MMSA
Michigan Municipal Services Authority
PO BOX 12012, LANSING MI 48901-2012

PUBLIC NOTICE OF A REGULAR MEETING

The **Executive Committee of the Michigan Municipal Services Authority** (Authority) will hold a regular meeting on the following date, at the following time, and at the following location:

Date	**Time**	**Location**
Thursday, November 10, 2016	1:30 PM	Capitol View Building Constitution Room – 9th Floor 201 Townsend Street Lansing, MI 48933

The meeting is open to the public and this notice is provided under the Open Meetings Act, 1976 PA 267, MCL 15.261 to 15.275.

The meeting location is barrier-free and accessible to individuals with special needs. Individuals needing special accommodations or assistance to attend or address the meeting should contact the Authority at (248) 925-9295 prior to the meeting to assure compliance with Subtitle A of Title II of the Americans with Disabilities Act of 1990, Public Law 101-336, and 42 USC 12131 to 12134.

A copy of the proposed meeting minutes will be available for public inspection at the principal office of the Authority within 8 business days. A copy of the approved minutes of the meeting, including any corrections, will be available for public inspection at the principal office of the Authority within 5 business days after approval.

MMSA
Michigan Municipal Services Authority
PO BOX 12012, LANSING MI 48901-2012

EXECUTIVE COMMITTEE
REGULAR MEETING

Thursday, November 10, 2016 at 1:30 PM

Capitol View Building
201 Townsend St Suite 900
Lansing, MI 48933

AGENDA

I. Call to Order

II. Roll Call

III. Approval of Agenda

IV. Approval of Minutes

a. Minutes of the September 22, 2016 regular Executive Committee meeting

V. Administrative Report

a. Financial Report
b. Program Reports

VI. New Business

a. Resolution 2016-31 Second Amendment to Employment Agreement with Chief Executive Officer

VII. Public Comment

VIII. Other Business

IX. Adjournment

A copy of the proposed minutes of the meeting will be available for public inspection at the principal office of the Authority within 8 business days. A copy of the approved minutes of the meeting, including any corrections, will be available for public inspection at the principal office of the Authority within 5 business days after approval.

Michigan Municipal Services Authority
PO BOX 12012, LANSING MI 48901-2012

EXECUTIVE COMMITTEE
REGULAR MEETING

Thursday, September 22, 2016 at 2:00 p.m.

Grid 70 LLC
70 Ionia Avenue Southwest
Grand Rapids, MI 49503

MINUTES

☒ Proposed Minutes ☐ Approved Minutes

MEETING TYPE: ☒ Regular ☐ Special

I. Call to Order

The meeting was called to order at 2:35 PM.

II. Roll Call

Executive Committee Member Attendance:

Stacie Behler, Chairperson	☒ Present	☐ Absent
James Cambridge, Secretary*	☒ Present	☐ Absent
Eric DeLong, Treasurer	☒ Present	☐ Absent
Doug Smith, Member*	☒ Present	☐ Absent
Al Vanderberg, Member	☒ Present	☐ Absent

*Participated via teleconference.

Other attendees:

- Robert Bruner, Michigan Municipal Services Authority
- Kristen Delaney, Michigan Municipal Services Authority
- Steven Liedel, Dykema

III. Approval of Agenda as Amended

Agenda for September 22, 2016 amended to Authorize Authority CEO to Submit RFP to Provide ERP Services to Oakland County as New Business, Item “c”.

Moved by: DeLong
Supported by: Vanderberg

Yes: X *No: __*

IV. Approval of Minutes

a. Minutes of the August 11, 2016 regular Executive Committee meeting

Moved by: DeLong
Supported by: Vanderberg

Yes: X *No: __*

V. Administrative Report

The administrative report was delivered by CEO Robert Bruner at the earlier Authority Board meeting.

VI. New Business

a. Resolution 2016-29 FY 2016-2017 General Appropriations Act

Moved by: DeLong
Supported by: Vanderberg

Yes: X *No: __*

b. Resolution 2016-30 Regular Meeting Schedule Amendment

Moved by: DeLong
Supported by: Vanderberg

Yes: X *No:__*

c. Authorize Authority CEO to Submit RFP to Provide ERP Services to Oakland County

The RFP will be a joint effort between the Authority and CGI.

Moved by: DeLong
Supported by: Vanderberg

Yes: X *No: __*

II. Public Comment

None

III. Other Business

None

IV. Adjournment

Motion to adjourn the meeting at 3:02 PM.

Moved by: DeLong
Supported by: Vandenberg

Yes: X *No: __*

Certification of Minutes

Approved by the Executive Committee on November 10, 2016.

Authority Secretary _____ Date _____

MMSA

Michigan Municipal Services Authority

Administrative Report

Prepared November 7, 2016

Collaborate • Innovate • Serve

Financial Report

MMSA Administrative Report

Michigan Municipal Services Authority
General Fund

Fund	Activity		FYE 2017 Adopted	October 2016	FYE 2016 Year to Date	FYE 2016 Budget to Date	Variance
		Operating Revenues					
101	539	State Grants		$ -	$ -	$ -	
		Transfer from VHWM	$ 127,706	$ 9,389	$ 9,389	$ 10,642	-11.8%
		Transfer from FMS	$ 127,706	$ 9,389	$ 9,389	$ 10,642	-11.8%
		TOTAL OPERATING REVENUES	$ 255,412	$ 18,778	$ 18,778	$ 21,284	-11.8%
		Operating Expenses					
101	101	Governing Body	$ 2,000	$ -	$ -	$ 167	-100.0%
101	173	Chief Executive	$ 224,812	$ 18,406	$ 18,406	$ 18,734	-1.8%
101	191	Accounting	$ 5,000	$ 372	$ 372	$ 417	-10.7%
101	223	External Audit	$ 10,600	$ -	$ -	$ 883	-100.0%
101	228	Information Technology	$ 4,000	$ -	$ -	$ 333	-100.0%
101	266	Attorney	$ 9,000	$ -	$ -	$ 750	-100.0%
		TOTAL OPERATING EXPENSES	$ 255,412	$ 18,778	$ 18,778	$ 21,284	-11.8%
		Change in Net Position	$ -	$ 0	$ -	$ -	

Michigan Municipal Services Authority
VHWM

Fund	Activity		FYE 2016 Adopted	October 2016	FYE 2016 Year to Date	FYE 2016 Budget to Date	Variance
		Operating Revenues					
501	539	State Grants	$ -	$ -	$ -	$ -	
501	600	Charges for Services	$ 600,000	$ 84,504	$ 84,504	$ 50,000	69.0%
		TOTAL OPERATING REVENUES	$ 600,000	$ 84,504	$ 84,504	$ 50,000	69.0%
		Operating Expenses					
501	266	Attorney	$ 6,000	$ 3,395	$ 3,395	$ 500	579.0%
501	271	Program Management	$ 60,000	$ -	$ -	$ 5,000	-100.0%
501	272	Contractual Services	$ 540,000	$ 19,839	$ 19,839	$ 45,000	-55.9%
501		Transfer to General Fund	$ 127,706	$ 9,389	$ 9,389	$ 10,642	-11.8%
		TOTAL OPERATING EXPENSES	$ 733,706	$ 32,623	$ 32,623	$ 61,142	-46.6%
		Change in Net Position	$ (133,706)	$ 51,882	$ 51,882	$ (11,142)	-565.6%

Michigan Municipal Services Authority
FMS

Fund	Activity		FYE 2016 Adopted	October 2016	FYE 2016 Year to Date	FYE 2016 Budget to Date	Variance
		Operating Revenues					
502	539	State Grants	$ -	$ -	$ -	$ -	0.0%
502	600	Charges for Services	$ 2,863,430	$ -	$ -	$ 238,619	-100.0%
		TOTAL OPERATING REVENUES	$ 2,863,430	$ -	$ -	$ 238,619	-100.0%
		Operating Expenses					
502	266	Attorney	$ 6,000			$ 500	-100.0%
502	271	Program Management	$ 50,000	$ -	$ -	$ 4,167	-100.0%
502	272	Contractual Services	$ 2,679,047	$ 1,250	$ 1,250	$ 223,254	-99.4%
502		Transfer to General Fund	$ 127,706	$ 9,389	$ 9,389	$ 10,642	-11.8%
		TOTAL OPERATING EXPENSES	$ 2,862,753	$ 10,639	$ 10,639	$ 238,563	-95.5%
		Change in Net Position	$ 677	$ (10,639)	$ (10,639)	$ 56	-18957.9%

Michigan Municipal Services Authority
All Funds

	FYE 2016 Adopted	October 2016	FYE 2016 Year to Date	FYE 2016 Budget to Date	Variance
OPERATING REVENUES					
General	$ 255,412	$ 18,778	$ 18,778	$ 21,284	-11.8%
VHWM	$ 600,000	$ 84,504	$ 84,504	$ 50,000	69.0%
FMS	$ 2,863,430	$ -	$ -	$ 238,619	-100.0%
TOTAL OPERATING REVENUES	$ 3,718,842	$ 103,282	$ 103,282	$ 309,904	-66.7%
OPERATING EXPENSES					
General	$ 255,412	$ 18,778	$ 18,778	$ 21,284	-11.8%
VHWM	$ 733,706	$ 32,623	$ 32,623	$ 61,142	-46.6%
FMS	$ 2,862,753	$ 10,639	$ 10,639	$ 238,563	-95.5%
TOTAL OPERATING EXPENSES	$ 3,851,871	$ 62,039	$ 62,040	$ 320,989	-80.7%
CHANGE IN NET POSITION	$ (133,029)	$ 41,243	$ 41,243	$ (11,086)	-472.0%

Michigan Municipal Services Authority
Balance Sheet
As of October 31, 2016

ASSETS

CURRENT ASSETS			
Cash in Bank	$	649,657.29	
Due From Cities		153,790.56	
Due from State		48,027.55	
Total Current Assets			851,475.40
PROPERTY AND EQUIPMENT			
TOTAL ASSETS			$ 851,475.40
CURRENT LIABILITIES			
Accounts Payable	$	183,883.88	
Accrued State W/H		536.80	
Accrued Federal W/H		1,728.00	
Accrued FICA		2,809.17	
Accrued MESC		27.63	
Accrued Salaries & Wages		8,998.33	
Total Current Liabilities			197,983.81
LONG-TERM LIABILITIES			
Total Liabilities			197,983.81
FUND BALANCE			
Fund Balance Retained		612,248.29	
Current Revenue over Expenses		41,243.30	
Total Fund Balance			653,491.59
TOTAL LIABILITIES AND FUND BALANCE			$ 851,475.40

Michigan Municipal Services Authority
Statement of Income
For the 1 Month and 1 Month Ended October 31, 2016

	1 Month Ended October 31, 2016	1 Month Ended October 31, 2016
Revenues		
Contract Revenue	$ 84,504.07	$ 84,504.07
Operating Expenses		
Salary Director	$ 9,461.54	$ 9,461.54
Wages - Administrative Staff	4,400.00	4,400.00
Outside Service Contractors	21,088.75	21,088.75
Payroll Taxes	1,060.40	1,060.40
Office Expense	2,729.61	2,729.61
Legal & Accounting	3,694.80	3,694.80
Mileage Reimbursement	754.04	754.04
Bank Service Charges	71.63	71.63
Total Operating Expenses	43,260.77	43,260.77
Revenues over Expenses	$ 41,243.30	$ 41,243.30

See Accountants' Compilation Report

MICHIGAN MUNICIPAL SERVICES AUTHORITY

Summary of Revenues and Expenditures

Date	Check Number	Invoice Number	Description	Check Amount	Deposits/ Other Credits	Account Balance
9/30/16			Beginning Balance			$ 608,414.03
10/6/16	Direct Deposits		Payroll	$ 5,268.18		$ 603,145.85
	ACH		EFTPS - payroll tax	$ 3,848.84		$ 599,297.01
	ACH		State of Mich - payroll tax	$ 536.80		$ 598,760.21
10/7/16	ACH		Plante Moran	$ 1,250.00		$ 597,510.21
	ACH		Robert Bruner Jr.	$ 2,729.61		$ 594,780.60
	ACH		Robert Bruner Jr.	$ 613.19		$ 594,167.41
10/13/16	charge		Bank Service Charge	$ 71.63		$ 594,095.78
10/20/16	Direct Deposits		Payroll	$ 5,268.16		$ 588,827.62
10/21/16	ACH		Segal Consulting	$ 1,800.00		$ 587,027.62
	ACH		Segal Consulting	$ 18,038.75		$ 568,988.87
	ACH		Michael A Tawney & Co PC	$ 300.00		$ 568,688.87
	ACH		Dykema Gossett	$ 3,394.80		$ 565,294.07
	ACH	Expenses	Kristen Delaney	$ 140.85		$ 565,153.22
10/28/16	DEPOSIT		City of Detroit		$ 84,504.07	$ 649,657.29
			TOTAL MI MUN SERV AUTH CASH BALANCE			$ 649,657.29
				$ 43,260.81		

BANK RECONCILIATION

Name of Client: Michigan Municipal Services Authority Month: Oct, 2016

Bank: Fifth Third Prepared By:

General Ledger Acct Balance:		$ 608,414.03	Balance per bank statement: 10/31/16		$ 649,657.29
Add Debits:			Add Deposits in Transit:		
Deposits	$ 84,504.07				
Total Dr $	$ 84,504.07				
Total		$ 692,918.10			
Less Credits:					
checks	$ -		Total in Transit:	$ -	
Payroll	$ 14,921.98		Total:		$ 649,657.29
Online payments	$ 28,267.20				
SC	$ 71.63		Less Checks Outstanding:		
			(see list below)		
Total Cr $	$ 43,260.81		Total:	$ -	
Bank Balance - Per General Ledger:		$ 649,657.29			$ 649,657.29

Checks Outstanding

Number	Amount	Number	Amount	Number	Amount
	$ -		$ -		$ -

FIFTH THIRD BANK

(WESTERN MICHIGAN)
P.O. BOX 630900 CINCINNATI OH 45263-0900

MICHIGAN MUNICIPAL SERVICES AUTHORITY
PO BOX 12012
LANSING MI 48901-2012

0

4519

Statement Period Date: 10/1/2016 - 10/31/2016
Account Type: Comm'l 53 Analyzed
Account Number: 7166385711

Banking Center: Grand Rapids
Banking Center Phone: 616-653-5440
Commercial Client Services: 866-475-0729

Account Summary - 7166385711

10/01	**Beginning Balance**	**$609,014.03**	Number of Days in Period	31
1	Checks	$(600.00)		
13	Withdrawals / Debits	$(43,260.81)		
1	Deposits / Credits	$84,504.07		
10/31	**Ending Balance**	**$649,657.29**		

Check

1 check totaling $600.00

* Indicates gap in check sequence i = Electronic Image s = Substitute Check

Number	Date Paid	Amount
7500 i	10/07	600.00

Withdrawals / Debits

13 items totaling $43,260.81

Date	Amount	Description
10/05	613.19	Michigan Municip CREDITS 4616288140 100516 OFFSET TRANSACTION
10/05	1,250.00	Michigan Municip PAYMENTS 4616288140 100516 OFFSET TRANSACTION
10/05	2,729.61	Michigan Municip CREDITS 4616288140 100516 OFFSET TRANSACTION
10/05	5,268.18	Michigan Municip CSI PAYROLL PAYROLL Michigan Municipal Ser 100516
10/13	71.63	SERVICE CHARGE
10/17	3,848.84	IRS USATAXPYMT 270669113300209 MICHIGAN MUNICIPAL SER 101716
10/18	300.00	Michigan Municip PAYMENTS 4616288140 101816 OFFSET TRANSACTION
10/18	1,800.00	Michigan Municip PAYMENTS 4616288140 101816 OFFSET TRANSACTION
10/18	18,038.75	Michigan Municip PAYMENTS 4616288140 101816 OFFSET TRANSACTION
10/19	5,268.16	Michigan Municip CSI PAYROLL PAYROLL Michigan Municipal Ser 101916
10/20	140.85	Michigan Municip CREDITS 4616288140 102016 OFFSET TRANSACTION
10/20	536.80	MI Business Tax Payment SMIBUS000621930 TawneyMichael 102016
10/20	3,394.80	Michigan Municip PAYMENTS 4616288140 102016 OFFSET TRANSACTION

