established in Step 5.

ARTICLE 29 COPIES OF THE CONTRACT

29.1 The City agrees to deliver a printed copy of this Agreement to the Association's Executive Officers and shall post an electronic copy of the Agreement on the City website and/or intranet for access by all members of the Association and agrees to provide to the President of the Association, for the Association files, a copy of all insurance policies in force and applicable to the members of the Association as governed by this Agreement.

ARTICLE 30 MODIFICATION

30.1 The City and Association shall have the right, during the period of negotiations of this Agreement, to change, delete from and/or add to any and all of the provisions contained herein; and to add further requests for consideration during these negotiations.

ARTICLE 31 DURATION OF AGREEMENT

31.1 This is the sole agreement between the parties. This agreement shall be binding upon the parties from January 1, 2015 to December 31, 2019.

ARTICLE 32 CITY'S RIGHTS AND RESPONSIBILITIES

32.1 It is recognized by the parties that the government and management of the City, the control and management of its properties and the maintenance of municipal functions and operations are reserved by the City and that all legal prerogatives of the City shall be paramount and shall be solely the City's right and responsibility. Such rights and responsibilities belonging solely to the City are hereby recognized, prominent among which, but by no means wholly inclusive are: All rights involving public policy and the right to assign personnel to various duties

with the Police Department. It is further recognized that the selection and direction of the working forces including the right to hire, suspend or discharge, assign, promote or transfer, to determine the hours of work and to relieve employees from duty because of the lack of work are solely the responsibilities of the City. The City agrees that it shall exercise these rights in conformity with the terms of the Agreement as they pertain hereto.

**ARTICLE 33
STRIKES AND LOCKOUTS**

33.1 It is mutually agreed between the parties hereto that the Union or Association will not call, authorize, or participate in any strike during the term of this Agreement and that the City will not engage in any lockout of employees during the term of said Agreement.

**ARTICLE 34
SAVINGS CLAUSE**

34.1 If any article or section of this Agreement or any appendices or supplements thereto should be held invalid by operation of law or by a tribunal of competent jurisdiction, or if compliance with or enforcement of any article or section should be restrained by such tribunal, the remainder of this Agreement shall not be affected thereby, and the parties shall enter into immediate collective bargaining negotiations for the purpose of arriving at a mutually satisfactory replacement for such article or section.

**ARTICLE 35
EDUCATION**

35.1 College Courses – Based upon the amount of funding approved in each fiscal year budget, the City agrees to pay tuition refund, up to a maximum of \$4,000 per calendar year for employees hired prior to July 1, 2014 and tuition reimbursement up to a maximum of \$2,500 per calendar year for employees hired on or after July 1, 2014. This refund covers classes that are necessary in securing an Associate's, Bachelor's or Master's Degree in Police Science, Police Administration, Business Administration, computer Science, and/or Criminal Justice, subject to the following conditions:

35.2 That the employee secures approval from the Chief prior to enrollment for said class.

35.3 That the employee receives a passing grade, excluding the grade of D.

35.4 However, any time off work, so that the employee can attend class, shall be at the discretion of the Chief.

35.5 Text books will be provided from the Police Department Library or purchased for the use of the employee. However, at the conclusion of said classes, the books shall be returned to the City and shall be retained at the Police Department Library.

35.6 Should an employee resign or be discharged within five (5) years of receipt of any particular tuition reimbursement, employee shall repay to the City the reimbursement(s) received as follows: termination date within twelve (12) months of receipt of reimbursement – 100%, 1-2 years – 80%, 2-3 years – 60%, 3-4 years – 40% and within 4-5 years – 20%. Employee has no obligation to reimburse for receipt of any particular tuition reimbursement after serving five or more years with the City following that tuition reimbursement.

35.7: Officers hired prior to July 1, 2014 shall receive the following stipends as noted below to be paid the second pay in July. Each employee shall only receive one stipend annually (stipends are non-cumulative). For instance, an officer has earned a Master's degree and has also completed all required training, SWAT training and previously earned a Bachelor's degree. Officer shall only receive the \$3,000 for earning the Master's degree.

- A. Officers who have completed, in addition to all required training, training in SWAT, Breathalyzer, Narcotics, Accident Prevention/Reconstruction and/or Interview & Interrogation Training shall receive \$2,000.
- B. Officers with above training who have completed a Bachelor's degree shall receive a total of \$2,500.
- C. Officers with above training who have completed a Master's degree shall receive a total of \$3,000.

This Education stipend is included in AFC for retirement, capped at \$2,000 for all officers hired prior to July 1, 2014. The Education stipend does not apply to employees with a hire date on or after July 1, 2014.

ARTICLE 36 PENSION

36.1 The City shall provide pension benefits for Officers hired prior to July 1, 2014 as required by Act 345 of Public Acts of Michigan of 1937, as amended, except as may be provided otherwise under Article 36 of this Agreement. The City shall provide that the regular retirement pension payable to retired police officers shall be the average final compensation multiplied by 2.8% per year of the first thirty (30) years of service and 1% per each year of additional service to officers who retire with at least 25 years of credited service.

36.2 The Average Final Compensation (AFC) for officers hired prior to January 1, 2010 shall be computed on the best three (3) of the employee's last ten (10) years of service and will include employee's average final compensation shall be computed on the best three years of the last ten years of the employee's AFC factors. AFC factors shall include:

- Base Wage
- Holiday Pay
- Uniform Allowance up to \$1,250

Weapons Qualification Allowance up to \$1,000
Education Allowance up to \$2,000
Senior Knowledge Pay up to \$3,500
Pay for unused sick leave up to 1,200 hours
Pay for unused vacation leave up to 1,120 hours

36.3 The AFC for officers hired on or after January 1, 2010 and prior to July 1, 2014 shall be calculated on base pay and overtime pay.

36.4 The pension for Police Officers with an original hire date that is on or after July 1, 2014 shall include a 1.75% multiplier, with normal retirement at age fifty (50) and vesting at ten (10) years of uninterrupted service. There shall be no escalator or cost of living increases and AFC shall only be calculated on base wages and based upon the employee's best five (5) years of service.

