

**2021-2024**

**Master Agreement**

**Between**

**The**

**Wayne County Community College District**

**Board of Trustees**

**And the**

**Professional and Administrative Association**

**TABLE OF CONTENTS**

Article I	Agreement .....	4
Article II	Recognition .....	5
Article III	Scope of Agreement .....	6
Article IV	Conformity to Law .....	7
Article V	Employer’s Rights .....	8
Article VI	Fair Employment Practices.....	9
Article VII	Union Dues.....	10
Article VIII	Grievance Procedure.....	11
Article IX	Position Security.....	14
Article X	Employment Status.....	18
Article XI	Evaluation of Employees.....	20
Article XII	Disciplinary Action, Termination .....	23
Article XIII	Communications .....	25
Article XIV	Negotiations.....	27
Article XV	Personnel Files.....	28
Article XVI	Civic and Academic Freedom .....	29
Article XVII	Vacancies .....	30
Article XVIII	Outside or Part-Time Employment.....	31
Article XIX	Standing Committees.....	33
Article XX	Leaves .....	34
Article XXI	Vacations .....	40
Article XXII	Holiday.....	42
Article XXIII	Fringe Benefits.....	45
Article XXIV	Mileage and Parking.....	48
Article XXV	Miscellaneous.....	49
Article XXVI	Salary Schedules .....	50
Article XXVII	Compensation in Higher Classification.....	54
Article XXVIII	Interim Appointment, Temporary Job Assignment,	

*P&AA Master Agreement 2021-2024*

	And The Temporary Assignment of Additional Duties.....	55
Article XXIX	Job Upgrading.....	57
Article XXX	Release Time.....	58
Article XXXI	Waiver.....	59
Appendix A - #1	P&AA/AFT Full-Time Salary Grade and Job Classification Schedule .....	60
Appendix A - #2	P&AA/AFT Part-Time Salary Grade and Job Classification Schedule.....	64
APPENDIX B	Administrative Performance Appraisal Forms (I & II).....	65
APPENDIX C	Formal Grievance Form .....	656
APPENDIX D	Medical Benefit Plans .....	688

**ARTICLE I**

**AGREEMENT**

- A. This Agreement is made by and between the Wayne County Community College District Board of Trustees, and its successors, (hereinafter referred to as the “Employer” or “Board”), and the Wayne County Community College District Professional and Administrative Association, affiliated with the American Federation of Teachers and School Related Personnel, Local 4467, AFT, AFL-CIO, (hereinafter referred to as the “Union”).
- B. This Agreement shall commence upon the date that it is formally approved by the Board of Trustees and shall continue in effect until midnight, June 30, 2024. However, no grievance may be filed with respect to matters occurring before the effective date of this Agreement. This Agreement shall be extended only by written agreement of the Employer and the Union.
- C. An emergency manager appointed under the local financial stability and choice act, 2012 PA 435 (the Act), is permitted to reject modify, or terminate this Agreement as provided in the Act.
- D. The purpose of this Agreement is to set forth terms and conditions of employment, such as wages, hours, and working conditions; and to establish the machinery for collective bargaining; and to promote orderly and peaceful labor relations between the Employer and the employees. To the above end, it is the intent of the parties to abide by the terms of this Agreement at all times.
- E. The phrase “Board of Trustees” includes the Board of Trustees or its designee.

**ARTICLE II**

**RECOGNITION**

- A. The Board recognizes the Professional and Administrative Association/Union as the sole and exclusive bargaining representative for the Bargaining Unit, consisting of all full-time and part-time administrators and professional employees pursuant to Michigan Employment Certification R71-G297 and Michigan Employment Certification R88-C-93.
- B. It is mutually agreed that the personnel listed in Appendix A are included in the Bargaining Unit.
- C. Excluded from the Bargaining Unit are full-time and all regular and temporary part-time faculty members; Professors, Instructors, Counselors, Coaches and Librarians; full-time and part-time secretarial, clerical, and custodial employees; the senior administrative staff which includes but shall not be limited to: Administrative Secretary, Administrative Specialist, Assistant to Campus President, Assistant Title IV Compliance Auditor, Assistant to Chancellor for Policy and Compliance, Assistant to the Chancellor for Special Projects, Assistant to the Vice Chancellor for Administration & Finance, Associate Dean, Associate District Director Financial Aid, Assistant Facilities Administrator, Associate Vice Chancellor, Benefits Coordinator, Campus Security Officer, Campus Security Officer Supervisor, Chancellor, Chief Academic Officer, Compensation Specialist, Dean, Development Officer, Director Campus Business Operations, Director Facilities, Director Facilities (Evenings), Director Government Relations, Director Human Resources, Director Internal Audit, Director Public Affairs, District Academic Officer, District Director Acquisitions & Contracts, District Director Financial Aid, District Director Information Technology, District Director Public Safety, District Director Special Projects for Finance & Administration, District Director Workforce & Economic Development, District Registrar, District Reviewer of Financial Operations, Executive Assistant to the Chancellor, Executive Assistant to Vice Chancellor, Executive Vice Chancellor, Executive Director Plant Management, Executive Secretary, Human Resources Manager, Human Resources Specialist, Labor Relations Specialist, Lead Campus Service Officer, Provost, Regional Director Public Affairs/Communications, Senior Associate Vice Chancellor, Senior Campus Safety Officer, Senior Financial Analyst, Special Assistant for Pathway Projects, Transportation Trainer, Vice Chancellor, the Executive Secretary to the Board of Trustees, and the College General Counsel.
- D. In the event that the Board or designee creates a new position which may have a possible “community of interest” within the Bargaining Unit, the Director of Human Resources, representing the Board, shall inform the President of the Union of this new position prior to announcing it publicly, and the Union and the Director of Human Resources shall meet to determine whether such position shall be included in the Bargaining Unit.
- E. Unless specifically stated in this Agreement, no provision of this Agreement may be waived or altered by the Employer of the employee unless mutually agreed upon by both the Employer and the Union. All individual Professional and Administrative Association member’s employment status shall be made expressly subject to the terms of this Agreement.

**ARTICLE III**

**SCOPE OF THE AGREEMENT**

- A. This Agreement shall supersede any rules, regulations, practices, or contracts inconsistent with its terms unless mutually adjusted in writing by the Employer and the Union as ratified by the membership of the P&AA/AFT and the Board of Trustees.
- B. Such an adjustment between the Employer and the Union shall be made when it has been demonstrated amply that a particular program cannot be designed to comply with specific provisions of this Agreement and that all efforts to design the program in question so as to comply with this Agreement have been exhausted.
  - 1. The written adjustment between the Employer and the Union shall specify which provisions of this Agreement shall be adjusted and how they shall be adjusted.
  - 2. Any such adjustments shall apply only to the programs specifically mentioned therein.
  - 3. Any such adjustments shall be made after successful funding of any restricted fund program.

**ARTICLE IV**

**CONFORMITY TO LAW**

- A. This Agreement is subject in all respects to the law of the State of Michigan and the United States with regard to the powers, rights, duties, and obligations of the Employer, the Union, and employees of the Bargaining Unit.
- B. In those instances where any state law is contested, the provisions of that law shall be binding until such time as a court of competent jurisdiction declares it to be unconstitutional, null, or void.
- C. In the event that any provisions of this Agreement shall at any time be held to be contrary to law by a court of competent jurisdiction from whose final judgment or decree no appeal has been taken within the time provided for doing so, such provision shall be void and inoperative. The parties shall meet for the purpose of rewriting directly affected provisions of this contract and those provisions only. However, all other provisions of this Agreement shall continue in effect, and such court determination shall not affect any other portion of this Agreement.

**ARTICLE V**

**EMPLOYER'S RIGHTS**

The College, on its own behalf and on behalf of its electors, hereby retains and reserves unto itself without limitations, all customary and usual powers, rights, authority, duties and responsibilities conferred upon and vested in it by the laws and the constitution of the State of Michigan and of the United States, and any modifications made thereto, and any resolution passed by the Board of Trustees or appointed officials. Further, all rights which ordinarily vest in and are exercised by employers, except collective bargaining rights and those that are specifically relinquished in this Agreement, are reserved to and remain vested in the College, including but without limiting, the generality of the foregoing. The right:

- A. to manage its affairs efficiently and economically, including the determination of quantity and quality of services to be rendered, the control of materials, tools and equipment to be used, and the discontinuance of any services, material or method of operations;
- B. to introduce new equipment, methods, machinery, or processes, change or eliminate existing equipment and institute technological changes, decide on materials, supplies, equipment and tools to be purchased;
- C. to subcontract or purchase the construction of new facilities or the improvement of existing facilities;
- D. to determine the number, location, and type of facilities and installations;
- E. to determine the size of the work force and increase or decrease its size;
- F. to hire, assign, and lay off employees;
- G. to direct the work force, assign work, and determine the number of employees assigned to operations;
- H. to establish, change, combine, or discontinue job classifications and prescribe and assign job duties, content, and classification, and to establish wage rates for any new or changed classification;
- I. to discipline and discharge employees for cause;
- J. to adopt, revise, and enforce personnel policies and operational procedures, and to implement cost and general improvement programs;
- K. to transfer and promote employees from one department or location to another;
- L. to select employees, for positions and, prior to hire, to determine the qualifications and competency of employees to perform available work.

The College agrees that the rights of the Union are specifically listed in this Agreement. It is understood and agreed that none of the foregoing rights and responsibilities will be exercised in a manner which is inconsistent with the provisions of this Agreement.



**ARTICLE VI**

**FAIR EMPLOYMENT PRACTICES**

- A. The Employer and the Union recognize their respective responsibilities under federal, state, and local laws relating to fair employment practices.
- B. The Employer and the Union recognizes the moral and legal principles involved in the area of civil rights and reaffirm in this collective bargaining agreement their commitment not to discriminate because of race, religion, color, national origin, age, sex, marital status, sexual orientation, disability, political beliefs and activities, political affiliation, membership or participation in any labor organization, by adhering to existing equal employment opportunity, affirmative action, and Title IX guidelines and rules and regulations.
- C. Whenever the word “he” or “employee” is used in this document, it shall be deemed to include male and female and non-binary.

**ARTICLE VII**

**UNION DUES**

CHECKOFF

- A. When the Union presents to Human Resources a signed Authorization to deduct dues from the member, the Employer will collect bi-weekly dues or service fees from his/her payroll check.
- B. During the life of this Agreement and in accordance with applicable law and the terms of the Authorization to Deduct Dues form, the Employer agrees to deduct membership dues, or service fees, levied in accordance with the By-Laws of the Union from the pay of each employee who executes or has executed the Authorization form.
- C. The initial deduction for any employee shall not begin unless the Authorization form and the verification of the Union's financial officer as to the amount of the periodic Union dues or service fees has been delivered to the Employer's Payroll Department at least fifteen (15) calendar days prior to the affected pay day.
- D. All sums deducted by the Employer shall be remitted to the Union's financial officer once each month by the fifteenth (15<sup>th</sup>) calendar day of the month following the month in which deductions were made, together with a list of current employees showing the amount of Union dues or service fees deducted from each employee.
- E. In cases where a deduction is made which duplicates a payment already made to the Union by an employee, or where a deduction is not in conformity with the By-Laws of the Union, refunds to the employee shall be made by the Union.
- F. An employee may revoke his Authorization to Deduct Dues form by written notification to the Human Resources Department provided such written notice also is given to the Union by certified mail. This written notice must be received by the Human Resources Department and the Union thirty (30) days prior to the employee's elected effective pay date.
- G. The Employer shall not be responsible for checking off or collecting dues or service fees from an employee on leave of absence during which the employee receives no pay from the Employer.
- H. The Employer shall not be liable to the Union by reason of this Article for the remittance or payment of any sum other than the constituting actual deductions made from the pay earned by the employee.
- I. The Employer shall not, during the life of this Agreement, deduct dues or service fees from employees for any organization other than the Union, without the Union's written permission.
- J. The Union shall 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.

**ARTICLE VIII**

**GRIEVANCE PROCEDURE**

A. GRIEVANCE

A grievance shall mean a complaint submitted by a Bargaining Unit member or by a group of employees, or by the Union on its own behalf, to the Administration concerning any specific, alleged violation of this Agreement or disciplinary action. Any personnel policies or practices of the College that are clearly inconsistent with this Agreement may also be grieved. All grievances shall be settled in accordance with the following procedure:

B. STEP ONE

The Employer and the Union shall make reasonable efforts as herein defined to resolve employee grievances at the informal stage by facilitating meetings between the grievant and his immediate supervisor.

1. Prior to the filing of a written grievance, but no later than five (5) working days after the cause of the grievance, the grievant, with or without a representative of the Union, shall meet with the appropriate administrator in whose area the grievance arose to discuss the matter with the object of conflict resolution. In the event the appropriate administrator does not meet with the grievant within the above time period, the grievant may then file a written grievance.
2. If the grievance remains unresolved after informal discussion, the Union may submit a written grievance no later than fifteen (15) working days after the grievant's knowledge that a grievance exists. All written grievances should be placed on a form as indicated in Appendix C. A copy of the written grievance shall be dated and signed by the grievant and/or Union representative and submitted by the Union to the administrator with whom the grievance has been discussed along with any attachments which the Union deems relevant to the case. In no event shall the Grievance Procedure be involved for a grievance based on the Agreement later than the expiration date of this Agreement.
3. Within five (5) working days after the grievance was presented to him, the appropriate administrator shall communicate his decision in writing to the appropriate supervisor and to the Union.

C. STEP TWO

1. If the grievance remains unresolved after Step One, the Union may submit the grievance to the Manager of Labor Relations within ten (10) working days after receipt of the grievance answer from the appropriate administrator.
2. Within fifteen (15) working days after receipt of the written grievance from the Union, the Manager of Labor Relations shall arrange and hold an informal hearing concerning the grievance with a member of the Grievance Committee of the Union.

D. STEP THREE

1. If the grievance remains unresolved after Step Two of the Grievance Procedure, the Union shall request a meeting between the Manager of Labor Relations, and the President of the Union within five (5) working days after receipt of the grievance answer from the Manager in order to discuss the grievance further. If, however, at this step either the Union or the administration deems further meetings unproductive, written notification shall be made by either party to go directly to Step Four of the Grievance Procedure.

***P&AA Master Agreement 2021-2024***

2. Within fifteen (15) working days after receipt of the request for an additional meeting, the Manager of Labor Relations shall arrange and hold a hearing with the Union President and the Chairperson of the Grievance Committee.
3. Within ten (10) working days after this hearing, the Manager of Labor Relations shall communicate his decision in writing, including a written explanation thereof, to the President of the Union.

**E. STEP FOUR**

1. If the grievance remains unresolved after Step Three of the Grievance Procedure, the Union may submit the grievance to arbitration. Official written notice of the desire for arbitration shall be submitted to the American Arbitration Association with a copy sent to the Manager of Labor Relations no later than thirty (30) working days after the receipt of the grievance answer from the Manager in Step Three.
2. The arbitration proceedings shall be conducted under the rules of the American Arbitration Association by an arbitrator to be selected by the Employer and the Union within thirty (30) working days after notice of the desire for arbitration has been sent to the American Arbitration Association. If the parties cannot agree upon an arbitrator, they may file for arbitration by an arbitrator selected by the American Arbitration Association or Federal Mediation and Conciliation Services.
3. The arbitrator shall hear the matter promptly and shall issue his decision no later than thirty (30) days from the close of the hearing(s).
4. The fees and expenses of the arbitrator shall be shared equally by the Employer and the Union. All other expenses shall be borne by the party incurring them and neither party shall be responsible for the expense of witnesses called by the other.
5. The decision and award of the arbitrator shall be in writing and shall set forth his opinions and conclusions on the issue submitted to him.
6. The decision and award of the arbitrator will be in accordance with his jurisdiction and authority under this Agreement, shall be accepted as final by the Employer, the Union, and the employee or employees involved.
7. Nothing in the foregoing shall be construed to empower the arbitrator to make any decision amending, changing, subtracting from, or adding to the provisions of this Agreement.

**F. GENERAL PROVISIONS**

1. All formal grievances shall be typed and shall be submitted on the Grievance Report Form illustrated in the Appendix to this Agreement. All subsequent decisions or answers by the Employer shall be typed.
2. The grievant shall have the right to be present personally, to be accompanied by an official of the Union, or to be represented by an official of the Union at any stage of the proceedings. Either party shall have the right to bring in witnesses necessary for the processing of the grievance.
3. Hearings and conferences held under this procedure shall be conducted at a time and place which shall afford a fair and reasonable opportunity for all persons, including witnesses required to be present, to attend. When such hearings and conferences are held during working hours, all employees whose presence is required shall be excused for that purpose without loss of pay.

***P&AA Master Agreement 2021-2024***

4. Grievances shall be processed as rapidly as possible. The number of working days indicated at each level shall be considered a maximum and every effort shall be made to expedite the grievance process. For purposes of this Agreement, a “working day” shall be defined as any weekday, Monday through Friday, excluding holidays and any other days on which the College is closed officially.
5. A grievance involving a continuing monetary liability to the College must be appealed within the applicable time limits, and failure to do so shall result in said grievances being deemed withdrawn. Failure of the College to communicate the decision on a grievance within the specified time limits shall permit lodging an appeal at the next step of this procedure within the time allotted had the decision been given. Time limits may be extended by mutual written agreement of both parties.
6. A grievance may be initiated at any higher applicable level by mutual written agreement of both parties. The Union may withdraw a grievance without prejudice and without establishing a precedent at any step of the procedure.
7. No restraining, coercive, discriminatory, or retaliatory action of any kind shall be taken by the Employer against any party of interest, any Union representative, or any official participant in the Grievance Procedure by reason of such participation.
8. All discussions with respect to the grievance shall be kept confidential by the parties involved during the procedural steps of the grievance. However, either party may release pertinent information on any or all personnel related to the grievance.
9. No decision on a grievance or an adjustment thereof shall be contrary to any provision of this Agreement. No terms shall be added to or subtracted from this Agreement nor any provisions changed by the Grievance Procedure.
10. The Union Grievance Committee shall meet with the Manager of Labor Relations at least once every two (2) weeks if requested by either party in order to discuss current grievances.
11. All grievances filed on behalf of a group of bargaining unit members shall be initiated at Step 2.

**ARTICLE IX**

**POSITION SECURITY**

A. The Employer shall not hire nor utilize non-bargaining unit employees or consultants when such employment effects a decrease in the number of full-time and part-time employees in the Bargaining Unit.

B. Staff Reductions – Indefinite Duration

1. In the event it should become necessary to reduce the number of employees in the Bargaining Unit or to discontinue formally a College position to which a full-time or part-time employee is assigned because of reorganization, abolishment of a position, insufficient enrollment, or reduction in funds, the Employer shall provide the Union and each employee initially effected with a minimum of thirty (30) calendar days' notice. In such an event, the Employer shall meet within five (5) working days with the Union President to discuss how the layoffs shall be implemented.
2. The Board agrees to issue layoff notices to bargaining unit members who are to be laid off for an indefinite period of time by inverse bargaining unit seniority date within the classification to be affected.

C. Reassignment Rights – Indefinitely Laid Off Employees

A Bargaining Unit member served with a layoff notice, or a Bargaining Unit member who has been bumped pursuant to the provisions of this Article shall in order of Bargaining Unit seniority, be offered available positions as follows.

1. Full-time Bargaining Unit members shall be offered in the priority and sequence listed below:
  - a. Any full-time vacancy at an equivalent pay grade for which the Bargaining Unit member is qualified and has the current ability to perform as determined by the Employer.
  - b. If no vacancy of an equivalent pay grade is available, then any full-time vacancy at a lower pay grade for which the Bargaining Unit member is qualified and has the current ability to perform as determined by the Employer.
2. Part-time Bargaining Unit members shall be offered in the priority and sequence listed below:
  - a. Any part-time vacancy at an equivalent pay grade for which the Bargaining Unit member is qualified and has the current ability to perform as determined by the Employer.
  - b. If no vacancy at an equivalent pay grade is available, then any part-time vacancy at a lower pay grade for which the Bargaining Unit member is qualified and has the current ability to perform as determined by the Employer.

***P&AA Master Agreement 2021-2024***

**D. Bumping Rights – Indefinitely Laid Off Employees**

If no Bargaining Unit position is vacant, a Bargaining Unit member shall bump in order of Bargaining Unit seniority. The sequence of bumping shall be as follows:

1. The least senior Bargaining Unit member in his or her pay grade, holding a position for which the employee is qualified and has the current ability to perform as determined by the Employer.
2. A less senior Bargaining Unit member in a lower pay grade, within his or her pay grade grouping, holding a position for which the employee is qualified and has the current ability to perform as determined by the Employer.
3. For the purpose of this Article, Bargaining Unit seniority shall accrue from a Bargaining Unit member's first date of entry into the P&AA/AFT Michigan Bargaining Unit. A separate seniority list shall be maintained for full-time and part-time Bargaining Unit members. Should such member remain a College employee by transferring to another bargaining unit, or exempt position, and later transfer back into the P&AA/AFT Michigan Bargaining Unit, Bargaining Unit seniority shall be retained and not accumulate until reentry into the P&AA/AFT Michigan Bargaining Unit. If there is a period when a person is not employed by the College and not on layoff status, their Bargaining Unit seniority shall accrue from the date of the person's reentry into the Bargaining Unit at or after the time of their rehire at the College. A Bargaining Unit member who voluntarily leaves for an exempt position for more than 3 months shall forfeit the right to return to the Bargaining Unit. A Bargaining Unit member who accepts any position outside of the Bargaining Unit on a temporary or involuntary basis can remain outside the Bargaining Unit one time only for a maximum period of nine (9) months and still maintain Bargaining Unit seniority. The Bargaining Unit member's position will not be filled on a permanent basis during this one time only absence. After the one time only absence for maximum nine (9) month duration, the Bargaining Unit position must be filled on a permanent basis and follow Article XVII, Vacancies, unless the position is placed on hold or abolished.
4. The Board and Union agree that ties in seniority shall be broken by reference to the following sequence: first by reference to the most recent entered on duty date of each seniority equal bargaining unit member, the earlier date having priority, and finally, if seniority ties shall persist, the last four digits of the Bargaining Unit member's social security number (which appears on their application for employment) shall be examined and priority shall be given to the Bargaining Unit member having the highest last four digit number.
5. The bumping rights of temporary contract Bargaining Unit members shall be restricted to the ability to bump other Bargaining Unit members in temporary positions who have less bargaining unit seniority within their pay grade grouping.
6. Bumping rights will be granted to part-time Bargaining Unit members with three (3) or more continuous years of service at the College. Bumping rights are limited to part-time positions of the same or lower pay grade for which the employee is qualified and has the current ability to perform as determined by the Employer.
7. The Board and the Union agree that bumping rights are restricted to Bargaining Unit members not on probation. A continuing contract or temporary Bargaining Unit member may bump a temporary or probationary Bargaining Unit member, provided the continuing contract or the temporary Bargaining Unit member has greater seniority than the temporary Bargaining Unit member and is qualified and has the current ability to perform the job duties as determined by the Employer based on the certified education and work history on file with the Human Resource Department as of the date of the layoff notice.