Deposits / Credits

1 item totaling $84,504.07

Date	Amount	Description
10/28	84,504.07	CITY OF DETROIT 13803 FIN A/P 57 200781 MICHIGAN MUNICIPAL SER 102816

Daily Balance Summary

Date	Amount	Date	Amount	Date	Amount
10/05	599,153.05	10/17	594,632.58	10/20	565,153.22
10/07	598,553.05	10/18	574,493.83	10/28	649,657.29
10/13	598,481.42	10/19	569,225.67		

Michigan Municipal Services Authority
Check Register

Check Number	Check Date	Payee		Amount
Checks				
20161001	10/07/16	Plante Moran		1,250.00
20161002	10/07/16	Robert J. Bruner Jr.		2,729.61
20161003	10/07/16	Robert J. Bruner Jr.		613.19
20161004	10/21/16	Segal Consulting		1,800.00
20161005	10/21/16	Segal Consulting		18,038.75
20161006	10/21/16	Michael A. Tawney & Co PC		300.00
20161007	10/21/16	Dykema Gossett PLLC		3,394.80
20161008	10/21/16	Kristen Delaney		140.85
Total checks	8		Total	28,267.20

Michigan Municipal Services Authority
Check List

All Bank Accounts
October 1, 2016 - October 31, 2016

Check Number	Check Date	Payee		Amount
Payroll Direct Deposit				
5303	10/06/16	Bruner Jr., Robert J		3,574.98
5304	10/06/16	Delaney, Kristen A		1,693.20
5305	10/20/16	Bruner Jr., Robert J		3,574.96
5306	10/20/16	Delaney, Kristen A		1,693.20
			Payroll Direct Deposit Total	10,536.34
Vendor Checks				
5301	10/06/16	Internal Revenue Service		3,848.84
5302	10/06/16	State of Michigan		536.80
			Vendor Check Total	4,385.64
			Check List Total	14,921.98

Check count = 6

FMS Program Update

MMSA Administrative Report

FMS Program Update

Program Management

- No major issues reported during the November 3 FMS Leadership meeting
- Next FMS Leadership meeting is December 8
- Kent County: Budget and finance are live (troubleshooting finance reporting); Human resources go live has been postponed from November and is to be determined (maybe March 2017)
- Grand Rapids: Budget and finance are live (troubleshooting interfaces); Human resources is scheduled to go live in December
- Genesee County: Finance go live has been postponed from October and is to be determined; Human resources go live has been postponed from December and is to be determined; Budget is scheduled to go live in January but that may change too

FMS Program Update

Program Development

- Oakland County
  - Proposal submitted November 1, 2016
- Wayne County
  - Issued Request for Proposals on September 13, 2016
  - Proposals due November 14, 2016

FMS Program Update

Grant Management

- CGAP Grant FY 2014 (Round 1)
  - Q1 2016 CGAP grant report was submitted April 15
  - Q2 2016 CGAP grant report was submitted July 25
  - Q3 2016 CGAP grant report was submitted October 19
  - First reimbursement request was submitted October 27
  - Q4 2016 CGAP grant report is due January 30, 2017

VHWM Program Update

MMSA Administrative Report

VHWM Program Update

Invoices

- August 2016: Invoice sent to the City of Detroit for payment on September 1, 2016. Payment was received by the Authority on November 3, 2016.
- September 2016: Invoice sent to the City of Detroit for payment on September 30, 2016. Payment was received by the Authority on October 28, 2016.
- October 2016: Invoice sent to the City of Detroit for payment on October 31, 2016. Payment is pending.

VHWM Program Update

Invoices

- The City of Detroit has implemented a new invoice submission system. Segal has reviewed the updated process. Registration has been completed and it has been approved by the City of Detroit. Segal has requested, and is still awaiting, log-in access in order to submit invoices via the new system. Both Segal and the Authority have followed up with the City on the system access with the last follow-up on October 31, 2016.

VHWM Program Update

Call Center Update

- The City has moved to the general call center pool effective September 1, 2016 in preparation for open enrollment. They will remain in the general pool through at least the end of 2017. They will also keep their current, dedicated phone line and will still have access to many of the same call statistics (e.g., call volume, wait times).

VHWM Program Update

Call Center Update

- Wait times for the month September averaged 44.3 seconds and 15.05 seconds for the month of October. As expected by moving to the general pool of CSRs, the wait times have gone down.
- Open enrollment begins on November 1, 2016. We expect that calls will be answered by CSRs rather than using the messaging system which has been utilized for previous open enrollment periods.

VHWM Program Update

City of Detroit - Other Updates

- Open Enrollment: Open enrollment for City of Detroit active employees is currently underway and will close on November 15, 2016. Two new dental plans are available for 2017 through DenCap and Golden Dental Plans.

VHWM Program Update

City of Detroit - Other Updates

- C.O.P.S. Trust Medical Plan: City of Detroit Police and Fire unions previously offered medical and prescription drug coverage, separate from the City offerings, through C.O.P.S. Trust. Due to the significant losses incurred by this plan, they have notified the City that they will not continue to offer coverage in 2017. Therefore, we expect close to 1,200 police and fire employees to migrate back to one of the City-sponsored medical plans during this open enrollment period.

VHWM Program Update

City of Detroit - Other Updates

- The Police and Fire unions and the City of Detroit are exploring the possibility of another plan offering for these employees sometime in 2017. We have been asked to assist in reviewing RFP questionnaires and to analyze responses.

VHWM Program Update

City of Detroit - Ultipro Payroll

- Full implementation of the Ultipro census and payroll system file interfaces: The implementation of UltiPro is now delayed until sometime in 2017. A new go-live date is not yet set. We have provided additional payroll files for additional testing in October. We expect the implementation to be staggered with different groups going live at different points over the next year or so.

VHWM Program Update

City of Detroit - Contract Renewal

- Due to the departure of the retirees from City's benefits administration, the monthly reimbursement for the MMSA services was greatly reduced beginning in January, 2016, as the MMSA fees are based on a fixed per employee per month amount. In order for the City to continue receiving the same level of service from the MMSA and Segal, the MMSA proposed the City be charged the same hourly rate that the MMSA is charged by Segal, $100 per hour capped at $15,000 per month. This began in June, 2016.

VHWM Program Update

City of Detroit - Contract Renewal

- The City's Procurement Director has approved implementation of the new cost structure. Retroactive time charges above the PEPM cap for June and July were added to the August invoice and the August charges included on the September invoice. Both invoices have been paid by the City.

VHWM Program Update

City of Detroit - Contract Renewal

- Final updates to the MMSA Contract and the one-year Benefit Express renewal were reviewed with the City of Detroit on November 4, 2016. The contract will be presented to City Council for approval on November 7, 2016.

MI SHIP Update

MMSA Administrative Report

MI Self-Funded Healthcare Program (MI SHIP) Update

Next Steps

- Continue discussions with Western Michigan Health Insurance Pool (WMHIP) to determine interest in a joint venture
- Meet with Michigan Municipal Risk Management (MMRMA) to determine interest in a joint venture
- Meet with City of Grand Rapids to share Financial Analysis

Municipal Talent Pipeline Update

MMSA Administrative Report

Municipal Talent Pipeline Update

Assessing

- Met with Orion Solutions Group and WCA Assessing on November 2
- The Authority and WCA Assessing need both certified assessors and potential apprentices in order to meet demand
- Orion believes they can successfully recruit both

Program Development Update

MMSA Administrative Report

Potential Programs & Services

CISO as a Service

- November 18 meeting before Mi-GMIS Regional Roundtable

Fleet Management

- Shared draft RFP with Kalamazoo on October 18

Potential Programs & Services

Administrative Services

- The Local Community Stabilization Authority, a Michigan metropolitan authority under the Local Community Stabilization Act, is currently staffed by the Department of Licensing and Regulatory Affairs (LARA). LARA may want to stop providing administrative services in 2017 and the Authority may be a logical successor.

City of Detroit Major Activities by Month
Segal Consulting

Project Scope: The original scope of the MMSA/City of Detroit project included the implementation of an online enrollment and eligibility system for ongoing use and the implementation of a customer service call center for the active and retiree open enrollment period, originally scheduled for November 2013 for both groups. The items in **bold** below indicate tasks that fall outside of the original project scope due to changes made by the City of Detroit. Some of these changes also resulted in additional programming by Benefit Express, which are managed through work orders. These work orders are also shown in **bold.**

These out of scope changes include the following:

1. The effective date for retiree benefits moved from 01/01/14 to 03/01/14 creating a requirement for a second open enrollment period. The second enrollment period extended the overall timeframe of support required by the Segal team due to planning and project management support, communication/data/system updates, support at retiree enrollment sessions, and our ongoing support of the call center.

2. The City's bankruptcy proceedings produced a settlement agreement that created the requirement for a third open enrollment period. The third enrollment period has further extended the overall timeframe of support required by the Segal team due to planning and project management support, communication/data/system updates, retention and support of a document verification vendor, and our ongoing support of the call center.

3. Complexities in the data needs of the City that were unforeseen at the outset of the project have also extended the timeframe for support required by the Segal team. The City moved from a completely manual benefits administration process to an automated enrollment system. As such, there are multiple factors that require ongoing tracking and support by the Segal team. For example, the City has a number of retirees who return to work as active employees. Per the City's eligibility rules, these people are eligible for benefits as an active employee and as a retiree. As such, they are currently set up with two accounts in Benefit Express. This causes inaccuracies from an audit perspective and may require additional programming to resolve.

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
August 2013	$15,000	150	• Online enrollment and eligibility vendor/customer service vendor review and negotiation • Benefit Express selected as vendor for both online enrollment/eligibility and customer service
September 2013	$15,000	307	• Implementation of Benefit Express enrollment/ eligibility system and call center begins • Implementation kick-off meetings/calls held with all carriers • Developed and edited retiree and active employee benefit communications • Twice weekly implementation/status calls with Benefit Express, City of Detroit and Segal begin
October 2013	$15,000	345	• Twice weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Benefit Express enrollment site development o Data requests from carriers o Data requests from City of Detroit o Finalize carrier group structures o Finalize and test enrollment site o **Added retiree paid dental and vision plans (7,200 non-Medicare retirees are provided a benefit where enrollment services must be provided)**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			○ **Work Order #6 – 10/23/2013: Add optional life and AD&D coverage selection to the active open enrollment windows. Not included in original programming request.** • Retiree informational meetings held – provided overview of new online system ○ 12 sessions were held at the City of Detroit main office and at Macomb Community College
November 2013	$15,000	323	• Twice weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • **Retiree open enrollment is postponed until 3/1/2014** • Active employee open enrollment begins • Assisted with responses to call center questions and escalations • Develop monthly invoice and assist with work order processing • Active employee enrollment sessions held ○ 15 sessions were held at multiple City of Detroit work locations for active employees to receive one on one assistance with enrollment on the new site. • **Work Order #7A- 11/4/2013: Last minute system changes for open enrollment; includes retirement status code updates, BCBSM/CMS compliance updates, and changes to the retiree HAP Rx only plan.** • **Work Order #8 – 11/5/2013: Additional ports required for toll-free phone line. Call volumes were 2.5 times higher than anticipated and caused the phone line to fail. Benefit Express had to add additional phone line ports in order to properly manage the call volume.** • **Work Order #12 – 11/20/2013: Extension of the active open enrollment period to 11/22/2013.** • **Work Order #13 – 11/21/2013: Extending call center support for 10 weeks. Added due to continued high call volume.** • **Work Order #15 – 11/25/2013: Hiring six additional customer service reps for 4 weeks due to higher than expected call volume.** • **Work Order #18 – 11/24/2013: Adding semi-monthly and monthly payroll schedules. These payroll schedules were not provided during system set-up.**
December 2013	$15,000	273	• Twice weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Data clean-up from active open enrollment