36.5 Upon ratification of the CBA, all active Police Officers hired prior to July 1, 2014 shall contribute 5% of their pensionable earnings toward their retirement and all active Police Officers hired on or after July 1, 2014 shall contribute 3% of their pensionable earnings toward their retirement; said contributions shall be made on a pre-tax basis through payroll deduction.

36.6 The City shall permit the pension rights of each police officer to vest upon completion of ten (10) years on the job. Upon the completion of ten years on the job, the surviving spouse shall have all pension rights as specified in P.A. 345, Sec. 6a (1) and (2).

36.7 Employees shall be entitled to a one-time adjustment to their monthly pension of five percent beginning the first month after the completion of six full years of regular retirement status.

36.8 An employee may receive additional service credit by purchasing up to six (6) years of past police and/or military service prior to employment as a sworn officer with the City. Effective December 31, 2001, additional credit purchase rights are limited to one (1) year credit for three (3) years' service capped at three (3) years' worth of pension service credit. In order to receive prior service credit for military service or service as a full-time (2,080 hours/year or more) sworn law enforcement officer, employee must submit documentation from the military or former employer(s) that verify the month, day and year employee commenced paid employment with the former employer as well as the month, day and year service with prior employer ended and affirm that employee was employed in a full-time capacity, i.e. minimum of forty (40) hours per week. Purchase of credit must be made in cash at 5% per year of the employee's total previous year's AFC factors.

36.9 Effective July 1, 1989, employees may receive additional service credit by purchasing past cadet service time prior to employment as a sworn officer with the City. Except as provided in Section 36.8, an employee can only purchase a maximum of six (6) years of prior time, cadet time or police time.

36.10 Annuity Withdrawal

- A. The de facto operation of the Retirement System for the City of Westland since at least January 1, 1992, consists of a defined benefit plan commonly referred to as an annuity plan which have been treated by the parties to this Agreement and the Board of Trustees of the Retirement System as qualified plans, under the provisions of the Internal Revenue Code. The parties acknowledge that not all administrative procedures regarding operation of two plans were put into place prior to 1992. The parties will continue the qualified status of the two plans within the Pension Trust Fund and agree to take action which may be required by Internal Revenue Service rules and regulations and the tax laws to maintain qualified plan status of the defined benefit plan (pension plan) and the defined contribution plan (annuity plan) under Section 401(a) or any other applicable Section of the Internal Revenue Code. The parties agree to all requirements with respect to maintaining the plans as qualified plans. The parties will request, and cooperate with, the Board of Trustees to apply for qualified plan status determination letters for each (i.e. the pension and annuity) of the plans of the Retirement System. It is agreed that, other than additional administrative and processing costs and nominal actuarial costs, the action required by the City pursuant to this Section, shall not result in additional costs to the employer or the Pension Fund.
- B. Both the Defined Contribution Plan and the Defined Benefit Plan of the Retirement System are intended to be a plan qualified under Section 401(a) of the Internal Revenue Code. The defined contribution plan provides for employer contributions to be made by the employer to the member's account, in amounts as determined by collective bargaining and any income, gains or losses as determined by investment performance, collective bargaining or the Board of Trustees, less expenses as determined by the Board of Trustee of the Retirement System.
- C. Except as provided in Section 36.12, if a member makes an election, for lump sum withdrawal of defined contribution plan amounts, an annuity (defined contribution plan) portion of any retirement allowance shall be reduced by an amount which reflects the actuarial reduction (actuarial value of the withdrawn amount) so that this benefit does not result in an increase to employer costs to provide the total Retirement System benefit.
- D. The defined contribution plan and the defined benefit plan together will provide the total retirement benefit payable per collective bargaining for union employees and established benefits for non-union employees.
- E. This option is only available with respect to regular service retirement benefits and to disability retirants at the time they begin to receive benefits as if they were regular service retirants (i.e., same benefit computation) which occurs upon reaching age fifty-five (55) years with twenty-five years of service or per collective bargaining agreement. The Board of Trustees of the Retirement System will decide any issues with respect to this matter subject to applicable collective bargaining provisions, and shall adopt appropriate policies and procedures to implement this agreement which decision of the Board of Trustees shall be final and binding on all parties.

36.11 Duty Disability

A. If an employee retires under the duty disability provision of Act 345, he shall receive a pension equal to the base salary he received as an active member of the department. Said pension shall be recalculated as necessary to continue to provide a retired member eighty-five (85%) percent of the base pay of the classification from which he retired until he meets what would have been his normal age and service requirements necessary to receive a normal retirement. In the event the Internal Revenue Code is hereafter amended to adversely affect the taxability of Worker's Compensation benefits, to the extent that it does, then this provision shall be adjusted proportionally from 85% to 100% of base salary.

B. At the time the employee reaches what would have been his normal service requirements (25 years of combined service and duty disability pension), shall be calculated the same as a regular retirement pension.

C. Said disability retirement shall include the continuance of medical and life insurance plan of this and future contracts until the recalculations to normal retirement as described above or death, whichever comes first, providing the employee does not earn more than fifty (50%) percent of his base pay in other employment. In the event the employee earns more than fifty (50%) percent of his base pay, there will be a dollar-for-dollar offset for all earnings over fifty (50%) percent.

D. A duty disability retiree shall select an option within sixty (60) days after receiving his/her first duty disability retirement check. If the duty disability retiree is incapable of selecting an option within sixty (60) days, then the duty disability retiree or retiree's spouse or guardian may request a sixty (60) day extension of time in which to select an option. If the duty disability retiree does not select an option within the extended sixty (60) days, then the retiree's spouse or guardian shall make the selection if a duty disability retiree does not select an option prior to the retiree's death, then an option shall be selected as follows:

1. If the duty disability retiree was married at the time of disability and married to the same spouse at the time of death, the surviving spouse shall receive a pension equal to 60% of the regular retirement pension of the deceased retiree.

2. If the duty disability retiree was not married at the time of retirement and at the time of death, his/her or her youngest dependent child shall receive a pension equal to fifty (50%) percent of the regular retirement pension of the deceased retiree, until the child attains the age of nineteen (19), or graduates from post-high school education, but not to exceed the age of twenty-three (23).

