Walled Lake

Professional Fire Fighters Association

Collective Bargaining Agreement

July 1, 2023 – June 30, 2027

Michigan Association of Fire Fighters
(MAFF)

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AGREEMENT

This Agreement is made and entered into on the 23 day of August, 2023 and shall be in effect for years commencing July 1, 2023 to and including June 30, 2027, by and between the City of Walled Lake, hereinafter referred to collectively as the "Employer," and the Walled Lake Professional Fire Fighter's Association and Michigan Association of Fire Fighters, hereinafter referred to as the "Union." It is the desire of both parties to this Agreement to continue to work harmoniously and to promote and maintain high standards between the Employer and employees which will best serve the citizens of the City of Walled Lake.

ARTICLE 1
RECOGNITION

Section 1.1 The Employer recognizes the Union as the exclusive representative of the full-time Fire Officers, Fire Fighters and Fire Marshall of the City of Walled Lake Fire Department, excluding all casual and temporary employees, the Director of Public Safety, Deputy Director of Public Safety, Fire Chief, On-Call Fire Fighters, Part-time Fire Fighters (Reserves) and all other employees, for the purpose of collective bargaining with respect to rates of pay, salaries, hours of employment in the bargaining unit for which it has been certified and in which the Union is recognized as collective bargaining representative, subject to and in accordance with, the provisions of Act 336 of the Public Acts of 1947, as amended.

It shall be considered a violation of this Agreement for any bargaining unit member(s) or anyone acting in their behalf to approach any of the seven (7) member City Council, except as set forth in this Agreement, concerning any matter which is a subject of the collective bargaining agreement between the City and the Union, or which is a grievance under the grievance and arbitration procedure.

ARTICLE 2
NO-DISCRIMINATION

Section 2.1 The provisions of this Agreement shall be applied equally to all employees in the

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bargaining unit without discrimination as to age, sex, marital status, race, color, creed, national origin, political affiliation or disability. The Union shall share equally with the City, the responsibility for applying the provisions of this Agreement.

Any matter in which a civil remedy is pursued by a grievant, at law or in equity, in any state or federal court, or administrative agency, involving issues claimed or raised in a grievance shall not be subject to arbitration unless a court of competent jurisdiction rules that the grievant must first exhaust his/her administrative remedies.

ARTICLE 3
MANAGEMENT RESPONSIBILITY

Section 3.1 The right to hire, promote, discharge, or discipline, and to maintain discipline and efficiency of employees is the sole responsibility of the Employer, except that the Union members shall not be discriminated against as such. In addition, the work schedules, methods and means of departments' operations are solely and exclusively the responsibility of the Employer, subject, however, to the provisions of this Agreement. All rights and responsibilities of the Employer are subject to the rights provided to the Union and employees which emanate from the language of this agreement.

ARTICLE 4
SENIORITY

Section 4.1 **New Employees**. New employees may acquire seniority by working eighteen (18) continuous months in which event the employee's seniority will date back to the date of the most recent hire into the Department. (See probationary employment Article 5 (Section 3). When the employee acquires seniority, his/her name shall be placed on the seniority list in the order of his/her seniority date. Past practice notwithstanding seniority shall be defined as years of continuous full-time service with the City of Walled Lake. Past practice notwithstanding, an employee shall be terminated and lose his/her seniority for the following reasons:

A. If the employee resigns or retires.

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B. If the employee is discharged and not reinstated.

C. Is absent without a reasonable excuse acceptable to the City for three (3) consecutive working days and without notice to the City of such excuse within three (3) days or a reasonable excuse for failing to notify the City within the three (3) days.

D. If the employee does not return to work at the end of an approved leave.

E. If the employee does not return to work when recalled from a layoff.

F. For any approved leave of absence except for the first thirty (30) days thereof.

G. Is laid off for a period of more than six (6) months.

H. If the employee falsifies any document during the pre-employment process or during employment.

Section 4.2 Employment Outside the Fire Department. If an employee leaves the bargaining unit to assume another position with the City, his/her seniority, under this contract, shall be frozen as of the date of his/her departure from the bargaining unit. Such an employee would continue to accrue seniority, under this contract, only upon his/her return to the bargaining unit from other employment with the City, but will not receive seniority, under this contract, for the time he was employed outside of the bargaining unit.

ARTICLE 5
PROBATIONARY EMPLOYMENT

Section 5.1 Length of Probationary Period. Employees hired from the outside of the Walled Lake Fire Department shall serve an eighteen (18) month probationary period. Employees hired from the Paid-on-Call/Part-time Fire Department bargaining unit shall serve a six (6) month probationary period. No later than fifteen (15) days prior to the end of the applicable probationary period, they will be evaluated by the Department Head on a form prepared by the City. An employee who is evaluated shall be provided with a copy of said evaluation. The employee shall have the right, to the extent established through State Law, to review his/her personnel file at any reasonable time during normal City Hall business hours.

Section 5.2 Extensions. The Department Head shall extend the probationary period for an

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additional six (6) months if, in his/her judgment, he is not able to adequately evaluate the employee.

Section 5.3 Right to Seniority. Employees who have not completed their probationary period of service with the Department shall have no seniority right during such probationary period but shall be subject to all other clauses of this Agreement, unless specifically excluded. All employees who have successfully completed their probationary period with the Department shall become permanent employees. Upon the satisfactory completion of the probationary period and effective date of this contract, the probationary period shall be considered part of the employee's seniority provided; however, the City shall have the right to terminate without compliance with the terms of the Agreement, the employment of any such new employee within during their probationary period from the commencement or extension of the probationary period. New employee's seniority will date back to the date of most recent hire into the Department.

Section 5.4 Holiday Compensation. Probationary employees shall not be entitled to paid holidays until they have completed 180 days of employment prior to the holiday. However, if an employee is scheduled to work on a scheduled holiday during the 180-day employment, he shall be entitled to holiday pay.

ARTICLE 6
DUES CHECK-OFF

Section 6.1 Non-Discrimination. The Employer and the Union agree they will not discriminate against any employee based on the employee's choice concerning union membership or to otherwise pay dues/fees to the Union for bargaining and defending the Collective Bargaining Agreement; nor will the Employer or the Union discriminate against any Employee who chooses not to be a member of or elects not to pay dues/fees to the Union.

Section 6.2 Option to Join. Upon being hired, a new member of the bargaining unit will be offered the choice to join or not join the Union. If an Employee voluntarily submits a dues/fees deduction form, the Employer agrees to deduct Union dues/fees in accordance with this Article, following the Employee's completion and submission of the dues' authorization form. If an

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employee chooses to opt-out of the Union, he/she shall submit to the Union a signed opt-out form with the original to MAFF and a copy to the Employer.

Section 6.3 Complying with Laws. All dues authorization forms shall comply with respective State and Federal Laws and shall be filed with the Employer, who may return an incomplete or incorrectly completed form to the Employee for correction prior to any deductions until such deficiency is corrected.

Section 6.4 Dues Withdrawal. If the Employee chooses to withdraw his/her dues authorization, the Employee shall notify the Employer and the Michigan Association of Fire Fighters in writing on the form provided by the MAFF. No deduction shall be made commencing with the first full pay period after the authorization was withdrawn by the Employee.

Section 6.5 Return to Membership. Should an Employee opt out of Union membership, his/her return to Union membership shall be at the sole discretion of the Michigan Association of Fire Fighters.

Section 6.6 Payroll Deduction. The Employer agrees to deduct the Union membership initiation fees and dues, once each month, from the second pay of the month from those Employees who individually authorize in writing that such deduction shall be made. All authorizations delivered to the Employer prior to the first of the month shall become effective during the succeeding month. Check-off shall be remitted together with an itemized statement to MAFF, within fourteen (14) days after deductions have been made.

Section 6.7 Employer Hold Harmless. The Employer shall not be liable to the Union by reason of requirements of this Article for remittance or payment of any sum other than that constituting actual deductions made from wages earned by employees. The Union will protect and save harmless the Employer from any and all claims, demands, suits and other forms of liability by reason of action taken or not taken by the Employer for the purpose of complying with this Article. All claims made against the City for errors committed by the City must be submitted to the City Manager within fifteen (15) working days or the error will stand.

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ARTICLE 7
BASIS OF REPRESENTATION

Section 7.1 Union Board. There shall be two (2) stewards, one of whom shall be designated as the Chief Steward. The alternate may act as a steward only in the absence of the Chief Steward. The steward and his/her alternate may act only within their own department. The Chief Steward and the steward will be permitted to leave their work after obtaining approval of the Department Head or his/her designee. The steward and the Chief Steward shall record their time for the purpose of adjusting grievances under Article 19 and for reporting to the grievant a change in status of his/her grievance. Permission for the Chief Steward and the steward to leave their workstations will not be unreasonably withheld. The stewards will report their time to their supervisor upon returning from a grievance discussion.

Section 7.2 Time Off Work. The privilege of the Chief Steward and the steward to leave their work during working hours, without loss of pay, is extended with the understanding that the time will be devoted to the prompt handling of grievances and will not be abused, and that they will continue to work at their assigned jobs at all times except when permitted to leave their work to handle grievances.

For purposes of allowing the Chief Steward to attend meetings of the Union Executive Board, the Chief Steward (no more than once each month) may request to be allowed to trade shifts with another employee; provided that: the Chief Steward must submit a written request at least two (2) weeks in advance, the Chief Steward will still be responsible for his/her scheduled shift and the Chief Steward will be responsible for trading the shift with the other employees and notifying the Department of the name of the employee at the time the written request is filed. It is understood that under no circumstances will the City incur any overtime pay liability to any employee by reason of shift trade.

Section 7.3 Grievance Committee. There shall be a grievance committee consisting of the Chief Steward and one other member to be selected by the Union and certified in writing to the Employer.

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The Employer shall meet whenever necessary at a mutually convenient time with the Union Grievance Committee. The purpose of the Grievance Committee meetings will be to adjust pending grievances and to discuss procedures for avoiding future grievances. In addition, the Committee may discuss with the Employer other issues which would improve the relationship between the parties.

ARTICLE 8
DEFINITIONS

Section 8.1 Day Defined. Unless otherwise stated within Articles and Sections in this contract, the term "day" will be equal to 24 hours for employees assigned to a twenty-four-hour shift, 12 hours for employees assigned to a twelve-hour shift, and 8 hours for employees assigned to an eight (8)-hour shift. For short-term disability, long-term disability or worker's compensation, a 12- or 24-hour shift employee will be considered to be on a normal forty-hour (40) week schedule and "day" will mean eight (8) hours.

Section 8.2 Position Classification. For purposes of this agreement, "Fire Fighter" shall mean an employee in the bargaining unit who has not completed Fire Officer III training, as certified by the State of Michigan. For purposes of this agreement, "Fire Officer" shall mean an employee in the bargaining unit who has completed Fire Officer I, II and III training, as certified by the State of Michigan. For purposes of this agreement, "Fire Officer Paramedic" shall mean an employee in the bargaining unit who has completed Fire Officer I, II and III training and has received a Paramedic certificate from an accredited college or university.

ARTICLE 9
DUTY-CONNECTED DISABILITY

Past practice notwithstanding, a duty disability leave shall mean a leave as a result of the employee incurring a compensable duty related illness or on-the-job injury while in the employment of the City.

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In order to be eligible for duty disability leave, an employee shall immediately report any illness or injury, however minor, to his immediate supervisor.

Permanent or probationary employees who are unable to work as a result of an injury or illness sustained in the course of employment with the City shall receive duty disability pay as follows:

The City shall, for a period not to exceed one (1) year from the date of injury, supplement, without charge to sick leave or PTO, the difference between Worker's Compensation benefits and the regular rate of pay, excluding any overtime pay. The purpose of this section is that the employee's net pay remains the same through the period of duty related disability. Additionally, the City will continue to pay the employee's health, dental, and vision insurance for this period.

If an employee is disabled longer than one (1) year, he shall be entitled to receive whatever weekly benefits are available under Michigan Workers Compensation Law, Social Security and/or the MERS retirement plan, but not to exceed one hundred (100%) percent of his/her regular pay at the time of disability.

If an employee suffers a duty disability and it is ascertained that the nature of the injury or illness is such that the employee will be permanently unable to work, such employee will, at the discretion of the City, and if the employee is eligible under the City's retirement plan, be retired under the City retirement plan.

ARTICLE 10
FUNERAL LEAVE

Section 10.1 In case of a death occurring in the employee's immediate family requiring his/her absence and during a duty period, the employee will be granted a leave of absence of two (2) workdays with pay. In the discretion of the Department Head one (1) additional workday with pay may be granted.

Immediate family is defined as follows:

1. Employees' spouse

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2. Child, sibling
3. Parent, Grandparent
4. Any relative living in the employee's household
5. Parent-in-Law's
6. Stepparents and stepchildren

ARTICLE 11
PAID TIME OFF

Section 11.1 Paid Time Off (PTO). Permanent full-time employees will be entitled to paid time off which shall be used for days off also known as vacation, sick and personal time. Eligibility for PTO shall be determined as of the employee's anniversary date. Past practice notwithstanding, PTO is acknowledged to be earned and given at the beginning of each July 1, and is based on the seniority attained in the previous fiscal year, and no portion of said PTO is accrued in one year to be payable in the next. Employees with less than one year of service on July 1 shall receive three (3) hours of PTO if on an 8-hour or 12-hour schedule or fourteen (14) hours if on a 24-hour schedule for each full month of service from their hire date.

Hire Date Prior to 07-01-2016

	Maximum PTO		
Seniority	8hr Workday	12hr Workday	24hr Workday
9 years and over	200 hours	232 hours	384 hours

Hire Date Of 07-01-2016 or After

	Maximum PTO		
Seniority	8hr Workday	12hr Workday	24hr Workday
Over 1 year but less than 5 years	40 hours	40 hours	180 hours
5 Years but less than 10 Year	80 hours	80 hours	210 hours
9 years and over	120 hours	120 hours	240 hours

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Section 11.2 Period for Taking Paid Time Off. Except as provided below, PTO must be taken during the year it is earned and given and no more than 48 hours may be carried over from one year to the next unless they have prior approval from the City Manager. PTO will be granted at such times during the year as are suitable considering both the wishes of the employee and the efficient operation of the City. PTO will be taken in periods of consecutive days. PTO may be split into one or more weeks, providing such scheduling does not interfere with the operations of the employee's department. Employees required to take compulsory military training shall be allowed to take their PTO at the time such training must be taken.

Section 11.3 Scheduling. There will be PTO periods as follows:

A. Summer will consist of seven (7) twenty-eight (28) day cycles (months of April – September of each year); and

B. Winter will consist of six (6) twenty-eight (28) day cycles (months of October – March of each year).

In order to determine employee preferences, employees are required to submit a written application stating their first and second choices for each PTO period and submit the application to the Department Head. Applications for summer PTO must be submitted during the month of February. The City will post the summer PTO list by March 10 of each year. Applications for winter PTO must be submitted during the month of August. The City will post the winter PTO list by September 10th of each year. When authorized by the City, the employee may change the requested PTO period. The Department Head may, when in the Department Head's opinion, it is necessary for the efficient operation of the department, cancel an employee's scheduled PTO and request the employee to submit a request for a new PTO period. Cancelling of PTO shall not be done in an arbitrary or capricious manner. In the event an employee does not apply during the required months (February and August), he may thereafter file such application, but it must be filed no later than thirty (30) days prior to the requested PTO period. Such application shall be approved or denied by the Employer within five (5) regularly scheduled workdays (i.e. Monday through and including Friday, but excluding Holidays) of the receipt of the application. The posted PTO list will take precedence over such application.

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If more requests for a PTO on a date are received than can be granted, preference for PTO will be allocated on the basis of seniority for those who turn in the application during the required month. Those who apply after the required month will be assigned PTO based on a first come, first serve basis.

In the event any employee fails to submit a request for PTO, the Department Head may schedule the employee's PTO only until the employee's PTO bank reaches forty-eight (48) hours.

Non-scheduled PTO requested for unanticipated absence due to sickness, injury, disability or an unexpected personal or family related emergency shall be per established Departmental rules, regulations, policies, and shall not be unreasonably denied.