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• **Assisted with responses to call center questions and escalations. The call center was originally intended to be open only during the first enrollment period in November 2013. With the effective date change for retiree benefits, the call center continues to remain open and requires our ongoing support.** • **Planning for retiree open enrollment begins** • **Developed and edited new retiree benefit communications for 3/1/2014 effective date.** • **Secured new vendor for printing and mailing of retiree benefit communication, as the usual vendor was not able to accommodate the request over the holidays.** • Develop monthly invoice and assist with work order processing • **Work Order #14 – 12/2/2013: Change opt-out credit for active employees from $900 to $950. The original calculation of the opt-out credit was incorrect. The change was made post-enrollment and applied to all affected records.** • **Work Order #19 – 12/6/2013: Leave administration set-up, which includes two additional rate discriminators not originally included.** • **Work Order #22 – 12/19/2013: Retiree open enrollment changes for new 3/1/2014 effective date.**
January 2014	$15,000	282.75	• Twice weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Active benefits are effective 1/1/2014 • Data clean-up from active open enrollment continues • Develop monthly invoice and assist with work order processing • Maintain open and closed items logs • **Assisted with responses to call center questions and escalations. The call center was originally intended to be open only during the first enrollment period in November 2013. With the effective date change for retiree benefits, the call center continues to remain open and requires our ongoing support.** • **Coordinated and scheduled COD and Segal on-site representation for retiree enrollment sessions with BCBSM and HAP** • **Provided BCBSM and HAP representatives training on the Benefit Express enrollment site.**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• **Provided on-site assistance with retiree enrollment sessions** o **41 sessions were held across the City for retirees to receive one on one assistance with their enrollment in a City sponsored or individual plan.** • **Finalized and tested enrollment site for retiree enrollment** • **Retiree open enrollment begins**
February 2014	$15,000	246.75	• Twice weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • **Data clean up from retiree open enrollment.** • **Data clean up from active open enrollment continues. Some of these issues are more complex than originally anticipated which requires us track them on an ongoing basis.** • **Assisted with responses to call center questions and escalations. The call center was originally intended to be open only during the first enrollment period in November 2013. With the effective date change for retiree benefits, the call center continues to remain open and requires our ongoing support.** • Develop monthly invoice and assist with work order processing • **Work Order #28 –2/12/2014: Extension of 12 customer service reps through 3/28/2014.**
March 2014	$15,000	181	• Twice weekly implementation/status calls with Benefit Express and the City of Detroit • Maintain open and closed items logs • **Retiree benefits are effective 3/1/2014** • **Data clean up from retiree open enrollment continues. Some of these issues are more complex than originally anticipated which requires us track them on an ongoing basis** • **Data clean up from active open enrollment continues. Some of these issues are more complex than originally anticipated which requires us track them on an ongoing basis** • **Assisted with responses to call center questions and escalations. The call center was originally intended to be open only during the first enrollment period in November 2013. With the effective date change for retiree benefits, the call center continues to remain open and requires our ongoing support.** • **Developed weekly MAPD file reconciliation process**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• **BCBSM MAPD file reconciliation for managing deceased retirees/surviving spouses requires additional programming of the Benefit Express system** • **Planning for special enrollment period for retiree settlement changes begins for benefits effective 8/1/2014.** • **Work Order #29 – 3/4/2014: System set-up for special enrollment period for retiree settlement changes.** • **Work Order #32 – 3/18/2014: Add system option for benefits effective date of hire and/or file processing option for ad-hoc benefit effective dates.** • Develop monthly invoice and assist with work order processing
April 2014	$15,000	263	• Twice weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • **Planning for special enrollment period for retiree settlement changes continues** • **Retiree settlement agreement requires document verification for implementation of stipend changes. Hodges Mace selected as the vendor for this process.** • **Implementation activity with verification vendor begins** • **Assisted with responses to call center questions and escalations. The call center was originally intended to be open only during the first enrollment period in November 2013. With the effective date change for retiree benefits, the call center continues to remain open and requires our ongoing support.** • **Prepare data updates for Benefit Express system for special enrollment period.** • **Data clean up from retiree open enrollment continues. Some of these issues are more complex than originally anticipated which requires us track them on an ongoing basis** • **Work Order #34 – BCBSM MAPD File Reconciliation/Retiree Death Processing – 04/15/2014** • Develop monthly invoice and assist with work order processing
May 2014	$15,000	260.25	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • **Draft and edit communication material for retirees regarding special enrollment period and verification process. Develop mailing lists for enrollment communication and verification process.** • **Prepare data updates for Benefit Express system for special enrollment period.** • **Assist with responses to call center questions and escalations. The call center was originally intended to be open only during the first enrollment period in November 2013. With the effective date change for retiree benefits, the call center continues to remain open and requires our ongoing support.** • **Data clean up from original retiree open enrollment continues. Some of these issues are more complex than originally anticipated which requires us track them on an ongoing basis** • **Work Order #37 – Amendment to Work Order #29 – Fees due to late rates received, additional field required on stipend export file, payroll data updates for active employees – 05/16/14** • **Work Order #38 - Transfer EMS to General City Benefits – 05/16/14** • Develop monthly invoice and assist with work order processing
June 2014	$15,000	191.25	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • **Finalize and test enrollment site for special enrollment period** • **Special enrollment period held from 06/09/14 – 06/20/14.** • **Retiree stipend verification process held from 05/23/14 (date of notification) – 06/23/14.** • **Data clean-up from special enrollment period and stipend verification project begins** • **Data clean-up from active and retiree enrollment continues. Some of these issues are more complex than originally anticipated which requires us track them on an ongoing basis** • **Assist with responses to call center questions and escalations. The call center was originally intended to be open only during the first enrollment period in November 2013. With the addition of this**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			second retiree open enrollment, the call center continues to remain open and requires our ongoing support. • Develop monthly invoice and assist with work order processing
July 2014	$15,000	152	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • **Data clean-up from special enrollment period and stipend verification project continues** • **Data clean up from retiree enrollment continues. Some of these issues are more complex than originally anticipated which requires us track them on an ongoing basis** • **Assist with responses to call center questions and escalations. The call center was originally intended to be open only during the first enrollment period in November 2013. With the addition of this second retiree open enrollment, the call center continues to remain open and requires our ongoing support.** • **Create stipend file to load to Benefit Express** • **Create stipend file to load to pension and Flex-Plan that includes retroactive stipends** • Assist with finalizing contract between MMSA and the City of Detroit • Develop monthly invoice and assist with work order processing
August 2014	$15,000	168.75	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Benefits from special enrollment period effective 8/1/2014. • Begin planning for active and retiree open enrollment, tentatively scheduled for 11/10/2014 – 11/21/2014 (e.g. finalize rates, plans, other changes) • **Negotiate new pricing terms with Benefit Express for the transition of the retirees to standalone VEBA administrators.** • **Data clean up from special enrollment period continues** • Assist with responses to call center questions and escalations.

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• Develop monthly invoice and assist with work order processing
September 2014	$15,000	172.50	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Continue planning for active and retiree open enrollment, tentatively scheduled for 11/10/2014 – 11/21/2014 • Training for COD Benefits Administration staff on ongoing processing in the Benefit Express system • Assist with documenting work order necessary for active and retiree open enrollment site changes • Draft and edit communication material and mailing lists for active and retiree open enrollment • Assist with responses to call center questions and escalations. • Coordinate with carriers on open enrollment material needed – SBCs, EOCs, benefit summaries, rates, etc. • Data updates for Benefit Express site for active and retiree open enrollment. • Develop monthly invoice and assist with work order processing • **Finalize pricing terms with Benefit Express for the transition of the retirees to standalone VEBA administrators** • **Develop MMSA project budget estimates for 2014, 2015 and 2016 plan years** • **Work Order #40 – BCN MAPD File Reconciliation/Retiree Death Processing** • **Work Order #41 – Manual Employee Data Update Hourly Charges (Ongoing)**
October 2014	$15,000	232.50	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Review and finalize work order for active and retiree open enrollment changes – Work Order #42 – 2015 Annual Enrollment Changes • Coordinate with carriers on open enrollment material needed – SBCs, EOCs, benefit summaries, rates, etc. • Set schedule for in-person open enrollment meetings for actives and retirees, coordinate with carriers on additional support needed, and conduct enrollment training with carriers, if needed

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• Finalize and test enrollment site • Assist with responses to call center questions and escalations. • Develop monthly invoice and assist with work order processing • Finalize contract between MMSA and COD and MMSA and Benefit Express • **Begin planning for retiree transition to two separate VEBA administrators tentatively set for 04/01/15**
November 2014	$15,000	150.50	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Active and retiree open enrollment begins – 11/10/2014 – 11/21/2014 • **Work Order #43 - Extend open enrollment by nine days to 11/30/14** • Assist with responses to call center questions and escalations. • Develop monthly invoice and assist with work order processing • Finalize contract between MMSA and Benefit Express • **Continue planning for retiree transition to two separate VEBA administrators effective 04/01/15**
December 2014	$15,000	151.75	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree open enrollment data clean –up. • Assist with responses to call center questions and escalations • Develop monthly invoice and assist with work order processing • **Work Order #44 - Update active Heritage Vision rates and contributions** • **Add new "active" plan for non-Medicare police and fire surviving spouses and children and conduct another open enrollment** • **Continue planning for retiree transition to two separate VEBA administrators effective 04/01/15**
January 2015	$15,000	153.25	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree open enrollment and ongoing data clean –up. • Assist with responses to call center questions and escalations • Develop monthly invoice and assist with work order processing • **Work Order #45 – Update to allow Medicare-eligible, duty disabled retirees to add dependents to dental and vision coverage** • **Work Order #46 - Update to add Medicare information to retiree dental segments on BCBSM eligibility file** • **Work Order #47 – Update BPIDs/group structure for BCBSM active eligibility file** • **Add new "active" plan for non-Medicare police and fire surviving spouses and children and conduct another open enrollment. (Note – an additional open enrollment period was not necessary. This was a closed group of employees. Benefit changes were implemented for this group only).** • **Continue planning for retiree transition to two separate VEBA administrators effective 04/01/15**
February 2015	$9,275	92.75	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree open enrollment and ongoing data clean –up. • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • **Work Order #48 – Update to implement tracking for special classes of employees and implement a "waive" option for retiree medical coverage. Also to include an import file to fill in the new fields for the special classes as well as updating other data fields (married to another employee (duplicate SSN issue resolution), union local no, second address, etc.).** • **Continue planning for retiree transition to two separate VEBA administrators effective 04/01/15** • **Create eligibility and other data files for new VEBA administrators. The VEBAs began requesting data**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			from Benefit Express in February 2015. This process is currently being reviewed and refined.
March 2015	$15,000	184.50	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree open enrollment and ongoing data clean –up. • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • **Continue planning for retiree transition to two separate VEBA administrators effective 04/01/15** • **Create eligibility and other data files for new VEBA administrators. The VEBAs began requesting data from Benefit Express in February 2015. The City was provided with data and will coordinate all future data requests** • **Work Order #49 – VEBA Transition Updates: Create new HRA plan to replace current stipend plan, update group structures for carriers where needed, and update 834 files where needed. Develop communication outlining the change for affected retirees** • **Create production file for FlexPlan for new HRA plan** • **Review duplicate SSN report, document necessary changes and provide data to clean up some of the duplicates (Work Order #48 import file)**
April 2015	$12,225	122.25	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree continued data clean –up. • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • **Coordinate with carriers (BCBSM, BCN, HAP, BCBSM dental, Golden Dental and Heritage Vision) to provide split billing to accommodate both VEBAs** • **Review and document Audit #25 report to clean – up benefit class effective date issues**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• **Review and document discrepancies between April and May FlexPlan production files** • **Work Order #50 – Update BCN MAPD eligibility file to add retiree's phone number** • **Assist with cleaning-up weekly audit reports from Benefit Express** • **Continue planning for retiree transition to two separate VEBA administrators effective 04/01/15**
May 2015	$15,000	170.75	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree continued data clean –up. • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • **Review and document discrepancies between May and June FlexPlan production files** • **Provide information to City of Detroit benefits manager on ACA hours tracking and reporting vendors; assist with scheduling demos of various systems** • **Provide coordination assistance between Benefit Express and the City for the implementation of the new Ultipro payroll/HRIS system.** • **Work Order #51 – Provide Medicare Advantage enrollment calls for BCBSM/BCN on a quarterly basis for auditing purposes** • **Coordinate with BCBSM dental to provide split billing to accommodate both VEBAs** • **Provide training to staff to clean–up benefit class effective date issues (Audit #25 report)** • **Develop import file (Work Order #48) to include married/dependent of another employee indicator with corresponding SSN, retiree special tracking classes indicator, pre-2015 retiree indicator, address corrections, union local number corrections** (Note that additional hours in May were billed for other Segal staff members for the analysis and development for a proposed pooling arrangement for the VHWM, which does not apply to the City.)
June 2015	$11,025	110.25	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree continued data clean –up. • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • Begin review and update of active enrollment guides for the next open enrollment period • **Review and document discrepancies between June and July FlexPlan production files** • **Provide information to City of Detroit benefits manager on ACA hours tracking and reporting vendors; assist with scheduling demos of various systems. BE has provided Work Order #52, if the City would like to use their ACA tracking and reporting capabilities.** • **Work Order #53 - Provide coordination assistance between Benefit Express and the City for the implementation of the new Ultipro payroll/HRIS system** • **Coordinate with BCBSM dental to provide split billing to accommodate both VEBAs** • **Analyze catastrophic drug claim reports for retirees to determine reimbursement amounts (part of the settlement agreement)**
July 2015	$14,200	142	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree continued data clean –up • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • Continue to review and update the active enrollment guides for the next open enrollment period • **Review and document discrepancies between July and August FlexPlan production files** • **Work Order #53 - Provide coordination assistance between Benefit Express and the City for the implementation of the new Ultipro payroll/HRIS system** • **Maintain separate meeting minutes for the UltiPro project**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• **Work Order #54 – System upgrade to add same-gender spouses to coverage** • **Review data requests from police and fire retiree VEBA actuary** • **Analyze catastrophic drug claim reports for retirees to determine reimbursement amounts (part of the settlement agreement)**
August 2015	$15,000	174.50	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree continued data clean –up • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • Begin preparation for open enrollment. Review issues from last year to determine next steps. • Continue to review and update the active enrollment guides for the next open enrollment period • **Review and document discrepancies between August and September FlexPlan production files** • **Maintain separate meeting minutes for the UltiPro project** • **Continue to analyze catastrophic drug claim reports for retirees to determine reimbursement amounts (part of the settlement agreement)**
September 2015	$15,000	183.5	• Bi-weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree continued data clean –up • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • Continue preparation for open enrollment. Review issues from last year to determine next steps • Continue to review and update the active enrollment guides for the next open enrollment period • **Review and document discrepancies between September and October FlexPlan HRA production files**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• **Maintain separate meeting minutes for the UltiPro project** • **Work with BE to audit and prepare census and enrollment data files for each retiree VEBA**
October 2015	$15,000	186.25	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree continued data clean –up • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • Work Order #56 – Open Enrollment System Updates and Customer Service Support • Continue preparation for open enrollment. Review issues from last year to determine next steps. • Review, update and finalize active enrollment guides for the next open enrollment period • **Review and document discrepancies between October and November FlexPlan HRA production files** • **Maintain separate meeting minutes for the UltiPro project** • **Provide assistance with the review and updates to the Ultipro payroll deduction test files** • **Work with BE to audit and prepare census and enrollment update data files for each retiree VEBA**
November 2015	$15,000	165	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree continued data clean –up • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • Work Order #61 – Extend Open Enrollment through 11/29/15. • Assist the city with post-open enrollment auditing and data clean-up • **Assist the City with the analysis of ScriptGuideRx proposal**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• **Review and document discrepancies between November and December FlexPlan HRA production files** • **Maintain separate meeting minutes for the UltiPro project** • **Work with BE to audit and prepare refresh census and enrollment update data files for each retiree VEBA** • **Assist the city with nondiscrimination testing**
December 2015	$11,400 Included Preliminary actuarial work for the MMSA risk pooling project ($1,200)	114	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports for active and retiree continued data clean –up • Assist with responses to call center questions and escalations • Develop monthly invoice, run corresponding census report and assist with work order processing • Continue to assist the city with post-open enrollment auditing and data clean-up • **Assist the City/Benefit Express to finalize ACA reporting set-up as needed** • **Continue to assist the City with the analysis of ScriptGuideRx proposal** • **Work Order #62 – Employee data refresh file for ACA reporting (adding new field for distribution of form)** • **Maintain separate meeting minutes for the UltiPro project** • **Provide assistance with the review and updates to the Ultipro payroll deduction test files** • **Work with BE to audit and prepare final census and enrollment data files for each retiree VEBA** • **Assist the city with nondiscrimination testing**
January 2016	$11,725 Included Preliminary actuarial work for the MMSA risk pooling project ($3,500)	117.25	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports continued data clean –up • Assist with responses to call center questions and escalations as needed • Develop monthly invoice, run corresponding census report and assist with work order processing • Assist the city with finalizing post-open enrollment auditing and data clean-up