36.12 In the event that the employee shall disagree with the finding of any City Doctor as to his medical condition, he can elect to obtain a medical opinion from some other doctor at his own expense. A Doctor shall be defined as an M.D. or D.O.

36.13 Military or police service shall not be creditable if it is, or would be, creditable under any other Federal, State or publicly supported retirement system.

36.14 The employee shall be obligated to pay the monies referred to in Section 36.5, 36.6 and 36.7 at the same time as when the City pays to the employee his last check for wages and other benefits normally paid to employees upon their separation from service with the City of Westland; however, an employee may pay the monies to the City at an earlier time. Any controversy between any employee and the City that may exist at the time of final payoff as to the amounts that may be due and owing an employee at the time an employee separates from service with the City of Westland, shall not act, nor shall same be construed to act, to relieve the employee from the liability and obligation of paying the monies due the retirement system. Failure to pay the amounts due the retirement system by the employee shall act as a bar to any claims brought by the employee or his beneficiaries against the City and/or Act 345 Retirement Board and System for pension benefits for the years of military service or prior police service not paid for by the employee as required hereunder.

36.15 Members shall be allowed to withdraw their accumulated contributions (with interest) at retirement. Upon such withdrawal, the member's pension shall be reduced by the portion of his retirement allowance which was financed by the member's contribution. In order to determine the formula to be used to compute the assumed rate of investment return, the parties agree to rely on a formula to be drafted by a recognized actuarial firm; however, it is the intent of the parties that said formula use a PBGC index.

36.16 Employees shall be permitted to receive a normal retirement after twenty-five (25) years of service, regardless of age at the time of retirement.

36.17 Effective upon ratification of this agreement, if a police officer dies in the line of duty, his or her surviving spouse shall be paid a pension and benefits equal to the pension and benefits the officer would have been entitled to receive if he or she had 25 years of service at the time of death (calculated using the base pay of the employee), and said pension and benefits shall continue for the life of the surviving spouse or until the remarriage of the surviving spouse. It is intended that this provision shall supplant and replace the "Widows duty death pension" that is set forth in Section 6(2)(a) of Public Act of 345 of 1937, as amended, being MCLA 38.556(2)(a), as amended.

36.18 Both parties agree not to negotiate a change in pension provisions from date of contract until 2030 for employees hired prior to July 1, 2014 unless required by the Michigan Employment Relations Commission (MERC).

ARTICLE 37 PROMOTIONS

37.1 Promotional procedures established in P.A. 78 of 1935, as amended, are to be utilized for promotions affecting bargaining members, except as otherwise provided in Article 37.

37.2 A passing score in the promotional testing process shall be seventy percent (70%) in the written portion of the exam and seventy percent (70%) in the oral portion of the exam.

37.3 The promotional testing process shall include weight given to the components of the test as follows:

- 70% upon the written portion of the examination.
- 25% upon the oral portion of the examination.
- Up to 5% additional seniority credit based on ½% per year of service to a maximum of 5%.

37.4 The oral portion of the examination shall be conducted by a three-member oral board. Neither the City nor civil service employees nor personnel shall be members of the oral board. The oral board shall consist of Police/Public Safety Administrators from departments in the Metro area (exclusive of Westland).

37.5 The promotional testing process shall take place within sufficient time to maintain in effect, at all times, a current eligibility list. There must be at least a sixty-day notice prior to the beginning of a promotional exam. The promotional process will be initiated in January of each appropriate year with a two week period for application, a sixty day notice period prior to testing, and with certification to follow as soon thereafter as possible.

**ARTICLE 38
DEPUTY CHIEF CLASSIFICATION**

38.1 It is agreed that the position of Deputy Chief shall be included in the bargaining unit. The position of Deputy Chief shall be a promoted position, through competitive testing, from the next highest rank or ranks in the bargaining unit.

**ARTICLE 39
SPECIAL INVESTIGATION UNIT**

39.1 The Employer may utilize non-bargaining unit members from the non-supervisory bargaining unit to perform duties in the special investigation unit of a self-generated origin pertaining solely and exclusively to narcotics matters and stolen car cases. The non-bargaining unit members shall be under the direct supervision of a command officer. The Chief of Police shall have the right to assign further duties to the non-bargaining unit individuals within the narcotics/stolen car area only.

**ARTICLE 40
IRS RULINGS**

40.1 The City, in cooperation with the Board of Trustees of the Retirement System and the Association, agrees to petition the Internal Revenue Service seeking a ruling to determine whether employee contributions to the pension plan within the retirement system and to determine if a participant who elects to receive a lump sum payment attributable to all or part of contributions must include in gross income an amount determined in accordance with the Internal Revenue Code to the extent that such amount exceeds the investment in the contract.

**ARTICLE 41
DETECTIVE BUREAU**

41.1 The employer may utilize non-bargaining unit members from the non-supervisory bargaining unit to perform investigatory duties with regard to misdemeanor cases. Such non-bargaining unit members from the non-supervisory bargaining unit may also be assigned to assist bargaining unit Sergeants and Lieutenants in the investigation of felony matters.

41.2 Non-bargaining unit members from the non-supervisory bargaining unit shall remain under the direction and supervision of a command officer in the Detective Bureau.

41.3 Non-bargaining unit members from the non-supervisory bargaining unit may be assigned to the Detective Bureau for periods not to exceed two years.

41.4 The Detective Bureau minimum staffing level of one (1) Sergeant and one (1) Lieutenant shall be maintained during any period that non-bargaining unit members from the non-supervisory bargaining unit are utilized to perform duties and assignments as allowed in this article.

41.5 The Chief in his discretion may assign patrol officers as Polygraph Operators. The assignment will not be limited to the three (3) years time restraint.

**ARTICLE 42
DRUG POLICY**

42.1 PURPOSE

The purpose of this policy is to provide all sworn employees with notice of the provisions of the departmental drug testing program.

42.2 POLICY

It is the policy of this department that the critical mission of law enforcement justifies maintenance of a drug-free work environment through the use of a reasonable employee drug testing program.