*P&AA Master Agreement 2021-2024*

E. Compensation Revisions

In a case of reassignment or bumping, there shall be no reduction in the employee's bargaining unit seniority, and the employee shall receive the rate of pay in the classification to which the employee is transferred that is equivalent to his old rate or the next highest rate if no rate is equivalent. If the highest rate of pay in the new classification does not equal the rate of pay that was the employee's when the employee was laid off, the employee shall be paid at the highest rate in that new classification.

F. Faculty Vacancies

An employee served with a lay off notice shall be allowed to apply for a vacant, full-time faculty position for which the employee is qualified according to Article XVII, Vacancies, prior to their last day of work. If a full-time faculty position is available, the posting shall specify that preference will be given for previous Wayne County Community College District administrative experience. When the employee secures a position as a faculty member, the employee shall be paid according to the current Agreement between the Employer and the Wayne County Community College District Federation of Teachers.

G. Recall Rights – Indefinitely Laid-Off Employees

1. A full-time Bargaining Unit member shall have the right to be recalled to a full-time position in the bargaining unit in inverse order of their placement on layoffs for a period not to exceed one (1) calendar year, provided they are qualified and have the current ability to perform as determined by the Employer. A part-time Bargaining Unit member shall have the right to be recalled to part-time position in the Bargaining Unit in inverse order of their placement on layoff for a period not to exceed one (1) calendar year provided they are qualified and have the current ability to perform as determined by the employer. Bargaining Unit seniority shall continue to accrue during the one (1) calendar year period following their placement on layoff.
2. Any full-time Bargaining Unit member who refuses a call to a full-time position in the bargaining unit shall be removed from the seniority list and shall be deemed a voluntary quit. Any part-time Bargaining Unit member who refuses a call to a part-time position in the bargaining unit shall be removed from the seniority list and shall be deemed a voluntary quit.
3. Notice of recall shall be sent to the laid off employee at his or her last address of record by certified mail or mailgram. A copy of said notice must be mailed to the Union simultaneously.

A recalled employee shall be deemed to have refused a recall if they do not notify the Employer in writing of their acceptance of the recall within ten (10) calendar days of the mailing date of the recall notice.

H. Reorganization and Subcontracting

In the event the Employer considers a reorganization plan for the College which would affect members of the Union, it is mutually agreed that the Employer shall meet with the President of the Union to discuss the intended plan. Said meeting shall take place prior to the formal adoption of a reorganization by the Board of Trustees, prior to the delivery of any layoff notice (Article IX, Position Security), and prior to the implementation of the reorganization plan. It is expressly understood that such a meeting shall not be for the reorganization plan's approval or disapproval by the Union but for information and opportunity for input by the President of the Union.

The Employer further agrees to meet with the Union's negotiating team to negotiate the effects on Bargaining Unit members of any adopted reorganization plan.

This provision shall equally apply in the event the Employer decides to subcontract bargaining unit work.



***P&AA Master Agreement 2021-2024***

I. General Provisions

1. Full-time Bargaining Unit members shall have recall rights only to the classification from which they were laid off or from which they were bumped. Laid off Bargaining Unit members shall be given primary consideration for vacancies which occur during the one (1) calendar year following the effective date of their layoff, for which they are qualified and have the ability to perform the work as determined by the Employer.
2. Bargaining Unit members may choose to accept layoffs without exercising their reassignment options or bumping rights by communicating the same, in writing, to the Director of Human Resources as soon as possible but not later than five (5) working days after the issue date of the layoff notice.
3. The Employer shall allow a Bargaining Unit member an orientation period of ten (10) working days to acquaint the employee with the work station environment and to familiarize this employee with the duties and responsibilities of the position to which the Bargaining Unit member has been reassigned or bumped to pursuant to the provisions of this Article.
4. The Employer shall have the sole right to determine if an employee is qualified and has the ability to perform available work.

**ARTICLE X**

**EMPLOYMENT STATUS**

A. GENERAL PROVISIONS

All employees in the bargaining unit shall fall under one of the following designations: probationary, temporary, interim, or continuing.

All employees in the bargaining unit shall be apprised of their employment status when their employment commences or is renewed.

B. PROBATIONARY STATUS

1. The probationary period for all full-time employees in the bargaining unit shall consist of one hundred eighty (180) calendar days for any given classification.
2. The probationary period for part-time employees in the bargaining unit shall consist of two hundred seventy (270) calendar days for any given classification.
3. No Bargaining Unit member shall serve more than one (1) probationary period.
4. There shall be no employment rights for laid-off or recall rights for probationary employees, and no such matters shall be subject to the grievance procedure.
5. All probationary employees are subject to discharge without recourse to either Article VIII or Article XII.

C. TEMPORARY FULL-TIME AND PART-TIME STATUS

1. DEFINITION

Temporary employment status within the Bargaining Unit is defined as being any full or part-time job classification which is known to be temporary at the time of hire. This temporary status shall not exceed twelve (12) months. Any individual occupying a temporary job classification beyond twelve (12) months, shall be given continuing contract status.

2. A temporary, full-time or part-time employee who is subsequently hired into a position offering full-time continuing employment shall have his seniority date back to the first date of hire in the temporary position.

D. CONTINUING FULL-TIME AND PART-TIME STATUS

1. Definition

Continuing employment status is the full-time and part-time employees' assurance of employment security until retirement, provided said employee is not terminated for just cause such as but not limited to the following: gross insubordination, pillage, intoxication (drugs, alcohol), incompetence, or failure to observe safety rules or regulations. However, every attempt shall be made by the Employer and Union to rehabilitate those Bargaining Unit members who experience drug and/or alcohol related problems.

2. Continuing Status Eligibility

- a. All present full-time employees in the bargaining unit who have completed one hundred eighty (180) calendar days of satisfactory service shall be given continuing employment status retroactive to the date of hire.
  - b. All present full-time employees in the bargaining unit who have completed less than one hundred-eighty (180) calendar days of service shall be given continuing employment status retroactive to the date of hire upon the completion of one hundred eighty (180) calendar days of satisfactory service.
  - c. All present part-time employees in the bargaining unit who have completed two hundred seventy (270) calendar days of satisfactory service shall be given continuing employment status retroactive to the date of hire.
  - d. All present part-time employees in the bargaining unit who have completed less than two hundred seventy (270) calendar days of service shall be given continuing employment status retroactive to the date of hire upon the completion of two hundred seventy (270) calendar days of satisfactory service.
3. Full-time employees hired after the effective date of this Agreement shall be given continuing employment status retroactive to the date of hire upon completion of one hundred eighty (180) calendar days of satisfactory service.
  4. Part-time employees hired after the effective date of this Agreement shall be given continuing employment status retroactive to the date of hire upon completion of two hundred seventy (270) calendar days of satisfactory service.

E. INTERIM FULL-TIME AND PART-TIME EMPLOYMENT STATUS

1. In the event an employee with continuing full-time employment status accepts an interim full-time appointment as outlined in Article XXVIII, Interim Appointments, Temporary Job Assignments and the Temporary Assignment of Additional Duties, all continuing employment rights shall obtain as stipulated and defined in Section D of this Article.
2. In the event an employee with continuing part-time employment status accepts an interim part-time or full-time appointment as outlined in Article XXVIII, Interim Appointments, Temporary Job Assignments and the Temporary Assignment of Additional Duties, all continuing employment rights shall obtain as stipulated and defined in Section D of this Article.

F. PART-TIME EMPLOYEES – HOURS OF WORK

Part-time employees shall not work more than thirty-five (35) hours per week unless required during high activity registration periods at the beginning of each semester. These high activity periods will not exceed four (4) consecutive weeks and will not occur more frequently than three (3) times per year. During these specific periods, part-time employees may be required to work no more than thirty-eight (38) hours per week.

**ARTICLE XI**

**EVALUATION OF EMPLOYEES**

A. The Employer and the Union recognize the importance of periodical evaluations of employees in the bargaining unit. The Union supports the evaluation principle and agrees to cooperate fully with the Employer in these evaluation procedures.

B. EVALUATION PERIODS

1. Probationary, Full-time Employees

Each probationary employee shall be evaluated and given an evaluation interview by the employee's immediate supervisor twice during the employee's probationary period.

- a. The first evaluation and evaluation interview shall be completed between the sixtieth (60<sup>th</sup>) and the ninetieth (90<sup>th</sup>) calendar day of the employee's employment.
- b. The second evaluation and evaluation interview shall be completed between the one hundred fiftieth (150<sup>th</sup>) and one hundred eightieth (180<sup>th</sup>) calendar day of the employee's employment.
- c. If this second evaluation indicates satisfactory or better performance, the probationary employee shall be granted continuing employment status beginning the one hundred eighty first (181<sup>st</sup>) calendar day of the employee's employment, provided the employee is not employed on a temporary, full-time basis.

2. Probationary Part-time Employees

Each probationary employee shall be evaluated and given an evaluation interview by the employee's immediate supervisor three times during the employee's probationary period.

- a. The first evaluation and evaluation interview shall be completed between the sixtieth (60<sup>th</sup>) and the ninetieth (90<sup>th</sup>) calendar day of the employee's employment.
- b. The second evaluation and evaluation interview shall be completed between the one hundred fiftieth (150<sup>th</sup>) and one hundred eightieth (180<sup>th</sup>) calendar day of the employee's employment.
- c. The third evaluation and evaluation interview shall be completed between the one hundred eightieth (180<sup>th</sup>) and the two hundred seventieth (270<sup>th</sup>) calendar day of the employee's employment.
- d. If this third evaluation indicates satisfactory or better performance, the probationary employee shall be granted continuing employment status beginning the two hundred seventy first (271<sup>st</sup>) calendar day of the employee's employment, provided the employee is not employed on a temporary, part-time basis.

3. Employees in Trial Periods of Continuing Employment
  - a. The evaluation and evaluation interview shall be completed between the sixtieth (60<sup>th</sup>) and ninetieth (90<sup>th</sup>) calendar day of the employee's trial period.
  - b. If this evaluation indicates satisfactory or better performance, the employee shall be given continuing employment status in that position.
  - c. In cases of trial employment involving promotions and lateral transfers only, the Employer shall not fill any vacancy created by such action on a permanent, full-time basis until after the completion of the evaluation and evaluation interview. In the event the Employee issues an unsatisfactory evaluation in the promoted position, the Bargaining Unit member shall have the right to return to their former position, provided the Bargaining Unit member exercises that right within five (5) working days after receipt of the written evaluation. In order to exercise the right to return, the Bargaining Unit member must deliver written notice of such intent not later than the end of the fifth (5<sup>th</sup>) working day following receipt of the unsatisfactory written evaluation, to the Manager of Labor Relations. Any such negative evaluation shall be removed from the employee's personnel file upon return to the Bargaining Unit member's previous position.
4. Other Employees

All other employees shall be given an annual evaluation between April 1 and May 31.

C. GENERAL PROVISIONS

1. All evaluations indicated above shall be made by the immediate supervisor directly responsible for the employee's work by completion of the Performance Evaluation Form enclosed in the Appendix of this Agreement.
2. The immediate supervisor evaluating the employee shall conduct a private interview with the employee to discuss the evaluation and compare it with prior evaluations.
  - a. The immediate supervisor evaluating the employee shall sign the Performance Evaluation Form. The employee shall sign the form indicating only that the employee has reviewed the completed form in an evaluation interview. The employee's signature does not necessarily indicate agreement by the employee with the evaluation. If the employee chooses to do so, the employee may comment on the evaluation and said comment will be filed in the employee's personnel file.
  - b. A copy of the signed evaluation form shall be given to the employee at the evaluation interview and a copy shall be placed in the employee's personnel file, and the provisions of this Agreement covering personnel files shall apply. A department copy may be retained by the supervisor.
3. An employee may request an informal oral evaluation session with the employee's immediate supervisor apart from the formal evaluation and evaluation interview procedures described above as frequently as both parties deem necessary.

*P&AA Master Agreement 2021-2024*

4.
  - a. In utilizing the evaluation form exhibited in Appendix B of this Agreement, the supervisor shall cite specific incidents for each appraisal factor which supports the rating given.
  - b. In utilizing the evaluation form in Appendix B of this Agreement, the supervisor shall list as appraisal factors on the first page of the form only measurable goals and objectives.
5. Nothing in this Article shall preclude the immediate supervisor from using forms not referred to herein, provided that the immediate supervisor employs relevant and uniform criteria in an evaluation which does not deviate from the standard procedure. However, any written evaluation shall be discussed with the employee in an evaluation interview as described above, and the rules concerning these interviews as described above shall apply.

**ARTICLE XII**

**DISCIPLINARY ACTION, TERMINATION**

A. DISCIPLINARY ACTION

1. The Employer and the Union agree to use corrective discipline for disciplinary action. An employee shall not be disciplined without just cause. The steps for corrective discipline shall be:
  - a. Informal discussion.
  - b. Oral warning.
  - c. Written warning.
  - d. Suspension.
  - e. Termination.

The parties agree that the corrective discipline process normally requires that an employee be given the opportunity to correct the deficiency. Within the principle of corrective discipline; however, certain conduct may warrant immediate suspension or discharge when appropriate. The parties expressly agree that this type of conduct includes, but is not limited to, falsification of resume or other employment materials, committing or threatening any violent acts, and the offenses listed in Article X, Section D. 1.

2. In the event problems arise between an employee and his immediate supervisor, it is agreed that such problems will be solved informally whenever possible. The employee and the immediate supervisor shall meet in private in an attempt to mutually identify, clarify and resolve any job related difficulties. In the event the immediate supervisor is unable to meet privately with the employee on a timely basis, the immediate supervisor shall inform the employee in writing that a problem exists and shall establish a meeting to discuss the problem.
3. The Employer and the Union agree that any oral reprimand shall take place in private.
4. The Employer and the Union agree that no reprimand shall be placed in an employee's personnel file prior to discussion between the person issuing the reprimand and the employee being reprimanded.
5. The employee shall receive a copy of any written reprimand prior to its placement in the employee's personnel file. This reprimand shall cite the reasons for the reprimand. However, if the Employer is unable to secure the employee's signature after three (3) working days from the issuance of the reprimand, the reprimand may be placed in the employee's personnel file without his/her signature.

B. SUSPENSION

In the event the Employer elects to suspend a Bargaining Unit member, such suspension shall be for just cause.

C. TERMINATION

Except as provided for in Article IX, Position Security, and Article X, Employment Status, an employee in the Bargaining Unit shall be subject to termination only for just cause. The following procedure shall be adhered to whenever termination proceedings are initiated against an employee in the Bargaining Unit:

1. The employee's Campus President or Divisional Head shall initiate a termination recommendation. The recommendation shall be in writing and shall set forth the reasons for the termination. The recommendation shall be reviewed by the employee's Divisional Head or Human Resources. If the Divisional Head or Human Resources concurs in the recommendation, the Divisional Head or Head Resources shall forward the recommendation with his approval to the Chancellor of the College.

***P&AA Master Agreement 2021-2024***

2. The Chancellor of the College or his designee shall review the recommendation. If the Chancellor concurs in the recommendation, the Chancellor shall authorize the Divisional Head or Human Resources to inform the employee, by letter, of his or her termination. The letter shall be given to the employee in person, if possible. At the same time, a copy of the letter shall be given to the Union and a copy placed in the employee's personnel file.
- 
- D. An employee in the Bargaining Unit, except as limited by Article X, Section B. 5., who is terminated shall have recourse to the grievance procedure. The Union may begin the grievance at step 4 of the formal grievance procedure.



**ARTICLE XIII**

**COMMUNICATIONS**

- A. The Union's designee shall be furnished a copy of the agenda of each public meeting of the Board of Trustees with all normal attachments not confidential as determined by the Board at the same time regular distribution is made to the Board.
- B. Upon written request by the Union, its officially designated representative shall appear as an item of new business on the agenda of each monthly public meeting of the Board of Trustees for which the request was made, provided that such request shall be made in writing and received by the office of the Secretary to the Board at least three (3) work days prior to the meeting. Said request shall state the reason for appearing before the Board and shall include any available, relevant materials related to the subject matter of the request. If sufficient advance notice of a public meeting is not given to the Union in order to allow for its request to be delivered within the prescribed time limits, such request shall be made within a reasonable time after receipt of the notice of the meeting.
- C. The Employer shall make available to the Union upon its written request and within ten (10) working days thereafter such available statistical, financial, and personnel information and reports related to the operation of the College as are necessary for processing of grievances or the negotiation or implementation of collective bargaining agreements, provided that nothing included herein is intended to require the Employer to present information in forms not normally followed nor in forms not already compiled as provided by law.
- D. There shall be a regularly scheduled meeting between the Manager of Labor Relations and the President of the Union at least once every month. The parties may bring individuals they feel are necessary for the conduct of business at these meetings.
- E. Upon written request, the Union shall be provided with a copy of the organizational chart of the College, complete with names, titles, salaries, office locations, office telephone numbers and extensions of each Bargaining Unit member. The Union shall be promptly notified of changes in the organizational chart.
- F. The Employer shall be provided with a list of Union officers, committee members, and other officials of the Union along with office locations and office telephone numbers and extensions. The Employer shall be promptly notified of changes in this data.
- G. Employees shall be responsible for providing the Employer and the Union with changes in their addresses or telephone numbers within five (5) working days of such changes.
- H. The Employer shall supply each employee of the Bargaining Unit with a copy of this Agreement within a reasonable time after its ratification by both parties. Each new hire, rehire, reinstated, or transferred employee who does not have a copy of the Agreement shall be supplied a copy by the Employer. The Employer shall supply the Union with twenty-five (25) copies of the Agreement for the Association's own use. Cost of any outside printing of this Agreement shall be shared equally by both parties. The outside printer shall receive a copy of the Ratification Agreement within twenty (20) working days after ratification by the Union and the Employer. A copy of this Agreement shall be maintained in the office of each administrator and supervisor of the College and on the College's website. Maintaining the Agreement on the College's website shall be deemed to satisfy the requirement of a copy being in the office of each administrator and supervisor.

***P&AA Master Agreement 2021-2024***

- I. The Employer will provide the following information on a monthly basis to the President of the Union for each Bargaining Unit member: name, address, home telephone, job title, pay grade, duration of appointment, enter on duty date, classification seniority, bargaining unit seniority (separate list maintained for full-time and part-time Bargaining Unit members), job location and cost center. In addition, the Employer shall provide a salary chart to the President of the Union for all Bargaining Unit members on a quarterly basis.
  
- J. The employer shall provide the Union President copies of all personnel action notices and all Employment Authorization Forms generated pertaining to bargaining unit members within five working days.

**ARTICLE XIV**

**NEGOTIATIONS**

- A. During the period of this Agreement, any time after one hundred eighty (180) calendar days preceding the termination date, either party may notify the other of its intentions to negotiate, and negotiations shall begin within sixty (60) days after such notice is received.
- B. During the period of negotiating an Agreement, both parties shall meet at reasonable intervals and for reasonable periods of time. Every effort shall be made to schedule bargaining sessions at times which shall not conflict with scheduled assignments or otherwise disrupt or create discontinuities in normal College operations.
- C. The President and members of the bargaining team (which shall be limited to not more than four (4) officials of the Union) shall be granted a reasonable amount of release time from the Manager of Labor Relations, beginning one hundred eighty (180) calendar days prior to the termination date of this Agreement for the purpose of preparing for and conducting contract negotiations.
- D. Whenever, a question arises concerning the application and interpretation of this Agreement which affects all or substantially all of the members of the Bargaining Unit, by mutual consent the parties may convene their professional negotiation teams to discuss the matter.