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• **Assist the City/Benefit Express to finalize ACA reporting as needed** • **Continue to assist the City with the analysis of ScriptGuideRx proposal** • **Maintain separate meeting minutes for the UltiPro project and assist with status calls as needed.** • **Provide assistance with the review and updates to the Ultipro payroll deduction test files** • **Work with BE to audit and prepare final census and enrollment data files for each retiree VEBA** • **Assist the city with nondiscrimination testing**
February 2016	$8,800 Included actuarial work for the MMSA risk pooling project ($3,325)	88	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports continued data clean –up • Assist with responses to call center questions and escalations as needed • Develop monthly invoice, run corresponding census report and assist with work order processing • Assist the city with finalizing post-open enrollment auditing and data clean-up • **Assist the City/Benefit Express to finalize ACA reporting as needed** • **Continue to assist the City with the analysis of ScriptGuideRx proposal** • **Maintain separate meeting minutes for the UltiPro project and assist with status calls as needed.** • **Provide assistance with the review and updates to the Ultipro payroll deduction and census files.** • **Assist with the set-up of the Ultipro ACA reporting file.**
March 2016	$9,275 Included actuarial work for the MMSA risk pooling project ($1,075)	92.75	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports continued data clean –up • Assist with responses to call center questions and escalations as needed • Develop monthly invoice, run corresponding census report and assist with work order processing • **Assist the City/Benefit Express to finalize ACA reporting as needed** • **Assist the City with locating a vendor to complete the 1094-C transmission**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• **Continue to assist the City with the analysis of ScriptGuideRx proposal** • **Work Order #64 – Set up of new Rx option for LSA members (ScriptGuide). This is not final.** • **Maintain separate meeting minutes for the UltiPro project and assist with status calls as needed.** • **Provide assistance with the review and updates to the Ultipro payroll deduction, census and ACA files.**
April 2016	$10,050 - includes $6,150 - City of Detroit Support $3,900 - Actuarial Work and New Program Development for the Risk Pool	81.00	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports continued data clean –up • Assist with responses to call center questions and escalations as needed • Develop monthly invoice, run corresponding census report and assist with work order processing • **Assist the City/Benefit Express to finalize ACA reporting as needed** • **Assist the City/Benefit Express with ongoing system set-up for ACA reporting** • **Assist the City with implementation of vendor to complete the 1094-C transmission** • **Finalize analysis of ScriptGuideRx proposal** • **Maintain separate meeting minutes for the UltiPro project and assist with status calls as needed.** • **Provide assistance with the review and updates to the Ultipro payroll deduction, census and ACA files.** • **Attend City Vendor meetings with BCBSM, HAP, Navia Benefits and CVS to collect FAQ's for open enrollment material.**
May 2016	$4,875 – City of Detroit Support $4,100 - Actuarial Work and New Program Development for the Risk Pool	48.75 – City of Detroit Support 20.5 – Actuarial Work and New Program Development for the Risk Pool	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports continued data clean –up • Assist with responses to call center questions and escalations as needed • Develop monthly invoice, run corresponding census report and assist with work order processing • **Assist the City/Benefit Express to finalize ACA reporting as needed**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
			• **Assist the City/Benefit Express with ongoing system set-up for ACA reporting** • **Assist the City and the selected vendor to complete the 1094-C transmission** • **Assist the City with development of HSA plan and a Minimum Value plan for certain contractors.** • **Finalize analysis of ScriptGuideRx proposal** • **Maintain separate meeting minutes for the UltiPro project and assist with status calls as needed.** • **Provide assistance with the review and updates to the Ultipro payroll deduction, census and ACA files.** • **Attend City Vendor meetings with BCBSM, HAP, Navia Benefits and CVS to collect FAQ's for open enrollment material.** • **Begin 2017 renewal process and data request to vendors**
June 2016	$6,475 – City of Detroit Support $12,300 - Actuarial Work and New Program Development for the Risk Pool	64.75 – City of Detroit Support 61.5 – Actuarial Work and New Program Development for the Risk Pool	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports continued data clean –up • Assist with responses to call center questions and escalations as needed • Develop monthly invoice, run corresponding census report and assist with work order processing • **Assist the City/Benefit Express to finalize ACA reporting as needed** • **Assist the City/Benefit Express with ongoing system set-up for ACA reporting** • **Assist the City and the selected vendor to complete the 1094-C transmission and any necessary corrections.** • **Assist the City with development of HSA plan and a Minimum Value plan for certain contractors.** • **Maintain separate meeting minutes for the UltiPro project and assist with status calls as needed.** • **Provide assistance with the review and updates to the Ultipro payroll deduction, census and ACA files.** • **Begin review of 2017 renewals development of 2017 rates.**
July 2016	$4,100 – City of Detroit Support $2,300 - Actuarial Work and New Program	41.00 – City of Detroit Support 11.5 – Actuarial	• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
	Development for the Risk Pool	Work and New Program Development for the Risk Pool	• Run and review audit reports continued data clean –up • Assist with responses to call center questions and escalations as needed • Develop monthly invoice, run corresponding census report and assist with work order processing • **Begin planning for open enrollment.** • **Assist the City/Benefit Express to finalize ACA reporting as needed** • **Assist the City/Benefit Express with ongoing system set-up for ACA reporting** • **Assist the City and the selected vendor to complete the 1094-C transmission and any necessary corrections.** • **Assist the City with development of HSA plan and a Minimum Value plan for certain contractors.** • **Maintain separate meeting minutes for the UltiPro project and assist with status calls as needed.** • **Provide assistance with the review and updates to the Ultipro payroll deduction, census and ACA files.**
August 2016	$5,675 – City of Detroit Support $1,800 - Actuarial Work and New Program Development for the Risk Pool		• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports continued data clean –up • Assist with responses to call center questions and escalations as needed • Develop monthly invoice, run corresponding census report and assist with work order processing • Continue planning for open enrollment (finalizing rates, determine system changes, request work order, etc.). • **Assist the City/Benefit Express to finalize ACA reporting as needed** • **Assist the City/Benefit Express with ongoing system set-up for ACA reporting** • **Assist the City with development of HSA plan and a Minimum Value plan for certain contractors.** • **Maintain separate meeting minutes for the UltiPro project and assist with status calls as needed.** • **Provide assistance with the review and updates to the Ultipro payroll deduction, census and ACA files.** • **Update Scriptguide Rx claims target with actual data and provide support in negotiations**

City of Detroit Major Activities by Month
Segal Consulting

Month	Segal Fees Invoiced to the MMSA	Total Hours	Major Activities
September 2016	$6,125 – City of Detroit Support $1,400 - Actuarial Work and New Program Development for the Risk Pool		• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports continued data clean –up • Assist with responses to call center questions and escalations as needed • Develop monthly invoice, run corresponding census report and assist with work order processing • Continue planning for open enrollment (finalize rates, finalize work order, review and update benefit book, etc.). • **Assist the City with development of HSA plan and a Minimum Value plan for certain contractors.** • **Maintain separate meeting minutes for the UltiPro project and assist with status calls as needed.** • **Provide assistance with the review and updates to the Ultipro payroll deduction, census and ACA files.**
October 2016			• Weekly implementation/status calls with Benefit Express, the City of Detroit and Segal • Maintain open and closed items logs • Weekly status calls with the City of Detroit and Segal • Run and review audit reports continued data clean –up • Assist with responses to call center questions and escalations as needed • Develop monthly invoice, run corresponding census report and assist with work order processing • Finalize planning for open enrollment (complete system testing, review documentation (rates and approval forms), review and update employee communications (forms, open enrollment presentation and open enrollment book)). • **Assist the City with development of HSA plan and a Minimum Value plan for certain contractors.** • **Maintain separate meeting minutes for the UltiPro project and assist with status calls as needed.** • **Provide assistance with the review and updates to the Ultipro payroll deduction, census and ACA files.** • **Assist the City with analysis related to separate Police and Fire medical plan.**

MMSA
Michigan Municipal Services Authority
PO BOX 12012, LANSING MI 48901-2012

EXECUTIVE COMMITTEE
RESOLUTION 2016-31

Second Amendment to Employment Agreement with Chief Executive Officer

The executive committee of the Michigan Municipal Services Authority (the "**Authority**") resolves as follows:

- that the following agreement (the "**Second Amendment**") amending the employment agreement between the Authority and Robert J. Bruner, Jr. dated August 12, 2014, as amended on December 10, 2015, is hereby approved by the Authority:

"AMENDMENT NO. 2 TO EMPLOYMENT AGREEMENT

This agreement is between the MICHIGAN MUNICIPAL SERVICES AUTHORITY, a Michigan public body corporate (the "**Authority**") and ROBERT J. BRUNER, JR., an individual (the "**Executive**").

The parties entered into an employment agreement dated August 14, 2014 under which the Executive serves as the chief executive officer of the Authority and that employment agreement was previously amended by the parties on December 10, 2015 (as amended the "**Employment Agreement**").

The parties want to again amend the Employment Agreement to modify the compensation of the Executive and authorize the provision of benefits provided to the Executive.

The parties therefore agree as follows:

1. **Defined Terms.** Defined terms used but not defined in this agreement are as defined in the Employment Agreement.

2. **Amendment to Section 4(a).** Section 4(a) of the Employment Agreement is hereby amended in its entirety to read as follows:

"(a) During the Employment Period, the Authority shall pay the Executive a salary of: $118,000.00 per year before January 1, 2016; $123,000.00 per year after December 31, 2015 and before January 1, 2017; $110,485.68 per year after December 31, 2016 and before January 1, 2018; and $123,000.00 per year after December 31, 2017. The salary will be paid in equal bi-weekly installments consistent with the payroll dates used by the state of Michigan for its employees.".

3. **Amendment to Section 4(e).** Section 4(e) of the Employment Agreement is hereby amended in its entirety to read as follows:

> (e) The Executive's compensation is subject to an annual review by the executive committee. The Executive may participate in the Authority's Deferred Compensation Plan offered pursuant to section 457(b) of the Internal Revenue Code. For coverage during the calendar year that begins on January 1, 2017 and ends on December 31, 2017, the Authority shall pay up to the following annual premium amounts for health, prescription drug, dental, and vision insurance plans provided by Blue Cross Blue Shield of Michigan for the Executive and the Executive's dependents: Simply Blue[SM] HSA PPO Gold $1450 0% Medical Coverage with Prescription Drugs ($11,407.56); Blue Dental[SM] PPO Plus 100/80/50 SG – Non-voluntary $25/$75 deductible ($985.08); and Blue Vision Adults-only SG with VSP Choice Network 12/12/12[SM] ($121.68). Except as authorized in this Section 4(e), the Executive is not otherwise eligible for other compensation or to participate in an employee pension, retirement, health, or other fringe benefit plan.".

4. **Effectiveness; Date.** This agreement will become effective when all the parties have signed it. The date this agreement is signed by the last party to sign it (as indicated by the date associated with that party's signature) will be deemed the date of this agreement. If a party signs but fails to date a signature, the date that the other party receives the signing party's signature will be deemed to be the date that the signing party signed this agreement, and the other party may inscribe that date as the date associated with the signing party's signature.

Each party is signing this agreement on the date stated opposite that party's signature.

MICHIGAN MUNICIPAL SERVICES AUTHORITY

Date: November ____, 2016 By: _____
Stacie Behler
Executive Committee Chairperson

Date: November ____, 2016 By: _____
ROBERT J. BRUNER, JR.";

- that the chairperson of the executive committee is hereby authorized to sign the Second Amendment on behalf of the Authority; and

- that the chairperson of the executive committee is hereby authorized to sign documents and take other action necessary to provide the chief executive officer with the insurance coverage described in section 4(e) of the employment agreement between the Authority and the chief executive officer as amended by the Second Amendment.

Secretary's Certification:

I certify that this resolution was adopted by the executive committee of the Michigan Municipal Services Authority at a properly-noticed open meeting held with a quorum present on November 10, 2016.

By: _____
James Cambridge
Authority Secretary

4811-7979-6524.1

AMENDMENT NO. 2 TO EMPLOYMENT AGREEMENT

This agreement is between the MICHIGAN MUNICIPAL SERVICES AUTHORITY, a Michigan public body corporate (the "**Authority**") and ROBERT J. BRUNER, JR., an individual (the "**Executive**").

The parties entered into an employment agreement dated August 14, 2014 under which the Executive serves as the chief executive officer of the Authority and that employment agreement was previously amended by the parties on December 10, 2015 (as amended the "**Employment Agreement**").

The parties want to again amend the Employment Agreement to modify the compensation of the Executive and authorize the provision of benefits provided to the Executive.

The parties therefore agree as follows:

1. **Defined Terms.** Defined terms used but not defined in this agreement are as defined in the Employment Agreement.

2. **Amendment to Section 4(a).** Section 4(a) of the Employment Agreement is hereby amended in its entirety to read as follows:

> "(a) During the Employment Period, the Authority shall pay the Executive a salary of: $118,000.00 per year before January 1, 2016; $123,000.00 per year after December 31, 2015 and before January 1, 2017; $110,485.68 per year after December 31, 2016 and before January 1, 2018; and $123,000.00 per year after December 31, 2017. The salary will be paid in equal bi-weekly installments consistent with the payroll dates used by the state of Michigan for its employees.".

3. **Amendment to Section 4(e).** Section 4(e) of the Employment Agreement is hereby amended in its entirety to read as follows:

> "(e) The Executive's compensation is subject to an annual review by the executive committee. The Executive may participate in the Authority's Deferred Compensation Plan offered pursuant to section 457(b) of the Internal Revenue Code. For coverage during the calendar year that begins on January 1, 2017 and ends on December 31, 2017, the Authority shall pay up to the following annual premium amounts for health, prescription drug, dental, and vision insurance plans provided by Blue Cross Blue Shield of Michigan for the Executive and the Executive's dependents: Simply Blue℠ HSA PPO Gold $1450 0% Medical Coverage with Prescription Drugs ($11,407.56); Blue Dental℠ PPO Plus 100/80/50 SG – Non-voluntary $25/$75 deductible ($985.08); and Blue Vision Adults-only SG with VSP Choice Network 12/12/12℠ ($121.68). Except as authorized in this Section 4(e), the Executive is not otherwise eligible for other compensation or to participate in an employee pension, retirement, health, or other fringe benefit plan.".

4. **Effectiveness; Date.** This agreement will become effective when all the parties have signed it. The date this agreement is signed by the last party to sign it (as indicated by the date associated with that party's signature) will be deemed the date of this agreement. If a party signs but fails to date a signature, the date that the other party receives the signing party's signature will be

deemed to be the date that the signing party signed this agreement, and the other party may inscribe that date as the date associated with the signing party's signature.

Each party is signing this agreement on the date stated opposite that party's signature.

MICHIGAN MUNICIPAL SERVICES AUTHORITY

Date: November ____, 2016

By: _____
Stacie Behler
Executive Committee Chairperson

Date: November ____, 2016

By: _____
Robert J. Bruner, Jr.
Chief Executive Officer

4810-4188-2427.1

Monthly to Annual Conversion

Relationship	Simply Blue HSA Gold $1450 0% w/ EA	SG BDPPO Plus 100/80/50	Blue Vision 12-12-12 $5/$10
1-Employee	$380.73	$27.05	$5.07
2-Spouse	$380.73	$27.05	$5.07
3-Dependent	$189.17	$27.99	$0.00
Total Monthly Premium:	**$950.63**	**$82.09**	**$10.14**
Total Annual Premium:	**$11,407.56**	**$985.08**	**$121.68**

Blue Cross Blue Shield Blue Care Network of Michigan

EMPLOYEE WAIVER FORM

Company name: Michigan Municipal Services Authority
(Please print)

Employee Name: Kristen Delaney
(Please print)

I understand that by waiving coverage I will not be eligible to enroll until the group's next open enrollment.

Please check the appropriate box below and provide all applicable information.

If your employer offers multiple choices of health insurance plans, please complete the following section:

☐ I am waiving BCN coverage from my employer because I am currently enrolled in BCBSM

BCBSM Group Number _____

☐ I am waiving BCBSM coverage from my employer because I am currently enrolled in BCN

BCN Group Number _____

☐ I have coverage other than BCBSM or BCN, offered by my employer

Carrier Name _____ Policy/Contract Number: _____

☐ Carrier Coverage indicated is through Marketplace Exchange

If you are waiving coverage offered by your employer for another reason, please complete the following section:

☒ I have my own individual coverage that my employer does not provide any contribution or reimbursement of premiums HSA/Open Access Plus

Carrier Name: CIGNA Policy/Contract Number: U42001782 02

☐ Carrier Coverage indicated is through Marketplace Exchange effective date 9/1/12 Robert Delaney

☑ I am covered under another group health plan, vision plan or dental plan not offered by this employer (through spouse, self, parent, etc)

Carrier Name: _____ Policy/Contract Number: _____

Policyholder Name: _____ Relationship to Employee: _____

☐ Carrier Coverage indicated is through Marketplace Exchange

☐ I was not offered health care coverage, vision coverage or dental coverage by this employer.