ARTICLE 12
HOLIDAYS

Section 12.1List of Holidays. Past practice notwithstanding, the following days shall be considered recognized and observed paid holidays:

1. New Year's Day
2. Memorial Day
3. 4th of July
4. Labor Day
5. Veteran's Day
6. Thanksgiving Day
7. Day After Thanksgiving
8. December 24th
9. Christmas Day
10. December 31st
11. Good Friday

Section 12.2 Eligibility and Payment. Past practice notwithstanding, Employees shall only receive holiday pay for holidays worked. Employees shall be paid at a rate of double time and a half (2 ½) of the hourly rate as defined in Section 21.3 for all hours worked on a holiday. Holiday hours will include any hours that are within the time frame of 12:00 am and 11:59 pm on the dates listed above. Holidays shall be offered first to the full-time employee who is regularly scheduled to work that day and then to members by bargaining unit seniority. When an employee chooses to work a holiday, it shall count as one (1) of their regularly scheduled workdays in that twenty-eight

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(28) day work cycle. The hours worked in a work cycle cannot exceed two hundred sixteen (216) hours as a direct result of the holiday without the express consent of the Department Head. Any open regular shift that was on the employee's regular rotation that was vacated to cover the holiday shall be filled by a full-time bargaining unit member first. If no bargaining unit member is available to fill the position, the Department Head may fill with a part-time employee. The Fire Department employee chosen to fill the vacated shift shall be chosen by the department head for the efficient operation of the department.

The Union Steward or his/her designee shall be responsible for maintaining the seniority list within the bargaining unit for eligible members. Members not working shall be offered the holiday on a rotating basis by bargaining unit seniority, and a refusal or acceptance to work will cause the member to go to the bottom of the rotation. The list shall continuously rotate and if all members refuse then a part-time fire fighter shall work the holiday. The union president or his/her designee shall submit the holiday list to the Department Head sixty (60) days prior to the holiday. If the list is incomplete, or not submitted to the Department Head, the shifts shall be filled at his/her discretion.

If an employee calls in sick or refuses to work the holiday, within 48 hours of the beginning of the shift, the Department Head shall fill the holiday as needed for the efficient operation of the department.

The holiday benefit shall not be used to add, cube, and/or pyramid overtime charges to the city.

Nothing shall preclude the Department Head from scheduling more than one full-time firefighter per holiday shift.

ARTICLE 13
SICK LEAVE

Section 13.1 Sick Leave. Past practice notwithstanding, after July 1, 2013, no further sick time will be accrued by any employee subject to this bargaining agreement.

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ARTICLE 14
LONGEVITY PAY

Section 14.1 Longevity Pay. Past practice notwithstanding, effective July 1, 2019, after five (5) years of service longevity shall be paid for Fire Marshall classification at $4,250 for Captain classification at $3,250, on the employee's anniversary date each year ending June 30th. Effective July 1, 2023, after (10) years of full-time service, an additional longevity shall be paid for Fire Marshall classification at $720.00 and for Captain classification at $700.00 on the employee's anniversary date each year ending June 30th.

ARTICLE 15
UNIFORM ALLOWANCE

Section 15.1 Requirement. Employees are required to wear a uniform. As needed, at the Department Head's discretion, uniforms, including duty boots from a City vendor as chosen by the Department Head will be provided by the City. Members are expected to provide reasonable care and maintenance of the supplied uniforms. The employee shall reimburse the City for the employee's negligent, loss, or damage to the uniform.

Section 15.2 City Obligation. The cost of any changes in the uniform, which changes are directed by the City, and which require immediate replacement of the uniform, will be at the expense of the City, without deduction from the employee's uniform allowance.

ARTICLE 16
RETIREMENT

Section 16.1 Pension. Past practice notwithstanding, bargaining unit members under this contract shall receive the Municipal Employees Retirement System (MERS) pension with the following benefits:

A. Effective September 1, 2013 the benefit multiplier will bridge down from 2.5% to 1.7%. Final average compensation (FAC) will be calculated using the frozen FAC-

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3 method. Other pension options include FAC-3, D-2 with an unreduced retirement allowance at age 55 with 25 years of service to the city.

B. MERS wages shall be comprised of the base wage as used to compute the employee's hourly rate and all contributions from the employer and deductions from the employee will be calculated using the base wage.

C. Effective September 1, 2013 employees shall contribute five percent (5.00%) of their base wages toward the cost of their pension plan. These payments will be made by payroll deduction.

D. Employees hired after June 30, 2016 will be enrolled in a MERS pension division with a 1.5% multiplier, 5% employee contribution, 3-year FAC on the base wage, unreduced early retirement of 55/25. This division also includes the D-2 provision.

Section 16.2 Deferred Compensation. The City will offer a deferred compensation program as provided in Section 457 of the Internal Revenue Code to be financed by voluntary salary reduction contributions by the employees electing to participate.

Section 16.3 Badge. Upon retirement, Past practice notwithstanding, the City shall present an employee in good standing with his/her duty badge, and a retiree badge with proper identification.

Section 16.4 Retirement Healthcare. The City will make monthly contributions of $52.00 for individuals and $104.00 for employees with two person or family medical coverage into an agreed upon Healthcare Savings Program; provided such program is individually owned and managed, all account expenses are the responsibility of the employee, funds are accessible after termination of employment with the City, funds will grow tax free, subject to the IRS limitations on qualified medical expenses. All deposits will be immediately vested.

ARTICLE 17
INSURANCE & OTHER BENEFITS

Section 17.1 Healthcare. Past practice notwithstanding, the City will provide health, prescription, dental, and vision insurance for each employee covered under this bargaining agreement as an insurance benefits package. The current health insurance plan, dental plan and

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vision plan are identified in Appendices A, B and C.

Past practice notwithstanding, the City may change the insurance carrier(s), plan(s) or policies at its discretion upon prior notification to the Union, if there is no lapse in coverage and that equivalent benefit levels are maintained.

Past practice notwithstanding, the City will recognize as dependents such definition as noted by the Affordable Care Act and will treat all dependents the same for purposes of expense sharing between the employee and the City.

Section 17.2 Life Insurance. Each full-time employee who qualifies shall receive the life insurance benefits to which he is entitled under the City's present insurance program being 1.25 times the employee's salary plus $5,000 to a maximum of $100,000.

Section 17.3 Unemployment Insurance. The City will provide unemployment insurance for members of this bargaining unit in accordance with the Michigan Employment Security Commission Act or applicable City Ordinance.

Section 17.4 Off-Duty Sickness and Accident Insurance. Past practice notwithstanding, effective July 1, 2013 the City will provide increased coverage for loss of income due to sickness and accident as follows:

Short-term Disability

Sixty (60%) percent of weekly earnings to a maximum of one thousand ($1000) per week, less any amounts received or to which the employee is entitled under the mandatory provision of any "no-fault" motor vehicle plan and/or state compulsory benefit act or law. Benefits begin on the 1st day of injury or the 8th day of sickness. Benefits are payable for thirteen (13) weeks.

Long-term Disability

Sixty (60%) percent of basic monthly earnings not to exceed five thousand ($5,000)

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dollars per month, less any other income benefits. Benefits begin after 13 weeks and would continue until the individual becomes eligible for social security benefits. The City shall continue to pay an employee's medical benefit premium for a maximum of eighteen (18) months.

Exclusions

This section does not apply to compensable sickness or accidents which are provided for under Article 9 of this Agreement.

Section 17.5 Limitations of Insurance Coverage. Eligibility, coverage, and benefits under the above insurance plans are subject to the terms and conditions in the contract between the City and the carrier. Any rebates or refunds on premiums paid by the City shall accrue to the City. The City will continue to have the right to select the carrier, to change carriers, or to become self-insured, provided that there shall be no reduction in benefits. It is further agreed that the only liability assumed by the City under this Article with respect to providing insurance coverage through a third party is to pay the premiums as provided herein. Any claim settlement between the employee and the insurance carrier shall not be subject to the Grievance Procedure.

Section 17.6 Opting Out of Healthcare. Employees who voluntarily opt out of the City's Health and/or Dental Insurance coverage will be eligible for a stipend payable in the second pay period of the month. The stipend shall be computed based upon the following table:

RATE PLAN	*Opting Out of Both Dental and Health Insurance*	*Opting Out of Health Insurance Only*	*Opting Out of Dental Insurance Only*
Single	*$300.00/ Month*	*$275.00 / Month*	*$25.00 / Month*
Two-Person	*$550.00 / Month*	*$505.00 / Month*	*$45.00 / Month*
Family	*$600.00 / Month*	*$545.00 / Month*	*$55.00 / Month*

To be eligible for the stipend, the employee must provide proof of health insurance from another source and sign an insurance waiver provided by the City. The employee may resume coverage

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under the City's insurance subject to the approval of the insurance carrier.

Section 17.7 Flu and Tetanus Shots. The City agrees to provide flu, tetanus, hepatitis, and TB shots or any costs not covered by health insurance including deductibles during the month of October (flu) for all employees who desire such shots.

Section 17. 8 Training Programs. In order to maintain a professional department, the City promotes policies and programs designed to provide training for employees to enable them to better service the community.

Section 17.9 Tuition Reimbursement. For employees, the City will reimburse 100% of the cost of tuition and registration fees for undergraduate degree credits. The City will further reimburse the employee for purchase of textbooks, lab fees and related materials. The Employee must receive a grade of 'C' or better to be eligible for reimbursement and must complete a City reimbursement form and submit the same together with the required documents to the City Manager for approval of reimbursement.

Reimbursement is available only to the employee who wishes to pursue the completion of one (1) Associate degree, Bachelor's degree or certificate or who has been assigned or approved by the City to attend a specialized course of study.

Undergraduate schools and courses must be approved in writing by the City Manager prior to enrollment. Approval will not be unreasonably withheld. Approval shall not be granted for courses from schools or graduate schools not approved by an accrediting agency that is recognized by the U.S. Department of Education and included in their Office of Postsecondary Educations' database. If an employee leaves within (2) years of any reimbursement under this Article for education or training, the money will be repaid to the Employer through a withholding of the final paycheck and a payment plan for any further monies outstanding.

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ARTICLE 18
DISCIPLINARY PROCEDURE, DISCHARGE AND DISCIPLINE

If the employer has reason to reprimand an employee, it shall be done in a manner that will not embarrass the employee nor in front of other employees or the public.

Section 18.1 Cause. No member of this bargaining unit shall be disciplined or discharged except for just cause. Discharge and/or discipline shall be the responsibility of the Department Head or his/her designee.

Section 18.2 Past Infractions. In imposing any discipline on a current charge, the City will not take into account any prior infractions which occurred more than four (4) years previously, unless such prior infractions would have justified suspension of the employee at the time or unless the discipline imposed at the time involved a period of probation extending more than a period of two (2) years.

Section 18.3 Employee Rights. The discharged or disciplined employee will be allowed to discuss the discharge or suspension with the Steward within five (5) working days after the effective date of such action taken and the City will make available an area where he may do so before he is required to leave the property of the City. Upon request, the Department Head will discuss the discharge or discipline with the employee and the Steward.

Section 18.4 Appeal Process. Should the discharged or disciplined employee or the Union consider the discharge or discipline to be improper, a complaint shall be presented in writing, through the Steward, to the Department Head within fifteen (15) regularly scheduled working days after receipt of discharge or discipline. The Department Head will review the discharge or discipline and answer the complaint in writing within fifteen (15) regularly scheduled working days after receiving the complaint. If the decision is not satisfactory to the Union, the question of discharge or discipline may be appealed within fifteen (15) regularly scheduled working days thereafter, to the City Manager, who shall, within fifteen (15) regularly scheduled working days thereafter, grant a hearing to the Union, review the complaint and answer thereto, hear such other testimony, or examine other evidence which is relevant to the discharge or discipline, and within

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thirty (30) working days after the hearing, shall uphold, reverse, or modify the discharge or discipline in writing. Past practice notwithstanding, this step is not optional and if the union fails to acknowledge this step in the process it shall void the grievance.

The issuance of this answer shall begin the time in which the Union must process the grievance to arbitration.

Both the Union and Employer agree that use of a mediator prior to Arbitration is beneficial.

Section 18.5 Arbitration. Past practice notwithstanding, if the Union disagrees with the decision of the City Manager on the question of the discharge or discipline, within thirty days (30) thereafter, the Union may demand arbitration in accordance with Article 20, Section 7 of this Agreement. In reviewing the discharge or discipline, the Arbitrator shall apply the principles set forth in Article 19, Sections 1 and 2, and may make findings of fact and may issue a proposed order reversing or modifying the discharge or discipline only if he finds that the discharge or discipline was not imposed in accordance with such principles.

Section 18.6 Extension of Deadlines. The time limits set forth in this Article may be extended by mutual agreement, in writing, by the City and the Union.

ARTICLE 19
GRIEVANCE PROCEDURE

Every reasonable effort shall be made by the parties involved to arrive at a fair and equitable settlement of every grievance without resorting to the Grievance Procedure. If that is found to be impossible, the matter may be submitted to the Grievance Procedure in accordance with the terms of this Agreement.

Section 19.1 Savings Clause. Nothing in this article shall prevent any individual employee of the Union from exercising the rights granted in Act 336 of the Public Acts of 1947, as amended.

Section 19.2 Definition. For the purpose of this Agreement, a grievance is defined as an alleged

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violation of this Agreement. Grievances involving the discharge or discipline of an employee shall be processed under Article 19 of this Agreement.

Section 19.3 Procedure. The Employer and the Union support and subscribe to an orderly method of adjusting grievances. To this end, the Employer and the Union agree that an employee should first bring his/her problem to the attention of his/her immediate supervisor, with or without his/her steward, who shall attempt to resolve the grievance informally.

The following procedure shall be followed to present a grievance to the City.

A. The employee or the Union shall present the grievance in writing to the Department Head within fifteen (15) regularly scheduled working days of the event, or knowledge of the event, which gave rise to the grievance.

B. A grievance shall be answered in writing by the appropriate Department Head or his/her designee within fifteen (15) regularly scheduled working days after the grievance is presented to the Department Head.

C. If no further action is taken within fifteen (15) days after service of the written answer upon the employee or Steward, the answer will be considered accepted and no further action may be taken upon the grievance.

D. Past practice notwithstanding, if the decision is not satisfactory to the Union, a hearing before the City Manager may be requested within fifteen (15) regularly scheduled working days thereafter, by written notice to the City Manager, who shall, within fifteen (15) regularly scheduled working days thereafter, grant a hearing to the employee, review the grievance and answer thereto, hear other testimony or examine other evidence which is relevant and within thirty (30) regularly scheduled working days after the hearing, shall uphold, reverse, or modify the City's answer to the grievance in writing. This step is not optional and if the union fails to acknowledge this step in the process it shall void the grievance.

Section 19.4 Withdrawal. A grievance may be withdrawn by the employee or the Steward, but if withdrawn, it shall not be reinstated. The notice of grievance withdrawal shall be submitted to

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the Department Head in writing.

Section 19.5 Adherence to Time Limits. Any grievance not submitted in writing within the time periods provided for shall be considered waived or, if not re-submitted after one of the answers provided for, shall be considered resolved by the answer.

Section 19.6 Back Wages. No claim for back wages involved in any grievance shall exceed the amount of wages the employee would have otherwise earned.

Section 19.7 Arbitration. If the matter cannot be resolved by the parties as set forth in Section 19.3 above, the matter may be submitted to arbitration within thirty (30) days thereafter. This time limit may be extended by mutual agreement. The arbitration shall be conducted in accordance with the rules, regulations and procedures of the American Arbitration Association.

The arbitrator may not add to, subtract from, change or amend any terms of this Agreement and shall only concern himself with the interpretation and application of the terms of this Agreement. The decision of the arbitrator, acting within the scope of his/her authority, shall be final and binding upon all parties. The expense of the arbitrator shall be borne equally by the parties to this Agreement.

Section 19.8 Regular Workdays Defined. The following are to be considered regular working days for grievance processing: Monday through and including Friday. Saturday, Sunday and Holidays are not to be considered regular working days for grievance processing.