**ARTICLE XV**

**PERSONNEL FILES**

- A. An official personnel file shall be maintained by the Employer for each employee in the Bargaining Unit and all such files shall be maintained in a centrally located office.
- B. Each personnel file shall have a cover sheet upon which shall be recorded the date of the insertion of any material, the subject and origin of the material, and the names of those persons who insert and inspect the material.
- C. At the request of the Employer, each employee shall be obligated to see that employment data, such as verification of job experience, transcripts of credits, and records of certification, necessary for initial salary placement and subsequent salary changes or adjustments are on file in the Human Resources Office. The employee shall be informed on the date of the request that failure to submit the aforementioned data within six (6) months may result in termination of employment.
- D. Each employee shall have the right to examine the contents of the employee's own personnel file, the only exclusion being confidential pre-employment credentials of an evaluative nature. The employee shall make an appointment with the Human Resources Office to examine his file. The Director of Human Resource or the Director's designee shall be present when the employee examines the employee's file and, if the employee so desires, the employee may be accompanied by a representative of the Union. If the employee designates in writing that the employee desires a representative of the Union to examine the employee's file in the employee absence, the designated representative shall be allowed to examine the file. The Employer acknowledges that the Union is entitled to see personnel files of other employees without their permission subject to a showing of legal relevancy.
- E. No materials originating from a nonprofessional source shall be placed in the employee's personnel file. No official report nor any derogatory statement about an employee shall be filed unless the employee is sent a dated copy. The employee has the right to submit a response to that report or statement, and the response shall be attached to and filed with the report or statement.
- F. All documents, communications, and records dealing with the processing of a grievance as outlined in this Agreement shall be filed separately from the personnel files of the participants. This provision shall be retroactive.
- G. Each employee shall have the right to place in the employee's personnel file relevant material which attests to the employee's professional competence.
- H. At the employee's request, the Employer shall reproduce any material in the employee's personnel file, except confidential pre-employment credentials of an evaluative nature, provided a reasonable duplication fee is paid by the employee.
- I. A Bargaining Unit member can request in writing the removal of the oldest reprimand in the employee's personnel file, provided said employee has not received a reprimand for one calendar year.

**ARTICLE XVI**

**CIVIC AND ACADEMIC FREEDOM**

To the extent protected by applicable law, an employee shall be free from administrative and institutional censorship and discipline when the employee speaks or writes as a citizen. The employee bears the responsibility to clarify the fact that the employee speaks or writes as an individual and not on behalf of the Employer, and to identify himself/herself at the time the employee speaks or writes.

**ARTICLE XVII**

**VACANCIES**

- A. The Employer will post all notices of any Union vacancies in a prominent and secure location in the immediate proximity of the Human Resource Office and will distribute such notice to each of the day/night instructional centers for the full duration of the application period. The Human Resource Office will assign a sequential number to each notice of position vacancy. The notice of position vacancy shall be posted only after notice of receipt has been signed off by the Union President or designee, provided said notice has been signed off within forty-eight (48) hours of receipt of said notice. Posting should be made at least fourteen (14) calendar days prior to the filling of the vacancy for full-time Bargaining Unit members and seven (7) calendar days prior to filling of the vacancy for part-time Bargaining Unit members unless waived in writing by the President of the Union or his designee.
1. The notice shall be in a form suitable for posting and shall include the date of the notice, a job description summary, remuneration offered, required qualifications, bargaining unit designation, and the final date for acceptance of applications.
  2. Any employee of the College may apply for the position by written application to the Director of Human Resource. An application for a position shall be recognized as a professional right and shall not adversely affect an employee's status in the employee's present position.
  3. The Employer shall notify all Union member applicants of the disposition of their applications for a position prior to the approval by the Board of Trustees of the name of the successful applicant.
- B. The Employer shall give primary consideration to applicants from within the Bargaining Unit if their qualifications are superior or equal to other qualified applicants, provided the selection of applicants is consistent with existing equal employment opportunity and affirmative action guidelines. Successful employment in the employee's existing classification shall be a recognized factor for filling a College position. When applying for a P&AA position at the College, the applicant from the P&AA Bargaining Unit with the most seniority shall be interviewed before any other internal or external candidate.
- C. Prior to the posting of a new position within the Bargaining Unit, the Director of Human Resources shall notify the President of the Union in writing of the new position and salary for said position by submitting a proposed job posting and job description for said position. The President of the Union may respond within five (5) working days from receipt of said notice.

**ARTICLE XVIII**

**OUTSIDE OR PART-TIME EMPLOYMENT**

A. GENERAL PROVISIONS

1. Each employee in the Bargaining Unit is expected to carry out the responsibilities of the employee's position at the College. A moderate amount of outside or part-time employment is permissible, provided it does not conflict with the employee's position at the College, does not adversely affect the quality of the employee's work, and is not carried out during hours normally devoted to the responsibilities of his position at the College.
2. If the Employer determines that an employee's outside or part-time employment conflicts with the employee's position at the College, adversely affects the quality of the employee's work, or is carried out during hours normally devoted to the responsibilities of the employee's position at the College, the employee shall be so advised, and the employee shall immediately take steps to remedy the situation.
3. No full-time employee of the College may hold another full-time job. Any other job held by a Bargaining Unit member shall be deemed a full-time job if the other employer classifies it as a full-time job. Any employee who continues to hold another full-time job after being notified that he is in violation of this provision shall be terminated. Such employer determination shall be subject to the grievance procedure.

B. EMPLOYEES WHO TEACH

An employee in the Bargaining Unit shall be allowed to instruct or to act in the capacity of counselor or librarian for remuneration in addition to the responsibilities of the employee's position at the College provided the above and following stipulations are adhered to:

1. The employee shall be qualified to perform the assignment and shall have an application and other employment credentials which attest to the employee's qualifications in the employee's personnel file.
2. The employee shall be allowed to teach or act in the capacity of counselor or librarian for a maximum of two classes per semester.
3. The employee's teaching or other assignments shall in no way result in the reduction of present full-time faculty positions.
4. The employee's teaching or other assignments shall in no way infringe on any full-time faculty member's priority in regular or overload assignments.
5. The employee's performance of the teaching or other assignments shall be evaluated using the same criteria as those applied to part-time faculty.
6. The employee shall be paid according to the existing part-time salary schedule as found in the current Agreement between the Employer and Wayne County Community College District Federation of Teachers.
7. The employee shall be liable to the Federation of Teachers for an amount equal to the appropriate dues or service fees.

***P&AA Master Agreement 2021-2024***

C. PART-TIME EMPLOYMENT WITHIN THE BARGAINING UNIT

Full-time employees in the bargaining unit shall have priority in the assignment of additional bargaining unit work that does not conflict with their normal working hours. Full-time employees in classifications A-1 through A-5 shall have first refusal as to additional work in any job classification P-1 through A-5. Full-time employees in job classification B-1 through B-6 shall have first refusal as to additional work in any job classification B-1 through B-6. Compensation shall be at the classification's appropriate full-time hourly rate.



**ARTICLE XIX**

**STANDING COMMITTEES**

- A. The Employer shall involve employees of the Bargaining Unit in the development of policies having a direct relationship to their interests or professional mission. This involvement shall be evident especially, but not exclusively, in the standing committees of the College.
- B. There shall be appropriate Union representation on all standing committees created by the Employer. Union representatives serving on standing committees shall be elected at large by the employees in elections conducted by the Union. Any employee shall have the right to place the employee's name on the ballot of any standing committee position available.
- C. The Union shall be provided with the agenda for all standing committee meetings at the same time it is sent to its members. This shall be done in order that the Union might submit written material pertinent to the items on the agenda of these meetings.
- D. If the Employer does not accept the recommendations of a standing committee, the reasons for such action shall be forwarded to the chairperson of the committee involved. In any opinion rendered by a standing committee, provision shall be made for minority opinion. The Union shall obtain an opinion of a standing committee by submitting a request in writing to the chairperson of the committee.
- E. Each standing committee shall have access to all non-confidential materials which are pertinent to its deliberations. It may use consultants as their need is determined, provided the use of consultants shall not obligate the committee or the Employer financially.
- F. Each standing committee shall be provided with adequate secretarial help and shall be provided with centrally located files for committee correspondence and records.

**ARTICLE XX**

**LEAVES**

A. LEAVES OF ABSENCE WITH PAY

1. General Provisions

- a. Leaves of absence with pay shall be granted only to full-time employees in the bargaining unit. (Except Emergency Situations and Jury Duty which shall also be granted to Part-time employees in the bargaining unit who are scheduled to work on the day(s) effected.)
- b. All leaves of absence with pay shall be granted without loss of seniority. Contractual benefits or rights accumulated by an employee prior to the effective date of the leave shall be carried forward and credited to him upon his return. Upon his return from a leave of absence with pay, the employee shall be returned to his position and pay grade, provided such position has not been eliminated by the Employer and his seniority entitles him to his former position and pay grade.
- c. An employee shall suffer no loss of pay during a leave of absence with pay except as limited in the following provisions.
- d. An employee shall accrue sick leave days and vacation days during a leave of absence with pay, and his insurance benefits shall continue for the duration of the leave. All full-time employees shall receive, in writing, an update of their accrued sick leave and vacation time every six months.

2. Sick Leave

- a. Each full-time employee shall accrue one and half (1-½) days of sick leave for each month employed, provided the employee worked a minimum of eighteen (18) days per month used in the computation. Any day for which the employee is compensated fully by the Employer shall be considered a day worked. The Employer shall minimally charge two (2) hours for each use of sick leave.
- b. Sick leave days shall be used only for the following purposes:
  - 1) Employee's illness, accident, or hospitalization.
  - 2) Pregnancy, miscarriage, abortion, childbirth, and recovery there from shall be included specifically in this category. Normally, routine dental and medical appointments should not be charged to sick leave. Each employee will make every attempt to secure all medical and dental appointments outside normal working hours. If such appointments are necessary during working hours, they shall be charged to sick leave.

3) Emergency Situations

Emergency situations shall be limited to the following: quarantine or employee or employee's living quarters; court appearance where the employee's attendance is required by subpoena or summons; such days as may be required by the employee's religion for holy observance and abstention from work; death in the family or death of a close associate; care for a member of the employee's family when no other arrangements are possible; weather conditions that make it impossible for the employee to report to work; conditions arising out of civil strife or riot which make it impossible for the employee to report to work.

4) Personal Business Leave

The Employer shall minimally charge one (1) hour for each use of personal business leave. Up to seven (7) uses per annum may be stipulated as personal business leave time. Personal business leave is provided for personal business of a nonprofit nature that cannot be taken care of outside of working hours. Personal business leave may be used to cover as little as one (1) hour, or as many as eight (8) hours, and such time will be deducted from the employee's sick bank. Personal business leave days shall not be allowed immediately prior to or immediately following a scheduled holiday or vacation day.

- c. An employee shall report each absence promptly to his immediate supervisor. Whenever possible, an employee shall report the absence before the beginning of the normal work day. The employee shall identify the reason for the absence except in the case of personal business leave. If an employee is absent for five (5) consecutive work days without notifying his immediate supervisor, the employee shall be subject to termination, notwithstanding the provisions of Article IX, Position Security, or Article VIII, Grievance Procedure.
- d. After five (5) consecutive work days of sick leave, an employee shall furnish to the Employer a statement from his physician verifying that the employee is unable to work. Clarification of medical statements may be required by the Employer. An employee who remains on extended sick leave in excess of fifteen (15) work days may be asked by the Employer to have a medical examination by a physician stipulated by the Employer in cases where sufficient evidence of continued illness and/or clarification is not obtainable by other means. An employee returning after five (5) or more consecutive work days of sick leave shall supply the Employer with a physician's statement attesting to the employee's ability to resume full-time employment.
- e. The Employer is responsible for keeping the records of each employee's sick leave account up to date. The Employer shall report sick leave balances as of the preceding pay period at the end of the current month as an enclosure with the paycheck.
- f. An employee may request a medical leave of absence for medical reasons. Such request for leave of absence shall be in writing and must be approved by Human Resources. Ordinarily, such medical leave of absence will be for a period of not less than fifteen (15) working days and may be extended for good medical reasons for longer periods of time. An employee who has gone on medical leave of absence for less than one (1) year's duration shall be entitled to return to the position which the employee left at the commencement of such medical leave, provided such position currently exists and further provided the employee can physically and emotionally perform the job. Such jobs, if filled, will be filled on a temporary basis subject to the employee's return from medical leave of absence. If the medical leave of absence extends one (1) year, the employee may return to the position they left provided the Bargaining Unit member returning from medical leave

of absence has more classification seniority than the Bargaining Unit member who filled this position on a temporary basis.

- g. An employee shall not be able to use sick leave days before they are accrued.
- h. An employee shall be allowed to use accrued vacation days as sick leave days when the employee's sick leave account is exhausted, provided notification of same is given to the immediate supervisor on a timely basis.
- i. An employee who leaves a position in the Bargaining Unit for another full-time position in the College shall be allowed to transfer each employee's sick leave account to the employee's new position.
- j. If an employee is sick for fifteen (15) consecutive work days, the employee must notify the Human Resource Department by the end of the fifteenth day as to whether they wish to begin receiving short term disability benefits as of their 16<sup>th</sup> consecutive day of absence, or whether they wish to designate when sick leave benefits shall terminate and when short term disability benefits shall begin. No other options shall be available to the employee. If the employee fails to notify the Human Resource Department by the end of the 15<sup>th</sup> day the employee shall begin receiving short-term disability benefits as of their 16<sup>th</sup> consecutive day of absence.

Once the employee has notified the Human Resource Department as to their choice or failed to notify the Human Resource Department of their choice, no changes may be made.

If an employee elects to exhaust their sick leave before receiving short term disability benefits, the employee's disability shall be deemed to have occurred on the 15<sup>th</sup> work day prior to the exhaustion of the employee's sick leave. Only employees who have more than fifteen (15) accrued sick leave days may avail themselves of this option.

### 3. Jury Duty Leave

Upon prior written request, a full-time or part-time employee called to jury duty shall be granted a leave of absence for the duration of that duty, or at the option of the employee, may elect to take any vacation/leave time that the employee has accrued. The Employer shall be obligated to pay only an amount equal to the difference between the employee's salary as computed on a daily basis and the daily jury fee paid. In order to be eligible for compensation from the Employer as noted above, each full-time employee must submit check stub(s), to the Employer indicating the amount of jury duty pay received. The Employer, upon receipt of check stub(s), will deduct the amount of all jury duty fees, exclusive of mileage allowances, from the employee's regular pay check.

### 4. Reservist Duty Leave

- a. Upon prior written request, an employee who is a member of the National Guard or organized Reserves of a United States Military Service and who is ordered to active duty for an annual training period shall be granted a leave of absence for the duration of that training period.
  - 1) The Employer shall be obligated only to pay an amount equal to the difference between the employee's salary as computed on a daily basis and the reservist' daily rate.
  - 2) The Employer shall be obligated only to pay the above difference for a maximum of fourteen (14) calendar days.
- b. Emergency Duty Leave

An employee who is a member of the National Guard or organized Reserves of a United States Military Service and who is ordered to emergency duty because of riot, flood, or other disaster, shall be granted a leave of absence for the duration of that emergency duty.

- 1) The Employer shall be obligated only to pay an amount equal to the difference between the employee's salary as computed on a daily basis and the stipend paid if that stipend is less than the employee's daily rate.
- 2) The Employer shall be obligated only to pay the above difference for a maximum period of thirty (30) calendar days.

5. Part-Time Employee Leave

Part-time employees who have completed one (1) year of employment shall be provided the following leave time.

- a. A maximum of seventy-five (75) hours of leave may be accrued each year of the contract.
- b. Leave banks will be established as of July 1, 1995 containing the leave time earned during 1994-95. Thereafter, leave will be accrued on the basis of 3.5 minutes per hour of work up to a maximum of 1,286 hours and may be used in one hour increments as it is earned. No leave time is granted for hours worked beyond 1,286.
- c. Leave may be used for vacation, sick, and personal business purposes. Leave used for vacation must be requested in writing thirty (30) days in advance.
- d. Seventy-five (75) hours can be carried over from one contract year to the next. All additional hours will be forfeited.

B. LEAVES OF ABSENCE WITHOUT PAY

1. General Provisions

- a. Leaves of absence without pay, except as provided for in the following provisions, shall be granted only to full-time Union members.
- b. All leaves of absence without pay shall be granted without loss of seniority. Contractual benefits or rights accumulated by a Union member prior to the effective date of the leave shall be carried forward and credited to the employee upon the employee's return. Upon the employee's return from a leave of absence without pay, the employee shall be returned to the employee's position and pay grade, provided such position has not been eliminated by the College and his seniority entitles the employee to the employee's former position and pay grade.
- c. Except as specifically provided for in any of the following provisions, no payment of any kind shall be made to or for a Union member on any leave of absence without pay.
- d. Except as specifically provided in any of the following provisions, an employee shall not have the employee's insurance benefits paid for him by the Employer for the duration of a leave of absence without pay. However, the Employer shall allow an employee on leave of absence without pay to continue the employee's insurance benefits through the Employer's insurance plans, provided the employee is responsible for all premium payments.
- e. All requests for leave of absence without pay shall be made in writing and shall be made initially with the employee's supervisor. They shall be subject to the approval of the employee's Divisional Head.

*P&AA Master Agreement 2021-2024*

- f. The Union shall be kept apprised of all extended leaves of absences without pay for members of the Bargaining Unit. Extensions for leaves of absence without pay shall comply with the procedure for the initial leave request.
- g. Each request for a leave without pay shall be filed in the Office of Human Resources at least two weeks prior to the requested starting date of the leave whenever possible.
- h. Failure to return to employment upon termination of a leave of absence without pay shall constitute termination of employment.

2. Extended Military Leave

A full-time member who enlists in or is conscripted into the United States Military Service shall be granted a leave of absence without pay in conformance with conditions established by federal and state law. If said employee volunteers for alternative service, in lieu of the Draft, he shall be entitled to the above mentioned rights.

3. Personal Leave

A member who is an expectant mother shall be granted a leave of absence without pay under the following provisions:

- a. The Employer shall grant a leave of absence without pay for maternity leave upon written request of such leave by the employee and certification of pregnancy by the employee's physician.
- b. The employee shall notify the administrator in charge of Human Resources by written statement from her physician within six (6) weeks after pregnancy has definitely been determined. The physician's statement must specify the expected delivery date and must further specify the date up to which, in the physician's opinion, the employee can continue full-time employment in her position without: 1) danger to the employee's health or that of the unborn child, or 2) impairment in any way of the employee's ability to perform her duties.
- c. The effective date of separation for maternity reasons shall be the date specified by the employee's physician as described in the above subsection.
- d. Within six (6) weeks after delivery of the child, the employee shall supply the administrator in charge of Human Resources with a statement from her physician specifying the date when, so far as the health of the child is concerned and without respect to any aspect of care in feeding of the child, the employee is able to resume full-time employment in her position without danger to the employee's health and without impairment in any way of the employee's ability to perform her duties.
- e. The date of resumption of employment shall be the date specified by the employee's physician as described in the above subsection.
- f. The employee may apply sick leave days to a maternity leave for a period not to exceed six (6) weeks after the birth of the child. Sick leave shall not be used beyond the six (6) week period except in those instances where the employee's physician certifies that the employee is physically unable to return to work.
- g. The Employer reserves the right at its option and expense to have the employee examined by a physician designated by the Employer with respect to the report ending date of the leave as set forth in subsection d. above. The employee will make herself available for such examination and will cooperate in furnishing any necessary information in connection therewith. The Employer's designated physician will provide the Employer and the employee with a statement specifying the same information as that required from the employee's physician and described in subsection "d" above. In event of conflict between the statements of the two physicians, a third physician shall be selected by the two physicians, and his/her diagnosis shall be controlling.

***P&AA Master Agreement 2021-2024***

- h. An employee who fails to return to work at the termination of the maternity leave, or any extension that may have been granted thereof, shall be subject to immediate termination.
- i. Hospitalization coverage shall be paid by the Employer for one hundred eighty (180) days beginning the first day of leave.

**4. Parental Leave of Absence**

- a. The Employer shall grant a leave of absence without pay for the care of an employee's newborn child for a period of up to one year upon written request for such leave by the employee and certification of the birth by the employee's physician.
- b. The request for parental leave shall be submitted at the same time as a request for maternity leave as described in the above paragraphs. Parental leave will begin at the date for expiration of maternity leave as described in the above paragraph 3. (d).
- c. A full-time male Bargaining Unit member shall be granted up to one (1) year's leave of absence without pay upon written request to the appropriate administrator provided such request is made within sixty (60) days of the birth of the child to his spouse.

**5. Medical Examination**

Should the Board or its agents have reason to suspect that an employee is being rendered incompetent by physical and/or emotional disability, the Board may require that said employee submit to a physical or psychiatric evaluation. The Board may designate an examiner who must be a licensed physician or psychiatrist, and the Board will assume the cost of the examination. The employee, at his expense, may select an additional examiner. In the event the examiners differ upon final diagnosis, the parties shall employ a third physician selected by the first two physicians whose diagnosis shall be binding on the parties. The parties shall split the cost of this final examination. All examination reports shall be confidential and none shall be placed in the personnel file of the employee until final determination of the employee's condition.

**6. Family and Medical leave (FMLA)**

Bargaining Unit members shall be eligible for FMLA in accordance with Federal law.

**7. Other Leaves of Absence Without Pay**

The Employer may grant other leaves of absence without pay if such leaves are recommended by the employee's immediate supervisor and approved by the employee's Divisional Head and the Director of Human Resources. A leave granted under this provision to one employee shall in no way set a precedent for other requests.