☐ I do not want coverage offered through this employer (Reason must be provided) _____

_____

The information provided above is true and accurate to the best of my knowledge.

July 27, 2015
Employee Date of Hire

Assistant to the CEO
Employee Job Title

Kristen A. Delaney
Employee signature

11/7/16
Date

_____
Employer signature

_____
Date

Proposal Request For:

Michigan Municipal Services Authoriy

PO Box 12012
Lansing, MI 48918

Presented By:

KIMBERLY ANN WIXSON

SEGAL COMPANY (MIDWEST) INC

Requested Effective Date: 01/01/2017
Renewal Effective Date: 01/01/2017
Quote ID: 70469
Quote Name: Michigan Municipal Services Authoriy
Quote Type: New

Company Name: Michigan Municipal Services Authoriy
Location/Subgroup: Michigan Municipal Services Authoriy

Michigan Municipal Services Authoriy

Total Eligible: 2
Total Enrolled: 1
Requested Effective Date: 01/01/2017
Requested Renewal Date: 01/01/2017

Agent Name: KIMBERLY ANN WIXSON
Sponsorship:
Area: G

Location/Subgroup Information:	
Name	All Employees
Address	PO Box 12012, Lansing, MI, 48918
ZIP Code	48918
County	Ingham

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Company Name: Michigan Municipal Services Authoriy
Location/Subgroup: Michigan Municipal Services Authoriy

Small Group Rates

First Name	Last Name	Relationship	Age	Rating Area	Member Type	Simply Blue HSA Gold $1450 0% w/ EA	SG BDPPO Plus 100/80/50	Blue Vision 12-12-12 $5/$10
	Employee	1-Employee	40	G	1-Regular	$380.73	$27.05	$5.07
	Employee	2-Spouse	40	G	1-Regular	$380.73	$27.05	$5.07
	Employee	3-Dependent	9	G	1-Regular	$189.17	$27.99	$0.00
						$950.63	$82.09	$10.14
Total Monthly Premium						**$950.63**	**$82.09**	**$10.14**

*BCBSM/BCN reserves the right to adjust rates if any of the assumptions or calculations used in the quoting process are incorrect. Final rates will be determined by BCBSM underwriting based on actual group enrollment and participation.

*Certificates, riders and rates are subject to regulatory approval.

*A Summary of Benefits and Coverage corresponding to the coverage being quoted has been provided to your agent by Blue Cross Blue Shield of Michigan. Your Agent is providing an SBC to you with this quote. A paper copy is available free of charge by contacting your agent that has provided the quote.

*Please submit quote with enrollment documentation.

*To comply with new requirements in the Patient Protection and Affordable Care Act (PPACA)(also referred to as health care reform) groups may be required to make changes to their health insurance coverage. If necessary, this may result in an adjustment to the rates. To learn more about the PPACA, please visit our webpage, http://www.bcbsm.com/healthreform/. You should also consult with your legal counsel on how you may comply with the law and regulations and the applicability to your plan.

Company Name: Michigan Municipal Services Authoriy
Location/Subgroup: Michigan Municipal Services Authoriy

Small Group Benefit Rate Comparison (with Estimated Premium)

Quote Benefits	Age Band				Monthly Cost (Based on Census Input)
	0-18	30	50	Comp	Total Monthly Premium
Simply Blue HSA Gold $1450 0% w/ EA	$189.17	$338.13	$532.07	$766.16	$950.63
SG BDPPO Plus 100/80/50	$27.99	$23.22	$32.29	$41.96	$82.09
Blue Vision 12-12-12 $5/$10	$0.00	$4.51	$7.09	$11.91	$10.14

*BCBSM/BCN reserves the right to adjust rates if any of the assumptions or calculations used in the quoting process are incorrect. Final rates will be determined by BCBSM underwriting based on actual group enrollment and participation.

*Certificates, riders and rates are subject to regulatory approval.

*A Summary of Benefits and Coverage corresponding to the coverage being quoted has been provided to your agent by Blue Cross Blue Shield of Michigan. Your Agent is providing an SBC to you with this quote. A paper copy is available free of charge by contacting your agent that has provided the quote.

*Please submit quote with enrollment documentation.

*To comply with new requirements in the Patient Protection and Affordable Care Act (PPACA)(also referred to as health care reform) groups may be required to make changes to their health insurance coverage. If necessary, this may result in an adjustment to the rates. To learn more about the PPACA, please visit our webpage, http://www.bcbsm.com/healthreform/. You should also consult with your legal counsel on how you may comply with the law and regulations and the applicability to your plan.

Small Group Rate Grid

Age Band	Simply Blue HSA Gold $1450 0% w/ EA	SG BDPPO Plus 100/80/50	Blue Vision 12-12-12 $5/$10
0 - 18	$189.17	$27.99	$0.00
19	$189.17	$20.94	$3.97
20	$189.17	$20.94	$3.97
21	$297.91	$20.94	$3.97
22	$297.91	$21.13	$3.97
23	$297.91	$21.34	$3.97
24	$297.91	$21.57	$3.97
25	$299.10	$21.82	$3.99
26	$305.06	$22.07	$4.07
27	$312.21	$22.32	$4.16
28	$323.83	$22.62	$4.32
29	$333.36	$22.91	$4.44
30	$338.13	$23.22	$4.51
31	$345.28	$23.54	$4.60
32	$352.43	$23.87	$4.70
33	$356.90	$24.23	$4.76
34	$361.66	$24.58	$4.82
35	$364.05	$24.96	$4.85
36	$366.43	$25.36	$4.88
37	$368.81	$25.76	$4.91
38	$371.20	$26.18	$4.95
39	$375.96	$26.61	$5.01
40	$380.73	$27.05	$5.07
41	$387.88	$27.52	$5.17
42	$394.73	$28.00	$5.26
43	$404.26	$28.48	$5.39
44	$416.18	$28.98	$5.55
45	$430.18	$29.50	$5.73
46	$446.87	$30.03	$5.96
47	$465.63	$30.57	$6.21
48	$487.08	$31.14	$6.49
49	$508.23	$31.70	$6.77
50	$532.07	$32.29	$7.09
51	$555.60	$32.90	$7.40
52	$581.52	$33.50	$7.75
53	$607.74	$34.13	$8.10
54	$636.04	$34.78	$8.48
55	$664.34	$35.43	$8.85
56	$695.02	$36.10	$9.26
57	$726.01	$36.79	$9.67
58	$759.07	$37.48	$10.12
59	$775.46	$38.19	$10.33
60	$808.53	$38.93	$10.77
61	$837.13	$39.66	$11.16
62	$855.90	$40.41	$11.41
63	$879.43	$41.19	$11.72
64	$893.73	$41.96	$11.91
65+	$893.73	$41.96	$11.91
COMP	$766.16	$41.96	$11.91

*BCBSM/BCN reserves the right to adjust rates if any of the assumptions or calculations used in the quoting process are incorrect. Final rates will be determined by BCBSM underwriting based on actual group enrollment and participation.

*Certificates, riders and rates are subject to regulatory approval.

Blue Cross Blue Shield of Michigan

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

Company Name: Michigan Municipal Services Authoriy

Simply Blue[SM] HSA PPO Gold $1450 0% Medical Coverage with Prescription Drugs
Benefits-at-a-Glance

Effective for groups on their plan year

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

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

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

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

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

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

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

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

	In-network	**Out-of-network ***
Deductibles **Note**: Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage. Note: The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	$1,450 for a one-person contract or $2,900 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)	$2,900 for a one-person contract or $5,800 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over) **Note**: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note**: Coinsurance amounts apply once the deductible has been met.	50% of approved amount for bariatric surgery	• 50% of approved amount for bariatric surgery • 20% of approved amount for most other covered services

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

Blue Cross Blue Shield of Michigan

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

Company Name: Michigan Municipal Services Authoriy

	In-network	**Out-of-network ***

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)
Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Annual out-of-pocket maximums Applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts.	$2,450 for a one-person contract or $4,900 for a family contract (2 or more members) each calendar year	$4,900 for a one-person contract or $9,800 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	None

Preventive care services

Health maintenance exam Includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening Laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices Includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered

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

Company Name: Michigan Municipal Services Authoriy

	In-network	Out-of-network *
Preventive care services		
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note**: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. One per member per calendar year.	80% after out-of-network deductible **Note**: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider. One per member per calendar year.
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note**: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. One per member per calendar year.	80% after out-of-network deductible One per member per calendar year.
Physician office services		
Office visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits		
Urgent care visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Emergency medical care		
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services Must be medically necessary	100% after in-network deductible	100% after in-network deductible
Diagnostic services		
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible

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

Company Name: Michigan Municipal Services Authoriy

	In-network	Out-of-network *
Diagnostic services		
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible
Maternity services provided by a physician or certified nurse midwife		
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% after in-network deductible	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Nonemergency services must be rendered in a participating hospital.	100% after in-network deductible Unlimited days	80% after out-of-network deductible Unlimited days
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care Must be in a participating skilled nursing facility	100% after in-network deductible Limited to a maximum of 90 days per member per calendar year	100% after in-network deductible Limited to a maximum of 90 days per member per calendar year
Hospice care	100% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home health care • must be medically necessary • must be provided by a participating home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	100% after in-network deductible	100% after in-network deductible
Surgical services		

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

Company Name: Michigan Municipal Services Authoriy

	In-network	Out-of-network *
Surgical services		
Surgery Includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note**: For voluntary sterilizations for females, see “Preventive care services.”	100% after in-network deductible	80% after out-of-network deductible
Elective Abortions	Covered 100% after in-network deductible	Covered 80% after out-ofnetwork deductible
Bariatric surgery	50% after in-network deductible Limited to a lifetime maximum of one bariatric procedure per member.	50% after out-of-network deductible Limited to a lifetime maximum of one bariatric procedure per member.
Human organ transplants		
Specified human organ transplants Must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible In designated facilities only
Bone marrow transplants Must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note**: BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible
Mental health care and substance abuse treatment		
Inpatient mental health care and inpatient substance abuse treatment	100% after in-network deductible Unlimited days	80% after out-of-network deductible Unlimited days
Residential psychiatric treatment facility • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: Facility and clinic	100% after in-network deductible	100% after in-network deductible In participating facilities only
Outpatient mental health care: Physician’s office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment In approved facilities only	100% after in-network deductible	80% after out-of-network deductible (In-network cost-sharing will apply if there is no PPO network)

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

Company Name: Michigan Municipal Services Authoriy

	In-network	Out-of-network *
Autism spectrum disorders, diagnoses and treatment		
Applied behavioral analysis (ABA) treatment **When rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18** **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited.	80% after out-of-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited.
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
Other covered services		
Outpatient Diabetes Management Program (ODMP) **Note**: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 100% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Rehabilitative care: **Outpatient physical and occupational therapy**	100% after in-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy	80% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a 30-visit maximum per member per calendar year Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy

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

Company Name: Michigan Municipal Services Authoriy

	In-network	**Out-of-network ***
Other covered services		
Rehabilitative care: **Chiropractic and osteopathic manipulation**	100% after in-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy	80% after out-of-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy
Outpatient speech therapy – when provided for rehabilitative care	100% after in-network deductible Limited to a 30-visit maximum per member per calendar year.	80% after out-of-network deductible Limited to a 30-visit maximum per member per calendar year.
Habilitative care: **Outpatient physical and occupational therapy (excludes chiropractic and osteopathic manipulation)**	100% after in-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy	80% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a 30-visit maximum per member per calendar year Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy
Outpatient speech therapy - when provided for habilitative care	100% after in-network deductible Limited to a 30-visit maximum per member per calendar year.	80% after out-of-network deductible Limited to a 30-visit maximum per member per calendar year.
Durable medical equipment **Note**: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	80% after in-network deductible
Private duty nursing care	Not covered	Not covered

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

Blue Cross Blue Shield of Michigan

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

Blue Preferred® Rx Prescription Drug Coverage
Custom Select Prescription Drug Plan, 5-Tier Copay/Coinsurance
Benefits-at-a-Glance

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

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

Select Controlled Substance Drugs – BCBSM may limit the initial fill of **select** controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. **Subsequent fills** of the **same** medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at **bcbsm.com/pharmacy**.

Member's responsibility (copays and coinsurance amounts)

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

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

		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 drugs	1 to 30-day period	After deductible is met, you pay $20 copay	After deductible is met, you pay $20 copay	After deductible is met, you pay $20 copay	After deductible is met, you pay $20 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible is met, you pay $40 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible is met, you pay $50 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	No coverage	No coverage

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

Member's responsibility (copays and coinsurance amounts), *continued*

		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 2 – Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $60 copay	After deductible is met, you pay $60 copay	After deductible is met, you pay $60 copay	After deductible is met, you pay $60 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible is met, you pay $120 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible is met, you pay $170 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $170 copay	After deductible is met, you pay $170 copay	No coverage	No coverage
Tier 3 – Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $80 or 50% of the approved amount (whichever is greater), but no more than $100	After deductible is met, you pay $80 or 50% of the approved amount (whichever is greater), but no more than $100	After deductible is met, you pay $80 or 50% of the approved amount (whichever is greater), but no more than $100	After deductible is met, you pay $80 or 50% of the approved amount (whichever is greater), but no more than $100 ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible is met, you pay $160 or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible is met, you pay $230 or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $230 or 50% of the approved amount (whichever is greater), but no more than $290	After deductible is met, you pay $230 or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
Tier 4 – Generic and preferred brand-name specialty drugs	1 to 30-day period	After deductible is met, you pay 20% of approved amount, but no more than $200	After deductible is met, you pay 20% of approved amount, but no more than $200	After deductible is met, you pay 20% of approved amount, but no more than $200	After deductible is met, you pay 20% of approved amount, but no more than $200 ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

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

Member's responsibility (copays and coinsurance amounts), *continued*

		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 5 – Nonpreferred brand-name specialty drugs	1 to 30-day period	After deductible is met, you pay 25% of approved amount, but no more than $300	After deductible is met, you pay 25% of approved amount, but no more than $300	After deductible is met, you pay 25% of approved amount, but no more than $300	After deductible is met, you pay 25% of approved amount, but no more than $300 ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

Covered services

	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance ***plus*** an additional 20% prescription drug out-of-network penalty
FDA-approved generic and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance ***plus*** an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance ***plus*** an additional 20% prescription drug out-of-network penalty

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

Covered services, *continued*

	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 **Note:** Needles and syringes have no copay/coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug ***plus*** an additional 20% prescription drug out-of-network penalty

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

Features of your prescription drug plan

Custom Select Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. ▪ **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. ▪ **Tier 2 (preferred brand)** – Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. ▪ **Tier 3 (nonpreferred brand)** – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs. ▪ **Tier 4 (generic and preferred brand-name specialty)** – Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Select Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay/coinsurance. ▪ **Tier 5 (nonpreferred brand-name specialty)** – Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay/coinsurance.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quality limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

Blue Cross Blue Shield of Michigan

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

Blue Vision (Pediatric Only)[SM] Benefits-at-a-Glance

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

Note: Vision benefits are only available to members through the last day of the year in which they turn age 19. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

	In-network	Out-of-network
Member's responsibility (copays)		
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per calendar year	
Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered – annual supply	
Elective contact lenses that **improve** vision (prescribed, but do **not** meet criteria of medically necessary) If prescription contact lenses do not meet criteria for medically necessary, members may elect one of the following quantities of lenses as covered in full: • Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities in your certificate, per calendar year	

Blue Cross Blue Shield of Michigan

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

Blue Traditional Medicare Supplemental Coverage: Blue Cross Option 2, Blue Shield Option 1 with Prescription Drugs Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after January 1, 2016

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** 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, 2016 and are subject to change yearly

	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	• **Medicare Part A** $1,288 (for days 1-60) each benefit period • **Medicare Part B** $166 per calendar year	None
Coinsurance/fixed dollar copays	• **Hospital stay** $322 per day (for days 61-90) and $644 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime) • **Skilled nursing facility stay** (a limit of 100 days each benefit period) $161 per day (for days 21-100)	None
Coinsurance/percent copay amounts	• 20% of Medicare approved amount for most general services • 20% of Medicare approved amount for outpatient mental health care	None

Preventive care services

Health maintenance exam (yearly "Wellness" visit)	Covered at 100% of Medicare approved amount*, once every 12 months **Note:** 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 **not** covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year
Pap smear screening – laboratory services only	Covered at 100% of Medicare approved amount*, once every 24 months (more frequently if at high risk)	When **not** covered by Medicare – covered at 100% of BCBSM approved amount, one per member per calendar year
Voluntary sterilizations for females	Not covered **Note:** Medicare covers voluntary sterilization if it's necessary for the treatment of an illness or injury.	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.