The law enforcement profession has several uniquely compelling interests that justify the use of employee drug testing. The public has a right to expect that those who are sworn to protect them are at all times both physically and mentally prepared to assume these duties. Second, there is sufficient evidence to conclude that the use of controlled substances and other forms of drug abuse will seriously impair an Officer's physical and mental health and, thus, job performance. Third, where law enforcement officers participate in illegal drug use and drug activity, the integrity of the law enforcement profession and public confidence in that integrity are destroyed. This confidence is further eroded by the potential for corruption created by drug use.

In order to ensure the integrity of the department and to preserve public trust and confidence in a fit and drug free police department, the department has implemented a drug testing program to detect prohibited drug use based upon a standard requiring probable cause.

42.3 DEFINITIONS

A. Drug Test - The production and submission of urine and/or blood by an employee in accordance with departmental procedures for chemical analysis to detect prohibited drug use.

B. Probable Cause - Cause must be based on specific objective facts, and any rationally derived inferences from those facts, about the conduct of an individual that would lead the reasonably trained person to suspect that the individual is or has been using drugs while on or off duty. Probable cause is that amount of facts and circumstances within the knowledge of a supervisor or the administrator which is sufficient to warrant a prudent person to believe it is more probable that not that an officer is or has been improperly using drugs while on or off duty.

C. Employee - Any individual whether sworn or civilian employed full-time, or part-time, by the Westland Police Department.

42.4 PROCEDURES

A. General Rules

1. All potential police employees, both sworn and civilian, must successfully pass a drug screen during their pre-employment physical examinations.

2. The following rules apply to all employees, while on and off work:

a. No employee shall illegally possess any controlled substances.

b. No employee shall ingest any controlled or prescribed substance, except under the direction of a licensed medical practitioner.

c. Employees shall notify their immediate supervisor when required to use prescription medicine that may influence their job performance. This notification will be in the form of a written memo.

d. Any violation of the substance abuse policy shall be immediately reported to the Chief or Deputy Chiefs.

B. Employee Drug Testing

1. The Chief or Deputy Chief may order an employee to take a drug test for probable cause. A written summary of the facts supporting the order shall be made

available to the employee prior to the actual test. The test will be conducted at a medical facility agreed to by the Union and Employer.

- a. If such employee's test is negative, the summary of facts supporting the order shall not be placed in his/her personnel file.
 - b. Test results reporting a presence of illegal drugs or narcotics, or the use of prescription drugs without a prescription or the abuse of any over-the-counter drugs, will be submitted to the Chief or Deputy Chiefs who will make a determination on any dispute, or rehabilitation as needed. In the event of a positive reading, the employee may request a second test at another authorized medical facility, agreed to be the Union and Employer.
 - c. At the time of the original test, the testing facility will draw two samples and adhere to chain-of custody procedures in regard to the care and custody of the samples. After the first sample returns a positive, the employee may request the second sample be tested at a second facility using a mass spectrometry procedure to verify the existence of improper drugs.
2. If an employee under his/her own volition makes the Department aware that he/she has a substance abuse problem of a prescription drug, that employee will be offered a Union and Department approved rehabilitation program. The employee will be held accountable to the conditions associated with the program.
 3. Failure to report for testing during the time period the employee is requested to test will be considered the same as testing positive.
 4. Persons assigned to the Special Investigative Unit must submit to a drug test as defined above prior to entering into the unit, randomly during the term of service in the unit, and upon exiting the unit.

IN WITNESS WHEREOF, the parties hereto have hereunto set their hands and seals the day the year first written by their respective duly authorized officers and agents.

FOR THE CITY:



Mayor William R. Wild



Clerk Eileen DeHart



Police Chief Jeff Jedrusik



Personnel Director Cindy C. King



Budget Director Debra Peck

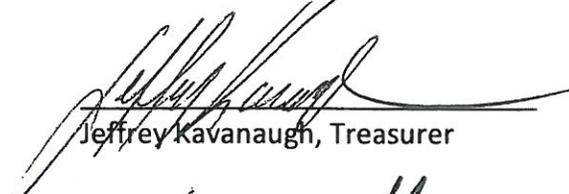
FOR THE ASSOCIATION:



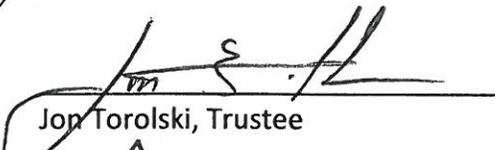
Kyle Dawley, President



Richard Kummert, Vice President



Jeffrey Kavanaugh, Treasurer



Jon Torolski, Trustee



Frank Guido, Attorney

Dated: 12-22-2015

**Letter of Understanding
between the
City of Westland
and the
Westland Lieutenants & Sergeants Association**

The City of Westland, hereinafter known as the "City," and the Westland Lieutenants and Sergeants Association, hereinafter known as the "Union," agree to the following terms and conditions as said terms and conditions concern the number of command officers within the bargaining unit. The City and Union hereby agree:

There is reserved exclusively to the City all responsibilities, power, rights and authority vested in it by the laws and Constitution of Michigan and the United States or which have been heretofore properly exercised by it, excepting where expressly and in specific terms limited by the provisions of the WLSA Collective Bargaining Agreement.

It is further recognized that the responsibility of Management of the City, selection and direction of the working forces, including the right to hire, suspend or discharge for cause, assign, promote or transfer, to determine the hours of work, to relieve employees from duty because of lack of work are solely the responsibilities of the City. The City agrees that it shall exercise these rights in conformity with the terms of the WLSA Collective Bargaining Agreement as they pertain herein, and shall not exercise these rights in conflict with the terms of that Agreement.

The City has the right to control and manage operations which includes the right to determine staffing levels in the WLSA. As such, the City shall eliminate through attrition, retirement, resignation or termination for cause up to nine (9) sergeant positions.

This Letter of Understanding is not precedent-setting.