**ARTICLE XXI**

**VACATIONS**

A. Each full-time employee in the Bargaining Unit shall be granted vacation days with pay. Vacation days shall be granted only in accordance with the following provision:

B. METHOD OF COMPUTING VACATION DAYS

1. Vacation days for full-time Bargaining Unit members shall accrue according to the following:
  - a. Vacation days shall accrue at the rate of one and three quarters (1  $\frac{3}{4}$ ) days for each month of full-time employment.
  - b. For purposes of this and the following paragraph, in order to accrue vacation days for any month, a full-time employee shall have worked a minimum of eighteen (18) days. Any day for which the employee is compensated fully by the Employer shall be considered a day worked.
  - c. The Employer shall minimally charge four (4) hours for each use of vacation leave.
2. Method of Scheduling Vacation Days
  - a. Each Bargaining Unit member shall request vacation on forms provided by the Employer. Any vacation time not used may be reserved for future provided, however, that the number of reserved hours for any Bargaining Unit member shall not exceed 336 hours. Any Bargaining Unit member who has a vacation balance greater than 336 hours as of June 30 of each year shall forfeit all hours in excess of the 336 hours reserve maximum.
  - b. All vacation requests must be submitted not later than forty-five (45) calendar days prior to the requested time off for vacation.
  - c. Approvals or denials of vacation time requests shall be made not later than two calendar weeks after receipt of same. If the supervisor does not respond to the employee's request within two (2) calendar weeks, the employee shall submit in writing his/her request to the College's Campus President or Vice-Chancellor who will have five (5) calendar days to respond. If the Campus President or Vice-Chancellor does not respond to the employee's vacation request within five (5) calendar days, the vacation time request shall be considered to be approved. If the employee's request is denied, the employee may resubmit as long as the new dates requested do not overlap with the original request.
  - d. In the event that an employee and his supervisor are unable to agree on the dates when vacation leave shall be granted, the employee may submit two (2) options in writing to the supervisor. These alternative options shall be for the same number of consecutive vacation days as originally requested and shall not overlap each other or the originally requested vacation period. The Employer must accept one of the two (2) alternatives.
  - e. Requests for changes in vacation time after approval shall be made in writing to the immediate supervisor. Approvals for vacation changes shall be effective only if signed by the Divisional Head and the Director of Human Resources.
3. Each employee, in addition to the above vacation days, shall be credited as vacation days those days occurring between the Christmas and New Year's holiday break each contract year, provided the



***P&AA Master Agreement 2021-2024***

employee is not scheduled to work during this period. If the employee is scheduled to work, the employee shall be allowed to reschedule these vacation days.

**C. GENERAL PROVISIONS**

1. The Employer is responsible for keeping the records of each employee's vacation account up to date. Accordingly, the Employer shall have printed on each paycheck stub the number of vacation hours remaining in the employee's account.
2. Notwithstanding any other provisions of this Article, vacation days shall be scheduled by the Employer at times when the least amount of disruption occurs at the work stations by any employee.
3. An employee cannot use vacation days before they are accrued.
4. A probationary employee shall accrue vacation days, but he shall not be able to use them during the period of his probation.
5. Vacation days shall not be waived by an employee and an employee shall not receive additional pay for working those days.
6. If any of the holidays stipulated in this Agreement should occur during an employee's scheduled vacation, the employee shall receive one (1) additional vacation day for each holiday.
7. If any employee becomes ill and presents a physician's statement that the employee was under the care of a physician during the employee's vacation, the employee may submit an amended Report of Absence charging the vacation days to the employee's sick leave account and reschedule the affected vacation days.
8. An employee shall be allowed to use accrued vacation days as sick leave days when the employee's sick leave is exhausted, provided notification of same is given to the immediate supervisor on a timely basis.
9. If an employee is indefinitely laid off, retired, or terminated for any reason, the employee shall be paid for any unused days including those accrued in the current year. Payment of accrued vacation days shall be made to an employee's estate in the event of the employee's death. All payment for vacation days not used shall be based on the current rate of pay.
10. An employee who leaves a position in the Bargaining Unit for another full-time position in the College shall be allowed to transfer the employee's vacation account to the employee's new position, provided the new position is not in the Wayne County Community College Federation of Teachers Bargaining Unit. If the new position is as an employee in the above named Bargaining Unit, the employee shall be paid for any unused vacation days as outlined in Paragraph 9 above.
11. An employee shall be paid vacation pay prior to the employee's departure on vacation, provided the employee gives the Payroll Department at least fifteen (15) calendar days advance notice.

**ARTICLE XXII**

**HOLIDAYS**

- A. Each regular, full-time employee shall be paid one day’s pay for each holiday listed below, provided the employee was scheduled to work during the pay period in which the holiday occurs.
- B. Each part-time bargaining unit member shall be paid their hourly rate for each hour he/she is scheduled to work during the pay period in which the holiday occurs. However, for the break between Fall and Spring semesters each part-time bargaining unit member shall be paid his/her hourly rate for each of the enumerated holidays based upon their daily average hours worked per week.
- C. The following are the paid holidays of this Agreement: however, in the event the academic calendar changes, these calendars may be modified accordingly:

Fiscal Year 2021 - 2022		
July 4, 2021	Sunday	Independence Day
July 5, 2021	Monday	Day After Independence Day (If no classes)
September 6, 2021	Monday	Labor Day
November 25, 2021	Thursday	Thanksgiving Day
November 26, 2021	Friday	Day After Thanksgiving Day
TBD by Chancellor in his/her discretion		Last Day of Work*
December 24, 2021	Friday	Christmas Eve
December 25, 2021	Saturday	Christmas Day
December 26, 2021	Sunday	Day After Christmas
December 31, 2021	Friday	New Year’s Eve
January 1, 2022	Saturday	New Year’s Day
January 2, 2022	Sunday	Day After New Year’s Day
TBD by Chancellor in his/her discretion		First Day of Work*
January 17, 2022	Monday	Martin Luther King’s Birthday
April 15, 2022	Friday	Good Friday
April 18, 2022	Monday	Winter Break
April 19, 2022	Tuesday	Sojourner Truth Day
May 30, 2022	Monday	Memorial Day

Fiscal Year 2022-2023		
July 4, 2022	Monday	Independence Day
July 5, 2022	Tuesday	Day After Independence Day (If no classes)
September 5, 2022	Monday	Labor Day
November 24, 2022	Thursday	Thanksgiving Day
November 25, 2022	Friday	Day After Thanksgiving Day
TBD by Chancellor in his/her discretion		Last Day of Work*

**P&AA Master Agreement 2021-2024**

December 24, 2022	Saturday	Christmas Eve
December 25, 2022	Sunday	Christmas Day
December 26, 2022	Monday	Day After Christmas
December 31, 2022	Saturday	New Year's Eve
January 1, 2023	Sunday	New Year's Day
January 2, 2023	Monday	Day After New Year's Day
TBD by Chancellor in his/her discretion		First Day of Work*
January 16, 2023	Monday	Martin Luther King's Birthday
April 7, 2023	Friday	Good Friday
April 10, 2023	Monday	Winter Break
April 11, 2023	Tuesday	Sojourner Truth Day
May 29, 2023	Monday	Memorial Day
Fiscal Year 2023 - 2024		
July 4, 2023	Tuesday	Independence Day
July 5, 2023	Wednesday	Day After Independence Day (If no classes)
September 4, 2023	Monday	Labor Day
November 23, 2023	Thursday	Thanksgiving Day
November 24, 2023	Friday	Day After Thanksgiving Day
TBD by Chancellor in his/her discretion		Last Day of Work*
December 24, 2023	Sunday	Christmas Eve
December 25, 2023	Monday	Christmas Day
December 26, 2023	Tuesday	Day After Christmas
January 1, 2024	Sunday	New Year's Eve
January 2, 2024	Monday	New Year's Day
January 3, 2024	Tuesday	Day After New Year's Day
TBD by Chancellor in his/her discretion		First Day of Work*
January 15, 2024	Monday	Martin Luther King's Birthday
March 29, 2024	Friday	Good Friday
April 1, 2024	Monday	Winter Break
April 2, 2024	Tuesday	Sojourner Truth Day
May 27, 2024	Monday	Memorial Day

\*Dates designated above as "First Day of Work" or "Last Day of Work" shall not be considered paid holidays.

- D. Whenever a state or federal statute requires that any of the above holidays be observed on the day or date other than as set forth above, the holiday shall be observed on the day or date prescribed by the controlling statute, except that any holiday falling on a Saturday or Sunday shall be observed on the respective Friday or Monday.
- E. Should any of the above holidays occur during an employee's scheduled vacation, he shall receive one (1) additional day of paid vacation for that holiday(s).
- F. In the event an employee is required to work on a scheduled holiday, such time shall be credited on an hour for hour basis to the employee's vacation account.
- G. When the national holiday falls on a Monday, an employee with the work schedule of Tuesday thru Saturday, holiday shall be deemed as the Tuesday following the national holiday. The national holidays are as follows:

***P&AA Master Agreement 2021-2024***

Martin Luther King's Birthday (January), Memorial Day (May), Independence Day (July) and Labor Day (September).

- H. When the national holiday and/or WCCCD designated "breaks" which include Saturday, an employee with the work schedule of Tuesday thru Saturday, work schedule shall be changed for that week of the holiday to Monday thru Friday. The national holiday and/or breaks are as follows: Good Friday; Winter Break; Sojourner Truth Day; Independence Day; Thanksgiving Day; Day after Thanksgiving; and last day of work in December.

**ARTICLE XXIII**

**FRINGE BENEFITS**

A. INSURANCE

With the exception of Workers' Compensation, only full-time employees in the Bargaining Unit shall be granted coverage by the following insurance programs. Commencement and duration of coverage and amount and nature of benefits shall be governed by the terms of the group insurance policy and the rules and regulations of the carrier.

1. Group Life Insurance

The Employer agrees to pay the necessary premiums to provide a group term life insurance policy with an accidental death rider of equal to two (2) times the employee's annual salary and to the nearest multiple of 1,000, not to exceed a maximum of \$100,000.

2. Short Term Disability Insurance

The Employer agrees to pay the necessary premiums to provide a short term sickness and accident disability policy for each full-time employee providing for twenty six (26) weeks disability pay at two thirds (2/3) of weekly salary to a maximum of \$500 per week.

3. Long Term Disability Insurance

The Employer agrees to pay the necessary premiums to provide long term disability insurance in the amount of 2/3 of the Bargaining Unit member's salary not to exceed \$2,500 per month. Disability benefits shall commence the twenty ninth (29th) week of total disability and continue for the period of disability or to age sixty five (65) whichever occurs first. During the time of total disability, there shall be excluded from the non-duplication offset any social security benefits in excess of those in effect at the time of disability.

4. Medical Insurance

a. The Employer agrees to contribute the maximum amount permitted under MCL 15.563, as adjusted from time-to-time by the state treasurer, for premiums to provide at the employee's option, any of the HAP (HMO) or BCBSM Community Blue (PPO) plans indicated in attached Appendix D or any other comparable plan for each full-time employee, spouse, and dependent children. The employee shall be responsible for paying the balance of the premium, the service co-pays and deductibles, if any, for the plan that is selected.

b. Full-time bargaining unit members who have full or partial health care coverage through another source may opt out of College provided health care coverage and receive \$2,500.00 per year. Cash reimbursements will be payable on a monthly basis through a cash in lieu of benefits plan implemented under IRS Code 125. No changes in beneficiaries can be made during the opt-out year. Cash reimbursements due bargaining unit members leaving the College will be made with other monies due upon separation from the employment with the College and shall be prorated. No opt out payments will be available when both the employee and the person who is the source of the employee's other coverage are employed by the College.

In order to drop health care benefits, the bargaining unit member must submit a written request to the Director of Human Resources and must present documents showing proof of alternative coverage. Such requests must be submitted between May 1 through May 30th each year. A Bargaining Unit member who elects not to be covered by a College health

***P&AA Master Agreement 2021-2024***

care plan must remain dropped from coverage for a period of one year (July 1 – June 30th) unless for any reason the Bargaining Unit member loses their alternative source of coverage. In such case, the Bargaining Unit member must present proof of loss health care coverage to the Director of Human Resources or designee who upon receipt and verification of such proof will immediately re-enroll the bargaining unit member in the College health care program selected. Coverage will be effective as soon as arrangements can be made with the insurance carrier selected.

5. Dental Insurance

Bargaining Unit members may participate in the Delta Dental Plan or comparable plan as provided by the Employer. The dental plan provides in most cases payment of ninety percent (90%) of the cost for dental care (90/90/50) up to a maximum of \$1,000.00 in one year for each full-time employee, the employee's spouse, and dependent children.

6. Optical Insurance

The Employer agrees to pay the necessary premiums to provide each full-time employee, his spouse, and dependent children, with the Basic Plan of Cooperative Services, Inc., Heritage Optical, or a comparable plan, provided said plan does not exceed \$100 per annum per employee.

7. Workers' Compensation

Workers' Compensation Insurance shall be carried by the Employer as required by the Michigan Workers' Compensation Act.

B. OTHER FRINGES

1. Tax Sheltered Annuity Program

The Employer shall make available to all bargaining unit employees an approved tax sheltered annuity program. The Employer shall provide no less than five (5) vendors to provide the tax sheltered annuity service. Each employee shall notify the appropriate administrator of their designation of vendor.

2. Retirement Fund

The Employer shall assume the cost of each Bargaining Unit member's contribution to the Michigan Public School Employees Retirement Fund. Employees eligible for retirement benefits may elect to participate in the Optional Retirement Plan.

3. Courses at the College

The Employer shall issue tuition waivers for each employee for courses taken at the College by the employee, the employee's spouse, and dependent under the age of twenty five (25).

4. Unemployment Insurance

Unemployment insurance shall be carried by the Employer as required by Michigan law.

5. Medical Insurance - Laid-Off Employees

A laid-off Bargaining Unit member may continue medical insurance as provided by law.

C. Medical Insurance for Part-Time Employees

*P&AA Master Agreement 2021-2024*

To the extent that applicable insurance plans are commercially available, the College agrees to administer a program of medical insurance for part-time bargaining unit members. All premiums will be paid by the part-time bargaining unit member.

The College agrees to implement under Internal Revenue Code 125 a plan to allow part-time bargaining unit members to pay insurance premiums through pre-tax payroll deductions. The College is not responsible for an employee's funds not being available for insurance premiums through a payroll deduction plan, and reserves the right to restrict the payroll deduction for any pay period during which an employee's compensation is not sufficient to cover the total amount of the payroll deduction. Un-deposited amounts will be included in the employee's regular check. The College is not responsible for subsequent cancellation of insurance due to non-payment of premiums by the employee.

D. Reimbursement Accounts

The College agrees to implement under IRS Code 125 a Reimbursement Account Plan for bargaining unit members to pay for medically necessary and doctor prescribed health services, and for dependent care services that are not covered under current insurance plans.

E. Employee Assistance Program

Employee assistance programming is a technique or method for reaching employees with personal problems, e.g., substance abuse, smoking, emotional, family, social, marital, financial, etc., and providing them with a mechanism to obtain treatment.

The Union and the College are committed to working together to ensure that the needs of the affected employees are met.

The Union and the College will jointly develop a written Employee Assistance Program (EAP). EAPs are based upon two concepts:

- a. The Program will offer a policy and procedure for dealing with employees whose job performance suffers or is deteriorating due to personal problems, including alcohol or other drug abuse, and
- b. The Program will offer a mechanism for employees to obtain assistance for personal problems, which are not necessarily affecting their work.

**ARTICLE XXIV**

**MILEAGE AND PARKING**

- A. The Employer shall reimburse each employee in the Bargaining Unit for the following expenses directly associated with the employee's official duties, provided the expenses are approved by the employee's immediate supervisor.
1. The Employer shall reimburse an employee the current rate in effect allowed by Internal Revenue Regulations Tax Code 162, for every mile traveled in the performance of the duties when the employee uses his own automobile. Travel to and from the employee's home is explicitly excluded from this provision. Employees must submit mileage refund within 30 days.
  2. The Employer shall reimburse an employee for parking fees paid while on regularly scheduled assignments for the Employer provided receipts for said fees do not exceed Twenty Dollars (\$20) per occurrence and receipts are submitted for same to the appropriate administrator. The Employer shall continue to provide parking without charge at the employee's major center of employment.



**ARTICLE XXV**

**MISCELLANEOUS**

A. UNION MEETINGS

The Union shall be permitted the use of College facilities for regular and special business meetings of the Union without charge, provided the Union secures permission from the Chief Administrator Officer of the Administrative Division or designee, and provided said meetings are not conducted during normal work hours and conform to all regulations as established.

B. TEACHING

Bargaining Unit members employed in the Instructional Division may be required to teach two (2) courses per semester as part of their job responsibilities. The College, whenever possible, shall give three (3) weeks' notice to any member that is to be required to teach in any given school semester. Any member required to teach shall choose the class within the member's department that they are qualified to teach provided said assignments are consistent with assignment priorities as listed in the existing American Federation of Teachers Master Agreement.

C. REST AREA

A central rest area shall be provided for use by the Bargaining Unit employees.

D. HEALTH AND SAFETY

The Employer shall make reasonable provisions for the health, safety, and first aid of its employees during hours of employment.

E. UNION ACTIVITIES NO STRIKE – NO LOCKOUT

The parties fully recognize that the status of the State of Michigan confers upon public employees and their organization, not only certain rights and privileges, but also certain duties to maintain and continue the function of government, in this case the operation of the public schools, without interruption or interference due to strikes or lockouts.

The Union agrees for itself and its individual members that during the term of this Agreement none of its officers or members shall instigate, authorize, call, support, maintain, or take part in any strike. The Employer agrees that during the term of this Agreement there will not be a lockout.

F. RETIREMENT

Retirement from College service is subject to Article IV, Conformity to Law.

G. Bargaining Unit members shall be compensated in accordance with applicable federal and state wage and hour laws.

**ARTICLE XXVI**

**SALARY SCHEDULES**

A. GENERAL PROVISIONS

It is understood that the salary percent increase agreed to will be no less than the salary percent increase received by other bargaining units during the life of this Agreement. Salary percent increase is defined as total money received in improvements. The foregoing notwithstanding, during the life of this Agreement, for the purpose of this paragraph, salary percent increase shall specifically exclude additional salary steps provided to and related increases received by members of other Bargaining Units.

Salary increase for full and part-time employees:

- 1) Year One: Upon approval by the Board, full-timers will receive a 3% lump sum payment equal to base compensation. Part-timers will receive a 3% lump sum payment equal to base compensation.
- 2) Year Two: Effective July 1, 2022, every full and part-time member will receive 3% added to base compensation.
- 3) Year Three: Effective July 1, 2023, every full and part-time member will receive 2% added to base compensation.

B. FULL-TIME SALARY SCHEDULES

1. Upon ratification by the Board of Trustees, the salary of full-time Union employees covered by this Agreement shall be as follows:

	<b><u>Full Time Salary Schedules</u></b>						
<b><u>Board Approval -2022</u></b>	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7
A-1	\$32,878.56	\$34,698.56	\$36,522.72	\$38,344.80	\$40,163.76	\$40,967.04	\$41,786.38
A-2	\$38,715.04	\$40,532.96	\$42,354.00	\$44,180.24	\$46,001.28	\$46,921.31	\$47,859.74
A-3	\$44,548.40	\$46,367.36	\$48,193.60	\$50,013.60	\$51,833.60	\$52,870.27	\$53,927.68
A-4	\$50,382.80	\$52,206.96	\$54,028.00	\$55,846.96	\$57,671.12	\$58,824.54	\$60,001.03
A-5	\$56,217.20	\$58,039.28	\$59,860.32	\$61,681.36	\$63,505.52	\$64,775.63	\$66,071.14
B-1	\$60,116.16	\$62,543.52	\$64,976.08	\$67,405.52	\$69,838.08	\$71,234.84	\$72,659.54
B-2	\$65,954.72	\$68,383.12	\$70,813.60	\$73,243.04	\$75,671.44	\$77,184.87	\$78,728.57
B-3	\$71,789.12	\$74,219.60	\$76,646.96	\$79,077.44	\$81,505.84	\$83,135.96	\$84,798.68
B-4	\$77,623.52	\$80,051.92	\$82,480.32	\$84,912.88	\$87,342.32	\$89,089.17	\$90,870.95
B-5	\$83,460.00	\$85,889.44	\$88,320.96	\$90,747.28	\$93,175.68	\$95,039.19	\$96,939.97
B-6	\$89,302.72	\$91,731.12	\$94,157.44	\$96,586.88	\$99,016.32	\$100,996.65	\$103,016.58

***P&AA Master Agreement 2021-2024***

<u>2022-2023</u>	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7
A-1	\$33,864.92	\$35,739.52	\$37,618.40	\$39,495.14	\$41,368.67	\$42,196.05	\$43,039.97
A-2	\$39,876.49	\$41,748.95	\$43,624.62	\$45,505.65	\$47,381.32	\$48,328.95	\$49,295.53
A-3	\$45,884.85	\$47,758.38	\$49,639.41	\$51,514.01	\$53,388.61	\$54,456.38	\$55,545.51
A-4	\$51,894.28	\$53,773.17	\$55,648.84	\$57,522.37	\$59,401.25	\$60,589.28	\$61,801.06
A-5	\$57,903.72	\$59,780.46	\$61,656.13	\$63,531.80	\$65,410.69	\$66,718.90	\$68,053.27
B-1	\$61,919.64	\$64,419.83	\$66,925.36	\$69,427.69	\$71,933.22	\$73,371.89	\$74,839.33
B-2	\$67,933.36	\$70,434.61	\$72,938.01	\$75,440.33	\$77,941.58	\$79,500.42	\$81,090.43
B-3	\$73,942.79	\$76,446.19	\$78,946.37	\$81,449.76	\$83,951.02	\$85,630.04	\$87,342.64
B-4	\$79,952.23	\$82,453.48	\$84,954.73	\$87,460.27	\$89,962.59	\$91,761.85	\$93,597.08
B-5	\$85,963.80	\$88,466.12	\$90,970.59	\$93,469.70	\$95,970.95	\$97,890.37	\$99,848.17
B-6	\$91,981.80	\$94,483.05	\$96,982.16	\$99,484.49	\$101,986.81	\$104,026.55	\$106,107.08
<u>2023-2024</u>	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7
A-1	\$34,542.22	\$36,454.31	\$38,370.77	\$40,285.05	\$42,196.05	\$43,039.97	\$43,900.77
A-2	\$40,674.02	\$42,583.93	\$44,497.11	\$46,415.76	\$48,328.94	\$49,295.53	\$50,281.44
A-3	\$46,802.55	\$48,713.55	\$50,632.20	\$52,544.29	\$54,456.38	\$55,545.51	\$56,656.42
A-4	\$52,932.17	\$54,848.63	\$56,761.82	\$58,672.82	\$60,589.28	\$61,801.06	\$63,037.08
A-5	\$59,061.79	\$60,976.07	\$62,889.25	\$64,802.44	\$66,718.90	\$68,053.28	\$69,414.34
B-1	\$63,158.04	\$65,708.22	\$68,263.87	\$70,816.24	\$73,371.89	\$74,839.32	\$76,336.11
B-2	\$69,292.03	\$71,843.31	\$74,396.77	\$76,949.14	\$79,500.41	\$81,090.42	\$82,712.24
B-3	\$75,421.65	\$77,975.11	\$80,525.30	\$83,078.76	\$85,630.04	\$87,342.64	\$89,089.49
B-4	\$81,551.27	\$84,102.55	\$86,653.82	\$89,209.47	\$91,761.84	\$93,597.08	\$95,469.02
B-5	\$87,683.08	\$90,235.45	\$92,790.00	\$95,339.09	\$97,890.37	\$99,848.17	\$101,845.13
B-6	\$93,821.44	\$96,372.71	\$98,921.81	\$101,474.18	\$104,026.55	\$106,107.08	\$108,229.22

2. The parties agree that the College may hire Bargaining Unit members at Step 1 through 3 on the salary schedule for the appropriate pay grade level (A-1 through A-5) and (B-1 through B-6), unless the parties agree to a higher amount.
3. Experience shall mean experience at Wayne County Community College with the Bargaining Unit.
4. Experience shall be recorded on a fiscal year basis, July 1 through June 30. A full year's experience shall be granted to employees hired prior to January 1 of the fiscal year. A Bargaining Unit member's Entered on Duty (E.O.D.) date shall be the employee's actual first day of work.
5. When an employee is promoted to a classification in a higher pay grade, an employee shall be paid the appropriate rate within that pay grade that reflects no less than a ten (10%) percent increase over and above the employee's current rate or the minimum of the new classification, whichever is greater.