	Original Medicare coverage	Medicare Supplemental coverage
Preventive care services, *continued*		
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 **not** 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 **not** 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 **Note:** A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible.	When **not** 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 **not** 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 **not** 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 • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit
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.

	Original Medicare coverage	Medicare Supplemental coverage
Physician office services		
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		
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		
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		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies – **does not** include private duty nursing		
• Days 1-60 of each benefit period	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance abuse)	Covers Medicare deductible
• Days 61-90 of each benefit period	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• **Lifetime reserve days** after day 90 of each benefit period (up to 60 days over your lifetime)	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• Additional days	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
Alternatives to hospital care		
Skilled nursing facility care – subject to medical criteria		
• Days 1-20 of each benefit period	Covered at 100% of Medicare approved amount	Covered in full by Medicare
• Days 21-100 of each benefit period	Covered at 100% of Medicare approved amount less daily coinsurance	Covers Medicare coinsurance
• Days 101 and after	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 **Medicare-certified** home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare

	Original Medicare coverage	Medicare Supplemental coverage
Surgical services provided by a physician		
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.		
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 **Note:** Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Not covered **Note:** 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		
Inpatient mental health care in psychiatric facility • Days 1-190 **lifetime**	See “Hospital care” benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance) **Note:** 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
• Additional days after 190 lifetime days are used	Not covered	Not covered
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible **Note:** 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		
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 **Note:** 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 **Note:** 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

	Original Medicare coverage	Medicare Supplemental coverage
Other covered services, *continued*		
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		
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

Blue Cross Blue Shield of Michigan

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

Blue Preferred® Rx SG Prescription Drug Coverage
3-Tier Copay
Benefits-at-a-Glance

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

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider or** mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

		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 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 60-day period	No coverage	You pay $20 copay	No coverage	No coverage
	61 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 60-day period	No coverage	You pay $80 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $110 copay	No coverage	No coverage
	84 to 90-day period	You pay $110 copay	You pay $110 copay	No coverage	No coverage
Tier 3 – Nonpreferred brand-name drugs	1 to 30-day period	You pay $80 copay	You pay $80 copay	$80 copay	You pay $80 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $160 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $230 copay	No coverage	No coverage
	84 to 90-day period	You pay $230 copay	You pay $230 copay	No coverage	No coverage

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

Covered services

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

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

Features of your prescription drug plan

BCBSM Custom Select Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. ▪ **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ **Tier 2 (preferred brand)** – Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand-name drugs are also safe and effective, but require a higher copay. ▪ **Tier 3 (nonpreferred brand)** – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs.
Prior authorization/step therapy	A process that requires the attending physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.

Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic drug, you will only have to pay a generic copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

Blue Vision℠ (Pediatric Only) Benefits-at-a-Glance

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

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

	In-network	Out-of-network
Member's responsibility (copays)		
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per calendar year	
Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered – annual supply	
Elective contact lenses that **improve** vision (prescribed, but do **not** meet criteria of medically necessary) If prescription contact lenses do not meet criteria for medically necessary, members may elect one of the following quantities of lenses as covered in full: • Standard (one pair annually) – 1 contact lens per eye (total of 2 lenses) • Monthly (six-month supply) – 6 contact lenses per eye (total of 12 lenses) • Bi-weekly (six-month supply) – 12 contact lenses per eye (total of 24 lenses) • Dailies (two-month supply) – 60 contact lenses per eye (total of 120 lenses)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	

Blue Cross Blue Shield of Michigan

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

Company Name: Michigan Municipal Services Authoriy

Blue Dental℠ PPO Plus 100/80/50 SG – Non-voluntary $25/$75 deductible Benefits-at-a-Glance

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

Note: Pediatric members are members who are age 18 or younger on the plan's effective date. They remain pediatric members through the end of the calendar year in which they turn 19.

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

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**

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

Members who go to non-PPO dentists can still save money through our Blue Par Select arrangement.

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

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

	PPO(In-network) Dentist	Non-PPO (Blue Par Select or Nonparticipating) Dentist
Member's responsibility (deductible, copays and dollar maximums)		
Deductibles Applies to Class II and Class III services only	$25 per member limited to a maximum of $75 per family per calendar year	$25 per member limited to a maximum of $75 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services)		
Class I services	None (covered at 100%)	None (covered at 100%)
Class II services	20%	20%
Class III services	50%	50%
Class IV services	Not Covered	Not Covered
Dollar Maximums		
Annual maximum for Class I, II and III services	$1000 per member The annual benefit maximum does not apply to pediatric members.	$1000 per member The annual benefit maximum does not apply to pediatric members.

Blue Cross Blue Shield of Michigan

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

Company Name: Michigan Municipal Services Authoriy

	PPO(In-network) Dentist	Non-PPO (Blue Par Select or Nonparticipating) Dentist
Member's responsibility (deductible, copays and dollar maximums)		
Lifetime maximum for Class IV services	Not covered For members up to their 19th birthday	Not covered For members up to their 19th birthday
Out-of-pocket maximum The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum does not apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, or non-covered services.	$350 for one pediatric member or $700 for two or more pediatric members per plan year There is no out-of-pocket maximum for non-pediatric members **Note**: This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).	$350 for one pediatric member or $700 for two or more pediatric members per plan year There is no out-of-pocket maximum for non-pediatric members **Note**: This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).
Plan's responsibility The plan's responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.		
Class I services		
Most diagnostic and preventative services: Routine oral examinations/evaluations – twice per calendar year	100% of approved amount	100% of approved amount
Routine prophylaxes (cleanings) – three times per calendar year for pediatric members; two times per calendar year for all other members	100% of approved amount	100% of approved amount
Fluoride treatments – twice per calendar year for pediatric members only	100% of approved amount	100% of approved amount
Topical fluoride varnish for moderate- to high-risk caries patients – four times per calendar year for members age 3 and younger only and two times per calendar year for members age 4 to 14 only in combination with fluoride treatments. For example, two fluoride treatments or two topical fluoride varnishes or one fluoride treatment and one topical treatment varnish are payable in a calendar year for high-risk members between the ages of 4 and 14. However, two fluoride treatments and two topical fluoride varnishes are not payable for these members	100% of approved amount	100% of approved amount

Company Name: Michigan Municipal Services Authoriy

	PPO(In-network) Dentist	Non-PPO (Blue Par Select or Nonparticipating) Dentist
Class I services		
Dental sealants – once per tooth per 36 months for first and second permanent molars for pediatric members only	100% of approved amount	100% of approved amount
Bitewing X-rays One set (up to four films) per calendar year	100% of approved amount	100% of approved amount
Oral brush biopsy sample collection Twice per calendar year	100% of approved amount	100% of approved amount
Class II services		
Other diagnostic and preventive services:		
Diagnostic tests and laboratory examinations	80% of approved amount after deductible	80% of approved amount after deductible
Space maintainers – once per quadrant per lifetime for missing posterior primary teeth for pediatric members only (recementation of a space maintainer is payable three times per quadrant per lifetime)	80% of approved amount after deductible	80% of approved amount after deductible
Panoramic or full-mouth X-rays Once per 60 months	80% of approved amount after deductible	80% of approved amount after deductible
Emergency palliative treatment	80% of approved amount after deductible	80% of approved amount after deductible
Minor restorative services:		
Amalgam and resin-based composite fillings and fillings of similar materials – once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth	80% of approved amount after deductible	80% of approved amount after deductible
Recementation or repair of posts, crowns, veneers, inlays and onlays – three times per tooth per calendar year	80% of approved amount after deductible	80% of approved amount after deductible
Extractions and surgical removal of non-impacted teeth	80% of approved amount after deductible	80% of approved amount after deductible
Non-surgical endodontic services:		
Root canal treatments – once per tooth per lifetime (retreatment of a root canal 12 or more months after the initial root canal treatment is payable once per tooth per lifetime)	80% of approved amount after deductible	80% of approved amount after deductible
Therapeutic pulpotomies or pulpal debridement	80% of approved amount after deductible	80% of approved amount after deductible
Vital pulpotomies on primary teeth	80% of approved amount after deductible	80% of approved amount after deductible

Company Name: Michigan Municipal Services Authoriy

	PPO(In-network) Dentist	Non-PPO (Blue Par Select or Nonparticipating) Dentist
Class II services		
Apexification	80% of approved amount after deductible	80% of approved amount after deductible
Non-surgical periodontic services:		
Periodontal maintenance – three times per calendar year in place of routine dental prophylaxis for pediatric members; two times per calendar year in place of routine dental prophylaxis for all other members	80% of approved amount after deductible	80% of approved amount after deductible
Periodontal scaling and root planing – once per quadrant per 24 months for pediatric members; once per quadrant per 36 months for all other members	80% of approved amount after deductible	80% of approved amount after deductible
Localized delivery of antimicrobial agents – one surface per tooth and three teeth per quadrant with a maximum of 12 teeth per year for non-pediatric members only	80% of approved amount after deductible	80% of approved amount after deductible
Limited occlusal adjustments – up to five times per 60 months for non-pediatric members only	80% of approved amount after deductible	80% of approved amount after deductible
Occlusal biteguards (and relines and repairs to occlusal biteguards) – once per 60 months for non-pediatric members only	80% of approved amount after deductible	80% of approved amount after deductible
Adjustments, repairs, relines, rebases and tissue conditioning for removable prosthetic appliances:		
Relines or rebases of partial dentures or complete dentures – once per 36 months per arch	80% of approved amount after deductible	80% of approved amount after deductible
Tissue conditioning – once per 36 months per arch	80% of approved amount after deductible	80% of approved amount after deductible
Adjunctive general services:		
General anesthesia or IV sedation	80% of approved amount after deductible	80% of approved amount after deductible
Office visits for observation (during regularly scheduled hours) for non-pediatric members only	80% of approved amount after deductible	80% of approved amount after deductible
Office visits after regularly scheduled hours	80% of approved amount after deductible	80% of approved amount after deductible
House and hospital calls for non-pediatric members only	80% of approved amount after deductible	80% of approved amount after deductible
Antibiotic injections for non-pediatric members only	80% of approved amount after deductible	80% of approved amount after deductible

Company Name: Michigan Municipal Services Authoriy

Class III services

	PPO(In-network) Dentist	Non-PPO (Blue Par Select or Nonparticipating) Dentist
Major restorative services:		
Onlays, crowns and veneers – once per permanent tooth per 60 months for members age 12 and older only	50% of approved amount after deductible	50% of approved amount after deductible
Substructures, including cores and posts	50% of approved amount after deductible	50% of approved amount after deductible
Oral surgery services other than extractions of non-impacted teeth:		
Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after deductible	50% of approved amount after deductible
Incision and drainage of celluliitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after deductible	50% of approved amount after deductible
Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after deductible	50% of approved amount after deductible
Excision of hyperplastic tissue per arch	50% of approved amount after deductible	50% of approved amount after deductible
Soft tissue biopsies for pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Frenulectomies	50% of approved amount after deductible	50% of approved amount after deductible
Surgical endodontic services:		
Apical surgeries on permanent teeth	50% of approved amount after deductible	50% of approved amount after deductible
Surgical periodontic services:		
Gingivectomies and gingivoplasties	50% of approved amount after deductible	50% of approved amount after deductible
Osseous surgeries for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Gingival flap procedures	50% of approved amount after deductible	50% of approved amount after deductible
Soft tissue grafts	50% of approved amount after deductible	50% of approved amount after deductible
Bone replacement grafts for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Prosthodontic services:		
Complete dentures – once per 84 months	50% of approved amount after deductible	50% of approved amount after deductible
Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics – once per 84 months for members age 16 and older only	50% of approved amount after deductible	50% of approved amount after deductible
Recementation and repairs of bridges	50% of approved amount after deductible	50% of approved amount after deductible

Company Name: Michigan Municipal Services Authoriy

	PPO(In-network) Dentist	Non-PPO (Blue Par Select or Nonparticipating) Dentist
Class III services		
Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after deductible	50% of approved amount after deductible
Endosteal implants and implant-related services – once per tooth per lifetime for teeth numbered 2 through 15 and 18 through 31 for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Class IV services – Orthodontic services for dependents under age 19		
Orthodontics and related services	Not Covered	Not Covered

Blue Cross Blue Shield of Michigan

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

Blue Vision Adults-only SG with VSP Choice Network 12/12/12[SM] Benefits-at-a-Glance

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

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

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

	In-network	Out-of-network
Member's responsibility (copays)		
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $34 less $5 copay (member responsible for any difference)
	One eye exam every 12 months (calendar year basis)	
Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, every 12 months (calendar year basis)	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $38.25 less $10 copay (member responsible for any difference)
	One frame every 12 months (calendar year basis)	
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	One pair of contact lenses every 12 months (calendar year basis)	
Elective contact lenses that improve vision (prescribed, but do **not** meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses are covered up to allowance every 12 months (calendar year basis)	

Blue Cross Blue Shield of Michigan

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

Michigan Municipal Services Authoriy

Coverage Period: Beginning on or after 01/01/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsm.com or by calling the number on the back of your BCBSM ID card.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$1,450 Individual / $2,900 Family	$2,900 Individual / $5,800 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.		You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses? (May include a co-insurance maximum)	$2,450 Individual / $4,900 Family	$4,900 Individual / $9,800 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.		The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.bcbsm.com or call the number on the back of your BCBSM ID card.		If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.		You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.		Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Group Number -

Questions: Call the number on the back of your BCBSM ID card or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number on the back of your BCBSM ID card to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge after deductible	20% co-insurance after deductible	---none---
	Specialist visit	No Charge after deductible	20% co-insurance after deductible	---none---
	Other practitioner office visit	No Charge after deductible for chiropractic and osteopathic manipulative therapy	20% co-insurance after deductible for chiropractic and osteopathic manipulative therapy	Limited to a combined maximum of 30 visits per member, per calendar year for chiropractic and osteopathic manipulative therapy, physical therapy and occupational therapy
	Preventive care/ screening/ immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible	20% co-insurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	20% co-insurance after deductible	---none---