Date: 12-22-2015

For the Union:

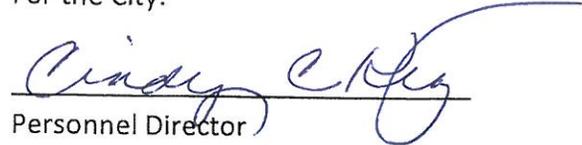


WLSA President



WLSA Officer

For the City:



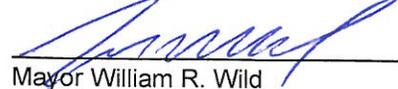
Personnel Director



Police Chief



City Clerk Eileen DeHart-Schoof, CMC



Mayor William R. Wild

**CITY OF WESTLAND
LIEUTENANTS & SERGEANTS ASSOCIATION
LETTER OF UNDERSTANDING
VACATIONS**

The City and the WLSA hereby agree to amend the terms of the current collective bargaining agreement of January 1, 2015 – December 31, 2019, Article 16 Vacations, 16.1 as follows:

Eliminate the language: Effective January 1, 2015, employees with a hire date prior to July 1, 2014 and with ten (10) or more years of seniority shall receive 272 hours in vacation pay.

Replace it with: Effective January 1, 2015, and for the remaining years of the CBA, employees with a hire date prior to July 1, 2014 and with ten (10) or more years seniority shall receive 288 hours in vacation pay.

Eliminate the language beginning "Effective January 1, 2016, and for the remaining year....shall receive 288 hours in vacation pay."

The remaining language in 16.1 shall remain unchanged.

This letter of understanding shall have immediate effect.

DATE: 2-1-16

By the Union:

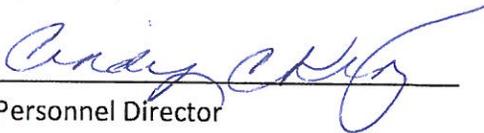


President



Vice-President

By the City:



Personnel Director



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

A0FRP9 – CITY OF WESTLAND 007006083-0017 Community BlueSM PPO 1 ASC – Medical Coverage Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after October 1, 2014

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.

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: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

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 disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

In-network

Out-of-network *

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

	In-network	Out-of-network *
Deductibles	None	\$250 for one member \$500 for the family (when two or more members are covered under your contract) each calendar year
Flat-dollar copays	<ul style="list-style-type: none"> \$10 copay for office visits and office consultations \$50 copay for emergency room visits 	\$50 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	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 20% of approved amount for mental health care and substance abuse treatment 20% of approved amount for most other covered services
Annual out-of-pocket maximums – applies to deductibles, 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 two or more members each calendar year	\$12,700 for one member \$25,400 for two or more members each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

* 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.

Community Blue ASC (DJC 081414)

In-network

Out-of-network *

Preventive care services

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 sterilizations for females	100% (no deductible or copay/coinsurance)	80% 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)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 6 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.	80% 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		
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.	80% after out-of-network deductible
One per member per calendar year		

Physician office services

Office visits – must be medically necessary	\$10 copay per office visit	80% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Office consultations – must be medically necessary	\$10 copay per office visit	80% after out-of-network deductible
Urgent care visits – must be medically necessary	\$10 copay per office visit	80% after out-of-network deductible



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

In-network

Out-of-network *

Emergency medical care

Hospital emergency room	\$50 copay per visit (copay waived if admitted or for an accidental injury)	\$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Diagnostic services

Laboratory and pathology services	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Diagnostic tests and x-rays	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Therapeutic radiology	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

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

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible Unlimited days
Inpatient consultations	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chemotherapy	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Alternatives to hospital care

Skilled nursing care – must be in a participating skilled nursing facility	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) 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	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
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	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)



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

In-network

Out-of-network *

Surgical services

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

Human organ transplants

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
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Specified oncology clinical trials Note: BCBSM covers clinical trials in compliance with PPACA.	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.

This means when these services are performed by an in-network provider, you will have no in-network deductible. You will be responsible for the flat-dollar member copay that applies to office visits. When these services are performed by an out-of-network provider, you will be responsible for your annual out-of-network deductible and the coinsurance amount that applies to covered out-of-network services.

Inpatient mental health care and inpatient substance abuse treatment	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Unlimited days		
Outpatient mental health care: • Facility and clinic	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance), in participating facilities only
• Physician’s office	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

In-network

Out-of-network *

Autism spectrum disorders, diagnoses and treatment

Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 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. ABA and AAEC services are not available outside of Michigan.	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

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.	100% (no deductible or copay/coinsurance) for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% (no deductible or copay/coinsurance)	80% 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	100% (no deductible or copay/coinsurance)	80% 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.	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Prosthetic and orthotic appliances	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Private duty nursing care	50% (no deductible)	50% (no deductible)



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

Blue Preferred[®] Rx ASC Prescription Drug Coverage Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after October 1, 2014

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, copay and /or 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 initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

Note: Your prescription drug copays, including mail order copays, 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

	In-network pharmacy	Out-of-network pharmacy
Generic or prescribed over-the-counter prescription drugs	\$5 copay	\$5 copay plus an additional 25% of BCBSM approved amount for the drug
Brand name prescription drugs	\$10 copay	\$10 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Copay for up to a 90 day supply: <ul style="list-style-type: none"> • \$5 copay for generic drugs • \$10 copay for brand name drugs 	No coverage

Covered services

	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand-name prescription preventive drugs, supplements, and vitamins	100% of approved amount	75% of approved amount less plan copay

Note: An **in-network** pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An **out-of-network** pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

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.



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

Covered services, continued

	In-network pharmacy	Out-of-network pharmacy
Other FDA-approved brand-name prescription preventive drugs, supplements, and vitamins	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no deductible or copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

Features of your prescription drug plan

Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay 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. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com/pharmacy , along with the preferred medications. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.



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

A0GAY5 – CITY OF WESTLAND 007006083-0044 Community BlueSM PPO2 ASC with ECM – Medical Coverage Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after October 1, 2014

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.

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: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

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 disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

	In-network	Out-of-network *
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Deductibles	\$100 for one member \$200 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived for covered services performed in an in-network physician's office.	\$250 for one member \$500 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	<ul style="list-style-type: none"> \$10 copay for office visits and office consultations \$10 copay for chiropractic services and osteopathic manipulative therapy \$50 copay for emergency room visits 	\$50 copay for emergency room visits
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 10% of approved amount for mental health care and substance abuse treatment 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 30% of approved amount for mental health care and substance abuse treatment 30% of approved amount for most other covered services

* 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.