***P&AA Master Agreement 2021-2024***

**C. PART-TIME HOURLY SALARY SCHEDULES**

1. Upon ratification by the Board of Trustees, the hourly rates of part-time Union employees covered by this Agreement shall be as follows:

<u>2021-2022</u>					
	Step 1	Step 2	Step 3	Step 4	Step 5
P-1	\$10.83	\$11.09	\$11.30	\$11.53	\$11.76
P-2	\$14.40	\$14.40	\$14.63	\$14.92	\$15.22
P-3	\$18.34	\$18.57	\$18.79	\$19.17	\$19.55
P-4	\$22.51	\$22.73	\$22.96	\$23.42	\$23.89
<u>2022-2023</u>					
P-1	\$11.15	\$11.42	\$11.64	\$11.88	\$12.11
P-2	\$14.83	\$14.83	\$15.07	\$15.37	\$15.68
P-3	\$18.89	\$19.13	\$19.35	\$19.75	\$20.14
P-4	\$23.19	\$23.41	\$23.65	\$24.12	\$24.61
<u>2023-2024</u>					
P-1	\$11.38	\$11.65	\$11.87	\$12.11	\$12.36
P-2	\$15.13	\$15.13	\$15.37	\$15.67	\$15.99
P-3	\$19.27	\$19.51	\$19.74	\$20.14	\$20.54
P-4	\$23.65	\$23.88	\$24.12	\$24.61	\$25.10

2. Experience shall mean experience at Wayne County Community College with the Bargaining Unit.
3. Experience shall be recorded on a fiscal year basis, July 1 through June 30. A full year’s experience shall be granted to employees hired prior to January 1 through June 30. A full year’s experience shall be granted to employees hired prior to January 1 of the fiscal year. A Bargaining Unit member’s Entered on Duty (E.O.D.) date shall be the employee’s actual first day of work.

**D. TUITION AND PROFESSIONAL REIMBURSEMENT**

1. The parties to this Agreement support the principle of continuing education for members of the Bargaining Unit. Accordingly, the Employer agrees to reimburse each member of the Bargaining Unit for any course taken by such member that leads to a degree and is job related or a seminar that is job related, provided however that such course or seminar is not offered by the College, in any amount not to exceed the sum of \$2,500.00 per contract year.
2. In order to be reimbursed for tuition, conference attendance, or membership in professional organizations, each Bargaining Unit member must submit a Prior Approval Request Form to the Human Resource Office no later than June 15 of each contract year. The Human Resource Office within five (5) working days will approve and disapprove requests in accordance with guidelines in Article XXVI, Section, C.1., 2 and 3. Any Prior Approval Request Form submitted after June 15 will, if approved, be charged against the Bargaining Unit member’s Tuition and Professional Reimbursement entitlements for the next contract year.

***P&AA Master Agreement 2021-2024***

3. Each Bargaining Unit member to be reimbursed for tuition must submit to the Human Resource Office evidence of payment and satisfactory completion of any approved course in order to receive reimbursement. Similarly, each Bargaining Unit member to be reimbursed for professional conferences fees, for memberships must submit evidence of attendance at conferences or membership in organizations and receipts for expenditures in order to receive reimbursement. The required evidence must be submitted no later than July 15 of each contract year.
4. All reimbursements for tuition, conferences, fees, or memberships shall be made to the Bargaining Unit member within thirty (30) calendar days after submission as stipulated in Article XXVI, C.1.

**ARTICLE XXVII**

**COMPENSATION IN A HIGHER CLASSIFICATION**

- A. When a full-time or part-time employee in the bargaining unit is employed in a higher classification on an interim basis or temporary assignment, he shall be compensated according to the base rate for the higher classification or ten percent (10%) above his own rate, whichever is greater. When a full-time or part-time employee in the bargaining unit is assigned additional duties outside of his/her job description, such duties shall be reduced to writing and a copy forwarded to the Union President. A bargaining unit member shall be compensated at ten percent (10%) above his/her own rate. Such compensation shall begin the first day of the interim appointment, temporary job assignment or the temporary assignment of additional duties and shall continue for the duration of the assignment.
- B. If any member receives ten percent (10%) in pay for interim appointment, temporary job assignment or the temporary assignment of additional duties, the President of the Union shall receive a copy of the personnel action notice indicating such assignments and the starting and ending dates. Notifications shall come from the Director of Human Resources or his/her designee.
- C. When the employee returns to the classification he held prior to the interim or temporary assignment, he shall be compensated according to the rate then in effect in his classification.

**ARTICLE XXVIII**

**INTERIM APPOINTMENT, TEMPORARY JOB ASSIGNMENT, AND THE  
TEMPORARY ASSIGNMENT OF ADDITIONAL DUTIES**

A. INTERIM APPOINTMENTS

In the event it becomes necessary to fill a position on an interim basis prior to its being filled by a permanent employee, the Employer and the Union agree to the following procedures:

1. The interim appointment and the official posting of the position will occur simultaneously.
2. The Union shall be informed in writing by the Director of Human Resources of any interim appointment. Any employee appointed to an interim position must consent to same in writing. Primary consideration shall be given to Bargaining Unit members for an interim appointment.
3. In filling a full-time Bargaining Unit position on an interim basis, such position will be first offered to qualified full-time Bargaining Unit members before being filled by a person outside the Bargaining Unit.
4. In filling a part-time Bargaining Unit position on an interim basis, such position will first be offered to qualified part-time Bargaining Unit members before being filled by an individual outside the Bargaining Unit.
5. Said appointment shall consist of no more than six (6) months in duration. There shall be only one six (6) month interim appointment period for any vacant position. If at the end of the six month interim period a position is not filled, posting and hiring for this position shall be in accordance with Article XVII, Vacancies, unless the position is placed on hold or abolished.
6. If the position remains unfilled by a permanent employee at the end of the six (6) month interim appointment, the interim appointee shall fill the position on a permanent basis or return to his former position. However, no interim appointee after six months will be allowed to fill the interim position on a permanent basis if the appointee does not possess the minimum qualifications for the job.
7. An interim appointee shall be compensated in the manner indicated in Article XXVII, Compensation in a Higher Classification, while employed in an interim position.
8. An interim appointment shall be evaluated in the manner indicated in Article XI, Section B.2., Evaluations. In the event an interim appointee receives a negative evaluation, the employee has the option of immediately returning to the employee's former position. A negative evaluation in an interim position shall not be made part of the employee's personnel file. Further, it is specifically understood and agreed that the contract status of an interim appointee shall in no way be affected by an interim appointment.
9. In the event an employee outside the Bargaining Unit is appointed to an interim position within the Bargaining Unit, the provisions of Article VII, Section 2, Agency Shop, shall obtain.

***P&AA Master Agreement 2021-2024***

**B. TEMPORARY JOB ASSIGNMENT**

In the event it becomes necessary to temporary fill a position because of a Bargaining Unit member's absence for any reason, the Association and the Employer agree to the following procedure:

1. The Association shall be informed in writing by the Director of Human Resources of any temporary job assignment. Any employee assigned to a temporary job must consent to same in writing.
2. In filling full-time temporary job assignments as described in this Article such jobs will first be offered to qualified full-time Bargaining Unit members before being filled by an individual outside the Bargaining Unit. In filling part-time job assignments as described in this Article, such jobs will first be offered to qualified part-time Bargaining Unit members before being filled by an individual outside the Bargaining Unit.
3. A temporary job assignment shall not exceed six (6) months unless mutually agreed to by both the Association and the Employer.
4. A negative evaluation while filling a temporary job assignment shall not be made part of an employee's personnel file.
5. An employee shall be compensated in the manner indicated in Article XXVII, Compensation in a Higher Classification, while employed in a temporary job assignment.
6. A temporary job assignment shall not be offered to any currently employed Bargaining Unit member or outside individual while any Bargaining Unit member qualified to fill the temporary job assignment remains on lay off. The Employer shall recall any laid off Bargaining Unit member who is qualified to fill such a temporary job assignment.

**C. TEMPORARY ASSIGNMENT OF ADDITIONAL DUTIES**

In the event the Employer assigns extra duties to a Bargaining Unit member for any reason, the following criteria shall obtain:

1. The assignment shall be reduced to writing and shall not exceed one (1) year.
2. A negative evaluation while performing extra temporary duties shall not be made part of the employee's personnel file.
3. An employee shall be compensated in the manner indicated in Article XXVII, Compensation in Higher Classification, while performing additional duties.
4. Additional duties may not be assigned to Bargaining Unit members while any Bargaining Unit member qualified to perform those duties remains laid-off. The Employer shall recall any laid-off Bargaining Unit member who is qualified to perform needed job duties before the temporary assignment of additional duties, as described in this Article.



**ARTICLE XXIX**

**JOB UPGRADING**

- A. Any member of the Bargaining Unit may petition for a job upgrading. Job upgrading shall take the form of movement from a lower job classification, as said job classifications are established in the salary schedule, to a higher job classification at no reduction of pay. The process for job upgrading shall be as follows:
1. A bargaining unit member must submit in writing to his immediate supervisor a request for job upgrading along with supporting reasons and a copy must be forwarded to the Director of Human Resources.
  2. Within five (5) working days, the Bargaining Unit member's supervisor must forward the request along with a recommendation to the Division Head. Within ten (10) working days the Division Head must convene a committee made up of himself/herself, a representative of the Professional and Administrative Association/Union, the member's immediate supervisor, and the Director of Human Resources. This committee shall study both the request and the recommendations of the Division Head. As the majority vote of the committee so dictates, the Division Head either makes a recommendation to the Chancellor for job upgrading or denies the request.
  3. Notification for denial or approval to the member must be forwarded by the Human Resources Department. If the petition is not approved, a Bargaining unit member may appeal within five (5) working days directly to the Chancellor.
  4. After receiving recommendations from the upgrading committee, the Chancellor or his designee will forward a recommendation to the Board of Trustees and notify the Union of any disapproval within sixty (60) calendar days. Upon approval by the Board of Trustees or designee, said upgrading shall be retroactive to the date of the Chancellor's recommendation for same but not later than seventy-five (75) days from the date the request was received in the Human Resources Department.
  5. This provision on job upgrading shall not be subject to the grievance procedure. The decision of the Chancellor is final, and the Union waives any and all rights of recourse.

**ARTICLE XXX**

**RELEASE TIME**

- A. The following officials of the Association shall be granted reasonable release time for handling matters pertaining to this Agreement without suffering loss of earnings, provided that in all cases the official's supervisor or his designee is given proper written notice.
1. The Employer shall recognize the President as the Association's Chief Executive Officer and shall grant reasonable release time to the President to handle matters pertaining to the Association and to meet with the Director of Human Resources as needed.
  2. The Employer shall recognize the three (3) member Negotiating Committee as representatives of the Association and agrees to negotiate with this committee as the representative of its employees covered by this Agreement. Reasonable release time shall be granted to the Negotiating Committee to handle matters related to contract interpretation and negotiations.
  3. The Employer shall recognize a three (3) member Grievance Committee which will be granted reasonable release time for investigation and processing of grievances through arbitration, if needed.
  4. The Employer shall recognize the Executive Board and Committee as the governing bodies of the Association and shall grant reasonable release time to attend monthly board/committee meetings.
  5. The Employer shall recognize an Association Steward to serve as a Federation representative from each campus and the Central Administration Building. Reasonable release time shall be granted to Stewards for investigating, adjusting and reporting possible grievances and for handling other local matters pertaining to this Agreement.
- B. It is understood that the use of release time by Association Officials will not adversely affect an individual's performance of their job duties over time. The parties agree that Association officials' use of release time, as outlined in this Article shall be recorded on College Time Sheets, provided officials of all other Bargaining Units at the College also agree to record their use of release time on College Time Sheets.

**ARTICLE XXXI**

**WAIVER**

The parties acknowledge that during the negotiations which resulted in this Agreement, each had the unlimited right and opportunity to make demands and proposals with respect to any subject or matter not removed by law from the area of collective bargaining, and that understandings and agreements arrived at by the parties after the exercise of that right and opportunity are set forth in this Agreement. Therefore, the Employer and the Union, for the life of this Agreement, each voluntarily and unqualifiedly waives the right, and each agrees that the other shall not be obligated, to bargain collectively with respect to any subject or matter referred to or covered in this Agreement, or with respect to any subject or matter not specifically referred to or covered in this Agreement, even though such subjects or matters may not have been within the knowledge or contemplation of either or both of the parties at the time that they negotiated or signed this Agreement.

**APPENDIX A - #1**

**P&AA/AFT FULL-TIME SALARY GRADE AND  
JOB CLASSIFICATION SCHEDULE**

<u>Salary Grade</u>	<u>Job Classification</u>
A-1	Lab Assistant
A-2	Assistant Community Education Coordinator Assistant Learning Resources Coordinator Budget Assistant DALNET Computer/Media Assistant
A-3	Associate Manager At Risk Program Assistant Contracted Training Coordinator Community Education Coordinator Financial Aid Associate Multi-Cultural Recruitment Specialist (Bi-Lingual) Nursing Laboratory Coordinator Occupational Training Program Specialist Outreach Coordinator Placement Specialist Program Specialist Research Coordinator Transfer Coordinator
A-4	Academic Support Specialist (Bi-Lingual) Accountant Assistant Administrator Records Compliance Specialist Assistant Academic Support Services Coordinator – ACCESS Assistant Learning Resources Coordinator Budget Analyst Campus Student Service Advisor Coordinator of Admissions Coordinator of Career Planning and Placement Coordinator of Service Operations Coordinator Special Projects/Programs Development Specialist District Learning Coordinator Education Associate Financial Aid Advisor Graphic Arts & Publications Specialist Graphic Designer/Public Information Specialist Institutional Research & Planning Coordinator Instructional Telecommunication Specialist Library Specialist Multi-Media Specialist Project Coordinator Records Evaluator/Veterans Coordinator Telecourse Coordinator

*P&AA Master Agreement 2021-2024*

Training Coordinator  
Trio Coordinator

A-5

Accountant  
Academic Computer Lab Coordinator  
Academic Data Coordinator  
Academic Support Coordinator  
Adult Education Coordinator  
Assistant Facilities Administrator  
Auxiliary Services Coordinator  
Buyer  
Clinical Coordinator – Allied Health  
Clinical Coordinator – EMT  
Clinical Coordinator – Respiratory Therapy  
Communications Coordinator  
Community Education Supervisor  
Coordinator, Institutional Assessment, Research & Planning  
Facility Operations Coordinator  
Information/Technology System Support Specialist  
LRC System Coordinator  
Manager of Career and Technical Education  
Manager of Central Stores  
Mechanical Operations Coordinator  
Micro Computer Specialist  
Multi-Cultural Coordinator/Bi-Lingual  
Network Specialist  
Pre-Service Education/Urban Teacher Coordinator  
Production Control Supervisor  
Programmer Analyst  
Scheduling Coordinator  
Telecommunications Specialist

B-1

ACCESS Coordinator  
Alumni Affairs Coordinator  
Assistant Dean  
Assistant Registrar/Admissions Administrator  
Articulation Director  
Budget Specialist  
Cataloger  
Coordinator, Multi-Media Management & Digital Archiving  
Director of Academic Computing  
Director of Career Planning and Placement  
Director of Evening Programs  
Director of Hispanic Affairs  
Director of Student Activities  
Financial Aid Coordinator  
Grant Specialist  
Health Services Administrator  
Honors Program Coordinator  
Learning Center Administrator  
Learning Resources Coordinator  
Nursing Program Coordinator  
Ombudsman  
Operations Manager  
Physical Plant Manager  
Program Director – Business

*P&AA Master Agreement 2021-2024*

Program Director – Culinary Arts  
Program Director – Dental Hygiene  
Program Director – Dietetics  
Program Director – Electronics  
Program Director – Emergency Medical Technology  
Program Director – Gerontology  
Program Director – Heating, Ventilation and Air Conditioning  
Program Director – Manufacturing Technology  
Program Director – Occupational Therapy Assistant  
Program Director – Transportation Technology  
Program Director – Respiratory Care  
Program Director – Surgical Technology  
Program Director – Pharmacy Technology  
Program Director – Pre-Service/Education Urban Teacher Program  
Senior Analyst Programmer  
Senior Applications Programmer  
Senior Buyer  
Senior Research Analyst  
Technical Prep Coordinator  
Technical Production Coordinator  
Testing Administrator

B-2            Accounting Supervisor  
Assistant Dean of Accounts Receivables  
Manager of Cooperative Education  
Payroll Supervisor  
Restricted Fund Accountant  
Senior Assessment Analyst

B-3            Admissions Administrator  
Applications Lead Analyst Programmer  
Assistant Dean for Public Safety/Homeland Security & Continuing Education  
Assistant Dean for Student Services  
Assistant Dean for the Center for Instruction/Learning  
Assistant Dean – Western Campus  
Director of Academic Support Programs  
Director of Community Education  
Director of Marketing and Public Information  
Director of Student Services  
Director of Articulation & Support Programs  
Director of Radio/TV Media  
Director of Religious Studies  
Director for Retention  
Director of Tech Prep  
Director of Trade Programs  
Director Recruitment/Advising  
Senior Program Analyst  
Web Master

B-4            Applications Project Leader Development  
Assistant Campus Administrator  
Executive District Director, Student Services/Training  
Information Support Manager  
Media Specialist  
Special Projects Manager  
Student Services Administrator

***P&AA Master Agreement 2021-2024***

UNIX System Administrator

- B-5
- Campus Assistant Dean – Allied Health Programs
  - Campus Assistant Dean – Business/Information Systems
  - Campus Assistant Dean – Electronics
  - Campus Assistant Dean – Human and Community Development
  - Campus Assistant Dean – Arts & Sciences
  - Campus Assistant Dean – Life and Physical Sciences
  - Campus Assistant Dean – Social Sciences
  - Director of Health Occupations Division
  - Director of ACCESS
  - Executive Director of Student Services
  - Manager Applications System
  - Manager of Libraries
  - Network Systems Administrator
- B-6
- Chief Accountant
  - Technical Director

**APPENDIX A - #2**

**P&AA/AFT PART-TIME SALARY GRADE AND  
JOB CLASSIFICATION SCHEDULE**

<u>Salary Grade</u>	<u>Job Classification</u>
P-1	Blind Advocate Research Assistant
P-2	ACCESS Assistant ACCESS Analyst Assistant Project Coordinator Assistant Systems Support Specialist -- PT Computer Laboratory Assistant Instructional Aid Learning Assistant Specialist Tutor
P-3	Facility Coordinator Senior Research Specialist
P-4	Adaptive Equipment Specialist Bridges Program Coordinator Career Planning and Placement Specialist Financial Aid/Loan Packager Specialist Help Desk Associate LRC Assistant LRC Specialist Minority Language Implementer Project Coordinator Remedial Services Coordinator Senior Supervising Tutor Sign Language Interpreter Student Activities Specialist Student Services Specialist



**APPENDIX B**

Administrative Performance Appraisal Forms



**Year-End Individual Employee Performance Appraisal (IEPA)**

First Name:

Last Name:

Current Manager:

Job Title:

Employee Location:

Prior IEPA Review Date:

IEPA Review Date:

**CONFIDENTIAL**

**Section 1.**

Employee Signature: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_

**How do you view your overall performance during 2021-2022?**

**Comments:**

**What do you feel were your greatest successes during the past year?**

**Comments:**

**In hindsight, what would you do differently? What have you learned about your performance this past year that you plan to change or improve in the coming year?**

**Comments:**

**What are your individual goals for 2022-2023?**

**Comments:**

**What support do you need (from me, from other offices, through professional development, etc.) in order to achieve your individual performance improvements and goals during 2022-2023?**



Year-End Individual Employee Performance Appraisal (IEPA)

First Name:

Last Name:

Current Manager:

Job Title:

Employee Location:

Prior IEPA Review Date:

IEPA Review Date:

CONFIDENTIAL

Section 2. ACTION PLAN

"How do I get there based on my current situation (self-assessment)?"

GAP ANALYSIS

"What skills am I missing?"