Section 19.9 Sole Remedy. The sole remedy available to any employee for any alleged breach of this Agreement or any alleged violation of his/her rights hereunder will be pursuant to the Grievance Procedure; provided, that is an employee elects to pursue any legal or statutory remedy, such election will bar any further or subsequent proceedings for relief under the provisions of this Article.

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ARTICLE 20
WAGES

Section 20.1 Wage Scale. Past practice notwithstanding, effective the date of the signing the following salary schedule for base wages shall prevail for 212 hours worked in a 28-day cycle for all shifts:

FIRE CAPTAIN	
7/1/2023	$74,320
7/1/2024	$76,178
7/1/2025	$78,083
7/1/2026	$80,035
FIRE MARSHAL	
7/1/2023	$75,064
7/1/2024	$76,941
7/1/2025	$78,864
7/1/2026	$80,836

FIRE FIGHTER HIRED ON OR AFTER JULY 1, 2023

	BASE YEAR	AFTER 1 YEAR	AFTER 2 YEARS	AFTER 3 YEARS	AFTER 4 YEARS
7/1/2023	$49,608	$50,600	$51,620	$52,667	$60,623
7/1/2024	$50,600	$51,620	$52,667	$53,720	$61,845
7/1/2025	$51,620	$52,667	$53,720	$54,794	$63,082
7/1/2026	$52,667	$53,720	$54,794	$55,890	$64,344

Section 20.2 Meal Stipend. Past practice notwithstanding, there will be no stipends paid to employees under this section of the contract.

Section 20.3 Right of City Manager. With the approval of the City Manager, an employee may start at any step of the applicable salary schedule and will thereafter progress on the applicable

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salary schedule in one (1) year increments.

Section 20.4 Education Bonus. Employees will receive annually on the employee's anniversary date an education bonus(s), not to exceed in the cumulative $1,500 per year, for the following:

Fire Investigator 1 certification shall receive a bonus annually of $500

NFPA plan examiner certification shall receive a bonus annually of $500

Staff and Command certificate of completion shall receive a bonus annually of $500

ARTICLE 21
OVERTIME, HOURS OF WORK AND RESPONSIBILITIES

Section 21.1 Work Periods. All employees covered under this bargaining agreement shall be scheduled to work in twenty-eight (28) day cycles.

Section 21.2 Shift Cycles. Employees will work the work cycles set by the Department Head based on the schedules that were selected by seniority. The cycles will be posted fourteen days (14) days after PTO is scheduled for the summer and winter periods per Article 11, PTO, Section 3. There shall be no bumping of shifts.

In no case shall an employee be allowed or assigned to work more than three (3) consecutive twenty-four (24) hour shifts except under an emergency declaration by the Mayor.

When a vacancy occurs on a shift and no one is assigned to the shift, the shift will be assigned by the Department Head in a manner most beneficial to efficient operations of the department in the following manner:

1. Should no employee volunteer for the shift, the lowest seniority employee with the fewest hours shall be assigned by the Department Head to fill the vacancy.
2. Any employee who is not scheduled to work two hundred-twelve (212) hours in the twenty-eight (28) day cycle may be assigned to fill the vacancy and

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will be paid additional compensation at the regular rate.

Section 21.3 Regular Rate of Pay. "Regular rate" is defined to mean the employee's base wage salary divided by the number of hours worked in a year based on the employees shift schedule for thirteen (13) regular work cycles of twenty-eight (28) days. The total hours worked in a year are 2,756 hours for 24-hour shifts, 2,184 hours for 12-hour shifts and 2,080 hours for 10-hour or 8-hour shifts.

Section 21.4 Overtime. Past practice notwithstanding, overtime will be paid for hours worked in excess of 212 hours in a twenty-eight (28) day cycle for 24-hour shifts, 168 hours in a 28-day cycle for 12-hour shifts and 160 hours in a 28-day cycle for 8- or 10-hour shifts.

Overtime scheduled when the work schedule is originally posted will be considered "scheduled overtime." The overtime rate of pay for scheduled overtime will be one and one-half (1-1/2) times the employee's regular rate of pay.

Unscheduled overtime, including call-back pay, will be paid at the rate of one and one-half (1-1/2) times the employee's regular rate of pay. If an employee is called back or called in for duty by the Department Head or his/her designee at a time he would not normally be on duty, he will be entitled to not less than four (4) hours pay to be paid as follows:

1. At the appropriate overtime rate (time and one-half) for all hours worked.
2. Straight time for the remainder of the four (4) hours
3. Paid time off shall not be considered when computing overtime on a daily basis.

"Call-in" or "call-back" does not include any incident whereby the employee is required to respond to a communication from the department or a representative of the Employer. When this occurs, the employee will be paid time and one-half (1-1/2) for the actual time worked with no minimum. The City agrees to instruct its employees to keep such occurrences to a minimum and only under circumstances wherein contact with the employee cannot wait until the employee next reports to

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work.

Overtime shall be filled by assigning the overtime to the most senior employee, with the least amount of overtime, expressing an interest in the assignment and who is a member of the Walled Lake Professional Fire Fighters Association.

The City will make a good faith effort to equalize overtime on an annual basis. This provision will not apply to court time.

Section 21.5 Court Appearances. The rate of pay for court appearances will be paid based upon a pay rate of two thousand eight (2,080) hours per year. In the event that an employee is ordered by a Court to stand by for purposes of a court appearance and does not actually appear in court on that day, he shall be compensated at time and one-half for two (2) hours.

Section 21.6 Compensatory Time Off. In lieu of pay for overtime set forth above, an employee may request credit for compensatory time off. All requests for compensatory time off credit will be submitted in writing to the City Manager's office for his/her review and approval. Such requests shall be approved or denied by the City within five (5) regularly scheduled workdays (i.e., Monday, through and including, Friday, but excluding holidays) of the receipt of the request. Upon the City Manager's written approval, such compensatory time off shall be computed at one and one-half (1 1/2) hours for each hour worked by the employee on an overtime basis. Compensatory time may be accumulated to a maximum of one hundred twenty (120) hours outstanding at any time. Compensatory time may be taken upon advance approval of the City. Election for compensatory time must be indicated within the pay period it is earned. Compensatory time is subject to Administrative Policies and Regulations, adopted by the City Council and/or the City Manager not inconsistent herewith. Any denial of compensatory time off requests may be reviewed by the City Manager whose decision will be final and not subject to arbitration.

Section 21.7 Work and On-Duty for Call. Members shall work and be on duty for call on the following schedule.

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1. **Monday to Friday:**

   8:01 AM to 9:00 AM — On-duty for call.

   9:00 AM to 5:00 PM — Perform their designated special assignments, general work assignments as designated by the Department Head and general fire runs. During this period one (1) hour may be taken for lunch/break. The Department Head may designate the time of the lunch/break, if he so desires.

   5:00 PM to 8:00 AM — On-duty for call.

During any of the above periods, the Department Head may designate training.

2. **Saturday and Sunday**:

   8:01 AM to 9:00 AM — On-duty for call.

   9:00 AM to 3:00 PM — Perform general and special assignments as designated by the Department Head and general fire runs. During this period one (1) hour may be taken for lunch/break. The Department Head may designate the time of the lunch/break, if he so desires.

   3:00 PM to 8:00 AM — On-duty for call.

During any of the above periods, the Department Head may designate training.

Section 21.8 Additional Responsibilities. Members shall fill the following assignments:

1. Fire Marshall
2. Training Officer
3. Machinery/Equipment Officer
4. Supply Officer

Each employee may be cross trained in their job responsibilities of the other assignments listed in addition to that of his/her respective rank.

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ARTICLE 22
PROMOTIONS

Section 22.1 Requirement. Promotions shall be based upon merit to be ascertained by tests and upon the superior qualifications of the person promoted as shown by their previous service and experience. The City reserves the right to appoint an applicant from outside of the bargaining unit.

Section 22.2 Probationary Period. Past practice notwithstanding, all individuals promoted in the Fire Department shall serve a probationary period from the date of promotion in accordance with Article 5 of this Agreement.

ARTICLE 23
GENERAL CONDITIONS

Section 23.1 Re-Employment Rights. The re-employment rights of employees and probationary employees who are veterans will be limited by applicable laws and regulations.

Section 23.2 Establishment of Job Classifications. When a new job is placed into existence which cannot be properly placed in the existing classification and rate structure, or a new classification is established, or an existing classification is changed or combined with another classification, or job duties or responsibilities are changed, to an extent that materially different skills and responsibilities are required, the Union will be notified in writing.

Section 23.3 Notices. The Employer shall assign a bulletin board which shall be used by the Union for posting the following notices:

A. Notices of Union recreational and social affairs;
B. Notices of Union elections;
C. Notices of Union appointments and results of the Union elections;
D. Notices of Union meetings;
E. Other notices of bona fide Union affairs, which are not political or libelous in nature.

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Section 23.4 Vehicle License Suspension or Revocation. It is agreed that employees may be summarily suspended without pay if such members' right to operate a motor vehicle in the State of Michigan is suspended, revoked, or renewal is denied by the Secretary of State. Past practice notwithstanding any employee whose license is suspended for longer than 15 days shall be suspended without pay for up to six (6) months. Should the employee fail to regain the right to operate a motor vehicle in the State of Michigan at the end of the six (6) month suspension, said employee will be automatically removed from their position and shall be considered immediately terminated from employment with the city.

Section 23.5 Gender References. All references to employees in this Agreement designate both sexes and whenever the male gender is used, it shall be construed to include male and female employees.

Section 23.6 Worker Safety. Under no circumstances will an employee be required or be assigned to engage in any activity involving dangerous conditions of equipment. Employees shall immediately or at the end of their shift, report all defects of equipment, in writing on a form supplied by the Department Head and employees shall not be required to use the equipment until the same has been approved as being safe by the Department Head or the Shift Supervisor.

When the occasion arises where an employee gives a written report on forms supplied by the employer of the equipment being in unsafe operating condition, and receives no consideration from the Employer, he shall take the matter up with representatives of the Union who will take the matter up with the Employer.

An employee not notifying the Department Head or Department Head's designee of the occurrence of damage to any fire apparatus or malfunctioning of the apparatus immediately, or at the end of his/her shift, shall be subject to disciplinary action by the employer.

The City agrees to purchase two (2) complete sets of Personal Protection Equipment and one (1) set of S.C.B.A. Face Piece for each full-time employee.

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Section 23.7 Employee Health Testing. The City may require the employee to submit to physical and mental tests and examinations by the City-appointed doctors when such tests and examinations are considered to be of value to the City in maintaining a capable workforce, employee health and safety, etc., provided, however, that the City will pay for the costs of such tests and examinations.

Section 23.8 Training Cost Reimbursement. In the event the City approves and pays for City-approved (but not City-required) training or course work for bargaining unit employees, the employee shall agree in writing prior to receiving such payment, to reimburse the City for the payments if the employee terminates employment within two (2) years after the date on which the payment was made.

Section 23.9 Assignments.

A. Past practice notwithstanding, the Fire Department may assign on-call or part-time Fire Fighters to work at the discretion of the Department Head considering training and experience of the Fire Fighters. This section does not apply to emergency runs.
B. Employee assignments at parades or other City sponsored events shall be determined by the Department Head.

Section 23.10 Mileage Reimbursement. If the use of an employee's vehicle on City business is approved in advance by the City, the employee will receive mileage reimbursement under applicable City policy.

Section 23.11 Employee Contact Information. It shall be the responsibility of each employee to notify the Department Head of any change of address or telephone number as soon as possible. The employee's address and telephone number as it appears on the City's records shall be conclusive when used in connection with layoffs, recalls, or other notices to the employee.

Section 23.12 Equipment Turn In. All equipment must be turned in to the City at the time of termination from employment. The City may deduct the cost of the equipment not so returned to

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the City from the employee's final paycheck(s).

ARTICLE 24
LAYOFF, RECALL AND TRANSFER

Section 24.1 Layoff. The word "layoff" shall mean a reduction in the working force. Past practice notwithstanding, in all cases of layoff within each classification/rank, the principal of straight seniority by department shall be observed and length of service shall govern. When possible, the Employer will give at least thirty (30) calendar days notice prior to layoff to the employees affected, together with a list of the names of said employees to the Union. If and when an employee is laid off, he will be eligible for unemployment benefits compensation under the Michigan Unemployment Compensation Act or applicable City Ordinance, provided said employee remains eligible and conforms to all requirements under the applicable law. Exceptions to this procedure may be made by written agreement between the City and the Union. All City provided insurance coverage shall terminate at the end of the calendar month in which the layoff occurs.

Section 24.2 Recall. Employees will be recalled in the reverse order of the layoff, providing the employee can perform the available work. Notice of recall shall be sent to the employee at the last known address by registered or certified mail. Past practice notwithstanding, if an employee fails to contact the Department Head within ten (10) calendar days from the date of mailing of the notice of recall, he shall be considered to have voluntarily left the employment of the City and shall be automatically removed from their position and shall be considered immediately terminated from employment with the City.

Section 24.3 Transfer. If and when an employee is permanently transferred, the Union shall be notified of said transfer by the Department Head.

ARTICLE 25
LEAVES OF ABSENCE

Section 25.1 Temporary Discretionary Leave. The City Manager, in his/her sole discretion,

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may grant a temporary written leave of absence to employees for periods up to thirty (30) calendar days. A written request for such leave must be submitted to the City Manager and approved by him in writing, prior to the start of the leave. Such leave may be extended upon written approval by the City Manager.

Section 25.2 Military Leave. An employee on military leave for service in the Armed Forces of the United States shall be reinstated upon completion of such service in accordance with the requirement of the applicable laws of the United States.

Section 25.3 Illness or Disability Leave. An employee who is unable to perform his/her assigned duties because of personal illness or disability and who has exhausted all sick leaves available shall, at the written recommendation of a physician certifying the employee's inability to perform his/her duties, be granted a health leave of absence without pay or fringe benefits for up to six (6) months. Extensions may be granted by the City Manager. A written request for such a leave must be submitted to the City Manager prior to the start of the leave. At least thirty (30) days prior to the expiration of the leave, the employee shall notify the City in writing of his/her intent to return to work accompanied by a written statement from a physician selected by the Employer, certifying the physical and mental fitness of the employee to fulfill his/her duties. Upon expiration of the leave, the employee will be returned to his/her former classification, provided his/her seniority so entitles him/her and he/she can perform the available work. Upon return, the employee will be placed on the same position of the current salary schedule that was held at the start of the leave.

Section 25.4 Compensation and Benefits. All leaves are granted without pay or fringe benefits, provided that, if permitted by the applicable insurance carrier, the employee will be allowed to pay the insurance premiums by prepaying the premium in advance by depositing the amount each month with the City Treasurer or Finance Director. Seniority shall accumulate for up to thirty (30) calendar days. On leaves of thirty (30) days or less, the City will pay all insurance premiums. Employees on leave must report for work not later than the first working day following the expiration of their leave. An employee who seeks and/or obtains employment while on leave of absence will be automatically terminated from the City effective the date the leave of absence

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started.

Section 25.5 Written Requirement. All leaves shall be in writing signed by the City Manager and the employee receiving same.

Section 25.6 Family Medical Leave Act. Any paid or unpaid leave addressed in this contract which qualifies as a leave under the Family Medical Leave Act (FMLA) shall run concurrently with the leave to which the employee is eligible under the FMLA. Under the FMLA, an eligible employee may use twelve (12) work weeks of FMLA leave in a twelve (12) month period. This twelve (12) month period is measured back from the date the employee uses FMLA leave. In administering the FMLA, the City may take any actions consistent with that statute and the City's leave rules and policies.

ARTICLE 26
SCOPE OF AGREEMENT

Section 26.1 This Agreement represents the entire agreement between the Union and the City of Walled Lake and is not subject to any prior agreements or understanding between the parties and may be amended only in writing signed by both of the parties hereto. In the event of any of the provisions in this Agreement are found to be contrary to the provisions of any applicable provisions of law, such applicable provisions of law shall control, and the remaining provisions of this Agreement shall not be affected thereby. The four corners of this Agreement encompass the entire agreement and understanding of the Parties.