In-network

Out-of-network *

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

Annual coinsurance maximums – applies to coinsurance amounts for all covered services – including mental health and substance abuse services – but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	\$500 for one member \$1,000 for the family (when two or more members are covered under your contract) each calendar year	\$1,500 for one member \$3,000 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, 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 two or more members each calendar year	\$12,700 for one member \$25,400 for two or more members 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

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 sterilizations for females	100% (no deductible or copay/coinsurance)	70% 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)	70% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 6 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

* 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.

In-network

Out-of-network *

Preventive care services, *continued*

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.	70% 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		
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.	70% after out-of-network deductible
One per member per calendar year		

Physician office services

Office visits – must be medically necessary	\$10 copay per office visit	70% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	90% after in-network deductible	70% after out-of-network deductible
Office consultations – must be medically necessary	\$10 copay per office visit	70% after out-of-network deductible
Urgent care visits – must be medically necessary	\$10 copay per office visit	70% after out-of-network deductible

Emergency medical care

Hospital emergency room	\$50 copay per visit (copay waived if admitted or for an accidental injury)	\$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	90% after in-network deductible	90% after in-network deductible

Diagnostic services

Laboratory and pathology services	90% after in-network deductible	70% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	70% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	70% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Prenatal care visits	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Postnatal care visits	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Delivery and nursery care	90% after in-network deductible	70% after out-of-network deductible

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	90% after in-network deductible	70% after out-of-network deductible
Unlimited days		
Inpatient consultations	90% after in-network deductible	70% after out-of-network deductible
Chemotherapy	90% after in-network deductible	70% after out-of-network deductible

Alternatives to hospital care

Skilled nursing care – must be in a participating skilled nursing facility	90% after in-network deductible	90% 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)		

* 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.

In-network

Out-of-network *

Alternatives to hospital care, *continued*

Home health care: • must be medically necessary • must be provided by a participating home health care agency	90% after in-network deductible	90% 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	90% after in-network deductible	90% after in-network deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	90% after in-network deductible	70% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Voluntary sterilization for males Note: For voluntary sterilizations for females, see “Preventive care services.”	90% after in-network deductible	70% after out-of-network deductible

Human organ transplants

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
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	70% after out-of-network deductible
Specified oncology clinical trials Note: BCBSM covers clinical trials in compliance with PPACA.	90% after in-network deductible	70% after out-of-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	70% after out-of-network deductible

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.

This means when these services are performed by an in-network provider, you will have no in-network deductible. You will be responsible for the flat-dollar member copay that applies to office visits. When these services are performed by an out-of-network provider, you will be responsible for your annual out-of-network deductible and the coinsurance amount that applies to covered out-of-network services.

Inpatient mental health care and inpatient substance abuse treatment	90% after in-network deductible	70% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	90% after in-network deductible	90% after in-network deductible, in participating facilities only
• Physician’s office	90% after in-network deductible	70% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	90% after in-network deductible	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

* 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.



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

In-network

Out-of-network *

Autism spectrum disorders, diagnoses and treatment

Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 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. ABA and AAEC services are not available outside of Michigan.	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

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.	90% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training	70% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$10 copay per office visit Limited to a combined 24-visit maximum per member per calendar year	70% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation	90% after in-network deductible Limited to a combined 60-visit maximum per member per calendar year	70% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
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.	90% after in-network deductible	90% after in-network deductible
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

* 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.



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

Blue Preferred[®] Rx ASC Prescription Drug Coverage Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after October 1, 2014

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, copay and /or 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 initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

Note: Your prescription drug copays, including mail order copays, 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

	In-network pharmacy	Out-of-network pharmacy
Generic or prescribed over-the-counter prescription drugs	\$10 copay	\$10 copay plus an additional 25% of BCBSM approved amount for the drug
Brand name prescription drugs	\$20 copay	\$20 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Copay for up to a 90 day supply: • \$10 copay for generic drugs • \$20 copay for brand name drugs	No coverage

Covered services

	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand-name prescription preventive drugs, supplements, and vitamins	100% of approved amount	75% of approved amount less plan copay

Note: An **in-network** pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An **out-of-network** pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

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.

* 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.

Covered services, *continued*

	In-network pharmacy	Out-of-network pharmacy
Other FDA-approved brand-name prescription preventive drugs, supplements, and vitamins	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no deductible or copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

Features of your prescription drug plan

Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay 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. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com/pharmacy , along with the preferred medications. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.

* 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.



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

A0GFK4 - CITY OF WESTLAND

007006083-0045 BASE PLAN

Effective Date: On or after October 1, 2014

Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/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.

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: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided - select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analysis.

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 disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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

* 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.

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

Benefits	In-Network	Out-of-Network
Deductibles	\$250 for one member \$500 for the family (when two or more members are covered under your contract) each calendar year	\$500 for one member \$1,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also count toward the in-network deductible.
Flat dollar copays	<ul style="list-style-type: none"> • \$20 copay for office visits and office consultations • \$20 copay for chiropractic services and osteopathic manipulative therapy • \$100 copay for emergency room visits 	\$100 copay for emergency room visits
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> • 50% of approved amount for private duty nursing care • 10% of approved amount for mental health care and substance abuse treatment • 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) 	<ul style="list-style-type: none"> • 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance abuse treatment • 40% of approved amount for most other covered services
Coinsurance maximums – applies to coinsurance amounts for all covered services – including mental health and substance abuse services – but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	\$1,250 for one member \$2,500 for the family (when two or more members are covered under your contract) each calendar year	\$2,500 for one member \$5,000 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, 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 two or more members each calendar year	\$12,700 for one member \$25,400 for two or more members each calendar year Note: Out-of-network cost-sharing amounts also apply 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

Preventive care services, continued

Benefits	In-Network	Out-of-Network
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 sterilizations 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) <ul style="list-style-type: none"> ● 6 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

Preventive care services, continued

Benefits	In-Network	Out-of-Network
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 a in-network provider.
One per member per calendar year		
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	\$20 copay for office visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	90% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	\$20 copay for office visit	60% after out-of-network deductible
Urgent care visits - must be medically necessary	\$20 copay for office 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 necessary	90% after in-network deductible	90% after in-network deductible

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

Diagnostic services

Benefits	In-Network	Out-of-Network
Laboratory and pathology services	90% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	90% 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	90% 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 Note: Nonemergency services must be rendered in a participating hospital.	90% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	90% after in-network deductible	60% after out-of-network deductible
Chemotherapy	90% 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 facility	90% after in-network deductible	90% 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: <ul style="list-style-type: none"> ● must be medically necessary ● must be provided by a participating home health care agency 	90% after in-network deductible	90% after in-network deductible

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

Alternatives to hospital care, continued

Benefits	In-Network	Out-of-Network
Infusion therapy: <ul style="list-style-type: none"> • must be medically necessary • must be given by 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 	90% after in-network deductible	90% 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	90% 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. "	90% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-Network	Out-of-Network
Specified human organ transplants - in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	60% after out-of-network deductible

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

Human organ transplants, continued

Benefits	In-Network	Out-of-Network
Specified oncology clinical trials Note: BCBSM covers clinical trials in compliance with PPACA.	90% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	60% after out-of-network deductible

Mental health care and substance abuse treatment

Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.