PROFESSIONAL DEVELOPMENT PLAN

Knowledge, Competencies, Skills, Experience To Be Developed	Actions To Be Taken	By When	Progress

**APPENDIX C**

Number \_\_\_\_\_

Wayne County Community College District

Formal Grievance

Professional and Administrative Association

Employee's name \_\_\_\_\_ SS# \_\_\_\_\_

Employee's position \_\_\_\_\_ Date \_\_\_\_\_

Provision of Master Agreement allegedly violated:

	Violation 1	Violation 2	Violation 3	Violation 4	Violation 5
Article					
Section					
Sub-Section					
Page					
Date					

1. Facts Leading to Grievance

II. ACTION TAKEN PURSUANT TO PRE-GRIEVANCE PROCEDURE:

- Met with Supervisor – No Resolved
- Met with Supervisor – Resolved
- Unable to Meet with Supervisor
- Other (Explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. GRIEVANCE:

IV. RELIEF DEMANDED:

V. DISPOSITION:

Presented by: \_\_\_\_\_ Date: \_\_\_\_\_  
P&AA Grievance Chairperson

Received by: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**APPENDIX D**

**Medical Benefit Plans**



**Blue Cross  
Blue Shield**  
of Michigan

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

## WAYNE COUNTY COMMUNITY COLLEGE DISTRICT

### 0070119080001 - 03740

### Effective Date: 01/01/2022

### Supplemental Care Coverage

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care 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 Cross Blue Shield certificates and riders. For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare handbook (available on the Medicare Web site at [medicare.gov](http://medicare.gov) or at any Social Security office).

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

**Note:** Medicare deductible and coinsurance amounts are effective January 1, 2022 and are subject to change yearly.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	<ul style="list-style-type: none"> <li>• <b>Medicare Part A</b> \$1,556 (for days 1-60) each benefit period</li> <li>• <b>Medicare Part B</b> \$233 per calendar year</li> </ul>	None
Coinsurance/fixed dollar copays	<ul style="list-style-type: none"> <li>• <b>Hospital stay</b> \$389 per day (for days 61-90) and \$778 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime)</li> <li>• <b>Skilled nursing facility stay</b> (a limit of 100 days each benefit period) \$194.50 per day (for days 21-100)</li> </ul>	None
Coinsurance/percent copay amounts	<ul style="list-style-type: none"> <li>• 20% of Medicare approved amount for most general services</li> <li>• 20% of Medicare approved amount for outpatient mental health care</li> </ul>	None

### Preventive care services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Health maintenance exam (yearly "Wellness" visit)	Covered at 100% of Medicare approved amount*, once every 12 months  <b>Note:</b> Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit.	Covered in full by Medicare; no additional coverage by BCBSM
Gynecological exam	Covered at 100% of Medicare approved amount*, once every 24 months	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year

ADM COB-3;ADM MOS816 MED;ADM MOS816 RX;ADM PLANR JAN;BC-COMP;BS 65 OPTION 1;GCP-D;GPC-SAT 2;GPC-SAT-MHP-2;HCR MS PCB;HCR-MS-WCB-ECS;PDRX ASC;PDTTC104080RXC

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Pap smear screening - laboratory services only	Covered at 100% of Medicare approved amount*, once every 24 months (more frequently if at high risk)	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Voluntary sterilizations for females	Not covered  <b>Note:</b> Medicare covers voluntary sterilization if it's necessary for the treatment of an illness or injury.	Covered at 100% of BCBSM approved amount
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Not covered	Covered at 100% of BCBSM approved amount
Contraceptive injections - includes cost of medication when provided by the physician	Not covered	Covered at 100% of BCBSM approved amount
Screening fecal occult blood test	Covered at 100% of Medicare approved amount*, once every 12 months, if age 50 and older	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening flexible sigmoidoscopy	Covered at 100% of Medicare approved amount*, once every 48 months, if age 50 and older, or every 120 months after a previous screening colonoscopy for those not at high risk	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount*, once every 12 months, if over age 50  <b>Note:</b> A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Flu shots	Covered at 100% of Medicare approved amount*, one flu shot per flu season	Covered in full by Medicare; no additional coverage by BCBSM
Hepatitis B shots - for those at medium or high risk for Hepatitis B	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Pneumococcal shot	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Mammography screening	Covered at 100% of Medicare approved amount*, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening colonoscopy	Covered at 100% of Medicare approved amount*, once every 120 months (high risk every 24 months) or every 48 months after a previous flexible sigmoidoscopy	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount* every 12 months, subsequent well-baby and child care visits not covered	Covered at 100% of BCBSM approved amount <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>

ADM COB-3;ADM MOS816 MED;ADM MOS816 RX;ADM PLANR JAN;BC-COMP;BS 65 OPTION 1;GCP-D;GPC-SAT 2;GPC-SAT-MHP-2;HCR MS PCB;HCR-MS-WCB-ECS;PDRX ASC;PDTTC104080RXC

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Benefits	Original Medicare coverage	Medicare Supplemental coverage
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 and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount

\* Under Medicare coverage, you pay nothing for these services if the doctor or other qualified health care provider accepts assignment. You may be required to pay 20 percent of the Medicare approved amount for the doctor's visit.

Physician office services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Not covered

Emergency medical care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital emergency room (facility services) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Ambulance services - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Clinical laboratory services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Laboratory and pathology tests - used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare

Hospital care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies - <b>does not</b> include private duty nursing	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance use disorder)	Covers Medicare deductible
<ul style="list-style-type: none"> <li>Days 1-60 of each benefit period</li> </ul>		
<ul style="list-style-type: none"> <li>Days 61-90 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> <li>Lifetime reserve days after day 90 of each benefit period (up to 60 days over your lifetime)</li> </ul>	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> <li>Additional days</li> </ul>	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance

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## Alternatives to hospital care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Skilled nursing facility care - subject to medical criteria <ul style="list-style-type: none"> <li>Days 1-20 of each benefit period</li> <li>Days 21-100 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount	Covered in full by Medicare
<ul style="list-style-type: none"> <li>Days 101 and after</li> </ul>	Not covered	Not covered
Hospice care	Covered at Medicare approved amount less small copayment for outpatient prescription drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care services - must be medically necessary and must be provided by a <b>Medicare-certified</b> home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare

## Surgical services provided by a physician

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Surgery - includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

## Human organ transplants

**Note:** Payment is based on medical necessity and must be rendered in an approved facility.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Pancreas transplants	Not covered	Not covered
	<b>Note:</b> Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	<b>Note:</b> Covers Medicare deductible and coinsurance when covered by Medicare
Bone marrow transplants - under certain conditions	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Kidney, cornea and skin transplants	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance

## Mental health care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
<b>Inpatient</b> mental health care in psychiatric facility <ul style="list-style-type: none"> <li>Days 1-190 <b>lifetime</b></li> </ul>	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance)	Covers Medicare deductible and daily coinsurance
<ul style="list-style-type: none"> <li>Additional days after 190 lifetime days are used</li> </ul>	Not covered	Not covered

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Benefits	Original Medicare coverage	Medicare Supplemental coverage
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	Covers Medicare deductible and coinsurance

Other covered services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Allergy testing and therapy - with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic services (limited coverage) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> You pay all costs for noncovered services or tests ordered by a chiropractor (including x-rays and massage therapy).	Not covered
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copayment
Durable medical equipment - must be obtained from a Medicare-approved supplier	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare

Foreign travel		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount

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## BCBSM Preferred RX Program

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

**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, 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 Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to 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](http://bcbsm.com/pharmacy). If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

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

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

## Member's responsibility (copays and coinsurance amounts)

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

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

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Out-of-pocket maximum		\$7,150 per member, \$14,300 family (two or more members), per calendar year for all covered prescription drugs obtained from in-network retail pharmacies and BCBSM's approved mail order provider			
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$160 copay	No coverage	No coverage

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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
84 to 90-day period	You pay \$160 copay	You pay \$160 copay	No coverage	No coverage

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

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

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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
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs  <b>Note:</b> Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
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 <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> .	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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

## Features of your prescription drug plan

Custom Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 (generic)</b> - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment.</li> <li>• <b>Tier 2 (preferred brand)</b> - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.</li> </ul>
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b>, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</p>
Mandatory maximum allowable cost drugs	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you <b>MUST</b> pay the <b>difference</b> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <b>plus</b> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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**WAYNE COUNTY COMMUNITY COLLEGE DISTRICT**  
**0070119080002 - 03740**  
**Effective Date: 01/01/2022**

**Supplemental Care Coverage**

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care 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 Cross Blue Shield certificates and riders. For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare handbook (available on the Medicare Web site at [medicare.gov](http://medicare.gov) or at any Social Security office).

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

**Note:** Medicare deductible and coinsurance amounts are effective January 1, 2022 and are subject to change yearly.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	<ul style="list-style-type: none"> <li>• <b>Medicare Part A</b> \$1,556 (for days 1-60) each benefit period</li> <li>• <b>Medicare Part B</b> \$233 per calendar year</li> </ul>	None
Coinsurance/fixed dollar copays	<ul style="list-style-type: none"> <li>• <b>Hospital stay</b> \$389 per day (for days 61-90) and \$778 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime)</li> <li>• <b>Skilled nursing facility stay</b> (a limit of 100 days each benefit period) \$194.50 per day (for days 21-100)</li> </ul>	None
Coinsurance/percent copay amounts	<ul style="list-style-type: none"> <li>• 20% of Medicare approved amount for most general services</li> <li>• 20% of Medicare approved amount for outpatient mental health care</li> </ul>	None

**Preventive care services**

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Health maintenance exam (yearly "Wellness" visit)	Covered at 100% of Medicare approved amount*, once every 12 months  <b>Note:</b> Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit.	Covered in full by Medicare; no additional coverage by BCBSM
Gynecological exam	Covered at 100% of Medicare approved amount*, once every 24 months	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year

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Benefits	Original Medicare coverage	Medicare Supplemental coverage
Pap smear screening - laboratory services only	Covered at 100% of Medicare approved amount*, once every 24 months (more frequently if at high risk)	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Voluntary sterilizations for females	Not covered  <b>Note:</b> Medicare covers voluntary sterilization if it's necessary for the treatment of an illness or injury.	Covered at 100% of BCBSM approved amount
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Not covered	Covered at 100% of BCBSM approved amount
Contraceptive injections - includes cost of medication when provided by the physician	Not covered	Covered at 100% of BCBSM approved amount
Screening fecal occult blood test	Covered at 100% of Medicare approved amount*, once every 12 months, if age 50 and older	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening flexible sigmoidoscopy	Covered at 100% of Medicare approved amount*, once every 48 months, if age 50 and older, or every 120 months after a previous screening colonoscopy for those not at high risk	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount*, once every 12 months, if over age 50  <b>Note:</b> A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Flu shots	Covered at 100% of Medicare approved amount*, one flu shot per flu season	Covered in full by Medicare; no additional coverage by BCBSM
Hepatitis B shots - for those at medium or high risk for Hepatitis B	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Pneumococcal shot	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Mammography screening	Covered at 100% of Medicare approved amount*, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening colonoscopy	Covered at 100% of Medicare approved amount*, once every 120 months (high risk every 24 months) or every 48 months after a previous flexible sigmoidoscopy	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount* every 12 months, subsequent well-baby and child care visits not covered	Covered at 100% of BCBSM approved amount <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>

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Benefits	Original Medicare coverage	Medicare Supplemental coverage
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 and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount

\* Under Medicare coverage, you pay nothing for these services if the doctor or other qualified health care provider accepts assignment. You may be required to pay 20 percent of the Medicare approved amount for the doctor's visit.

Physician office services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Not covered

Emergency medical care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital emergency room (facility services) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Ambulance services - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Clinical laboratory services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Laboratory and pathology tests - used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare

Hospital care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies - <b>does not</b> include private duty nursing	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance use disorder)	Covers Medicare deductible
<ul style="list-style-type: none"> <li>Days 1-60 of each benefit period</li> </ul>		
<ul style="list-style-type: none"> <li>Days 61-90 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> <li>Lifetime reserve days after day 90 of each benefit period (up to 60 days over your lifetime)</li> </ul>	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> <li>Additional days</li> </ul>	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance

ADM COB-3;ADM MOS816 MED;ADM MOS816 RX;ADM PLANR JAN;BC-COMP;BS 65 OPTION 1;GCP-D;GPC-SAT 2;GPC-SAT-MHP-2;HCR MS PCB;HCR-MS-WCB-ECS;PDRX ASC;PDTC104080RXC

## Alternatives to hospital care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Skilled nursing facility care - subject to medical criteria <ul style="list-style-type: none"> <li>Days 1-20 of each benefit period</li> <li>Days 21-100 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount	Covered in full by Medicare
<ul style="list-style-type: none"> <li>Days 101 and after</li> </ul>	Not covered	Not covered
Hospice care	Covered at Medicare approved amount less small copayment for outpatient prescription drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care services - must be medically necessary and must be provided by a <b>Medicare-certified</b> home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare

## Surgical services provided by a physician

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Surgery - includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

## Human organ transplants

**Note:** Payment is based on medical necessity and must be rendered in an approved facility.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Pancreas transplants	Not covered	Not covered
	<b>Note:</b> Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	<b>Note:</b> Covers Medicare deductible and coinsurance when covered by Medicare
Bone marrow transplants - under certain conditions	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Kidney, cornea and skin transplants	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance

## Mental health care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
<b>Inpatient</b> mental health care in psychiatric facility <ul style="list-style-type: none"> <li>Days 1-190 <b>lifetime</b></li> </ul>	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance)	Covers Medicare deductible and daily coinsurance
<ul style="list-style-type: none"> <li>Additional days after 190 lifetime days are used</li> </ul>	Not covered	Not covered

ADM COB-3;ADM MOS816 MED;ADM MOS816 RX;ADM PLANR JAN;BC-COMP;BS 65 OPTION 1;GCP-D;GPC-SAT 2;GPC-SAT-MHP-2;HCR MS PCB;HCR-MS-WCB-ECS;PDRX ASC;PDTTC104080RXXCM

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	Covers Medicare deductible and coinsurance

Other covered services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Allergy testing and therapy - with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic services (limited coverage) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> You pay all costs for noncovered services or tests ordered by a chiropractor (including x-rays and massage therapy).	Not covered
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copayment
Durable medical equipment - must be obtained from a Medicare-approved supplier	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare

Foreign travel		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount

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## BCBSM Preferred RX Program

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

**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, 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 Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to 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](http://bcbsm.com/pharmacy). If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

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

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

## Member's responsibility (copays and coinsurance amounts)

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

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

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Out-of-pocket maximum		\$7,150 per member, \$14,300 family (two or more members), per calendar year for all covered prescription drugs obtained from in-network retail pharmacies and BCBSM's approved mail order provider			
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$160 copay	No coverage	No coverage

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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
84 to 90-day period	You pay \$160 copay	You pay \$160 copay	No coverage	No coverage

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

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

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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
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs  <b>Note:</b> Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
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 <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> .	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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

## Features of your prescription drug plan

Custom Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 (generic)</b> - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment.</li> <li>• <b>Tier 2 (preferred brand)</b> - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.</li> </ul>
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b>, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</p>
Mandatory maximum allowable cost drugs	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you <b>MUST</b> pay the <b>difference</b> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <b>plus</b> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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# WAYNE COUNTY COMMUNITY COLLEGE\_1

## 0070119080003 - 0373X

### Effective Date: 01/01/2022

## Supplemental Care Coverage

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care 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 Cross Blue Shield certificates and riders. For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare handbook (available on the Medicare Web site at [medicare.gov](http://medicare.gov) or at any Social Security office).

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

**Note:** Medicare deductible and coinsurance amounts are effective January 1, 2022 and are subject to change yearly.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	<ul style="list-style-type: none"> <li>• <b>Medicare Part A</b> \$1,556 (for days 1-60) each benefit period</li> <li>• <b>Medicare Part B</b> \$233 per calendar year</li> </ul>	None
Coinsurance/fixed dollar copays	<ul style="list-style-type: none"> <li>• <b>Hospital stay</b> \$389 per day (for days 61-90) and \$778 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime)</li> <li>• <b>Skilled nursing facility stay</b> (a limit of 100 days each benefit period) \$194.50 per day (for days 21-100)</li> </ul>	None
Coinsurance/percent copay amounts	<ul style="list-style-type: none"> <li>• 20% of Medicare approved amount for most general services</li> <li>• 20% of Medicare approved amount for outpatient mental health care</li> </ul>	None

## Preventive care services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Health maintenance exam (yearly "Wellness" visit)	Covered at 100% of Medicare approved amount*, once every 12 months  <b>Note:</b> Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit.	Covered in full by Medicare; no additional coverage by BCBSM
Gynecological exam	Covered at 100% of Medicare approved amount*, once every 24 months	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year

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Benefits	Original Medicare coverage	Medicare Supplemental coverage
Pap smear screening - laboratory services only	Covered at 100% of Medicare approved amount*, once every 24 months (more frequently if at high risk)	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Voluntary sterilizations for females	Not covered  <b>Note:</b> Medicare covers voluntary sterilization if it's necessary for the treatment of an illness or injury.	Covered at 100% of BCBSM approved amount
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Not covered	Covered at 100% of BCBSM approved amount
Contraceptive injections - includes cost of medication when provided by the physician	Not covered	Covered at 100% of BCBSM approved amount
Screening fecal occult blood test	Covered at 100% of Medicare approved amount*, once every 12 months, if age 50 and older	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening flexible sigmoidoscopy	Covered at 100% of Medicare approved amount*, once every 48 months, if age 50 and older, or every 120 months after a previous screening colonoscopy for those not at high risk	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount*, once every 12 months, if over age 50  <b>Note:</b> A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Flu shots	Covered at 100% of Medicare approved amount*, one flu shot per flu season	Covered in full by Medicare; no additional coverage by BCBSM
Hepatitis B shots - for those at medium or high risk for Hepatitis B	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Pneumococcal shot	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Mammography screening	Covered at 100% of Medicare approved amount*, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening colonoscopy	Covered at 100% of Medicare approved amount*, once every 120 months (high risk every 24 months) or every 48 months after a previous flexible sigmoidoscopy	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount* every 12 months, subsequent well-baby and child care visits not covered	Covered at 100% of BCBSM approved amount <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>

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Benefits	Original Medicare coverage	Medicare Supplemental coverage
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 and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount

\* Under Medicare coverage, you pay nothing for these services if the doctor or other qualified health care provider accepts assignment. You may be required to pay 20 percent of the Medicare approved amount for the doctor's visit.

Physician office services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Not covered

Emergency medical care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital emergency room (facility services) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Ambulance services - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Clinical laboratory services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Laboratory and pathology tests - used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare

Hospital care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies - <b>does not</b> include private duty nursing	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance use disorder)	Covers Medicare deductible
<ul style="list-style-type: none"> <li>Days 1-60 of each benefit period</li> </ul>		
<ul style="list-style-type: none"> <li>Days 61-90 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> <li>Lifetime reserve days after day 90 of each benefit period (up to 60 days over your lifetime)</li> </ul>	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> <li>Additional days</li> </ul>	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance

ADM COB-3;ADM MOS816 MED;ADM MOS816 RX;ADM PLANR JAN;ASCMOD 5943;BC-COMP;BS 65 OPTION 1;GCP-D;GPC-SAT 2;GPC-SAT-MHP-2;HCR MS PCB;HCR-MS-WCB-ECS;MOPD ASC;PD-BC \$10 ASC;PD-CR \$10 ASC;PD-PT ASC;PDRX ASC

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## Alternatives to hospital care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Skilled nursing facility care - subject to medical criteria <ul style="list-style-type: none"> <li>Days 1-20 of each benefit period</li> <li>Days 21-100 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount	Covered in full by Medicare
<ul style="list-style-type: none"> <li>Days 101 and after</li> </ul>	Not covered	Not covered
Hospice care	Covered at Medicare approved amount less small copayment for outpatient prescription drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care services - must be medically necessary and must be provided by a <b>Medicare-certified</b> home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare

## Surgical services provided by a physician

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Surgery - includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

## Human organ transplants

**Note:** Payment is based on medical necessity and must be rendered in an approved facility.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Pancreas transplants	Not covered	Not covered
	<b>Note:</b> Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	<b>Note:</b> Covers Medicare deductible and coinsurance when covered by Medicare
Bone marrow transplants - under certain conditions	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Kidney, cornea and skin transplants	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance

## Mental health care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
<b>Inpatient</b> mental health care in psychiatric facility <ul style="list-style-type: none"> <li>Days 1-190 <b>lifetime</b></li> </ul>	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance)  <b>Note:</b> In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covers Medicare deductible and daily coinsurance
<ul style="list-style-type: none"> <li>Additional days after 190 lifetime days are used</li> </ul>	Not covered	Not covered

ADM COB-3;ADM MOS816 MED;ADM MOS816 RX;ADM PLANR JAN;ASCMOD 5943;BC-COMP;BS 65 OPTION 1;GCP-D;GPC-SAT 2;GPC-SAT-MHP-2;HCR MS PCB;HCR-MS-WCB-ECS;MOPD ASC;PD-BC \$10 ASC;PD-CR \$10 ASC;PD-PT ASC;PDRX ASC

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Benefits	Original Medicare coverage	Medicare Supplemental coverage
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	Covers Medicare deductible and coinsurance

Other covered services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Allergy testing and therapy - with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic services (limited coverage) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> You pay all costs for noncovered services or tests ordered by a chiropractor (including x-rays and massage therapy).	Not covered
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copayment
Durable medical equipment - must be obtained from a Medicare-approved supplier	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare

Foreign travel		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount

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## BCBSM Preferred RX Program

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

**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, 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 Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to 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](http://bcbsm.com/pharmacy). If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

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

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

## Member's responsibility (copays and coinsurance amounts)

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

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

Benefits	In-network pharmacy	Out-of-network pharmacy
Out-of-pocket maximum	\$7,150 per member, \$14,300 family (two or more members), per calendar year for all covered prescription drugs obtained from in-network retail pharmacies and BCBSM's approved mail order provider	
Generic or select prescribed over-the-counter drugs	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
Brand name prescription drugs	You pay \$20 copay	You pay \$20 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	<b>Copay for up to a 30 day supply:</b> <ul style="list-style-type: none"> <li>• No copay for Tier 1 (generic) drugs</li> <li>• No copay for Tier 2 (formulary brand) drugs</li> </ul> <b>Copay for 31-90 day supply</b> <ul style="list-style-type: none"> <li>• No copay for Tier 1 (generic) drugs</li> <li>• No copay for Tier 2 (formulary brand) drugs</li> </ul>	Not covered

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

## Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

**ADM COB-3;ADM MOS816 MED;ADM MOS816 RX;ADM PLANR JAN;ASC MOD 5943;BC-COMP;BS 65 OPTION 1;GCP-D;GCP-SAT 2;GCP-SAT-MHP-2;HCR MS PCB;HCR-MS-WCB-ECS;MOPD ASC;PD-BC \$10 ASC;PD-CR \$10 ASC;PD-PT ASC;PDRX ASC**

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Benefits	In-network pharmacy	Out-of-network pharmacy
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved <b>generic</b> and <b>select brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	75% of approved amount
Other FDA-approved <b>brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	75% of approved amount
FDA-approved <b>generic</b> and <b>select brand-name</b> prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved <b>brand-name</b> prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
<b>Note:</b> Needles and syringes have no copay/coinsurance.		
Select diabetic supplies and devices (test strips, lancets and glucometers)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> .		