ARTICLE 27
NO-STRIKE NO-LOCKOUT

Section 27.1 Under no conditions will the Union cause or authorize or permit its members to cause, nor will any member of the Bargaining Unit take part in any strike, sit-down, stay-in, slowdown, or any violation of any State Law. In the event of a work stoppage or other curtailment, the Union shall immediately instruct the involved employee in writing that their conduct is in violation of the Agreement, and that all such persons shall immediately cease the offending conduct. Under no circumstances, will the Employer engage in a lockout of employees.

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ARTICLE 28
MAINTENANCE OF CONDITIONS

Section 28.1 The City shall make no changes that are contrary to the provisions of this Agreement in salaries, hours, or conditions of employment. This Agreement shall supersede any rules and regulations governing the appropriate Department which conflict with the provisions of this Agreement.

ARTICLE 29
CITY DEPARTMENT RULES

Section 29.1 The City shall continue to have the right to establish, adopt, change, amend and enforce reasonable City Rules and/or Departmental Rules and Regulations not in conflict with the terms of this Agreement, governing discipline, health and safety duties, rules of conduct and work rules, including, but not limited to, a fair and reasonable drug testing policy applicable to all persons covered by this Agreement, with such tests based upon reasonable suspicion. Such a drug testing policy will be consistent with current standards as established by the Michigan Commission on Law Enforcement Standards.

ARTICLE 30
DURATION AND TERMINATION

Section 30.1 This Agreement shall remain in full force and effect until 11:59 p.m., June 30, 2027. This Agreement shall remain in full force and be effective during the period of negotiations and until notice of termination of this Agreement is provided to the other party in the manner set forth in the following paragraph.

In the event that either party desires to terminate this Agreement, written notice must be given to the other party no less than ten (10) days prior to the desired termination date which shall not be before the termination date set forth in the preceding paragraph.

It is agreed and understood that the provisions contained herein shall remain in full force and effect so long as they are not in violation of applicable statutes and ordinances and remain within the

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jurisdiction of the City of Walled Lake.

ACCEPTED BY:

WALLED LAKE PROFESSIONAL
FIRE FIGHTERS ASSOCIATION

Karl Brown, Union Steward

Dated: 08/23/2023

James Steffes, MAFF Representative

Dated: 8/23/23

ACCEPTED BY:

CITY OF WALLED LAKE

L. Dennis Whitt, City Manager

Dated: AUG 23 2023

Miranda Gross, Human Resources Director

Dated: 8|23|23

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Current Health, Vision and Dental benefits attached on final draft

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Welcome

City of Walled Lake offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

In this Issue

Terms of Use

The following Terms of Use Agreement ("TOUA") describes the terms and conditions applicable to your access and use of the Employee Benefits Enrollment Guide ("Guide"). By using this guide, you are accepting and agreeing to the TOUA. If you do not agree to the TOUA, do not use this guide. We reserve the right to change the TOUA at any time, without notice to you. Continued use of the guide will constitute acceptance of such changes. This guide provides an overview and a brief description of the City of Walled Lake Health and Welfare Plan options available to you and your family members. Please review this information carefully. This guide is provided for informational use only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet Certificate, and Group Policy) to determine governing contractual provisions including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. If any conflict arises between this summary and any plan provisions, the terms of the actual summary plan description and plan documents will prevail in all cases. Benefits are subject to modification at any time. Nothing within this guide, nor the proposals or any other materials it illustrates, should be deemed a contract for coverage or a solicitation of an application for coverage. You may not be eligible for all the insurance products or services described in this guide even if you received this booklet. This guide does not constitute an offer of insurance and is subject to the approval of the respective insurance providers. No contract for the provision of a policy of insurance is formed by use of this guide.

Rating Guidelines

The approved rates submitted by the insurance carrier(s) have been used in our calculation. While every attempt has been made to provide you with an accurate cost for the premium based on those rates, the rates quoted in this guide may be subject to change based on final enrollment and/or final underwriting requirements. We do not make any warranties or representations regarding the quotes, fees, terms, rates, coverage or services offered or made available by the insurance carrier(s). We do not guarantee that quotes, fees, terms, rates, coverage or services offered by the insurance carrier(s) are the best available. Rates have not been adjusted for Federal or State COBRA enrollees. Please consult with City of Walled Lake Benefits Administrator for actual rates and benefits available to you. The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. Dependent Children may become ineligible for coverage on their 26th birthday; effective date of change may vary by carrier.

Waiver Provisions

Employee may elect to "Waive" the benefits offered by City of Walled Lake if you have access to coverage through a Spouse, Domestic Partner or another plan. Any employee who declines participation in the benefit plans offered by City of Walled Lake must complete and submit the Enrollment/Waiver form provided by City of Walled Lake. **Note:** You may enroll at a future date should you experience a "Qualifying Event" within 30-days of that event, documentation will be required. See Human Resources should this occur.

Qualified Event change in status include Marriage, Divorce, Legal Separation, Birth or Adoption of a Child, Change in Child's dependent status, Judgement or Decree of Court order (Qualified Child Medical Support Order), Death of a Spouse or Child, Change in Residence due to employment transfer for you or your spouse, Commencement or Termination of Adoption proceedings or changes in your Spouse's employment status.

Who is Eligible?

If you are an employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this Benefits Guide. You are eligible for benefits first of the month following date of hire.

The family members listed below are eligible for Medical, Dental & Vision insurance coverage:

- Your Spouse or Domestic Partner
- Your Child(ren) – biological, step or adopted through the end of the year in which they turn age 26

Coverage Period

April 1, 2023 – March 31, 2024

Coverage Terminates

At the end of the month that you are no longer eligible for company benefits. This includes but not limited to transitioning from full-time to part-time, no longer employed, secure coverage through your spouse or partner, etc.

How do I Enroll/Waive offered benefits?

First step is to review your current benefit elections. Next, verify your personal information is correct and make any changes, if necessary. Finally, make your selections from the 2023-2024 benefit plans offered in this Benefits Guide by completing the Enrollment/Waiver form provided by City of Walled Lake.

MEADOWBROOK INSURANCE AGENCY
MEMBER OF AMERITRUST GROUP

Glossary of Health Coverage and Medical Terms

Deductible	An amount you pay during the plan year for covered services before your plan begins to pay
Coinsurance	Your share of the cost of a covered health care service – example: 80/20 Plan, you pay 20% and the plan pays 80%
Maximum Out-Of-Pocket Cost	This is also referred to as TROOP – True Out of Pocket. This is the maximum you would pay for all services under the plan during the plan year
Copayment	A fixed amount you pay for covered health care services – example: $15.00 Office Visit or $150.00 Emergency Room Visit
In-Network	Means the Preferred Provider the Insurance Carrier has a contract with
Non-Network	Means the Provider does not have a contract with the Carrier - Balance Billing may apply plus HMO Insurance such as Blue Care Network do not cover Non-Network Providers or Services
Balance Billing	When a Provider bills you for the balance that your Insurance does not cover. This is the amount between the actual billed amount and the allowed amount set by the Insurance Carrier. Non-Network services is an example of Balance Billing
Excluded Services	Plan does not cover these services under any circumstances
Formulary RX	A list of drugs your plan covers
Coordination of Benefits	When a plan participant is entitled to coverage under more than one plan/policy. Example of this would be Husband & Wife covering child(ren) or Employers Insurance & Medicare. Husband & Wife; the Birthday Rule would apply for Dependents covered under both policies, whoever's Birthday is closest to January, they would be the Primary Insurance for Dependents with other Insurance being Secondary. For Employers & Medicare, Employers Insurance would be the Primary Insurance and Medicare is the Secondary Insurance.
Medically Necessary	Services or supplies needed to prevent, diagnose or treat and illness or injury that meet the accepted standards of medicine. Prior Authorization for the Insurance Carrier may be required
Prior Authorization	Also known as Preauthorization – A decision by your Health Insurance or plan that health care service or treatment plan is medically necessary, no guarantee Insurance/Plan will approve or pay for services
Primary Care Physician (PCP)	A physician who provides and coordinates a range of health care services for you, typically required with an HMO plan
Provider	A Physician or Facility that provides health care services such as a PCP, Hospital, Skilled Nursing Facility etc.
Specialist Provider	Physician or Facility that focuses on a specific area of medicine
Usual, Customary and Reasonable (UCR)	The amount paid for a service in a geographic area based on what providers in the area usually charge for the same or similar services

HealthEquity | HSA

Health Savings Account

An HSA lets you put money away for future healthcare costs while saving on taxes. How? HSAs are never taxed at a federal income tax level when used for qualified medical expenses. Contributions can come straight out of your paycheck, and your HSA can grow tax-free too.

- ☑ No 'use-it-or-lose-it,' keep your HSA forever
- ☑ Create a healthcare emergency safety net
- ☑ Invest[1] your HSA tax-free, like a 401(k)

Annual tax saving potential[2]

$1,550
Family plan

$770
Individual plan

2023 IRS Contribution Limits	
$7,750 Family plan	**$3,850** Individual plan
Members 55+ can contribute an extra $1,000	

Common qualified medical expenses:

- Pain relievers
- Doctor visits
- Dental cleaning
- Sleep aids
- Eyeglasses/contacts
- Cold/cough medicine
- Chiropractic care
- Insulin testing supplies

See how much you can save

HealthEquity.com/Learn/HSA

[1]Investments made available to HSA members are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. | [2]Estimated savings are based on an assumed combined federal and state income tax rate of 20%. Actual savings will depend on your taxable income and tax status. | HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

BCN HSA℠ HMO Gold $2,000 High Deductible Health Plan for Medical and Prescription Drug Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

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

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

Member's Responsibility: Deductible, Copays, Coinsurance and Out of Pocket Maximums

Note: The **Deductible** will apply to all services except preventive services

Deductible **Note:** deductible is combined for both medical and prescription drug coverage. The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract	$2,000 for a one-person contract, $4,000 for a family contract (2 or more members) each calendar year (No 4th quarter carryover)
Fixed Dollar Copay **Note:** Copay amounts apply once the deductible has been met	None
Coinsurance **Note:** Coinsurance amounts apply once the deductible has been met	0% and 50% for select services as noted below
Out of Pocket Maximum – total amount paid toward medical and pharmacy services including deductible, copays and coinsurance cost-sharing amounts	$4,000 for a one-person contract, $8,000 for a family contract (2 or more members) each calendar year

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Routine Maternity Prenatal and Postnatal Care	Covered – 100%

Physician Office Services

PCP Office Visits Note: Applicable cost sharing applies when other services are received in the office	Covered – 100% after deductible
Medical Online Visits - when received by a BCN participating provider or BCN designated online vendor	Covered – 100% after deductible
Consulting Specialist Care – when referred	Covered – 100% after deductible

Emergency Medical Care

Hospital Emergency Room	Covered – 100% after deductible
Urgent Care Center	Covered – 100% after deductible
Retail Health Clinic	Covered – 100% after deductible
Ambulance Services – medically necessary	Covered – 100% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100% after deductible
Diagnostic Tests and X-rays	Covered – 100% after deductible
Radiation Therapy	Covered – 100% after deductible

Maternity Services Provided by a Physician

Routine Prenatal and Postnatal Care visits	Covered - 100%
Delivery and Nursery Care	Covered – 100% after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 100% after deductible; unlimited days
Outpatient Surgery – see member certificate for specific surgical coinsurance	Covered – 100% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible
Home Health Care	Covered – 100% after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – Male - 50% after deductible
Elective Abortion (One procedure per two-year period of membership)	Not Covered
Human Organ Transplants (subject to medical criteria)	Covered – 100% after deductible
Reduction Mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)

Inpatient Mental Health Care and Residential Substance Use Disorder	Covered – 100% after deductible
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	Covered – 100% after deductible
Outpatient Substance Use Disorder	Covered – 100% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCN approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered – 100% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder Unlimited visits for physical, speech and occupational therapy with autism spectrum disorder diagnosis	Covered – 100% after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visits and preventive benefit

Other Services

Allergy Testing and Therapy	Covered – 100% after deductible
Allergy office visits	Covered – 100% after deductible
Allergy Injections	Covered – 100% after deductible
Chiropractic Spinal Manipulation – when referred	Covered – 100% after deductible; up to 30 visits per calendar year
Rehabilitative Services – subject to meaningful improvement within 90 days • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – 100% after deductible
Habilitative Services • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – 100% after deductible
Outpatient Cardiac and Pulmonary Rehabilitation	Covered – 100% after deductible; limited to a benefit maximum of 30 visits per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible
Durable Medical Equipment	Covered – 50% after deductible
Prosthetic and Orthotics Appliances	Covered – 50% after deductible
Diabetic Supplies **Note**: Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	Covered – 100% after deductible
Pediatric Vision • Eye Exam – Limited to once per calendar year through the last day of the year in which an individual turns age 19 • Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which an individual turns age 19	Covered – 100%

Prescription Drugs

Preferred Generic Tier	Covered – $15 copay after deductible
Non-Preferred Generic Tier	Covered – $40 copay after deductible
Preferred Brand Tier	Covered – $80 Copayment after deductible
Non-Preferred Brand Tier	Covered – $100 Copayment after deductible
Preferred Specialty Tier	Covered – 20% Coinsurance of the BCN Approved Amount after deductible (Maximum Copayment $200) – Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Non-Preferred Specialty Tier	Covered – 20% Coinsurance of the BCN Approved Amount after Deductible (Maximum Copayment $300) – Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Drugs for sexual dysfunction, weight loss, cough & cold	Not Covered
Diabetic Supplies	Select diabetic supplies and equipment are covered – applicable cost sharing will apply. Cost-sharing may not apply to certain preferred glucometers as defined on the drug list.
Contraceptives	Covered – Preferred Generic Tier – 100% , Non-Preferred Generic Tier – $40 copay after deductible, Preferred Brand Tier - $80 copay after deductible, Non-Preferred Brand Tier - $100 copay after deductible
Preventive Drugs	Covered – 100%
90 Day Retail: 84-90 day supply	Covered – Three times applicable copay minus $10 **Note:** If you have a Coinsurance, your Coinsurance will be based on the BCN Approved Amount for the quantity dispensed. If your Coinsurance includes a minimum and maximum Copayment, the minimum and maximum Copayment amounts are three times the 30-day supply minus $10.
Out-of-Pocket Maximum	Applies to deductibles, copays and coinsurance amounts for all covered medical and prescription drug services. See medical section above for out-of-pocket maximum limits. **Note:** Your benefit requires you to take advantage of BCN-approved coupon program for select medications. When a manufacturer coupon is used through the BCN high cost drug discount program, the amount paid after the discount applies toward the out- of-pocket maximum.

HDHPSM, 2000HD, 4KOMHD, PVSN, P1548D, 90D3X, RXVAR

Optional Rider:

- VACR50 – Elective Abortion 50% Coinsurance Rider

FYI for members

Generic drugs **save you money**

The unadvertised brand

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. That's because they're held to the same federal standards for safety and performance as the brand names.

Because they're not branded, generics can sell for 30 percent to 80 percent less than their brand-name equivalents.

Who makes generics?

Drugs are marketed first by their brand name, which is protected by patent. Until the patent expires, no other companies can produce the generic equivalent. When the drug patent expires, the drug can be manufactured by other companies at a considerable cost savings to the consumer.

The cost of advertising

Drug companies spend billions targeting consumers. Their ads for prescription drugs can increase your awareness of treatment options, which is good. But they may also create an artificial demand for a drug. As a result, you may often spend more money on an advertised prescription drug. It's one reason why generics can save you as much as 80 percent of the cost of brand-name medications.

Generics are endorsed

The U.S. Food and Drug Administration approves generics as safe and effective and enforces generic drug standards. The American Medical Association, the largest organization of medical doctors, endorses generic drugs as acceptable for the American public. Most hospitals routinely use generic drugs for patient treatment.

To learn more about generic drugs and see how much money you can save by switching to a generic, visit **theunadvertisedbrand.com**.

We encourage the use of generics

One way Blue Care Network works to keep costs down while maintaining high-quality care is to promote the use of generic drugs. Since the major difference between brand-name and generic drugs is price, your prescription will automatically be filled with the generic equivalent when medically appropriate.