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic drugs	After deductible, $20 co-pay for retail 30-day supply; After deductible, $50 co-pay for retail or mail order 90-day supply	After deductible, In-Network co-pay plus an additional 20% co-insurance of the approved amount for the drug	For information on women's contraceptive coverage, contact your plan administrator. 90-day supply not covered out-of-network. Specialty drugs limited to a 15 or 30-day supply per fill.
	Preferred brand-name drugs	After deductible, $60 co-pay for retail 30-day supply; After deductible, $170 co-pay for retail or mail order 90-day supply	After deductible, In-Network co-pay plus an additional 25% co-insurance of the approved amount for the drug	90-day supply not covered out-of-network. Specialty drugs limited to a 15 or 30-day supply per fill.
	Non preferred brand-name drugs	After deductible, 50% co-insurance of the approved amount	After deductible, In-Network co-pay plus an additional 25% co-insurance of the approved amount for the drug	90-day supply not covered out-of-network. Specialty drugs limited to a 15 or 30-day supply per fill.
	Generic and preferred brand-name specialty drugs	After deductible, 20% co-insurance of the approved amount, but no more than $200 for retail or mail order 30-day supply	After deductible, In-Network co-pay plus an additional 20% co-insurance of the approved amount for the drug.	Specialty drugs limited to a 15 or 30-day supply per fill.
	Nonpreferred brandname specialty drugs	After deductible, 25% co-insurance of the approved amount, but no more than $300 for retail or mail order 30-day supply	After deductible, In-Network co-pay plus an additional 25% co-insurance of the approved amount for the drug	Specialty drugs limited to a 15 or 30-day supply per fill.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fees	No Charge after deductible	20% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room services	No Charge after deductible	No Charge after deductible	---none---
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	---none---
	Urgent care	No Charge after deductible	20% co-insurance after deductible	---none---

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fee	No Charge after deductible	20% co-insurance after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
	Mental/Behavioral health inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
	Substance use disorder outpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
	Substance use disorder inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
If you are pregnant	Prenatal and postnatal care	Prenatal: No Charge Postnatal: No Charge after deductible	20% co-insurance after deductible	---none---
	Delivery and all inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	No Charge after deductible	---none---
	Rehabilitation services	No Charge after deductible	20% co-insurance after deductible	Physical and Occupational Therapy limited to 30 visits per member per calendar year, combined with chiropractic and osteopathic manipulative therapy. Speech therapy is limited to 30 visits per member per calendar year
	Habilitation services	No Charge after deductible for Applied Behavioral Analysis; No Charge after deductible for Physical, Speech and Occupational Therapy	No Charge after deductible for Applied Behavioral Analysis; 20% co-insurance after deductible for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism – when rendered by an approved board-certified behavioral analyst – is covered through age 18, subject to preauthorization. *** Effective 01/01/2017 -** Physical and occupational therapy is limited to 30 visits per member per calendar year; Speech therapy is limited to 30 visits per member per calendar year.
	Skilled nursing care	No Charge after deductible	No Charge after deductible	Limited to a maximum of 90 days per member per calendar year.
	Durable medical equipment	No Charge after deductible	No Charge after deductible	---none---
	Hospice service	20% co-insurance after deductible	20% co-insurance after deductible	---none---
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Eye exam	No Charge	You are responsible for the difference between the BCBSM approved amount and the amount charged by the provider.	Limited to once in a calendar year for members through the last day of the year in which they turn age 19.
	Glasses	No Charge	You are responsible for the difference between the BCBSM approved amount and the amount charged by the provider.	Frames (chosen from a select collection) and lenses are covered once in a calendar year for members through the last day of the year in which they turn age 19.
	Dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic Care
- Coverage provided outside the United States. See http://provider.bcbs.com
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered
- Non-Emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at the number on the back of your BCBSM ID card. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card. Or, you can contact Michigan Office of Financial and Insurance Regulation at **www.michigan.gov/ofir** or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services

For assistance in a language below please call the number on the back of your BCBSM ID card.
SPANISH (Español): Para ayuda en español, llame al número de servicio al cliente que se encuentra en este aviso ó en el reverso de su tarjeta de identificación.
TAGALOG (Tagalog): Para sa tulong sa wikang Tagalog, mangyaring tumawag sa numero ng serbisyo sa mamimili na nakalagay sa likod ng iyong pagkakakilanlan kard o sa paunawang ito.
CHINESE (中文): 要获取中文帮助，请致电您的身份识别卡背面或本通知提供的客户服务 号码。
NAVAJO (Dine): Taa'dineji'keego shii'kaa'ahdool'wool ninizin'goo, beesh behane'e naal'tsoos bikii sin'dahiigii binii'deehgo eeh'doodago di'naaltsoo bikaiigii bichi'hoodillnii.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Please note: Coverage examples are calculated based on individual coverage and calculations may not include a coinsurance maximum.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,920
- **Patient pays** $1,620

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,450
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$150
Total	**$1,620**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,200
- **Patient pays** $2,200

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,450
Co-pays	$670
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,200**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call the number on the back of your BCBSM ID card or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number on the back of your BCBSM ID card to request a copy.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important disclosure

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

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

Company Name: Michigan Municipal Services Authoriy

Quote Census

Name	Birth Date	Dependents Enrolling?	Relationship to Employee	Member Type	Status
Employee	08/05/1976	Yes	Employee	Regular	Enrolling
Employee	07/17/1976	No	Spouse	Regular	Enrolling
Employee	04/01/2007	No	Child	Regular	Enrolling

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

New Business Check List for Small Group

Federal Tax Id

4	6	-	1	6	2	8	8	1	4

- ☐ Group Enrollment and Coverage Agreement (Parts A, B & C)
- ☐ Premium binder check payable to BCBSM or BCN
- ☐ Current UIA 1028 (Quarterly Wage Detail Report)
- ☐ Proof of Federal Identification (if not pre printed on QWDR)
- ☐ Enrollment forms (ECOS) for all enrolling employees. Forms must be complete. Please ensure that dates of hire, job title, and signatures are included. Medicare and COBRA fields must be completed if applicable.
- ☐ Copy of final Rate Quote with Quoting Census
- ☐ Medical Loss Ratio and Enrollment Attestation
- ☐ Leasing Agreement with payroll invoice (if applicable)
- ☐ Union Contract (if applicable)
- ☐ Multiple location survey (if applicable)
- ☐ Small Group Pediatric Dental Essential Health Benefit Acknowledgement (if applicable)

Requested Effective Date 01 / 01 / 2017

Coverage will begin on the effective date, contingent upon approval from BCBSM/BCN Underwriting. BCBSM/BCN will send an acceptance letter to the group upon approval.

Blue Cross Blue Shield of Michigan

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

Group Enrollment and Coverage Agreement

Terms and Conditions - Part A **New Group**

Federal Tax Id

4	6	-	1	6	2	8	8	1	4

Blue Cross Blue Shield of Michigan (BCBSM) will provide health care coverage to Members, i.e., eligible persons enrolled through the group identified below (Group) and participating in Group's employee welfare benefit plan providing health benefits (Group Health Plan or GHP), subject to the terms of applicable certificates and riders (Certificates and Riders), BCBSM's administrative and underwriting requirements, the Group Administrative Guide (Guide) and the following terms and conditions of the Group Enrollment & Coverage Agreement consisting of Part A-Terms and Conditions, Part B-Group Information, and Part C-Coverage Selection (Agreement):

1. Effective Date; Plan Year. This Agreement will become effective on the date established by BCBSM ("Effective Date") and only after applicable premiums are paid, and it will continue unless terminated as provided in Section 13. Coverage is renewable annually if Group continues to meet eligibility requirements.

The GHP's Plan Year, as that term is defined in the Patient Protection and Affordable Care Act, as amended, and applicable regulations (collectively, "PPACA"), is the one year period beginning on the Effective Date and ending one year (or less) later on the last day of the month immediately preceding the month in which the Effective Date falls ("Effective Date Month"). Each Plan Year thereafter shall begin on the first day of the Effective Date Month and end one year later.

Notwithstanding the foregoing, if Group identified a different Plan Year for the GHP when applying for coverage under this Agreement, which Plan Year must start the first day of a month ("Plan Year Start Date"), coverage shall begin on the Effective Date and shall continue until the end of the month immediately preceding the next Plan Year Start Date, which also shall be the first Renewal Date (as defined below). Thereafter, coverage under this Agreement shall commence on the Renewal Date and end one year thereafter. "Renewal Date" is the designated date upon which Group annually renews coverage and on which BCBSM's rate re-determination for the next annual coverage period becomes effective.

Group will notify BCBSM at least six months in advance of any change in the GHP Plan Year.

2. Group as Agent. For all purposes of this Agreement, including the payment of premiums, Group is agent for all Members. Notice by or to Group will satisfy any notice requirements of this Agreement and applicable Certificates and Riders.

3. Premiums. Group must pay all premiums at least one-month in advance of the relevant monthly period. Group must pay all premiums related to any retroactive adjustments expressly permitted by BCBSM's underwriting rules. Refunds or retroactive credits of premium payments or retroactive additions or deletions of Members are not otherwise permitted under this Agreement. All premium rates are guaranteed for the applicable benefit period then in effect except for any government-mandated surcharges or subsidies and except if incorrect rates are identified for an area rated group. In the latter case, BCBSM will notify Group in writing that the rates will be corrected on the next available bill, 90 days following receipt of the notice of incorrect rates. At its discretion, BCBSM may terminate this Agreement immediately if premiums are more than thirty (30) days past due, with termination of coverage retroactive to the last date through which premiums were paid in full.

4. Eligibility. In order to be a Member, an enrolled individual must (A) meet the eligibility requirements set by Group and the requirements of BCBSM's underwriting rules, Certificates and Riders, and Part B of this Agreement and (B) be either (i) a proprietor, partner or shareholder actively managing Group's business, or (ii) a full time active employee of Group working at least thirty (30) hours per week or 17.5 to 30 hours per week, if that is the normal workweek for a full time employee and such policy is applied uniformly among all of Group's employees and without regard to health status-related factors. Deviation from 30 hours a week requires prior approval and must be noted in the exception area on Part B. A dependent of a Member shall also be deemed to be a Member if the dependent meets the requirement of (A) above.

Group warrants that all enrolled individuals meet the above requirements and that it will not enroll any ineligible individual. If an ineligible individual is enrolled, Group agrees to indemnify and hold BCBSM harmless and reimburse BCBSM for all benefit payments made on behalf of such individual and any judgment, settlement, costs, expenses and reasonable attorney fees in connection therewith.

Continued on Page 3

Group agrees with all terms as stipulated in this Group Enrollment and Coverage Agreement (Parts A, B & C), on the Enrollment/ Change of Status Form, and in the specified Blue Cross Blue Shield of Michigan Health Care Certificate(s) and Rider(s).

Company Name

M i c h i g a n M u n i c i p a l S e r v i c e s

Group Number:

Signature of Group Executive on behalf of the Group and the Group Health Plan: _____ Date: _____

Signature of BCBSM Rep: _____ Mail code: _____ Date: _____

Signature of Agent: _____ Date: _____

Signature of Underwriter/Group Administration: _____ Date: _____

5. Enrollment Requirements. Group may offer the coverage described in Part C of this Agreement to eligible individuals as described in Section 4. To continue coverage, the number of eligible individuals enrolled in a Blue Family Benefit Program (Blue Care Network or Traditional, PPO, or any other program that BCBSM may establish) must at all times equal or exceed BCBSM enrollment, participation and underwriting requirements. The Group agrees to provide BCBSM or its designee with all information required to conduct an annual underwriting review and a payroll audit.

6. Eligibility Information. Group shall provide timely and accurate eligibility information, including Medicare status, and identify all persons subject to the Medicare Secondary Payer statutes and regulations. Group acknowledges that BCBSM will rely upon the accuracy of all eligibility information Group provides, and Group shall indemnify and hold BCBSM harmless against loss, claim or action, including costs, penalties and reasonable attorney fees, arising from the provision of inaccurate eligibility information.

7. Enrollment Applications. Member applications for coverage shall only be submitted according to BCBSM's procedures that are set forth in the Guide. Rehires and persons renewing terminated memberships will be enrolled as new employees/Members. All applicable premiums, including those for any retroactive periods, must be paid before such persons shall be deemed to be eligible for coverage.

8. Claims Dispute Procedures. A Member who disagrees with how a claim was processed may take advantage of BCBSM's routine inquiry procedures. A Member who is still dissatisfied must exhaust all steps of the internal grievance procedures established pursuant to MCL 500.2213 or, if the GHP is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the procedures established pursuant to 29 CFR Part 2560, before seeking other remedies. A Member dissatisfied with the results of the internal grievance procedures may be entitled to request an external review from the Department of Insurance and Financial Services as provided in 2000 PA 251 (MCLA 550.1901 et seq., as amended), or may file suit in a court having jurisdiction as set forth in Section 12. If the GHP is subject to ERISA, a Member may also have a right to file a claim under § 502(a) of ERISA.

9. ERISA Fiduciaries. If the GHP is subject to ERISA, Group or its designee (other than BCBSM) shall be the Plan Administrator of the GHP under ERISA and shall have all of the responsibilities and authority of that position including ensuring compliance with ERISA, preparing and distributing summary plan descriptions, and advising all eligible individuals of: (i) available benefits and any changes in benefits, (ii) termination of coverage for any reason, including the failure to make any payments when due, and (iii) COBRA rights, if any. Group delegates the responsibility and discretionary authority to process and pay claims to BCBSM as "claims administrator" and retains all other responsibilities and duties under ERISA not specifically delegated to BCBSM. BCBSM agrees to assume such responsibility and authority, including any responsibility it may have as a "named fiduciary" (as defined under ERISA §402) for purposes of its claims administration duties, to the extent that under the GHP and ERISA it meets the definition of a "named fiduciary." As the named claims administrator, BCBSM shall have the power and discretion to construe the terms of this Agreement and to determine all questions pertaining to the administration, interpretation, and application of this Agreement and any Certificates and Riders that involve eligibility for benefits and the payment or denial of claims. In addition, the parties agree that BCBSM shall have the responsibility for ensuring that its claims procedures comply with the Department of Labor's Claims Procedures described in 29 C.F.R. Part 2560 and for handling all levels of appeal.

10. HIPAA Privacy Notices: BCBSM and the GHP are an "organized health care arrangement" with respect to protected health information (PHI), as those terms are defined in 45 C.F.R. § 164.50, created or received by BCBSM that relates to individuals who are or who have been participants or beneficiaries in the GHP. BCBSM will comply with the administrative requirements under 45 C.F.R. Parts 160 and 164 and prepare and distribute Notices of Privacy Practices appropriate for Group under 45 C.F.R. § 164.520. Group shall maintain the confidentiality of any PHI that may be disclosed by BCBSM.

11. Licensee Status of BCBSM. This Agreement is between Group and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans, to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by entering into this Agreement, Group agrees that it made this Agreement based solely on its relationship with BCBSM or its agents. The Group further agrees that BCBSA is not a party to, nor has any obligations under this Agreement, and that no obligations are created or implied by this language.

12. Litigation. Any suit arising out of this Agreement or any Certificates and Riders must be filed within 2 years after the cause of action arose and, unless pre-empted by ERISA, shall be brought in a Michigan court of competent jurisdiction. Under no circumstances may Group, the GHP, or a Member file suit before exhausting the internal BCBSM-administered steps of the applicable grievance procedure referenced in Section 8. However, exercising any rights described in Section 8 shall not extend the 2-year period in which any suit may be filed.

13. Termination. Upon thirty (30) days written notice, either party may terminate this Agreement for any reason consistent with applicable law. BCBSM may also terminate this Agreement as described in Section 3 above.

14. Assignment and Waiver. Neither party may assign this Agreement without the written permission of the other party. Any assignment by Group without BCBSM's written permission shall be deemed a voluntary termination of this Agreement by Group. The waiver by a party of any breach of this Agreement by the other party shall not constitute a waiver of any subsequent breach of this Agreement.