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

## Features of your prescription drug plan

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

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## Features of your prescription drug plan

Mandatory maximum allowable cost drugs

If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

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## WAYNE COUNTY COMMUNITY COLLEGE

### 0070119080004 - 03740

### Effective Date: 01/01/2022

### Supplemental Care Coverage

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care 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 Cross Blue Shield certificates and riders. For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare handbook (available on the Medicare Web site at [medicare.gov](http://medicare.gov) or at any Social Security office).

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

**Note:** Medicare deductible and coinsurance amounts are effective January 1, 2022 and are subject to change yearly.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	<ul style="list-style-type: none"> <li>• <b>Medicare Part A</b> \$1,556 (for days 1-60) each benefit period</li> <li>• <b>Medicare Part B</b> \$233 per calendar year</li> </ul>	None
Coinsurance/fixed dollar copays	<ul style="list-style-type: none"> <li>• <b>Hospital stay</b> \$389 per day (for days 61-90) and \$778 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime)</li> <li>• <b>Skilled nursing facility stay</b> (a limit of 100 days each benefit period) \$194.50 per day (for days 21-100)</li> </ul>	None
Coinsurance/percent copay amounts	<ul style="list-style-type: none"> <li>• 20% of Medicare approved amount for most general services</li> <li>• 20% of Medicare approved amount for outpatient mental health care</li> </ul>	None

### Preventive care services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Health maintenance exam (yearly "Wellness" visit)	Covered at 100% of Medicare approved amount*, once every 12 months  <b>Note:</b> Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit.	Covered in full by Medicare; no additional coverage by BCBSM
Gynecological exam	Covered at 100% of Medicare approved amount*, once every 24 months	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year

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Benefits	Original Medicare coverage	Medicare Supplemental coverage
Pap smear screening - laboratory services only	Covered at 100% of Medicare approved amount*, once every 24 months (more frequently if at high risk)	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Voluntary sterilizations for females	Not covered  <b>Note:</b> Medicare covers voluntary sterilization if it's necessary for the treatment of an illness or injury.	Covered at 100% of BCBSM approved amount
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Not covered	Covered at 100% of BCBSM approved amount
Contraceptive injections - includes cost of medication when provided by the physician	Not covered	Covered at 100% of BCBSM approved amount
Screening fecal occult blood test	Covered at 100% of Medicare approved amount*, once every 12 months, if age 50 and older	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening flexible sigmoidoscopy	Covered at 100% of Medicare approved amount*, once every 48 months, if age 50 and older, or every 120 months after a previous screening colonoscopy for those not at high risk	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount*, once every 12 months, if over age 50  <b>Note:</b> A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Flu shots	Covered at 100% of Medicare approved amount*, one flu shot per flu season	Covered in full by Medicare; no additional coverage by BCBSM
Hepatitis B shots - for those at medium or high risk for Hepatitis B	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Pneumococcal shot	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Mammography screening	Covered at 100% of Medicare approved amount*, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening colonoscopy	Covered at 100% of Medicare approved amount*, once every 120 months (high risk every 24 months) or every 48 months after a previous flexible sigmoidoscopy	When <b>not</b> covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount* every 12 months, subsequent well-baby and child care visits not covered	Covered at 100% of BCBSM approved amount <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>

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Benefits	Original Medicare coverage	Medicare Supplemental coverage
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 and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount

\* Under Medicare coverage, you pay nothing for these services if the doctor or other qualified health care provider accepts assignment. You may be required to pay 20 percent of the Medicare approved amount for the doctor's visit.

Physician office services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Not covered

Emergency medical care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital emergency room (facility services) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Ambulance services - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Clinical laboratory services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Laboratory and pathology tests - used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare

Hospital care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies - <b>does not</b> include private duty nursing <ul style="list-style-type: none"> <li>Days 1-60 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance use disorder)	Covers Medicare deductible
<ul style="list-style-type: none"> <li>Days 61-90 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> <li>Lifetime reserve days after day 90 of each benefit period (up to 60 days over your lifetime)</li> </ul>	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> <li>Additional days</li> </ul>	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance

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## Alternatives to hospital care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Skilled nursing facility care - subject to medical criteria <ul style="list-style-type: none"> <li>Days 1-20 of each benefit period</li> <li>Days 21-100 of each benefit period</li> </ul>	Covered at 100% of Medicare approved amount	Covered in full by Medicare
<ul style="list-style-type: none"> <li>Days 101 and after</li> </ul>	Not covered	Not covered
Hospice care	Covered at Medicare approved amount less small copayment for outpatient prescription drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care services - must be medically necessary and must be provided by a <b>Medicare-certified</b> home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare

## Surgical services provided by a physician

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Surgery - includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

## Human organ transplants

**Note:** Payment is based on medical necessity and must be rendered in an approved facility.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Pancreas transplants	Not covered	Not covered
	<b>Note:</b> Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	<b>Note:</b> Covers Medicare deductible and coinsurance when covered by Medicare
Bone marrow transplants - under certain conditions	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Kidney, cornea and skin transplants	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance

## Mental health care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
<b>Inpatient</b> mental health care in psychiatric facility <ul style="list-style-type: none"> <li>Days 1-190 <b>lifetime</b></li> </ul>	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance)	Covers Medicare deductible and daily coinsurance
<ul style="list-style-type: none"> <li>Additional days after 190 lifetime days are used</li> </ul>	Not covered	Not covered

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Benefits	Original Medicare coverage	Medicare Supplemental coverage
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	Covers Medicare deductible and coinsurance

Other covered services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Allergy testing and therapy - with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic services (limited coverage) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> You pay all costs for noncovered services or tests ordered by a chiropractor (including x-rays and massage therapy).	Not covered
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible  <b>Note:</b> There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copayment
Durable medical equipment - must be obtained from a Medicare-approved supplier	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare

Foreign travel		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount

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**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, 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 Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to 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](http://bcbsm.com/pharmacy). If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

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

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

## Member's responsibility (copays and coinsurance amounts)

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

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

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Out-of-pocket maximum		\$7,150 per member, \$14,300 family (two or more members), per calendar year for all covered prescription drugs obtained from in-network retail pharmacies and BCBSM's approved mail order provider			
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$160 copay	No coverage	No coverage

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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
84 to 90-day period	You pay \$160 copay	You pay \$160 copay	No coverage	No coverage

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

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

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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
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs  <b>Note:</b> Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
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 <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> .	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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

## Features of your prescription drug plan

Custom Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 (generic)</b> - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment.</li> <li>• <b>Tier 2 (preferred brand)</b> - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.</li> </ul>
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b>, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</p>
Mandatory maximum allowable cost drugs	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you <b>MUST</b> pay the <b>difference</b> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <b>plus</b> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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## WAYNE COUNTY COMMUNITY COLLEGE DISTRICT 0070119080001 - 07CNN Effective Date: 01/01/2022

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](http://bcbsm.com/importantinfo). Select **Approving covered services**.

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

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

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

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

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



## Eligibility Information

Members	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> <li>Subscriber's legal spouse</li> <li><b>Dependent children:</b> related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26</li> </ul>

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

Benefits	In-network	Out-of-network
Deductible	None	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year
Flat-dollar copays	<ul style="list-style-type: none"> <li>\$10 copay for office visits and office consultations</li> <li>\$10 copay for medical online visits</li> <li>\$10 copay for urgent care visits</li> </ul>	None
Coinsurance amounts (percent copays)	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> </ul>	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> <li>20% of approved amount for mental health care and substance use disorder treatment</li> <li>20% of approved amount for most other covered services</li> </ul>
<b>Annual out-of-pocket maximums</b> - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	\$600 for one member, \$1,200 for the family (when two or more members are covered under your contract) each calendar year	\$2,250 for one member, \$4,500 for the family (when two or more members are covered under your contract) each calendar year  <b>Note:</b> Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

## Preventive care services

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

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Benefits	In-network	Out-of-network
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	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) <p><b>Note:</b> Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.</p> <p style="text-align: center;">One per member per calendar year</p>	80% after out-of-network deductible <p><b>Note:</b> Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.</p>
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy <p><b>Note:</b> Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.</p> <p style="text-align: center;">One per member per calendar year</p>	80% after out-of-network deductible

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## Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$10 copay per office visit	80% after out-of-network deductible
Online visits - by physician must be medically necessary <b>Note:</b> Online visits by a vendor are not covered.	\$10 copay per online visit	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Office consultations - must be medically necessary	\$10 copay per office consultation	80% after out-of-network deductible
Urgent care visits - must be medically necessary	\$10 copay per urgent care visit	80% after out-of-network deductible

## Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Ambulance services - must be medically necessary	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

## Diagnostic services

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

## Maternity services provided by a physician or certified nurse midwife

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

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## Hospital care

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

## Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a <b>participating</b> skilled nursing facility	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Limited to a maximum of 120 days per member per calendar year		
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		
Home health care: <ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be provided by a <b>participating</b> home health care agency</li> </ul>	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Infusion therapy: <ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>• may use drugs that require preauthorization - consult with your doctor</li> </ul>	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

## Surgical services

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

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## Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a <b>designated</b> facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities <b>only</b>
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Specified oncology clinical trials	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
<b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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

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

Benefits	In-network	Out-of-network
<b>Inpatient</b> mental health care and <b>inpatient</b> substance use disorder treatment	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
		Unlimited days
Residential psychiatric treatment facility: <ul style="list-style-type: none"> <li>covered mental health services <b>must</b> be performed in a residential psychiatric treatment facility</li> <li>treatment <b>must</b> be preauthorized</li> <li>subject to medical criteria</li> </ul>	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) in participating facilities <b>only</b>
<ul style="list-style-type: none"> <li>Online visits</li> </ul> <b>Note:</b> Online visits by a vendor are not covered.	\$10 copay per online visit	80% after out-of-network deductible
<ul style="list-style-type: none"> <li>Physician's office</li> </ul>	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities <b>only</b>	100% (no deductible or copay/coinsurance)	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 behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
<b>Note:</b> 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.		

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Benefits	In-network	Out-of-network
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% (no deductible or copay/coinsurance) Physical, speech and occupational therapy <b>with an autism diagnosis</b> is unlimited	80% after out-of-network deductible
Other covered services, including mental health services, for autism spectrum disorder	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

## Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)  <b>Note:</b> 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.  <b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	<ul style="list-style-type: none"> <li>100% (no deductible or copay/coinsurance) for diabetes medical supplies</li> <li>100% (no deductible or copay/coinsurance) for diabetes self-management training</li> </ul>	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% (no deductible or copay/coinsurance)  Limited to a <b>combined</b> 24-visit maximum per member per calendar year	80% after out-of-network deductible
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% (no deductible or copay/coinsurance)  Limited to a <b>combined</b> 60-visit maximum per member per calendar year	80% after out-of-network deductible  <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment  <b>Note:</b> DME items required under the preventive benefit 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 preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Prosthetic and orthotic appliances	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Private duty nursing care	50% (no deductible)	50% (no deductible)

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## BCBSM Preferred RX Program

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

**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, 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 Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to 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](http://bcbsm.com/pharmacy). If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

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

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

## Member's responsibility (copays and coinsurance amounts)

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

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

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$160 copay	No coverage	No coverage
	84 to 90-day period	You pay \$160 copay	You pay \$160 copay	No coverage	No coverage

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

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

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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
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 <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> .	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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

## Features of your prescription drug plan

Custom Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 (generic)</b> - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment.</li> <li>• <b>Tier 2 (preferred brand)</b> - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.</li> </ul>
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b>, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</p>
Mandatory maximum allowable cost drugs	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you <b>MUST</b> pay the <b>difference</b> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <b>plus</b> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
Quantity limits	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>

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## WAYNE COUNTY COMMUNITY COLLEGE DISTRICT 0070119080002 - 07CNJ Effective Date: 01/01/2022

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](http://bcbsm.com/importantinfo). Select **Approving covered services**.

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

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

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

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

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## Eligibility Information

Member	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> <li>Subscriber's legal spouse</li> <li><b>Dependent children:</b> related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26</li> </ul>
Sponsored dependents	<ul style="list-style-type: none"> <li>Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.</li> </ul>

## 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
<b>Deductibles</b>	\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year	\$2,000 for one member, \$4,000 for the family (when two or more members are covered under your contract) each calendar year  <b>Note:</b> Out-of-network deductible amounts also count toward the in-network deductible.
<b>Flat-dollar copays</b>	<ul style="list-style-type: none"> <li>\$30 copay for office visits and office consultations</li> <li>\$30 copay for medical online visits</li> <li>\$30 copay for chiropractic and osteopathic manipulative therapy</li> <li>\$150 copay for emergency room visits</li> <li>\$30 copay for urgent care visits</li> </ul>	<ul style="list-style-type: none"> <li>\$150 copay for emergency room visits</li> </ul>
<b>Coinsurance amounts (percent copays)</b>  <b>Note:</b> Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> <li>20% of approved amount for most other covered services</li> </ul>	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> <li>40% of approved amount for most other covered services</li> </ul>
<b>Annual out-of-pocket maximums</b> - applies to deductibles, copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable.	\$3,500 for one member, \$7,000 for the family (when two or more members are covered under your contract) each calendar year	\$7,000 for one member, \$14,000 for the family (when two or more members are covered under your contract) each calendar year  <b>Note:</b> Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
<b>Lifetime dollar maximum</b>	None	

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## 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  <b>Note:</b> Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year  <b>Note:</b> Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening -laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance),	60% after out-of-network deductible
Prescription contraceptive devices- includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance),	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance),	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance), <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	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)  <b>Note:</b> Subsequent medically necessary mammograms performed during the <b>same</b> calendar year are subject to your deductible and coinsurance	60% after out-of-network deductible  <b>Note:</b> 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

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

Physician office services		
Benefits	In-network	Out-of-network
Office visits-must be medically necessary	\$30 copay for each office visit  <b>Note:</b> Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.  Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Online visits - by physician must be medically necessary <b>Note:</b> Online visits by a vendor are not covered.	\$30 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits-must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations-must be medically necessary	\$30 copay for each office consultation  <b>Note:</b> Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.  Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible

Urgent care visits		
Benefits	In-network	Out-of-network
Urgent care visits	\$30 copay for each urgent care visit  <b>Note:</b> Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.  Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible

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## Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	\$150 copay per visit (copay waived if admitted)	\$150 copay per visit (copay waived if admitted)
Ambulance services-must be medically necessary	80% after in-network deductible	80% after in-network deductible

## Diagnostic services

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

## Maternity services provided by a physician or certified nurse midwife

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

## Hospital care

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

## Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care-must be in a <b>participating</b> skilled nursing facility	80% after in-network deductible	80% after in-network deductible
Limited to a maximum of 120 days per member per calendar year		

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Benefits	In-network	Out-of-network
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: <ul style="list-style-type: none"> <li>must be medically necessary</li> <li>must be provided by a <b>participating</b> home health care agency</li> </ul>	80% after in-network deductible	80% after in-network deductible
Infusion therapy: <ul style="list-style-type: none"> <li>must be medically necessary</li> <li>must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>may use drugs that require preauthorization- consult with your doctor</li> </ul>	80% after in-network deductible	80% after in-network deductible

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

Human organ transplants		
Benefits	In-network	Out-of-network
Specified human organ transplants-must be in a <b>designated</b> facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities <b>only</b>
Bone marrow transplants -must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
<b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)		
Benefits	In-network	Out-of-network
<b>Inpatient</b> mental health care and <b>inpatient</b> substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	

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Benefits	In-network	Out-of-network
Residential psychiatric treatment facility: <ul style="list-style-type: none"> <li>covered mental health services <b>must</b> be performed in a residential psychiatric treatment facility</li> <li>treatment must be preauthorized</li> <li>subject to medical criteria</li> </ul>	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>	80% after in-network deductible	80% after in-network deductible in participating facilities <b>only</b>
<ul style="list-style-type: none"> <li>Online visits</li> </ul> <p><b>Note:</b> Online visits by a vendor are not covered.</p>	80% after in-network deductible	60% after out-of-network deductible
<ul style="list-style-type: none"> <li>Physician's office</li> </ul>	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment- in approved facilities <b>only</b>	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

## Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment-when rendered by an approved board-certified behavioral analyst-is covered through age 18, subject to preauthorization  <p><b>Note:</b> 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.</p>	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy <b>with an autism</b> diagnosis is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

## Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)  <p><b>Note:</b> Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider.</p> <p><b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>	<ul style="list-style-type: none"> <li>80% after in-network deductible for diabetes medical supplies</li> <li>100% (no deductible or copay/coinsurance) for diabetes self-management training</li> </ul>	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$30 copay per visit  <b>Note:</b> Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam  Limited to a <b>combined</b> 12-visit maximum per member per calendar year	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy-provided for rehabilitation	80% after in-network deductible  Limited to a <b>combined</b> 30-visit maximum per member per calendar year	60% after out-of-network deductible  <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment	80% after in-network deductible  <b>Note:</b> DME items required under the preventive benefit 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 preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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## BCBSM Preferred RX Program

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

**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, 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 Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to 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](http://bcbsm.com/pharmacy). If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

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

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

## Member's responsibility (copays and coinsurance amounts)

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

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

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$160 copay	No coverage	No coverage
	84 to 90-day period	You pay \$160 copay	You pay \$160 copay	No coverage	No coverage

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

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

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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
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 <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> .	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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

## Features of your prescription drug plan

Custom Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 (generic)</b> - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment.</li> <li>• <b>Tier 2 (preferred brand)</b> - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.</li> </ul>
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b>, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</p>
Mandatory maximum allowable cost drugs	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you <b>MUST</b> pay the <b>difference</b> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <b>plus</b> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
Quantity limits	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>

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## WAYNE COUNTY COMMUNITY COLLEGE\_1 0070119080003 - 07CNH Effective Date: 01/01/2022

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](http://bcbsm.com/importantinfo). Select **Approving covered services**.