Questions?

Call the Customer Service number on the back of your member ID card (TTY: 711).

The information included on this document does not apply to Medicare members.

Blue Care Network of Michigan

Confidence comes with every card.®

Blue Care Network of Michigan

What to expect with your HMO

HMO

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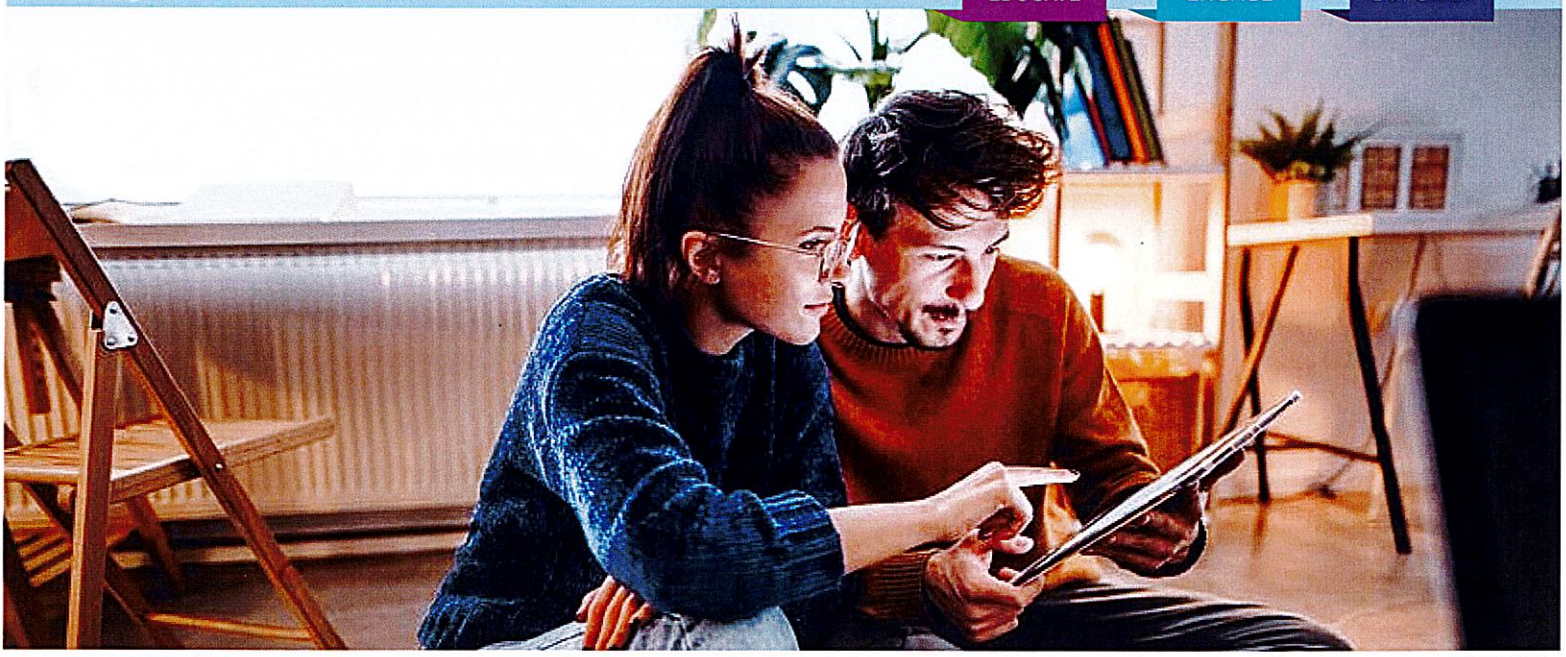


How an HMO works

Whether you're switching from a PPO plan or have been a Blue Care Network member for years, it's important to know how your HMO plan works so you can better manage your health care.

As an HMO, Blue Care Network contracts with physicians, hospitals and other medical professionals to provide a variety of health care services. Your coverage starts with preventive services that can keep minor problems from turning serious and includes special programs to help you reach your health and wellness goals. Coverage also includes the benefits you need when you're sick or injured, ranging from office visits and lab tests to hospitalization.

It all starts with your doctor

As an HMO member, you're required to select a primary care provider who will be your partner in health care.

1. Select primary care provider
2. Make sure the doctor you select is in your plan's network
3. Make an appointment

Sometimes, you'll need a routine checkup or an immunization. Other times, you might need treatment when you're sick. And, in some cases, you might have a more serious injury or illness and need to see a specialist.

No matter what your need, your starting point is your primary care provider. He or she is responsible for managing all the care you receive, from providing preventive health services to treating your illness to coordinating your care with specialists.

There are a few exceptions to the rule:

- Women can see any obstetrician/gynecologist, or OB-GYN, in their plan's network for routine services such as Pap tests, annual well-woman visits and obstetrical care without a referral from their primary care provider.
- If you have an accidental injury or medical emergency, we'll cover treatment no matter where you go.
- You don't need a referral for behavioral health services, but you must be seen by a provider in your plan's network.

Know your plan's network

BCN plans are built around a network, a group of providers (doctors, hospitals and other types of health care providers) that's contracted with us to provide health care services. Knowing your plan's network and how it works is important.

Check with your employer to see what BCN plan options are available to you.

We have different HMO networks throughout the state. Some are broad and include doctors and hospitals in almost every county in Michigan. Others are small and based in a certain geographic area.

Whichever plan you have, you need to make sure the doctor you've selected is part of your plan's network. Your plan won't cover care outside the network, except in an emergency.

Once you're enrolled, you'll receive information about your coverage and how your health plan works.

When you become a Blue Care Network member, you'll be able to create an account at bcbsm.com and select a primary care provider who participates in your plan's network.

Selecting doctors

You can select one primary care provider for everyone in your family, or you can select a different doctor for each person. For example, you may want the young child in your family cared for by a pediatrician, while other family members go to an internist.

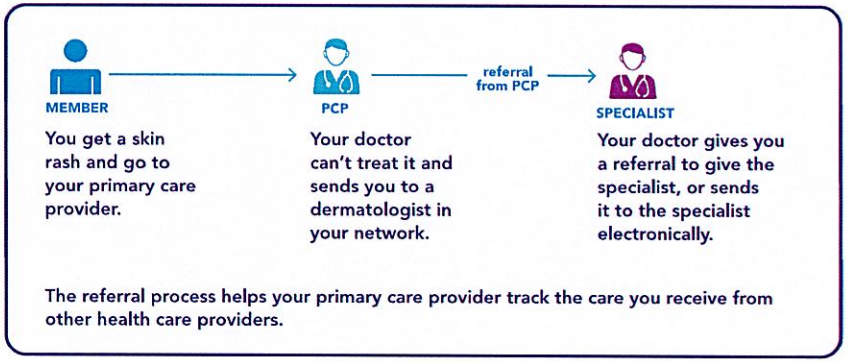
We make it easy for you to find a primary care provider who's in your plan's network. Once you're enrolled in a BCN plan, log in to your account at **bcbsm.com** to find or change your primary care provider.

What are referrals and authorizations?

As an HMO member, your primary care provider is providing or managing all your care.

If your primary care provider can't treat you, he or she may need to refer you to a specialist. **If the service requires a referral and your primary care provider or OB-GYN doesn't refer you, you're responsible for the charges.**

Example:



Getting a referral doesn't guarantee your plan will pay for everything. Certain medical services and services from specialists may also require prior approval by BCN to be covered.

At your service

Our knowledgeable Customer Service representatives are available by phone from 8 a.m. to 5:30 p.m. Monday through Friday. You'll find the number on the back of your BCN ID card.

An automated telephone response system is also available 24/7 to answer many of your questions. If our automated system doesn't give you the answer you need, leave us a message. We'll return your call within two business days.

We speak your language

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

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

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

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

ܐܢ ܐܢܬܘܢ، ܝܢ ܚܕ ܦܪܨܘܦܐ ܕܡܥܕܪܝܬܘܢ، ܣܢܝܩ ܠܗܘܢ ܗܝܪܬܐ، ܐܝܬ ܠܗܘܢ ܐܘܠܘܬܐ ܕܫܩܠܬܐ ܕܗܝܪܬܐ ܘܡܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܕܠܐ ܦܠܚܐ. ܠܡܡܠܠܬܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܚܬܒܐ ܕܐܝܠܗ ܥܠ ܒܣܪܐ ܕܟܪܛܝܣܘܟܘܢ ܝܢ 877-469-2583 TTY:711 ܐܢ ܗܘܢ ܠܝܬܘܢ ܗܕܡܐ.

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

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

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

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

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

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

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

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

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

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

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

Important disclosure

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

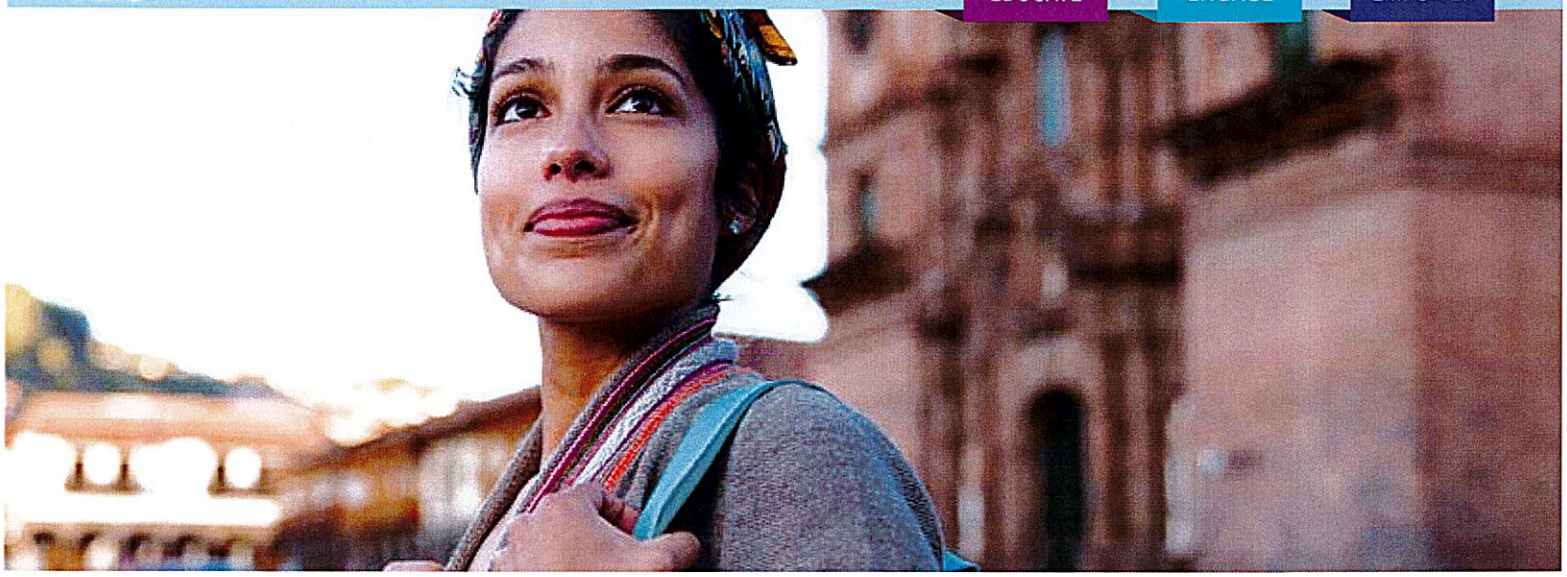
You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of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

Blue Care Network of Michigan

Care when you travel

HMO

EDUCATE ENGAGE EMPOWER



Coverage that travels

When you're a Blue Care Network member, you're always covered for emergency care — in Michigan, across the country and around the world. Just show your BCN member ID card. Because some BCN plans pay only urgent and emergency services outside Michigan, check your coverage before receiving care. Refer to your *Certificate of Coverage* and related riders once you enroll in your plan. Or call Customer Service at the number on the back of your BCN member ID card.

BlueCard® nationwide access

If you have a suitcase logo on your BCN member ID card, you're connected to BlueCard® Traditional doctors and hospitals when you travel outside Michigan but within the United States. BlueCard, a program through the Blue Cross and Blue Shield Association, gives you seamless national access to out-of-state BlueCard Traditional doctors and hospitals.

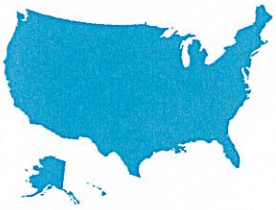
Other than the out-of-pocket expenses that your plan may require (deductible, copayments and coinsurance), you shouldn't have any up-front health care expenses if you use a BlueCard Traditional provider for covered services.

Refer to your *Certificate of Coverage* and riders to see what's covered when you travel or call Customer Service for details.

To locate a BlueCard Traditional provider

- Use your online member account at **bcbsm.com**.
- Use our mobile app.
- Visit **bcbsm.com/find-a-doctor**, and select your BCN plan.
- Call Customer Service using the number on the back of your BCN member ID card.
- Call BlueCard at **1-800-810-BLUE (2583)**.

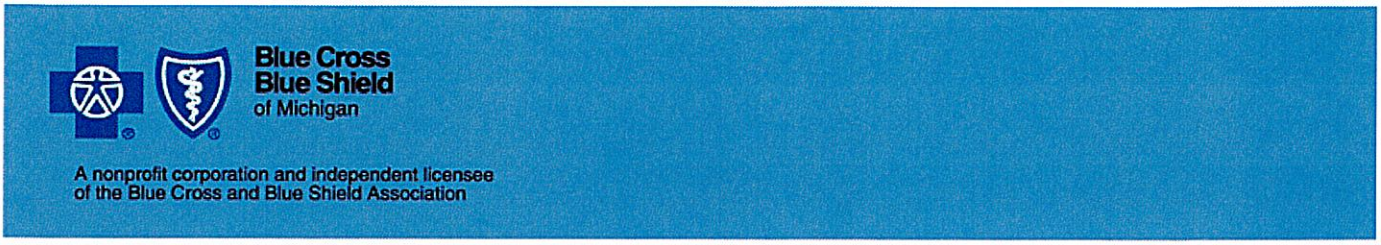
See the table below for how to get the care you need when you're on the go. Talk with your primary care provider before traveling to address any health concerns.

If you're traveling	And you need	Here's what you do
In Michigan 	EMERGENCY CARE (The symptoms are severe enough that someone with average health knowledge believes that immediate medical attention is needed.)	Call **911** or go to the nearest emergency room.
	URGENT CARE (The condition requires a medical evaluation within 48 hours.)	Go to the nearest urgent care center. To locate an urgent care center, **visit bcbsm.com/find-a-doctor** and select your BCN plan; use your online member account or our mobile app; call Customer Service using the number on the back of your BCN member ID card.
	NONURGENT CARE	Call your primary care provider to coordinate services that don't require immediate attention.
In the United States but outside Michigan 	EMERGENCY CARE	Call 911 or go to the nearest emergency room.
	URGENT CARE	Go to the nearest urgent care center. To locate an urgent care center, visit **bcbsm.com/find-a-doctor** and select your BCN plan; use your online member account or our mobile app; call Customer Service or call BlueCard at **1-800-810-BLUE (2583)**.
	ROUTINE CARE	Call Customer Service for details about your health benefits and required authorizations. To locate a nearby BlueCard Traditional physician: Visit **bcbsm.com/find-a-doctor** and select your BCN plan; use your online member account or our mobile app; call Customer Service or call BlueCard at **1-800-810-BLUE (2583)**.
	OTHER SERVICES (Such as elective surgeries, hospitalizations, mental health or substance use disorder services)	
Outside the United States	EMERGENCY CARE	Go to nearest emergency room. (You may be required to pay for services and then seek reimbursement.) Get an itemized bill and medical records to speed reimbursement.

The information provided here is for members with the BlueCard benefit who are traveling or temporarily located outside Michigan. Please note, different guidelines apply to Blue Elect Plus℠ POS and Blue Elect Plus HSA℠ POS members.