This means when these services are performed by an in-network provider, you will be responsible for your annual in-network deductible and you will be responsible for the member copay that applies to office visits. However, when these services are performed by an out-of-network provider, you will be responsible for your annual out-of-network deductible and the coinsurance amount that applies to covered out-of-network services.

Benefits	In-Network	Out-of-Network
Inpatient mental health care and inpatient substance abuse treatment	90% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	90% after in-network deductible	90% after in-network deductible - in participating facilities only
	90% after in-network deductible	60% after out-of-network deductible
• Physician's office	90% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse treatment - in approved facilities only	90% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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

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 limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. ABA and AAEC services are not available outside of Michigan.	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.	90% 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	\$20 copay per office visit	60% after out-of-network deductible
	Limited to a combined maximum of 24 visits per member per calendar year for chiropractic and osteopathic manipulative therapy.	

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

Other covered services, continued

Benefits	In-Network	Out-of-Network
Outpatient physical, speech and occupational therapy - provided for rehabilitation	\$20 copay per day Limited to a combined 60-visit maximum per member per calendar year	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
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.	90% after in-network deductible	90% after in-network deductible
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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



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

**A0GFK4 - CITY OF WESTLAND
68765-680**

Effective Date: On or after 10/01/2014

Benefits-at-a-Glance

Blue Preferred Rx® Prescription Drug Coverage

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. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many 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 Medco. (Medco 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. Log in under "I am a Member." 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 initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days) once applicable deductible has been met.

Member's responsibility (copays)

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable copay.

	In-network pharmacy	Out-of-network pharmacy
Tier 1 - Generic or prescribed over-the-counter drugs	\$10 copay	\$10 copay plus an additional 25% of the BCBSM approved amount for the drug
Tier 2 - Formulary brand-name drugs	\$30 copay	\$30 copay plus an additional 25% of the BCBSM approved amount for the drug
Tier 3 - Nonformulary brand-name drugs	\$60 copay	\$60 copay plus an additional 25% of the BCBSM approved amount for the drug

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

	In-network pharmacy	Out-of-network pharmacy
Mail order prescription drugs	Copay for up to a 30 day supply: <ul style="list-style-type: none"> • \$10 copay for Tier 1 (generic) drugs • \$30 copay for Tier 2 (formulary brand) drugs • \$60 copay for Tier 3 (nonformulary brand) drugs Copay for a 31 to 90 day supply: <ul style="list-style-type: none"> • \$20 copay for Tier 1 (generic) drugs • \$60 copay for Tier 2 (formulary brand) drugs • \$120 copay for Tier 3 (nonformulary brand) drugs 	Not Covered

Covered services

	Network pharmacy	Non-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand name prescription preventive drugs, supplements, and vitamins	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved brand name prescription preventive drugs, supplements, and vitamins	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand name prescription contraceptive medication (non-self-administered drugs are devices are not covered)	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved brand name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs. Note: Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug
Mail order (home delivery) prescription drugs - up to 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	100% of approved amount less plan copay	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.

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A non-network pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.

Features of your prescription drug plan

	Network pharmacy	Non-network pharmacy
Prior authorization/step therapy	<p>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. Log in under <i>I am a Member</i> and click on <i>Prescription Drugs</i>.</p>	
Drug interchange and generic copay waiver	<p>Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>	
Quantity limits	<p>Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com.</p>	

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



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

A0FTQ0 – CITY OF WESTLAND 007006083-0046 Custom Community BlueSM PPO ASC with ECM – Value Plan Medical Coverage Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after October 1, 2014

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.

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: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

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 disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

In-network

Out-of-network *

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

	In-network	Out-of-network *
Deductibles	\$500 for one member \$1,000 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived for covered services 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 Note: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	<ul style="list-style-type: none"> \$30 copay for office visits and office consultations \$30 copay for chiropractic services and osteopathic manipulative therapy \$150 copay for emergency room visits 	\$150 copay for emergency room visits
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 20% of approved amount for mental health care and substance abuse treatment 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 40% of approved amount for mental health care and substance abuse treatment 40% of approved amount for most other covered services

* 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.



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

In-network

Out-of-network *

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

Annual coinsurance maximums – applies to coinsurance amounts for all covered services – including mental health and substance abuse 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	\$5,000 for one member \$10,000 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, 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 two or more members each calendar year	\$12,700 for one member \$25,400 for two or more members 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

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 sterilizations 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) • 6 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



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

In-network

Out-of-network *

Preventive care services, *continued*

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		
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

Office visits – must be medically necessary	\$30 copay per office visit	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 visit	60% after out-of-network deductible
Urgent care visits – must be medically necessary	\$30 copay per office visit	60% after out-of-network deductible

Emergency medical care

Hospital emergency room	\$150 copay per visit (copay waived if admitted or for an accidental injury)	\$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

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

Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visits	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

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible	60% after out-of-network deductible
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

Skilled nursing care – must be in a participating skilled nursing facility	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)		

In-network

Out-of-network *

Alternatives to hospital care, *continued*

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

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

Human organ transplants

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
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 abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.

This means when these services are performed by an in-network provider, you will have no in-network deductible. You will be responsible for the flat-dollar member copay that applies to office visits. When these services are performed by an out-of-network provider, you will be responsible for your annual out-of-network deductible and the coinsurance amount that applies to covered out-of-network services.