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

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

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

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

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## Eligibility Information

Members	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> <li>Subscriber's legal spouse</li> <li><b>Dependent children:</b> related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26</li> </ul>
Sponsored dependents	<ul style="list-style-type: none"> <li>Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.</li> </ul>

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

Benefits	In-network	Out-of-network
Deductible	None	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year
Flat-dollar copays	<ul style="list-style-type: none"> <li>\$15 copay for office visits and office consultations</li> <li>\$15 copay for medical online visits</li> <li>\$50 copay for emergency room visits</li> <li>\$15 copay for urgent care visits</li> </ul>	<ul style="list-style-type: none"> <li>\$50 copay for emergency room visits</li> </ul>
Coinsurance amounts (percent copays)	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> </ul>	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> <li>20% of approved amount for mental health care and substance use disorder treatment</li> <li>20% of approved amount for most other covered services</li> </ul>
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	\$6,350 for one member, \$12,700 for the family (when two or more members are covered under your contract) each calendar year	\$12,700 for one member, \$25,400 for the family (when two or more members are covered under your contract) each calendar year  <b>Note:</b> Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

## Preventive care services

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

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Benefits	In-network	Out-of-network
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year  <b>Note:</b> Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance)  <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	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)  <b>Note:</b> 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  <b>Note:</b> 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

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Benefits	In-network	Out-of-network
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy  <b>Note:</b> Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible
One per member per calendar year		

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$15 copay per office visit	80% after out-of-network deductible
Online visits - by physician must be medically necessary <b>Note:</b> Online visits by a vendor are not covered.	\$15 copay per online visit	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Office consultations - must be medically necessary	\$15 copay per office consultation	80% after out-of-network deductible
Urgent care visits - must be medically necessary	\$15 copay per urgent care visit	80% after out-of-network deductible

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	\$50 copay per visit (copay waived if admitted or for an accidental injury)	\$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

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

Maternity services provided by a physician or certified nurse midwife		
Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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

## Hospital care

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

## Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a <b>participating</b> skilled nursing facility	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Limited to a maximum of 120 days per member per calendar year		
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		
Home health care: <ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be provided by a <b>participating</b> home health care agency</li> </ul>	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Infusion therapy: <ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>• may use drugs that require preauthorization - consult with your doctor</li> </ul>	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

## Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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Benefits	In-network	Out-of-network
Voluntary sterilization for males  <b>Note:</b> For voluntary sterilizations for females, see " <b>Preventive care services.</b> "	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Voluntary abortions	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

## Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a <b>designated</b> facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities <b>only</b>
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Specified oncology clinical trials  <b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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

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

Benefits	In-network	Out-of-network
<b>Inpatient</b> mental health care and <b>inpatient</b> substance use disorder treatment	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible  Unlimited days
Residential psychiatric treatment facility: <ul style="list-style-type: none"> <li>covered mental health services <b>must</b> be performed in a residential psychiatric treatment facility</li> <li>treatment <b>must</b> be preauthorized</li> <li>subject to medical criteria</li> </ul>	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) in participating facilities <b>only</b>
<ul style="list-style-type: none"> <li>Online visits</li> </ul> <b>Note:</b> Online visits by a vendor are not covered.	\$15 copay per online visit	80% after out-of-network deductible
<ul style="list-style-type: none"> <li>Physician's office</li> </ul>	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities <b>only</b>	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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## Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization  <b>Note:</b> 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% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% (no deductible or copay/coinsurance)  Physical, speech and occupational therapy <b>with an autism diagnosis</b> is unlimited	80% after out-of-network deductible
Other covered services, including mental health services, for autism spectrum disorder	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

## Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)  <b>Note:</b> 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.  <b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	<ul style="list-style-type: none"> <li>100% (no deductible or copay/coinsurance) for diabetes medical supplies</li> <li>100% (no deductible or copay/coinsurance) for diabetes self-management training</li> </ul>	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% (no deductible or copay/coinsurance)  Limited to a <b>combined</b> 24-visit maximum per member per calendar year	80% after out-of-network deductible
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible  <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.  Limited to a <b>combined</b> 60-visit maximum per member per calendar year
Durable medical equipment  <b>Note:</b> DME items required under the preventive benefit 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 preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Prosthetic and orthotic appliances	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Private duty nursing care	50% (no deductible)	50% (no deductible)

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## BCBSM Preferred RX Program

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

**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, 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 Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to 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](http://bcbsm.com/pharmacy). If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

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

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

## Member's responsibility (copays and coinsurance amounts)

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

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

Benefits	In-network pharmacy	Out-of-network pharmacy
Generic or select prescribed over-the-counter drugs	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
Brand name prescription drugs	You pay \$20 copay	You pay \$20 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	<p><b>Copay for up to a 30 day supply:</b></p> <ul style="list-style-type: none"> <li>• No copay for Tier 1 (generic) drugs</li> <li>• No copay for Tier 2 (formulary brand) drugs</li> </ul> <p><b>Copay for 31-90 day supply</b></p> <ul style="list-style-type: none"> <li>• No copay for Tier 1 (generic) drugs</li> <li>• No copay for Tier 2 (formulary brand) drugs</li> </ul>	Not covered

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

## Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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Benefits	In-network pharmacy	Out-of-network pharmacy
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved <b>generic</b> and <b>select brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	75% of approved amount
Other FDA-approved <b>brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	75% of approved amount
FDA-approved <b>generic</b> and <b>select brand-name</b> prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved <b>brand-name</b> prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
<b>Note:</b> Needles and syringes have no copay/coinsurance.		
Select diabetic supplies and devices (test strips, lancets and glucometers)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> .		

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

## Features of your prescription drug plan

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

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## Features of your prescription drug plan

Mandatory maximum allowable cost drugs

If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

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## WAYNE COUNTY COMMUNITY COLLEGE 0070119080004 - 07CNP Effective Date: 01/01/2022

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

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

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

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

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

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

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## Eligibility Information

Members	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> <li>Subscriber's legal spouse</li> <li><b>Dependent children:</b> related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26</li> </ul>
Sponsored dependents	<ul style="list-style-type: none"> <li>Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.</li> </ul>

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

Benefits	In-network	Out-of-network
<b>Deductible</b>	<p>\$100 for one member, \$200 for the family (when two or more members are covered under your contract) each calendar year</p> <p><b>Note:</b> Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.</p>	<p>\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year</p> <p><b>Note:</b> Out-of-network deductible amounts also count toward the in-network deductible.</p>
<b>Flat-dollar copays</b>	<ul style="list-style-type: none"> <li>\$30 copay for office visits and office consultations</li> <li>\$30 copay for medical online visits</li> <li>\$30 copay for chiropractic and osteopathic manipulative therapy</li> <li>\$250 copay for emergency room visits</li> <li>\$30 copay for urgent care visits</li> </ul>	<ul style="list-style-type: none"> <li>\$250 copay for emergency room visits</li> </ul>
<p><b>Coinsurance amounts (percent copays)</b></p> <p><b>Note:</b> Coinsurance amounts apply once the deductible has been met.</p>	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> <li>10% of approved amount for mental health care and substance use disorder treatment</li> <li>10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)</li> </ul>	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> <li>30% of approved amount for mental health care and substance use disorder treatment</li> <li>30% of approved amount for most other covered services</li> </ul>
<p><b>Annual coinsurance maximums</b> - applies to coinsurance amounts for all covered services - but <b>does not</b> apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts</p>	<p>\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year</p>	<p>\$1,500 for one member, \$3,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p><b>Note:</b> Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.</p>

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Benefits	In-network	Out-of-network
<b>Annual out-of-pocket maximums</b> - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	\$6,350 for one member, \$12,700 for the family (when two or more members are covered under your contract) each calendar year	\$12,700 for one member, \$25,400 for the family (when two or more members are covered under your contract) each calendar year  <b>Note:</b> Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
<b>Lifetime dollar maximum</b>	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  <b>Note:</b> Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year  <b>Note:</b> Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> <li>8 visits, birth through 12 months</li> <li>6 visits, 13 months through 23 months</li> <li>6 visits, 24 months through 35 months</li> <li>2 visits, 36 months through 47 months</li> <li>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	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

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Benefits	In-network	Out-of-network
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)  <b>Note:</b> Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	70% after out-of-network deductible  <b>Note:</b> Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy  <b>Note:</b> Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	70% after out-of-network deductible
	One per member per calendar year	

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$30 copay per office visit	70% after out-of-network deductible
Online visits - by physician must be medically necessary  <b>Note:</b> Online visits by a vendor are not covered.	\$30 copay per online visit	70% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	90% after in-network deductible	70% after out-of-network deductible
Office consultations - must be medically necessary	\$30 copay per office consultation	70% after out-of-network deductible
Urgent care visits - must be medically necessary	\$30 copay per urgent care visit	70% after out-of-network deductible

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	\$250 copay per visit (copay waived if admitted or for an accidental injury)	\$250 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	90% after in-network deductible	90% after in-network deductible

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## Diagnostic services

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

## Maternity services provided by a physician or certified nurse midwife

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

## Hospital care

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

## Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a <b>participating</b> skilled nursing facility	90% after in-network deductible	90% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care:	90% after in-network deductible	90% after in-network deductible
<ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be provided by a <b>participating</b> home health care agency</li> </ul>		

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Benefits	In-network	Out-of-network
Infusion therapy: <ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>• may use drugs that require preauthorization - consult with your doctor</li> </ul>	90% after in-network deductible	90% after in-network deductible

## Surgical services

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

## Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a <b>designated</b> facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities <b>only</b>
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	70% after out-of-network deductible
Specified oncology clinical trials	90% after in-network deductible	70% after out-of-network deductible
<b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	90% after in-network deductible	70% after out-of-network deductible

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

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

Benefits	In-network	Out-of-network
<b>Inpatient</b> mental health care and <b>inpatient</b> substance use disorder treatment	90% after in-network deductible	70% after out-of-network deductible
		Unlimited days
Residential psychiatric treatment facility: <ul style="list-style-type: none"> <li>• covered mental health services <b>must</b> be performed in a residential psychiatric treatment facility</li> <li>• treatment <b>must</b> be preauthorized</li> <li>• subject to medical criteria</li> </ul>	90% after in-network deductible	70% after out-of-network deductible

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Benefits	In-network	Out-of-network
Outpatient mental health care: <ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>	90% after in-network deductible	90% after in-network deductible in participating facilities <b>only</b>
<ul style="list-style-type: none"> <li>Online visits</li> </ul> <p><b>Note:</b> Online visits by a vendor are not covered.</p>	\$30 copay per online visit	70% after out-of-network deductible
<ul style="list-style-type: none"> <li>Physician's office</li> </ul>	90% after in-network deductible	70% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities <b>only</b>	90% after in-network deductible	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

## Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	90% after in-network deductible	90% after in-network deductible
<p><b>Note:</b> 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.</p>		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	90% after in-network deductible	70% after out-of-network deductible
	Physical, speech and occupational therapy <b>with an autism diagnosis</b> is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	90% after in-network deductible	70% after out-of-network deductible

## Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	<ul style="list-style-type: none"> <li>90% after in-network deductible for diabetes medical supplies</li> <li>100% (no deductible or copay/coinsurance) for diabetes self-management training</li> </ul>	70% after out-of-network deductible
<p><b>Note:</b> Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider.</p> <p><b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>		
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$30 copay per visit	70% after out-of-network deductible
	Limited to a <b>combined 24-visit</b> maximum per member per calendar year	

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Benefits	In-network	Out-of-network
Outpatient physical, speech and occupational therapy - provided for rehabilitation	90% after in-network deductible	70% after out-of-network deductible  <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a <b>combined</b> 60-visit maximum per member per calendar year	
Durable medical equipment  <b>Note:</b> DME items required under the preventive benefit 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 preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	90% after in-network deductible	90% after in-network deductible
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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## BCBSM Preferred RX Program

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

**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, 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 Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to 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](http://bcbsm.com/pharmacy). If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

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

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

## Member's responsibility (copays and coinsurance amounts)

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

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

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$160 copay	No coverage	No coverage
	84 to 90-day period	You pay \$160 copay	You pay \$160 copay	No coverage	No coverage

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

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

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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
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 <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> .	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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

## Features of your prescription drug plan

Custom Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 (generic)</b> - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment.</li> <li>• <b>Tier 2 (preferred brand)</b> - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.</li> </ul>
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b>, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</p>
Mandatory maximum allowable cost drugs	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you <b>MUST</b> pay the <b>difference</b> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <b>plus</b> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
Quantity limits	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>

ADM COB-3;ADM PLAN YR JAN;CB ASC;CB-AMB ASC;CB-ECM-IN\$500AS;CB-ECM-ON\$1.5KA;CB-ET \$250 ASC;CB-MTC \$30 ASC;CB-OPMIN 6350 A;CB-OV \$30 ASC;CBOPMON 12.7K A;PDRX ASC;PD TTC104080R XCM;SD ASC

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





**Health Alliance Plan of Michigan**  
**Health Maintenance Organization (HMO) Plan**  
 Summary of Benefits

Plan 1000  
 P&AA Only

AA000371 / XR000NEW / XW000NEW

Health Care Services	Coverage	Limitations*
<b>Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:</b>		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Annual Out-of-Pocket Maximum	\$6,600 Individual ; \$13,200 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
<b>Preventive Services:</b>		
Preventive Office Visit / Physical Exam	Covered	
Well Baby Office Visit	Covered	
Routine Hearing Exam	Covered	
Routine Eye Exam	Covered	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
<b>Outpatient &amp; Physician Services:</b>		
Personal Care Physician Office Visit	Covered	Visits are face-to-face, telephonic, or through secure electronic portal
Specialty Physician Office Visit	Covered	
Gynecology Office Visit	Covered	
Audiology Office Visit	Covered	
Eye Exam Office Visit	Covered	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Office Visit and Related Services	Not Covered	
<b>Emergency/Urgent Care:</b>		
Emergency Room Services	Covered	
Urgent Care Facility Services	Covered	
Emergency Ambulance Services	Covered	Emergency transport only
<b>Inpatient Hospital Services:</b>		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	
Bariatric Surgery & Related Services	\$1,000 Copay	One procedure per lifetime
<b>Maternity Services:</b>		
Initial Prenatal Office Visit	Covered	Covered under Preventive Services
Subsequent Prenatal Office Visits	Covered	Covered under Preventive Services
Postnatal Office Visits	Covered	
Labor, Delivery and Newborn Care	Covered	
<b>Mental /Behavioral Health:</b>		
Inpatient Services	Covered	
Outpatient Services	Covered	
<b>Substance Use Disorder:</b>		
Inpatient Services	Covered	
Outpatient Services	Covered	
<b>Other Services:</b>		
Home Health Care	Covered	Unlimited
Hospice Care	Covered	Up to 210 days per lifetime
Skilled Nursing Care	Covered	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetics & Orthotics	Not Covered	
Hearing Aid Hardware	Not Covered	
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 100%	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. <b>Women: Covered as Preventive Service</b>
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Covered	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Covered	One attempt of artificial insemination per lifetime
<b>Pharmacy:</b>		
Generic and Brand	\$2 Copay	Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 2 Copays Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays

Rev 08/2012

**Benefit Riders: 016,124,126,K60,MHE,MHP,403**

\* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.

\* Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.

\* In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.

\* Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.



**Health Alliance Plan of Michigan**  
**Health Maintenance Organization (HMO) Plan**  
 Summary of Benefits for

AA000586 / XR000920 / XW000317

Health Care Services	Coverage	Limitations*
<b>Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:</b>		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Annual Out-of-Pocket Maximum	\$6,600 Individual ; \$13,200 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
<b>Preventive Services:</b>		
Preventive Office Visit / Physical Exam	Covered	
Well Baby Office Visit	Covered	
Routine Hearing Exam	Covered	
Routine Eye Exam	Covered	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
<b>Outpatient &amp; Physician Services:</b>		
Personal Care Physician Office Visit	Covered	Visits are face-to-face, telephonic, or through secure electronic portal
Specialty Physician Office Visit	Covered	
Gynecology Office Visit	Covered	
Audiology Office Visit	Covered	
Eye Exam Office Visit	Covered	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Office Visit and Related Services	Not Covered	
<b>Emergency/Urgent Care:</b>		
Emergency Room Services	Covered	
Urgent Care Facility Services	Covered	
Emergency Ambulance Services	Covered	Emergency transport only
<b>Inpatient Hospital Services:</b>		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	
Bariatric Surgery & Related Services	\$1,000 Copay	One procedure per lifetime
<b>Maternity Services:</b>		
Initial Prenatal Office Visit	Covered	Covered under Preventive Services
Subsequent Prenatal Office Visits	Covered	Covered under Preventive Services
Postnatal Office Visits	Covered	
Labor, Delivery and Newborn Care	Covered	
<b>Mental/Behavioral Health:</b>		
Inpatient Services	Covered	
Outpatient Services	Covered	
<b>Substance Use Disorder:</b>		
Inpatient Services	Covered	
Outpatient Services	Covered	
<b>Other Services:</b>		
Home Health Care	Covered	Unlimited
Hospice Care	Covered	Up to 210 days per lifetime
Skilled Nursing Care	Covered	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetic & Orthotics	Not Covered	
Hearing Aid Hardware	Not Covered	
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 100%	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. <b>Women: Covered as Preventive Service</b>
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Covered	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Covered	One attempt of artificial insemination per lifetime
<b>Pharmacy:</b>		
Generic / Brand	\$10 / \$20 Copay	Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 2 Copays Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays

Rev 08/2012

**Benefit Riders: 126,124,016,K60,MHE,MHP,422**

- \* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.
- \* Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.
- \* In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.
- \* Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.



**Health Alliance Plan of Michigan**  
**Health Maintenance Organization (HMO) Plan**  
 Summary of Benefits for

AA000745 / XR001036

Health Care Services	Coverage	Limitations*
<b>Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:</b>		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Annual Out-of-Pocket Maximum	\$6,600 Individual ; \$13,200 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
<b>Preventive Services:</b>		
Preventive Office Visit / Physical Exam	Covered	
Well Baby Office Visit	Covered	
Routine Hearing Exam	Covered	
Routine Eye Exam	Covered	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
<b>Outpatient &amp; Physician Services:</b>		
Personal Care Physician Office Visit	\$20 Copay	Visits are face-to-face, telephonic, or through secure electronic portal
Specialty Physician Office Visit	\$20 Copay	
Gynecology Office Visit	\$20 Copay	
Audiology Office Visit	\$20 Copay	
Eye Exam Office Visit	\$20 Copay	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Office Visit and Related Services	Not Covered	
<b>Emergency/Urgent Care:</b>		
Emergency Room Services	\$150 Copay	Copay will be waived if admitted
Urgent Care Facility Services	\$20 Copay	
Emergency Ambulance Services	Covered	Emergency transport only
<b>Inpatient Hospital Services:</b>		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	
Bariatric Surgery & Related Services	\$1,000 Copay	One procedure per lifetime
<b>Maternity Services:</b>		
Initial Prenatal Office Visit	Covered	Covered under Preventive Services
Subsequent Prenatal Office Visits	Covered	Covered under Preventive Services
Postnatal Office Visits	\$20 Copay	
Labor, Delivery and Newborn Care	Covered	
<b>Mental/Behavioral Health:</b>		
Inpatient Services	Covered	
Outpatient Services	\$20 Copay	
<b>Substance Use Disorder:</b>		
Inpatient Services	Covered	
Outpatient Services	\$20 Copay	
<b>Other Services:</b>		
Home Health Care	Covered	Unlimited
Hospice Care	Covered	Up to 210 days per lifetime
Skilled Nursing Care	Covered	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetic & Orthotics	Not Covered	
Hearing Aid Hardware	Not Covered	
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 100%	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. <b>Women: Covered as Preventive Service</b>
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Covered	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Covered	One attempt of artificial insemination per lifetime
<b>Pharmacy:</b>		
Generic / Preferred Brand / Non-Preferred Brand	\$7 / \$20 / \$30 Copay	Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 2 Copays Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays

Rev 08/2012

**Benefit Riders: 573,133,126,124,118,016,K60, MHE,MHP,440**

- \* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.
- \* Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.
- \* In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.
- \* Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.



**Health Alliance Plan of Michigan**  
**Health Maintenance Organization (HMO) Plan**  
 Summary of Benefits for

HAP 1300

AA001842 / XR000948 / XW000346

Health Care Services	Coverage	Limitations*
<b>Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:</b>		
Benefit Period:	Calendar Year	
Annual Deductible	\$1,000 Individual ; \$2,000 Family	
Co-insurance (amount member pays)	30%	
Annual Co-insurance Maximum	\$2,000 Individual ; \$4,000 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover, deductibles, and copays
Annual Out-of-Pocket Maximum	\$6,600 Individual ; \$13,200 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
<b>Preventive Services:</b>		
Preventive Office Visit / Physical Exam	Covered - Deductible does not apply	
Well Baby Office Visit	Covered - Deductible does not apply	
Routine Hearing Exam	Covered - Deductible does not apply	
Routine Eye Exam	Covered - Deductible does not apply	
Immunizations	Covered - Deductible does not apply	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	
Pap Smears and Mammograms	Covered - Deductible does not apply	
<b>Outpatient &amp; Physician Services:</b>		
Personal Care Physician Office Visit	\$35 Copay - Deductible does not apply	Visits are face-to-face, telephonic, or through secure electronic portal
Specialty Physician Office Visit	\$35 Copay - Deductible does not apply	
Gynecology Office Visit	\$35 Copay - Deductible does not apply	
Audiology Office Visit	\$35 Copay - Deductible does not apply	
Eye Exam Office Visit	\$35 Copay - Deductible does not apply	
Allergy Treatment and Injections	Plan Pays 70% after Deductible	
Laboratory and Radiology Services	Plan Pays 70% after Deductible	
Dialysis	Plan Pays 70% after Deductible	
Chemotherapy	Plan Pays 70% after Deductible	
Radiation Therapy	Plan Pays 70% after Deductible	
Outpatient Surgery	Plan Pays 70% after Deductible	
Chiropractic Office Visit and Related Services	Not Covered	
<b>Emergency/Urgent Care:</b>		
Emergency Room Services	\$150 Copay - Deductible does not apply	Copay will be waived if admitted
Urgent Care Facility Services	\$40 Copay - Deductible does not apply	
Emergency Ambulance Services	Plan Pays 70% after Deductible	Emergency transport only
<b>Inpatient Hospital Services:</b>		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Plan Pays 70% after Deductible	
Bariatric Surgery & Related Services	Plan Pays 70% after Deductible	One procedure per lifetime
<b>Maternity Services:</b>		
Initial Prenatal Office Visit	Covered - Deductible does not apply	Covered under Preventive Services
Subsequent Prenatal Office Visits	Covered - Deductible does not apply	Covered under Preventive Services
Postnatal Office Visits	\$35 Copay - Deductible does not apply	
Labor, Delivery and Newborn Care	Plan Pays 70% after Deductible	
<b>Mental/Behavioral Health:</b>		
Inpatient Services	Plan Pays 70% after Deductible	
Outpatient Services	\$35 Copay - Deductible does not apply	
<b>Substance Use Disorder:</b>		
Inpatient Services	Plan Pays 70% after Deductible	
Outpatient Services	\$35 Copay - Deductible does not apply	
<b>Other Services:</b>		
Home Health Care	Plan Pays 70% after Deductible	Unlimited
Hospice Care	Plan Pays 70% after Deductible	Up to 210 days per lifetime
Skilled Nursing Care	Plan Pays 70% after Deductible	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetic & Orthotics	Not Covered	
Hearing Aid Hardware	Not Covered	
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Plan Pays 70% after Deductible	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 70% after Deductible	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. <b>Women: Covered as Preventive Service</b>
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Plan Pays 70% after Deductible	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Plan Pays 70% after Deductible	One attempt of artificial insemination per lifetime
<b>Pharmacy:</b>		
Generic / Preferred Brand / Non-Preferred Brand	\$5 / \$20 / \$40 Copay - Deductible does not apply	Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 2 Copays Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays

Value Plus

Rev 08/2012

**Benefit Riders: 016,124,126,133,141,148,272,357,K60,MHE,MHP,932**

\* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.

\* Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.

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