Pharmacy coverage when you travel

If your plan includes pharmacy coverage, you'll be able to fill prescriptions when you travel. Your BCN member ID card is accepted at the thousands of pharmacies nationwide that participate with Blue Cross plans, including most major chains.



Simply Blue℠ HSA PPO Gold $2000 0% with Rx Drug
Simply Blue PPO HSA℠ SG with Rx
Benefits-at-a-glance
Effective for groups on their plan year

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

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

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

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

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.

Benefits	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.	$2,000 for a one-person contract $4,000 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**	$4,000 for a one-person contract $8,000 for a family contract (two 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. Deductibles may increase annually. 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.	• 50% of approved amount for bariatric surgery	• 20% of approved amount for most other covered services • 50% of approved amount for bariatric surgery
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$4,500 for a one-person contract $9,000 for a family contract (two or more members) each calendar year	$9,000 for a one-person contract $18,000 for a family contract (two or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), two 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)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Benefits	In-network	Out-of-network
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	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	
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, if applicable.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered.	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-network	Out-of-network
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% 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)	80% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% 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	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Note: Nonemergency services must be rendered in a **participating** hospital.		
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% 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	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care	100% after in-network deductible	100% 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	100% after in-network deductible	100% 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	100% after in-network deductible	100% 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	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Elective abortions	Not covered	Not covered
Bariatric surgery	50% after in-network deductible	50% after out-of-network deductible
	Limited to a **lifetime** maximum of one bariatric procedure per member	

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% 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)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential treatment facility • treatment **must** be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	100% after in-network deductible	80% after out-of-network deductible
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

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.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-network	Out-of-network
Rehabilitative care: • Outpatient physical and occupational therapy	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
• Chiropractic and osteopathic manipulation	100% after in-network deductible	80% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy.**	
Outpatient speech therapy - when provided for rehabilitative care	100% after in-network deductible	80% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	
Habilitative care: Outpatient physical and occupational therapy (excludes chiropractic and osteopathic manipulation)	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical and occupational therapy**	
Outpatient speech therapy - when provided for habilitative care	100% after in-network deductible	80% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	
Durable medical equipment **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **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% after in-network deductible	80% after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	100% after in-network deductible	80% after out-of-network deductible
Private duty nursing care	Not covered	Not covered

Blue Cross Blue Shield of Michigan

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

Simply Blue℠ HSA PPO Gold $2000 0% with Rx Drug
Prescription Drug Coverage
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Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Pharmacy, 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. AllianceRx Walgreens Pharmacy will handle mail order prescriptions only for specialty drugs. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. ***If you go to a non-AllianceRx Walgreens Pharmacy, you may be responsible for 100% of the cost of the specialty drug.*** Other mail order prescription medications can continue to be sent to the OptumRx home delivery pharmacy. (OptumRx 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 AllianceRx Walgreens 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 to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

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

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible 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 copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The 20% member liability for covered drugs obtained from an out-of-network pharmacy will not contribute to your annual out-of-pocket maximum.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Generic drugs	1 to 30-day period	After deductible, you pay $20 copay	After deductible, you pay $20 copay	After deductible, you pay $20 copay	After deductible, you pay $20 copay plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay $40 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay $50 copay	No coverage	No coverage
	84 to 90-day period	After deductible, you pay $50 copay	After deductible, you pay $50 copay	No coverage	No coverage

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Preferred brand-name drugs	1 to 30-day period	After deductible, you pay $60 copay	After deductible, you pay $60 copay	After deductible, you pay $60 copay	After deductible, you pay $60 copay plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay $120 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay $170 copay	No coverage	No coverage
	84 to 90-day period	After deductible, you pay $170 copay	After deductible, you pay $170 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	After deductible, you pay $150 copay	After deductible, you pay $150 copay	After deductible, you pay $150 copay	After deductible, you pay $150 copay plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay $300 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay $440 copay	No coverage	No coverage
	84 to 90-day period	After deductible, you pay $440 copay	After deductible, you pay $440 copay	No coverage	No coverage
Generic and preferred brand-name specialty drugs	1 to 30-day period	After deductible, you pay 20% of the approved amount, but no more than $300	After deductible, you pay 20% of the approved amount, but no more than $300	After deductible, you pay 20% of the approved amount, but no more than $300	After deductible, you pay 20% of the approved amount, but no more than $300 plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Nonpreferred brand-name specialty drugs	1 to 30-day period	After deductible, you pay 25% of approved amount, but no more than $500	After deductible, you pay 25% of approved amount, but no more than $500	After deductible, you pay 25% of approved amount, but no more than $500	After deductible, you pay 25% of the approved amount, but no more than $500 plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

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

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA.	100% of approved amount	No coverage	100% of approved amount	80% of approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	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 prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/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 copay/coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug plus an additional 20% prescription drug out-of-network penalty
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

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

Features of your prescription drug plan

BCBSM Custom Select Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Generic drug tier** - This tier includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Preferred brand-name drug tier** - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive then generic and members pay more for them • **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs. • **Generic and preferred specialty drug tier** - This tier includes generic and preferred brand-name specialty drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective than nonpreferred specialty drugs. • **Nonpreferred specialty drug tier** - This tier includes nonpreferred brand-name, specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are cost-effective generic or preferred drugs available.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) 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. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

Blue Cross Blue Shield of Michigan

Prescription drug coverage through Blue Cross

PPO

EDUCATE ENGAGE EMPOWER

Convenience and value built into every plan

A Blue Cross Blue Shield of Michigan prescription drug plan offers convenience first. You'll have access to more than 2,300 pharmacies in Michigan and 65,000 pharmacies nationwide, including most major chains.

Your Blue Cross pharmacy plan will give you:

- Access to your medication through programs that help promote safety and lower costs
- Improved care and assistance for your individual health needs
- Online tools and guidance to help you get the most out of your plan
- Customer service and support

Because prescription drugs can be costly, we promote the use of generic drugs, which work the same as their brand-name equivalents. And we offer copay discounts when you get up to 90-day supplies of certain medications or enroll in convenient home delivery.

Advantages of combined Blue Cross medical and pharmacy coverage

You get comprehensive care when your medical care and pharmacy coverage are provided through the same plan. That's because your health and safety are the crucial link between the two.

With integrated coverage, you also get:

- Better management of chronic health conditions
- One member ID card
- One member account
- One mobile app
- One customer service team

Safety is paramount

We review the use of certain drugs through our prior authorization program to make sure you receive the most appropriate drug therapy. We make our decisions based on current medical information and the recommendations of our Pharmacy and Therapeutics Committee — a group of doctors, pharmacists and other health care experts.

The drugs we focus on are those that:

- Have dangerous side effects
- Are harmful when combined with other drugs
- Should only be used for certain health conditions
- Are often misused or abused

Narcotic drugs such as opioids fall into more than one of these categories.

We also look at drugs that are prescribed when other equally effective drugs are available at a lower cost. Specialty drugs must be filled through an AllianceRx Walgreens Prime pharmacy.

Coverage depends on your plan

Blue Cross Blue Shield of Michigan prescription drug plans are not all alike.

Visit **bcbsm.com/druglists** and browse our drug lists. You can also find the drug list for your plan by logging in to your online member account at **bcbsm.com** or through our mobile app. Every list shows the most frequently prescribed drugs, and whether the drug has special requirements for coverage.

Resources

When your doctor writes you a new prescription, you'll want to know whether your plan covers that drug and how much it will cost you. We make it easy for you to find the information in print and online.

Download our mobile app by searching **BCBSM** from your Apple® iPhone® or Android™ phone. Then use the app to research drug prices and see what your plan covers.

Create a member account at **bcbsm.com** to view your prescription drug benefits and cost-sharing information. Members can also locate participating pharmacies, print a personal prescription history and enroll in home delivery.

Once you're enrolled, you'll receive a welcome book in the mail. This booklet will include information about your drug coverage.

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Blue Cross Blue Shield of Michigan

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

Simply Blue℠ HSA PPO Gold $2000 0% with Rx Drug Vision Coverage (Pediatric) Benefits-at-a-glance Effective for groups on their plan year

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

Note: Vision benefits are only available to members up to age 19. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None

Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.		
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	

BV-PEDS;SBD HSA SG;SBHSA-$2,000/0%

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered - annual supply	
Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	

Employee online resources

For all businesses

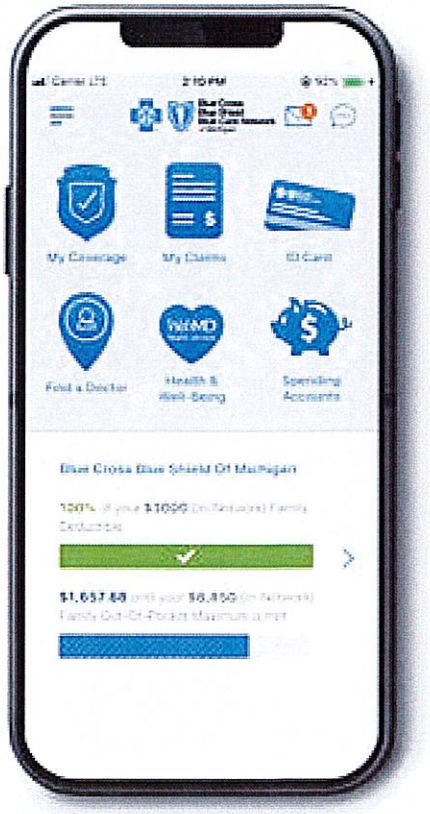
When you purchase Blue Cross Blue Shield of Michigan and Blue Care Network health plans, you receive more value with our included package of employee online member account and well-being resources.

Online member account

bcbsm.com | Blue Cross mobile app

Spend less time taking calls from employees by empowering them to find answers with their personal member accounts. Each employee gets everything they need to manage their health plan within one secure account. After they activate their account at **bcbsm.com/register** or through the mobile app, they can log in anytime to:

- **Review coverage details** of their medical plan and any other benefits they have, such as pharmacy, dental, vision or spending account information.
  - See who's enrolled on their plan
  - Find an overview of their copays
  - Quickly find deductible and out-of-pocket balances
  - Check on the status of referrals and authorizations
  - See remaining visits available for services, such as chiropractic or cardiac rehabilitation
  - Employees with pharmacy benefits can review prescription history, see what their plan covers, compare costs between brand and generic, find a pharmacy and sign up for lower-cost mail order drugs.
- **Monitor claims activity and see what providers billed them, what their plan paid and what they may owe**
- **Access their virtual member ID card and order new wallet cards when needed**
- **Use provider search and price transparency tools**
  - Find high quality care and make more responsible, cost-saving decisions
  - Research and compare provider qualifications, services and costs*
  - Plan for hospital stays and search for a Blue Distinction® hospital that excels in the specific type of care they'll need
- **Ask MIBlue Virtual Assistant℠ for help finding the plan information they need** — Our interactive, automated account chat feature provides immediate, 24/7 support through the member account



*Cost estimates are available for most non-Medicare members.

Online employee well-being resources

We include the following resources with all health care plans at no additional cost, giving your employees more tools to support their personal, financial, physical and emotional, whole-health journeys.

Blue365® member discounts

bcbsm.com | Blue Cross mobile app

Your employees' member accounts give them access to exclusive savings on national and Michigan-based products and services for a healthy and well-balanced lifestyle, including:

- Gym memberships, fitness gear and health magazines
- Weight-loss programs, cooking classes and cookbooks
- Travel and recreation
- Lasik and eye care services, dental care and hearing aids

Blue Cross Health & Well-Being℠, powered by WebMD®

bcbsm.com | Blue Cross mobile app

This member account resource includes a wealth of information and interactive tools that your employees can use to improve or maintain healthy lifestyles, such as:

- Health assessment
- Symptom Checker
- My Health Assistant
- My Pregnancy Assistant
- The Daily Victory℠ and Weigh Today apps
- Recipes
- Health Record
- Health Trackers
- Document Library
- Device and App Connection Center
- WebMD Health Topics℠
- Medical encyclopedia
- WebMD interactives
- WebMD videos
- Message board exchanges

Blue Cross Virtual Well-Being℠

bluecrossvirtualwellbeing.com

This online resource features two, live, weekly webinars — one tailored for your leaders and one for your employees. Webinars focus on subjects that encourage whole-person health and well-being, such as financial wellness, emotional health, physical health, social connectedness, happiness and meditation.

Each webinar offers related downloadable content you can use in your workplace. On-demand webinars are also available. Feel free to visit **bluecrossvirtualwellbeing.com** for a preview.

For more information about how our employee online resources can provide you more value, contact your Blue Cross or BCN sales representative or contracted agent, or visit **bcbsm.com/employers**.

Principal®

Appendix B

Policyholder: CITY OF WALLED LAKE

Group dental insurance
Benefit summary for all members

Your coverage renews every April 1
This summary was created on 03/16/2023 and shows benefits available at that time.

What's available to me?

Dental insurance helps pay for all, or a portion, of the costs associated with dental care, from routine cleanings to root canals.

Eligibility				
Eligible employees	All active, full-time employees			
	Calendar-year deductible		Coinsurance your policy pays	
	In-network	Out-of-network	In-network	Out-of-network
Preventive	$0	$0	80%	80%
Basic	$0	$0	80%	80%
Major	$0	$0	80%	80%
Orthodontia	$0	$0	50%	50%
Additional provisions				
Combined maximum	Maximums for preventive, basic, and major procedures are combined. In-network calendar year maximums are $1,000 per person or non-network calendar year maximums are $1,000 per person.			
Orthodontia lifetime maximum	$1,000 PPO in-network maximum / $1,000 PPO out-of-network maximum			
Maximum accumulation	Included			
Plan type	Unscheduled			

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period, or qualifying event.
- If you were covered as an employee, you're eligible as a retiree.

Which procedures are covered, and how often?

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 60 months
Fluoride	Once per calendar year (covered only for dependent children under age 16)
Sealants	Covered only for dependent children under age 16; once per tooth each 36 months

Basic	
Emergency exams	Subject to routine exam frequency limit
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to routine cleaning frequency limit
Fillings	Replacement fillings every 24 months
Oral surgery	Simple and complex
Simple endodontics	Root canal therapy for anterior teeth
Complex endodontics	Root canal therapy for molar teeth
Non-surgical periodontics, including scaling and root planing	Once per quadrant per 24 months
Periodontal surgical procedures	Once per quadrant per 36 months
Harmful habit appliance	Covered only for dependent children under age 16

Major	
General anesthesia / IV sedation (covered only for specific procedures)	Covered only for specific procedures
Crowns	Each 120 months per tooth if tooth cannot be restored by a filling
Core buildup	Each 120 months per tooth
Implants	Each 120 months per tooth
Bridges	120 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)
Repairs	Partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture, within policy limitations

Orthodontia	
Coverage	For your dependent children. Bands that are placed on a dependent child's teeth before age 19 may be covered.

Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 90th percentile of the usual and customary charges.
Maximum accumulation	Some of your unused annual benefit maximum can be carried over to the next year. To qualify, you must have had a dental service performed within the calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the out-of-network maximum benefit or $1,000. If the qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effective dates will start qualifying for rollover at the beginning of the next calendar year. You can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year
Emergency services	If you have a dental emergency and you can't see an in-network provider in a reasonable amount of time, your claim may be paid if you see an out-of-network provider.
Periodontal program	If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
Second opinion program	You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.

Cancer treatment oral health program	If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.
General anesthesia program	If you have autism, Down syndrome, cerebral palsy, muscular dystrophy, or spina bifida you may receive general anesthesia or intravenous sedation coverage. Services must be administered in a dental office. All other contractual limitations apply.

How do I find a network dentist?

When you receive services from a dentist in our network, your cost may be lower. Network dentists agree to lower their fees for dental services and not charge you the difference. You'll have access to the Principal Plan Dental network, with more than 117,000 dentists nationwide. Visit principal.com/dentist to find a dentist or call 800-247-4695.

What if my dentist isn't in the network?

You can refer your dentist to our network. Please submit the dentist's name and information by calling 800-247-4695, or submitting a form at principal.com/refer-dental-provider.

What are the limitations and exclusions of my coverage?