Inpatient mental health care and inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic • Physician’s office	80% after in-network deductible	80% after in-network deductible, in participating facilities only
	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse 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)



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

In-network

Out-of-network *

Autism spectrum disorders, diagnoses and treatment

Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 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. ABA and AAEC services are not available outside of Michigan.	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

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 office visit Limited to a combined 24-visit maximum per member per calendar year	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation	\$30 copay per day Limited to a combined 60-visit maximum per member per calendar year	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
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



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

Blue Preferred[®] Rx ASC Prescription Drug Coverage Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after October 1, 2014

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, copay and /or 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 initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

Note: Your prescription drug copays, including mail order copays, 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

	In-network pharmacy	Out-of-network pharmacy
Tier 1 – Generic or select prescribed over-the-counter drugs	\$10 copay	\$10 copay plus an additional 25% of BCBSM approved amount for the drug
Tier 2 – Formulary (preferred) brand-name drugs	\$30 copay	\$30 copay plus an additional 25% of BCBSM approved amount for the drug
Tier 3 – Nonformulary (nonpreferred) brand-name drugs	\$60 copay	\$60 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	<p>Copay for up to a 30 day supply:</p> <ul style="list-style-type: none"> • \$10 copay for Tier 1 (generic) drugs • \$30 copay for Tier 2 (formulary brand) drugs • \$60 copay for Tier 3 (nonformulary brand) drugs <p>Copay for a 31 to 90 day supply:</p> <ul style="list-style-type: none"> • \$20 copay for Tier 1 (generic) drugs • \$60 copay for Tier 2 (formulary brand) drugs • \$120 copay for Tier 3 (nonformulary brand) drugs 	No coverage

Note: An **in-network** pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An **out-of-network** pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

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.

Covered services

	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand-name prescription preventive drugs, supplements, and vitamins	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved brand-name prescription preventive drugs, supplements, and vitamins	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no deductible or copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

Features of your prescription drug plan

BCBSM Custom Formulary	<p>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 formulary is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> ▪ 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, making them the most cost-effective option for the treatment. ▪ Tier 2 (preferred brand) – Tier 2 includes brand-name drugs from the Custom Formulary. Preferred brand name drugs are also safe and effective, but require a higher copay. ▪ 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 for these drugs.
Drug interchange and generic copay waiver	<p>BCBSM's drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
Quantity limits	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>



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

Prescription drug preferred therapy

A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication.

Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com/pharmacy**, **along with the preferred medications.**

If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.



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

CITY OF WESTLAND 007006083-0047, 0051 Simply BlueSM PPO HSA ASC – Medical Coverage HDQHP with Prescription Drugs Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after October 1, 2014

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, copay and /or 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.

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: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

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 disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

In-network

Out-of-network *

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

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

	In-network	Out-of-network *
Deductibles Note: Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage. Note: The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	\$1,500 for a one-person contract or \$3,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)	\$3,000 for a one-person contract or \$6,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
	Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Please call your customer service center for an annual update.	
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	20% of approved amount for most covered services	40% of approved amount for most covered services
Annual out-of-pocket maximums – applies to deductibles and coinsurance amounts for all covered services – including prescription drug cost-sharing amounts	\$3,000 for a one-person contract or \$6,000 for a family contract (2 or more members) each calendar year	\$6,000 for a one-person contract or \$12,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

* Services from a provider for which there is no Michigan PPO network and services from a 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.

Simply Blue PPO HSA with Prescription Drugs ASC (DJC 081514)

In-network

Out-of-network *

Preventive care services

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 sterilizations 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)	60% 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) <ul style="list-style-type: none"> • 6 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		
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy Note: Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
One routine colonoscopy per member per calendar year		

In-network

Out-of-network *

Physician office services

Office visits – must be medically necessary	80% after in-network deductible	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	80% after in-network deductible	60% after out-of-network deductible
Urgent care visits – must be medically necessary	80% after in-network deductible	60% after out-of-network deductible

Emergency medical care

Hospital emergency room	80% after in-network deductible	80% after in-network deductible
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

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

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

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible	60% after out-of-network deductible
	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

Skilled nursing care – must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care	80% after in-network deductible	80% after in-network deductible
	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



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

In-network

Out-of-network *

Surgical services

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	80% after in-network deductible	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

Human organ transplants

Specified human organ transplants – must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	80% after in-network deductible – in designated facilities only
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 abuse treatment

Inpatient mental health care and inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities only
• Physician’s office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse 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

Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 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. ABA and AAEC services are not available outside of Michigan.	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



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

In-network

Out-of-network *

Other covered services

<p>Outpatient Diabetes Management Program (ODMP)</p> <p>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.</p> <p>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>	80% after in-network deductible	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	80% after in-network deductible	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	80% after in-network deductible	80% after in-network deductible
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.		
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	80% after in-network deductible	80% after in-network deductible



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

Simply BlueSM PPO HSA ASC – Prescription Drug Coverage Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after October 1, 2014

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, copay and /or 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 initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the **same deductible, same coinsurance and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage**. Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum:

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 20% member liability for covered drugs obtained from an out-of-network pharmacy

	In-network pharmacy	Out-of-network pharmacy
Coinurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	20% of approved amount	40% of approved amount plus an additional 20% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Coinurance for up to a 90 day supply: 20% of approved amount	No coverage

Covered services

	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance plus an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs – when covered by BCBSM	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance plus an additional 20% prescription drug out-of-network penalty

Note: An **in-network** pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An **out-of-network** pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

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.

Covered services, continued

	In-network pharmacy	Out-of-network pharmacy
State-controlled drugs	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved generic and select brand-name prescription preventive drugs, supplements, and vitamins	100% of approved amount	80% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements, and vitamins	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	80% of approved amount
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	Subject to Simply Blue HSA medical deductible and coinsurance	Subject to Simply Blue HSA medical deductible and coinsurance plus an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no deductible or coinsurance.	Subject to Simply Blue HSA medical deductible and coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and coinsurance for the insulin or other covered injectable legend drug plus an additional 20% prescription drug out-of-network penalty

Features of your prescription drug plan

Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay 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. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com/pharmacy, along with the preferred medications. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.