- Missing tooth –The initial placement of bridges, partials, and dentures to replace teeth missing before this coverage starts won't be covered. If this policy replaces coverage with another carrier, continuous coverage under the prior plan may be applied to the missing tooth provision requirement. This doesn't apply to pediatric essential benefits.
- Frequency limitations for services are calculated to the month and exact date from the last date of service or placement date.

There are additional limitations to your coverage. Please review your booklet for more information.

What are the restrictions of my coverage?

Orthodontia	If there is orthodontia (ortho) treatment in progress on the coverage effective date and you are covered under any prior group coverage for ortho, there will be immediate coverage for treatment if proof is submitted that shows: 1) The lifetime maximum under any prior group coverage has not been exceeded, 2) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and 3) Ortho treatment has been continued while insured under this policy. Principal Life will credit payments made by the prior carrier toward the Principal Life lifetime ortho payment limit. You will not be covered if ortho treatment is in progress prior to the effective date with Principal Life and you are not covered under any prior group coverage for ortho.

There are additional limitations to your coverage. A complete list is included in your booklet.

principal.com

This is a summary of dental coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

GP62509-11 1091056 - 10001 11/2022

Group benefits

Check your benefits when, where and how you want to

It's easy to keep track of your benefits from Principal® anytime — online or on your mobile device

Start by creating your account

1 | From your favorite browser, go to **principal.com**, select Log In, then Personal. Or, download the **Principal app** for free from the App Store or Google Play.

2 | Select **Create an account.**

3 | Enter personal information such as your date of birth and identification number.

4 | **Create a username** and password, and provide an email address.

5 | You'll receive an email within a few minutes to confirm your account is ready to go. You can access your account information anytime, 24/7, with the username and password you've just set.

Manage your benefits on Principal.com and the Principal mobile app

After logging in, you can manage your benefits and other Principal products you have when, where and how it's convenient for you. Depending on your coverages, you can:

- View and manage claims
- Get a 24-month history of your explanation of benefits (EOB)
- Access your summary of benefits, as well as benefit booklets
- Find a list of covered dependents
- View and print your dental ID card
- Search for and contact a network dentist
- Find discounts and services
- Calculate coverage needs and more

Keeping your account safe

Your information is important to us. That's why we use verification codes to prevent others from accessing your account — even if they have your password. The first time you log in — on Principal.com or the mobile app — you'll need to choose how you'll receive the codes, either by text or email.

If you log in from an unrecognized device, forget your password or we notice anything out of the ordinary, the codes help us confirm it's really you accessing your account. You can choose to receive a code every time you log in or only when we detect unusual activity.

Let's connect

Need help setting up your login, or have other questions? Call us at **800-986-3343.**

We're happy to help.

Principal®

principal.com

Insurance issued by Principal Life Insurance Company, Des Moines, Iowa 50392-0002, principal.com

You have the right to receive, free of charge, a paper copy of your benefit booklet and any changes at any time. Please contact your employer if you'd like to request a paper copy.

GP59610-08 | 03/2019 | © 2019 Principal Financial Services, Inc.

CITY OF WALLED LAKE

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

30% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the ADVANTAGE Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-888-203-7437**.
- For Lasik providers, call 1-877-5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Co-pay	Up to $35
Frames	$140 allowance; 20% off balance over $140	Up to $56
Standard Plastic Lenses		
Single Vision	$10 Co-pay	Up to $25
Bifocal	$10 Co-pay	Up to $40
Trifocal	$10 Co-pay	Up to $60
Standard Progressive Lens	$10 Co-pay	Up to $85
Premium Progressive Lens	$10; 70% of charge less $110 allowance	Up to $85
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$12	N/A
Tint (Solid and Gradient)	$12	N/A
Standard Plastic Scratch Coating	$12	N/A
Standard Polycarbonate	Covered in full	Up to $28
Standard Anti-Reflective Coating	$40	N/A
Other Add-Ons and Services	30% off retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $40	N/A
Premium Contact Lens Fit & Follow-Up	10% off Retail	N/A
Contact Lenses		
Conventional	$155 allowance; 15% off balance over $155	Up to $109
Disposable	$155 allowance; balance over $155	Up to $109
Medically Necessary	$0 Co-pay; Paid-in-Full	Up to $200
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing, Aniseikonic lenses, 2) Medical and/or surgical treatment of the eye, eyes or supporting structures, 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment. Safety eyewear, 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof, 5) Plano (non-prescription) lenses, 6) Non-prescription sunglasses, 7) Two pair of glasses in lieu of bifocals, 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

BLM2015

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.

Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	$10 Co-pay	Up to $35
Frames (Once every 12 months)	$140 allowance; 20% off balance over $140	Up to $56
Single Vision Lenses (Once every 12 months)	$10 Co-pay	Up to $25
Or		
Contacts (Once every 12 months)	$155 allowance; balance over $155	Up to $109

Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.

eyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters PEARLE VISION OPTICAL sears OPTICAL JCPenney | optical

*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections.

EYEMED MEMBERS APP

An app that fits your vision

Managing vision benefits with our mobile app for members is easy – just as it should be. When they download the EyeMed Members App from the App Store or Google Play, employees can:

1 GET STARTED

- Log in using their fingerprint or facial recognition (for iPhones and iPhone X)
- Learn about benefits
- Search thousands of in-network eye doctors

2 SEE AN EYE DOCTOR

- Schedule an eye exam straight from a phone or tablet
- Get turn-by-turn directions to the eye doctor
- Shake to view an ID card (and save it to Apple Wallet on iPhones)

3 USE THE TOOLS AND EXTRAS

- Create reminders to schedule an exam or reorder contact lenses
- Save prescription info
- Check out exclusive member deals and discounts

Help employees stay connected to life –
Contact your EyeMed rep or visit **starthere.eyemed.com**

S-1905-CB-392

United of Omaha Life Insurance Company
A Mutual of Omaha Company

› Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

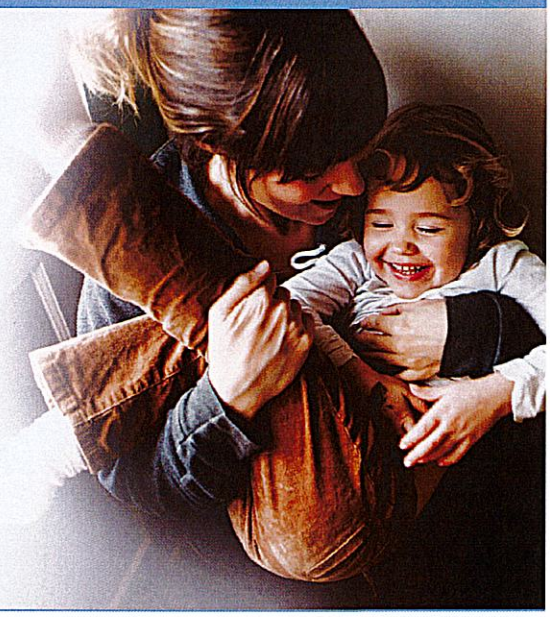
As an active employee of City of Walled Lake, you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.



ELIGIBILITY - ALL OTHER ACTIVE ELIGIBLE FULL-TIME EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 40 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.

BENEFITS	
Life Insurance Benefit Amount	For You: An amount equal to 1.5 times your annual salary, but in no event less than $0 or more than $100,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of your life insurance benefit.
FEATURES	
Living Care/ Accelerated Death Benefit	75% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $75,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Felonious Assault - Childcare - Child Education - Seat Belt - Airbag - Coma
Portability	Allows you to continue this insurance program should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com.

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 50%
- At age 75, amounts reduce to 35%

Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

Please contact your employer if you have questions prior to enrolling.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 40 hours per week.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you may have the right to continue this insurance under the Portability or Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 65, amounts reduce to 65%
  - At age 70, amounts reduce to 50%
  - At age 75, amounts reduce to 35%
- Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Life insurance and accidental death & dismemberment insurance are underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Policy form number 7000GM-U-EZ 2010 or state equivalent (in NC: 7000GM-U-EZ 2010 NC). United of Omaha Life Insurance Company is licensed nationwide, except New York.

United of Omaha Life Insurance Company
A Mutual of Omaha Company

› Short-Term Disability Insurance

How Would You Pay Your Bills if You Were Sick or Injured Temporarily?

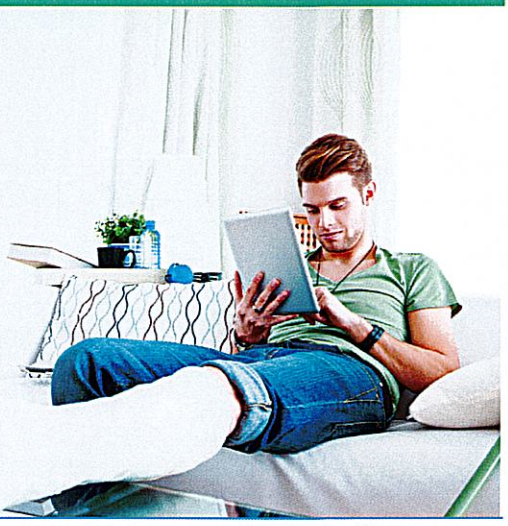
Even a short illness or injury could seriously impact your paycheck. Sick time will get you by while it lasts, but what happens when your sick days run out? A short-term disability policy provides you with cash benefits when you need it.

We've Got You Covered

As an active employee of City of Walled Lake, you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A disability income insurance policy can help provide security when you need it, plus give you peace of mind so you can recover faster and get back on the job sooner.

Coverage guidelines and benefits are outlined below.



ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 40 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: • On the day of your disabling injury. • On the 8th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources.
Maximum Benefit Period	Up to 13 weeks
Maximum Weekly Benefit	$1,000
Minimum Weekly Benefit	$25

Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
Definition of Weekly Earnings	Weekly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 52. Weekly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per week during the 6 month period immediately prior to the date disability begins. If employed for part of the prior 6 month period, weekly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
Reasonable Accommodation	Provides a benefit to the employer to assist in covering costs incurred to make workplace modifications for you to return to work.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 40 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, paid family leave, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

No, your STD insurance only provides benefits for off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- A pre-existing condition limitation does not apply.
- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Results from elective or cosmetic surgery or procedure, or resulting complications, unless such surgery or procedure is medically necessary for the appropriate diagnosis and treatment of your injury or illness
  - Arises out of or in the course of employment with the policyholder for benefits under any workers' compensation or occupational disease law, or receives any settlement from the workers' compensation carrier
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a failed drug test
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by the underwriting company. Disability income insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number G2018MP.

United of Omaha Life Insurance Company
A Mutual of Omaha Company

› Long-Term Disability Insurance

Your Ability to Earn an Income May Be Your Most Important Asset

Most people don't think twice about insuring their home, automobile or health. However, many people don't recognize just how important it is to insure their income.

We've Got You Covered

As an active employee of City of Walled Lake, you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A lengthy disability can be devastating, and is more common than you might think. It may lead to a loss of income, independence and financial security.

A disability income insurance policy can help provide security when you need it most. It pays you cash benefits when you're sick or hurt and can't work.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 40 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	Your benefits begin on the later of 90 calendar days after the onset of your disabling injury or illness or the date your short-term disability ends.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. The premium for your long-term disability coverage is waived while you are receiving benefits.
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	$100/10%

Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits.
DEFINITIONS	
Own Occupation	2 Years
Own Occupation Earnings Test	99%
Definition of Monthly Earnings	Monthly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 12. Monthly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per month during the 6 month period immediately prior to the date disability begins. If employed for part of the prior 6 month period, monthly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
Survivor Benefit	If you pass away while receiving disability benefits, a lump sum equal to 3 times your monthly benefit will be paid to your eligible survivor.
Reasonable Accommodation	Provides a benefit to the employer to assist in covering costs incurred to make workplace modifications for you to return to work.
SERVICES	
Employee Assistance Program (EAP)	Mutual of Omaha's team of master's level EAP professionals are available 24/7/365 to provide you and your loved ones resources for assistance with personal and workplace issues. Access to EAP services is obtained by calling 1-800-316-2796 or by using an online submission form for employee convenience at www.mutualofomaha.com/eap. Online are valuable resources and links for additional assistance, including current events, family and relationships, emotional well-being, financial wellness, substance abuse and addiction, legal assistance and work and career.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 40 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, paid family leave, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

Yes, your LTD insurance provides benefits for both on-the-job and off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Disabilities related to alcohol and drug abuse are only payable for up to 24 months while insured under the policy.
- Disabilities related to mental disorders are only payable for up to 24 months while insured under the policy.
- Disabilities related to self-reported conditions and specific conditions are only payable for up to 24 months while insured under the policy.
- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.
- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Results from elective or cosmetic surgery or procedure, or resulting complications, unless such surgery or procedure is medically necessary for the appropriate diagnosis and treatment of your injury or illness
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
  - Results from alcohol and drug abuse and/or substance abuse, except as noted above
  - Results from a mental disorder, except as noted above
  - Is caused by alcohol and drug abuse and/or substance abuse, while not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a failed drug test
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

Employee Assistance Program

Available Services When You Need Help the Most

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three sessions per year (per household) conducted by either face-to-face* counseling or video telehealth via a secure, HIPAA compliant portal
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers • Network continually expanding to meet customer needs • Flexibility to meet individual client/member needs

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions in a six-month period per person.

Continued on back.

Mutual of Omaha

Enhanced EAP Services *(continued)*

Features	Value to Company and Employees
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests • EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	• Valuable resources – legal libraries, tools and forms – available on EAP website • A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney • 25% discount for ongoing legal services for same issue
Employee Family Financial Services	• Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health • A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney • 25% discount for ongoing financial services for same issue
Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals

Online Services	• An inclusive website with resources and links for additional assistance, including:
	  • Current events and resources
	  • Family and relationships
	  • Emotional well-being
	  • Financial wellness
	  • Substance abuse and addiction
	  • Legal assistance
	  • Physical well-being
	  • Work and career
	• Bilingual article library

Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

Mutual Solutions

Your Hearing Discount Program

Program Benefits - In addition to your hearing care benefit, you will have access to complimentary aftercare*, including:

- ☑ **Custom hearing solutions** — wide choice of products from the industry's leading brands
- ☑ **Risk-free trial** — find your right fit by trying your hearing aids for 60 days
- ☑ **Follow-up care** — ensures a smooth transition to your new hearing aids
- ☑ **Battery support** — battery supply or charging station to keep your hearing aids powered
- ☑ **Warranty** — 3-year coverage for loss, repairs, or damage
- ☑ **Financing** — no interest for those who qualify
- ☑ **Savings for family and friends** — your parents, siblings, in-laws, and friends qualify, too

*Risk-free trial - 100% money back guarantee if not completely satisfied, no return or restocking fees. Follow-up care - for one year following purchase. Batteries - two year supply of batteries (80 cells/ear/year) or one standard charger at no additional cost. Warranty - Exclusions and limitations may apply. Contact Client Services (1-844-267-5436) for details.

Accessing Your Benefits is as Easy as ...

1. Call Amplifon at 1-888-534-1747 and a Patient Care Advocate will assist you in finding a hearing care provider near you.
2. Our advocate will explain the Amplifon process, request your mailing information and assist you in making an appointment with a hearing care provider.
3. Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.

To learn more visit amplifonusa.com/mutualofomaha.

	Level 1	Level 2	Level 3	Level 4	Level 5
Hearing Aid Features	Standard features	Additional, easy-to-use functions	Designed for work and play	Enhanced to keep you on the go	Leading technology keeps you connected
One Simple Price	$995	$1,495	$1,795	$2,195	$2,645

Mutual of Omaha | amplifon Hearing Health Care

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Mutual Solutions

Worldwide Travel Assistance That Travels With You

Take comfort in knowing that Travel Assistance* travels with you worldwide, offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations.

Enjoy Your Trip – We'll Be There If You Need Us – 24/7

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

Pre-trip Assistance**

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport, visa or other required documentation for foreign travel
- Travel, health advisories and inoculation requirements for foreign countries
- Domestic and international weather forecasts
- Daily foreign currency exchange rates
- Consulate and embassy locations

Emergency Travel Support Services

- Telephonic translation and interpreter services – 24/7 access to telephone translation services
- Locating legal services – referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- Baggage – assistance with lost, stolen or delayed baggage while traveling on a common carrier
- Emergency payment and cash – assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- Emergency messages – assistance with recording and retrieving messages between you, your family and/or business associates at any time
- Document replacement – coordination of credit card, airline ticket or other documentation replacement
- Vehicle return – if evacuation or repatriation is necessary, return your unattended vehicle to the car rental company

*Brought to you by Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Services provided by AXA Assistance USA (AXA)
**Available at any time, not subject to 100 mile travel radius

452632

Mutual of Omaha

WORLDWIDE TRAVEL ASSISTANCE

Services available for business and personal travel.

For inquiries within the U.S. call toll free:
1-800-856-9947

Outside the U.S. call collect:
(312) 935-3658

WORLDWIDE TRAVEL ASSISTANCE

Services available for business and personal travel.

For inquiries within the U.S. call toll free:
1-800-856-9947

Outside the U.S. call collect:
(312) 935-3658

Medical Assistance

- Locating medical providers and referrals
- Communication on your medical status with family, physicians, employer, travel company and consulate
- Emergency evacuation if adequate medical facilities are not available, including payment of covered expenses
- Transportation home for further treatment – in the event of death, assist in the return of mortal remains
- Transportation arrangements for the visit of a family member or friend if your hospitalization is more than seven calendar days
- Return home for dependent children if your hospitalization is more than seven calendar days
- Assistance with lodging arrangements if convalescence is needed prior to, or after, medical treatment
- Coordination with your health insurance carrier during a medical emergency
- Assistance obtaining prescription drugs or other necessary personal medical items

Identity Theft

Your Travel Assistance benefit automatically includes Identity Theft Assistance, coordinated at no additional cost. Whether at home or traveling, this benefit provides education, prevention and recovery information to help you protect your identity.

Education and Prevention

- Comprehensive ID theft assistance guide
- Tips to defend against ID theft

Recovery Information

- Information regarding the steps to recover from credit card and check fraud
- Guidelines if your Social Security number is compromised
- Instructions for lost or stolen passport
- Contact list for financial institutions, credit bureaus and check companies

Assistance

If you need help with an ID theft issue, case managers are available 24 hours a day, seven days a week and can be reached by calling the same toll-free number used to contact AXA: 800-856-9947.

Travel Assistance Plan Limitations

AXA will not pay emergency evacuation, medically necessary repatriation, repatriation of remains or other expenses incurred while traveling within 100 miles of participant's place of residence, or for any one of the following reasons:

- A single trip lasts more than 120 days in length
- Traveling against the advice of a physician
- Traveling for medical treatment
- Pregnancy and childbirth (exception: complications of pregnancy)

There is a maximum benefit amount per person associated with emergency evacuation, medical repatriation and/or return of mortal remains.

All additional costs would be the responsibility of the member. This includes medical costs which are the responsibility of the person receiving medical services. Services must be authorized and arranged by AXA Assistance USA, Inc. designated personnel to be eligible for this program. No reimbursement claims for out-of-pocket expenses will be accepted.

Mutual of Omaha

Carry this card with you when you travel

Brought to you by Mutual of Omaha.
Services provided by AXA Assistance USA.

Mutual of Omaha

Carry this card with you when you travel

Brought to you by Mutual of Omaha.
Services provided by AXA Assistance USA.

Mutual Solutions

Will Preparation Services

Services provided by Epoq, Inc.

Create your will at
www.willprepservices.com
and use the code MUTUALWILLS
to register

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die.

Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

That's why it's good you have access to FREE online will preparation services provided by Epoq, Inc. (Epoq).

Easy, Free and Secure

Epoq offers a secure account space that allows you to prepare wills and other legal documents. Create a will that's tailored to your unique needs from the comforts of your own home.

Epoq provides the following FREE documents:

- Last Will and Testament
- Power of Attorney
- Healthcare Directive
- Living Trust

Here's how it works:

- Log on to www.willprepservices.com and use the code MUTUALWILLS to register
- Answer the simple questions and watch the customization of your document happen in real time
- Download, print and share any document instantly
- Don't forget to update your documents with any major life changes, including marriage, divorce, and birth of a child
- Make the document legally binding — Check with your state for requirements

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

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Mutual Solutions

Identity Theft Assistance

Essential Service For Your Protection

Each year millions of Americans become victims of identity theft. Information that personally identifies you, such as your name, Social Security number or credit card numbers can be stolen and used to commit fraud or other crimes.

Identity Theft Assistance, provided by AXA Assistance, helps you and your dependents understand the risks of identity theft, learn how to prevent it, and most importantly, assist you if your information is compromised.

ID Theft Assistance is available as part of your overall Travel Assistance package offered by your employer. Services include:

Awareness and Education

We help you understand the growing threat of identity theft by:

- Promoting awareness of identity theft
- Answering your questions about identity theft and how to recognize if you've become a victim
- Educating you on how to avoid having your identity stolen

Identity Theft Recovery Assistance*

If your identity is compromised, the most important thing to do is respond quickly. We will provide you with educational resources regarding the steps to take to recover your identity from credit card and check fraud. We will also provide you with a contact list for financial institutions, credit bureaus and check companies.

**It's important to note that this is an educational resource and not a recovery service.*

Access ID Theft Assistance services by calling AXA Assistance toll-free at (800) 856-9947.

Mutual of Omaha

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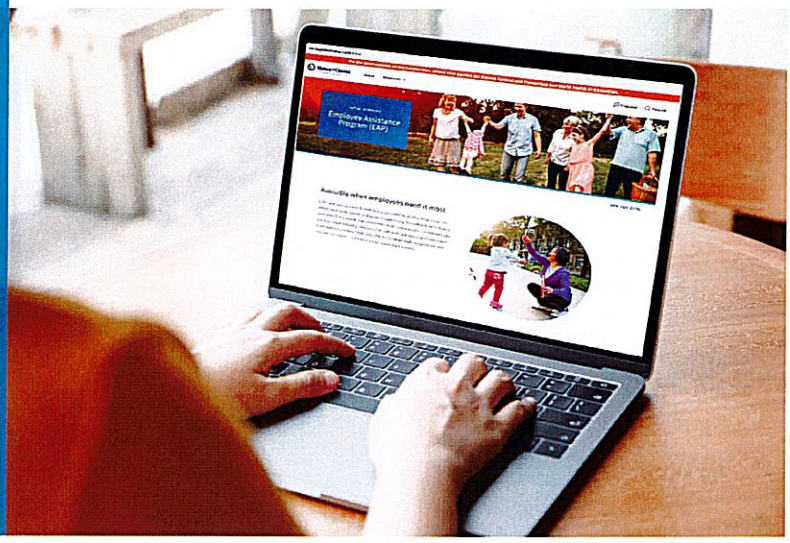
Employee Benefits

Our New Financial Wellness Tool Can Benefit You



How do you feel about your current financial situation? Nearly half of all employees nationwide say they worry about their personal finances while at work.* We don't want you to be part of that statistic.

To help you make better informed financial decisions, you now have access to a new financial wellness tool that's part of Mutual of Omaha's Employee Assistance Program.

The financial wellness tool from Enrich is a convenient, one-stop shop that provides you access to a variety of informational and educational resources with one goal in mind – to help you become financially healthy.

Here are the resources you'll find in the financial wellness tool:

- Online courses
- Webinars and financial coaching videos
- Budgeting tools and calculators
- Career development tools
- Chat functionality for technical support
- *And more!*

The availability of this tool comes at a great time as you are putting more focus and effort into exploring solutions to your financial situation.

Here's how it works:

Go to **mutualofomaha.com/eap**.

Click on **Managing Finances** to locate the Enrich link.

Click **Sign Up**.

Complete **registration** information and begin.

Set up your profile:

It's as easy as 1-2-3!

1. Complete your Financial Wellness Checkup. This will help Enrich make personalized recommendations for content, tools and courses.
2. Choose a cover photo of your top financial goals.
3. Upload a profile photo.

Mutual of Omaha

* Source: PwC's 9th annual Employee Financial Wellness Survey, PwC US, 2020.

464473

Department of Labor Annual Notices

Please review the following documents:

- HIPAA Privacy Notice
- Michelle's Law
- COBRA General Notice
- Creditable Coverage
- Health Insurance Marketplace
- HIPAA Special Enrollment Rights
- Women's Health & Cancer / Newborn's & Mothers Act
- CHIPRA
- Nonopioid Directive

Note: The "Plan" is in reference to your Employer.

Please contact the Plan Administrator listed below should you require additional information:

City of Walled Lake
Chelsea Pesta, Assistant City Manager / Finance Director
1499 E. West Maple Road
Walled Lake, MI 48390
cpesta@walledlake.com
(248) 624-4847

HIPAA Privacy Notice

In April 2003, the final regulations that place restrictions on how personally identifiable health information may be used and disclosed by certain organizations became effective. These regulations (the Privacy Rules) implement the privacy requirements contained within the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While some states have laws that protect health information, the HIPAA Privacy Rules establish a uniform, minimum level of privacy protection for all health information.

Summary of HIPAA Privacy Rules
The HIPAA Privacy Rules:

- Set limits on how health information may be used and disclosed
- Require that individuals be told how their health information will be used and disclosed
- Provide individuals with a right to access, amend and/or copy their medical records
- Give individuals a right to receive an accounting of disclosures, to request special restrictions and to receive confidential communications
- Impose fines where the requirements contained within the regulations are not met

Restrictions on Use and Disclosure
The HIPAA Privacy Rules allow health care providers, health plans and health care clearinghouses (Covered Entities) to use and disclose your personally identifiable health information for purposes of treatment, payment or health care operations.

For example, your health care provider may submit your health information to a health insurance company to seek payment for the treatment provided to you. Your primary care physician can share your health information with a specialist that he or she recommends you consult. In these cases, your written permission to disclose your health information is not required.

In general, any use or disclosure not considered treatment, payment or a health care operation requires your written authorization, unless an exception applies. For example, your physician may not share your health information with your employer or a life insurance carrier without your written permission. However, disclosure of health information is permitted for certain purposes specifically listed in the HIPAA Privacy Rules, such as national security, law enforcement and public health issues. If you authorize release of your health information to a third party, the information released may no longer be protected by HIPAA.

Notice of Privacy Practices
You are entitled to receive an explanation, from each of your healthcare providers, of how your personally identifiable health information will be used and disclosed.
For example, a physician or hospital is required to provide you with a Notice of Privacy Practices at your first visit. You will be required to sign an acknowledgment indicating that you received the Notice of Privacy Practices.

If you have health insurance coverage, the insurance company or health plan will also provide you with a Notice of Privacy Practices after you are enrolled in the plan. It is important that you read the Notice of Privacy Practices to understand your rights and know who to contact if you feel your privacy rights have been violated.

Right to Access, Amend or Copy
You have a right to view and copy your medical records. You may be charged a fee for the cost of reproduction.
If you believe that information within your medical records is incorrect or if important information is missing, you have a right to request that your medical records be amended.

Right to an Accounting of Disclosure
You also have a right to a list of uses and disclosures made of your medical records where the use or disclosure was not for purposes of treatment, payment, health care operations or pursuant to your written authorization.

Right to Request Restrictions
You may request, in writing, that a health care provider or health plan not use or disclose information for treatment, payment or other administrative purposes unless specifically authorized by you, when required by law or in emergency circumstances. Health care providers and health plans must consider your request but are not legally obligated to agree to those restrictions.
Confidential Communications
You have a right to receive confidential communications containing your health information. Health care providers and health plans are required to accommodate your reasonable requests. For example, you may ask a physician to contact you at your place of employment or send communications regarding treatment to an alternate address.

Violations of Privacy Rights
If you believe that your privacy rights have been violated, you may contact the Privacy Officer for the organization that you feel has violated your right to privacy. The name of the Privacy Officer should be included in the Notice of Privacy Practices provided to you by that organization.

If the Privacy Officer does not adequately resolve your concerns, you may contact the Department of Health and Human Services - Office of Civil Rights (OCR). OCR is responsible for enforcing the HIPAA Privacy Rules. For instructions on how to file a complaint, visit www.hhs.gov/ocr/privacy/hipaa/complaints. For a complaint form, visit www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintpackage.pdf.

Penalties for Noncompliance
The HIPAA Privacy Rules do not provide individuals with a private right to sue, although methodologies for allowing a portion of civil penalties to be paid to affected individuals must be established by February 17, 2012.

- Currently, health care providers, health plans and health care clearinghouses that do not comply with the HIPAA Privacy Rules may be subject to civil money penalties ranging from $100 to $50,000 per violation, with maximum penalties ranging from $25,000 per year to $1.5 million per year.
- Criminal violations of the HIPAA Privacy Rules may also be referred to the Department of Justice for enforcement. Criminal penalties for such violations include:
- $50,000 fine and/or up to 1 year in prison for knowingly obtaining or disclosing protected health information not permitted by law
- $100,000 fine and/or up to 5 years in prison for obtaining or disclosing protected health information under false pretenses; and
- $250,000 fine and/or up to 10 years in prison for obtaining protected health information with an intent to sell, transfer or use it for commercial advantage, personal gain or malicious harm

State Attorneys General (AG) may also sue Covered Entities to enjoin further violations and obtain damages on behalf of residents of their states if the Department of Health and Human Services has not already acted.
The State Attorneys General may seek damages of up to $100 per violation, with a maximum of $25,000 per year for identical violations.
HIPAA Privacy Resources
Department of Health and Human Services - Office of Civil Rights
www.hhs.gov/ocr/ www.healthprivacy.org

Michelle's Law Notice

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the Plan group health benefit provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of the Plan group health benefit coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the Plan group health benefit will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the Plan group health benefit, whichever is earlier.

To be eligible to continue coverage as a dependent during such leave of absence:

- The Plan group health benefit must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and
- Must being enrolled in the plan immediately prior to the first day of the medically necessary leave of absence.

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a *"dependent child."*

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment.
- Death of the employee.
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: The Plan Contact listed above.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event.

This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you have questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Creditable Coverage Important Notice from the Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Plan has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan coverage will not be affected. *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.] If you do decide to join a Medicare drug plan and drop your current Plan coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed on page one for further information:

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Sample Company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

SPECIAL ENROLLMENT RIGHTS WITH HIPAA

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP, and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact the person listed on page one of Department of Labor notices.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment- based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the plan administrator.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductible and coinsurance apply based on your plan selection. If you would like more information on WHCRA benefits, contact the person listed on page one for more information.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

Contact your Plan Administrator listed on page one of the Department of Labor notices section for more information.

NEWBORNS' and MOTHER'S HEALTH PROTECTION ACT

Group Health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48-hours following a vaginal delivery or less than 96-hours following a cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48-hours (or 96-hours if applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48-hours or 96-hours.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact yourState Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information onspecial enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

NONOPIOID DIRECTIVE

Michigan Department of Health and Human Services
Required by MCL 333.9145 effective 3/28/2019

MUST BE INCLUDED IN THE PATIENT'S MEDICAL RECORD

Patient Name	Date of Birth
Other names used by patient	Preferred language of patient
Emergency Contact	Name of primary care provider
Drug allergies	

The patient above must not be administered an opioid or offered a prescription for an opioid while this directive is in effect.

- An individual who has executed a nonopioid directive on their own behalf may revoke the directive at any time and in any way they are able to communicate their intent to revoke the form.
- A guardian or patient's advocate can revoke at any time by issuing a revocation in writing and providing notice of the revocation to the individual's health professional or their delegate.
- This directive does not apply to:
  - A patient receiving opioids for substance use disorder treatment;
  - A patient who is in hospice;
  - A patient is being treated at a hospital, or in a setting outside of a hospital in the case of an emergency, and, in the prescriber's professional opinion, the administration of the opioid is medically necessary to treat the individual.

Signature of patient, or if the patient is a minor, parent	Date
Printed name of Patient	Date
Signature of guardian or patient's advocate, if applicable	Date
Printed name of parent/guardian/patient's advocate, if applicable	Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

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BCN Medical Customer Service	Phone: (800) 662-6667 Website: www.bcbsm.com
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