The Group will immediately notify BCBSM in writing of any Change in Control, any change in Group's name, identity, ownership, or legal organizational structure, any change in, or addition to, a location of Group's place of business, and any merger, combination, sale of assets, or other similar material transaction in which Group is involved. For purposes of this Agreement, a "Change in Control" shall be deemed to be an assignment requiring BCBSM's consent and shall mean an event resulting in a change in the beneficial ownership of Group of 50% or more immediately after the event compared to one year before the event. "Beneficial ownership" means actual ownership or the right, directly or indirectly, to control voting power associated with ownership interests in Group.

Continued on Page 4

15. Exclusions. Notwithstanding anything contained in this Agreement, BCBSM will have no obligation to Group for any coverage not specified in the applicable Certificate and Riders, nor for any coverage that Group, in whole or in part, contracts with other carriers to provide on behalf of Group. The Group agrees to indemnify and hold BCBSM harmless against any loss, claims, actions, and damages, including costs and reasonable attorneys' fees, that may arise from any coverage not so provided by BCBSM.

16. Entire Agreement; Amendment. This Agreement, which, as defined, includes Parts A, B and C, together with any attachments, is the entire agreement between BCBSM and Group and supersedes all other agreements, oral or written, between the parties regarding the same subject matter. This Agreement may only be amended by written document signed by the parties, provided, however that this Agreement may be amended by BCBSM upon written notice to Group in order to facilitate compliance with applicable regulatory requirements, changes in regulations, or reporting requirements or data disclosure provided such amendment is applicable to all BCBSM Groups that would be similarly affected by the regulation in question.

BCBSM will provide thirty (30) calendar days notice of any such amendment and regulatory provision, unless a shorter notice is necessary in order to accomplish regulatory compliance.

Upon request by Group BCBSM will consult with Group regarding the regulatory basis for any amendment to this Agreement as a result of regulatory requirements.

17. Severability. If any provision of this Agreement is found invalid or unenforceable, the remaining provisions shall remain in full force and effect.

18. Governing Law. This Agreement is entered into in Michigan and, except as may be pre-empted by ERISA, shall be construed according to the laws of Michigan.

19. Quality Programs: Claims incurred by Enrollees include amounts that BCBSM reimburses health care providers, including reimbursement tied to value in accordance with "Quality Programs," which are governed by separate agreements with health care providers and are designed to improve health care outcomes and control health care costs. BCBSM has adopted a provider payment model that includes both fee-based and value-based reimbursement. BCBSM does not unbundle claims and does not retain any component of claims as compensation.

BCBSM negotiates provider reimbursement rates on its own behalf and makes those rates available to customers through its products and networks. The reimbursement rates can, and often do, vary from provider to provider. Providers may qualify for higher reimbursement rates for satisfying requirements of certain BCBSM Quality Programs, including, for example, Pay-for-Performance rates and Value Based Contracting rates earned by hospitals and Patient Centered Medical Home rates earned by physicians. Providers may also receive reward and incentive payments from BCBSM Quality Programs funded through an allocation from provider reimbursement or other agreed upon methods. Such allocations may be to a pooled fund from which value-based payments to providers are made. For example, pursuant to the Physician Group Incentive Program (PGIP), physicians agree to allocate a percentage of each claim to a PGIP fund, which in turn makes reward payments to eligible physician organizations demonstrating particular quality and pays physician organizations for participation in collaborative initiates.

Provider reimbursement rates also capture provider commitments to BCBSM Quality Programs. For example, hospitals participating in Hospital Collaborative Quality Initiatives agree to allocate a portion of their reimbursement to fund inter-hospital quality initiatives.

Value based reimbursement includes other obligations and entitlements pursuant to other Quality Programs funded in a similar manner to those described above. Additional information is available from BCBSM account representative representatives and at www.valuepartnerships.com.

Continued on Page 5

20. Rating Methodology Type. As shown by checked box below Group is either Small Group rated or Large Group rated under Formula II or Formula III.

Small Group Rating

☐ **Small Group Rating: Applies to groups of 50 or fewer eligible employees with 1 or more enrolled medical contracts. Groups of one enrolled must be an eligible employee.**
BCBSM Small Group Rating is an underwritten, modified community rating arrangement with member level rating as prescribed by the PPACA. No gains or losses are returned to or recovered from Group at renewal or at termination. There are no annual group settlements.

Large Group Rating

BCBSM Large Group Rating applies to groups of 51 or more eligible employees and is comprised of two rating formulas:

☐ **Large Group Formula II - Applies to groups with 51 or more eligible employees with 100 or more enrolled medical contracts**
Formula II is an experience rated, underwritten arrangement where gains and losses are not returned to or recovered from Group at termination, but they are considered when calculating renewal rates.

- Formula II includes an annual settlement with a Rate Stabilization Reserve (RSR) account
- Based on settlement projections renewal rates may include a rate credit up to 50% of a positive RSR balance or recoupment of a negative RSR balance based on a graded scale.
- A refund check may be issued for up to 50% of a positive RSR balance with the annual settlement if a rate credit was not elected.
- Upon termination of a Formula II arrangement, positive RSR balances are not returned, and there is no recoupment of a negative RSR balance.
- When a Formula II group changes to a different large group rating formula or an Administrative Services Contract (ASC) arrangement, the full RSR balance will transfer to the new funding arrangement. Positive/negative RSR balances will be credited/recouped under the new arrangement and may be amortized over a period of time
- When a Formula II group transfers to small group rating and subsequently returns to large group rating or an ASC arrangement, BCBSM may credit/recoup a prorated portion of the prior Formula II positive/negative RSR balance, which may be amortized over a period of time.
- When a Formula II group terminates its arrangement with BCBSM and subsequently reenrolls in a large group or Administrative Services Contract (ASC) rating arrangement, BCBSM may credit/recoup a prorated portion of the prior Formula II positive/negative RSR balance, which may be amortized over a period of time.

☐ **Large Group Formula III – Applies to groups of 51 or more eligible employees**
Formula III is an experience rated and/or demographically adjusted underwritten arrangement where gains and losses are not returned to or recovered from Group at renewal or at termination.

- No gains or losses are returned to or recovered from Group.
- There are no annual settlement accountings nor investment income credits or debits.
- There is no RSR account.

The above descriptions of the small group and large group rating methodologies are summaries only and are not intended to be complete. As previously noted, coverage under this Agreement is subject to the terms of applicable Certificates and Riders, BCBSM's administrative and underwriting requirements, the Guide, and the terms and conditions set forth in this Agreement.

21. Status Changes Requests. Group represents that any eligibility and status changes it requests are compliant with and permissible under applicable state and federal law, including PPACA, and agrees that it will only request eligibility and status change requests that are compliant with and permissible under applicable state and federal law, including PPACA.

22. Compliance with Law; Penalties. Group agrees to abide by all applicable state and federal law, including but not limited to PPACA. Any penalties, excise taxes, or similar charges ("Penalties") imposed on Group or BCBSM for the failure of either to comply with PPACA shall be allocated between BCBSM and Group on a basis proportional to the respective fault of the parties with respect to such failure.

In the event that BCBSM pays any portion of the Penalties for which Group was responsible, Group shall indemnify and hold BCBSM harmless against loss, claim or action, including costs, penalties and reasonable attorney fees, arising from Group's failure to pay such Penalties.

23. Group Disclosure of Other Coverage Vendors. Group agrees that, to the extent that BCBSM does not provide to GHP's participants all "essential health benefits," as defined by PPACA, Group shall identify for BCBSM all those vendors ("Vendors") that are also providing essential health benefits to GHP's participants, the benefits the Vendors are providing to them, the number of participants receiving such benefits, and the cost sharing arrangements for such benefits. In addition, Group shall cause its officers, directors, employees, and representatives and Vendor's officers, directors, employees, and representatives to fully and timely cooperate with BCBSM and provide it with the necessary information for BCBSM to (a) determine the correct medical loss ratio (MLR) and make such other determinations as are required by PPACA with respect to the GHP and (b) ensure its compliance and that of the GHP with PPACA to the extent BCBSM is obligated to do so by law or by contract. This information includes, but is not limited to, social security numbers or other forms of government identification numbers of each GHP participant.

Group authorizes all Vendors to, and shall inform the Vendors in Group's contract with them that they must, effective on the beginning of Group's first plan year on or after January 1, 2014, disclose to BCBSM on a daily basis (or some other regularly scheduled period as determined by BCBSM) all claims data for the essential health benefit(s) for GHP participants that they possess so that BCBSM may properly determine whether the maximum out-of-pocket amount is in compliance with PPACA.

Continued on Page 6

24. Other Data Requirements. Group agrees to provide to BCBSM all data reasonably necessary for BCBSM to comply with the requirements of PPACA or other applicable federal or state law. Such data includes, but is not limited to, data needed to comply with any reporting or other requirement of PPACA, e.g., the employer's share of any premium and social security and tax identification numbers. Group certifies that if it fails to provide all the data in the manner requested and if it has provided such information to BCBSM in response to a previous request, then Group shall be deemed to have certified to BCBSM that such information previously supplied remains correct and can be relied upon.

Group and Group's Vendors will maintain relevant books, records, policies, procedures, internal practices, and/or data logs relating to this Agreement in a manner that permits review for a period of seven (7) years (ten (10) years in the case of Medicare/Medicaid transactions) after the expiration of this Agreement. With reasonable notice and during usual business hours, BCBSM, or its designated third party (with appropriate confidentiality obligations), may audit those relevant books, records, policies, procedures, internal practices, and/or data logs of Group and/or its Vendors, as necessary to verify calculations related to the imposition of any taxes and fees under PPACA or other federal or state laws and to ensure compliance with this Agreement and any applicable federal and state laws. Group shall cooperate with BCBSM in all reasonable respects in connection with such audits.

BCBSM's failure to detect, failure to notify Group of detection, or failure to require Group's remediation of any unsatisfactory practices, does not relieve Group of its responsibility to comply with this Agreement or applicable law, does not constitute acceptance of such practice, and does not constitute a waiver of BCBSM's enforcement rights under this Agreement or applicable law.

If Group conducts, or contracts to have conducted, an internal audit or review of the services performed under any agreement with BCBSM, Group shall provide BCBSM with a copy of such audit or review within thirty (30) days of BCBSM's written request. This also applies to audits/reviews performed by or at the request of any federal or state regulatory agencies of BCBSM services. The selection of an independent auditor by Group to conduct an internal audit of Group does not preclude BCBSM from conducting an audit in accordance with the terms contained herein.

The provisions of this Section shall survive the termination of this Agreement.

25. Group Health Plan Type; Medical Loss Ratio Rebate; Attestation. Concurrently with the signing of this Agreement and each renewal, Group will provide BCBSM with a written certificate in form and substance satisfactory to BCBSM certifying to BCBSM whether the GHP is an ERISA plan, a non-federal governmental plan, or an ERISA-exempt church plan. If Group is an ERISA-exempt church plan, Group will provide BCBSM with an attestation, in form and substance satisfactory to BCBSM, providing written assurance that medical loss ratio rebates, if any, will be used for the benefit of then current subscribers in a manner consistent with 45 CFR §158.242(b).

26. Grandfather Status; Women's Preventive Care Religious Exemption. Group acknowledges and agrees that unless a written certificate of Group's PPACA grandfather status and indemnity in form and substance satisfactory to BCBSM was previously provided to BCBSM by Group or, for a Group new to BCBSM as of January 1, 2013, was provided to and accepted by BCBSM concurrently with the signing of this Agreement, Group will be considered non-grandfathered for all purposes. Notwithstanding any other provision, Groups of 50 or less eligible employees will be treated as non-grandfathered for all purposes.

In addition, Group acknowledges that the health care coverages provided to its Enrollees will include recommended women's preventive health services without cost sharing (as required by PPACA) unless it (i) is a grandfathered group health plan that has not provided such coverage or (ii) qualifies as either an exempt group health plan or one eligible for the temporary safe harbor under PPACA and has provided a certificate to that effect in form and substance satisfactory to BCBSM.

27. Record Access. Group will maintain adequate operational, financial and administrative records, contracts, books, files and other documentation directly or indirectly related to the performance undertaken by this Agreement (collectively referred to as "Records"). Such Records at a minimum shall be sufficient to enable BCBSM to enforce its rights under the Agreement, to determine whether the Agreement is being performed by Group in accordance with applicable laws, and for BCBSM compliance with laws as may be related to performance under this Agreement. Records also includes but is not limited to any records that pertain to any aspect of data reported to the Department of Health and Human Services or that pertain to rebate payments made and calculated under 45 Code of Federal Regulations Part 158, "Issuer Use of Premium Revenue: Reporting and Rebate Requirements" including but not limited to all administrative and financial books and records.

Group agrees that BCBSM and Government Authorities will have the right to access, audit, copy, evaluate, and inspect Records and that BCBSM and Government Authorities have the right to access all of Group personnel, premises, facilities, equipment and computers and other electronic systems to inspect, copy, evaluate and audit Group's performance under the Agreement or which pertains to any aspect of data reported to Department of Health and Human Services or that pertain to rebate payments made and calculated under 45 Code of Federal Regulations Part 158.

Group will provide immediate notice by telephone to be followed with written notice within three (3) business days, of receipt of any non-routine request from any Government Authority for records and/or access to Group's personnel, premises, facilities, equipment and computers and other electronic systems. Group shall provide BCBSM with copies of all Records inspected, evaluated, and audited, including but not limited to all Records of which any Government Authority made copies.

The terms of this Section will remain in effect for the longer of ten years from (i) the termination of this Agreement, (ii) completion of the audit, or (iii) such other time frame as required by federal or state law or a Government Authority.

Continued on Page 7

28. Summary of Benefits and Coverage (SBC). This provision applies only where Group and GHP are not exempt from federal SBC rules and regulations. BCBSM and Group agree to the following responsibilities for creation and distribution of SBCs:

BCBSM Responsibilities:

1. *Creation.* BCBSM shall create an SBC for each of Group's applicable BCBSM coverages.
2. *Distribution.* BCBSM shall provide Group with an SBC for applicable Group coverages as follows:
   - Group Quotes. BCBSM will provide the applicable SBC with a Group quote to Group or to Group's Agent, as the case may be, upon request where Group or Group's Agent requests a quote from BCBSM.
   - Website Posting. BCBSM will post Group SBCs for applicable BCBSM coverage to Group Secured, Agent Secured, and Member Secured Services websites.
   - Renewal. BCBSM will provide Group, either directly or through Group's Agent, with a renewal package containing the website address to access applicable SBCs for BCBSM coverages.
   - Upon Request. BCBSM will, upon request from a participant or beneficiary, provide him/her with the SBC for the coverage in which he/she is enrolled. BCBSM will provide Group with applicable SBCs for BCBSM coverages upon Group request.
3. *SBC Update.* BCBSM will seasonably update Group SBCs for applicable BCBSM coverages following a change in BCBSM coverage or in the context of a Notice of Material Modification affecting a previously issued SBC for BCBSM coverage.

Group Responsibilities:

1. *Dissemination.* Group shall be solely responsible for disseminating an electronic copy (via the internet or otherwise) or a paper copy of the applicable SBC to participants and beneficiaries (including pre-enrollees) in a manner compliant with (a) the Employee Retirement Income Security Act (ERISA, as amended), if applicable; (b) all the requirements of Section 2715 of the Public Health Service Act (PHSA) as added by Section 1001 of PPACA; (c) any applicable regulations implementing PHSA Section 2715 codified in the Code of Federal Regulations; and, (d) any sub-regulatory guidance regarding PHSA Section 2715. The circumstance under which Group shall provide an SBC to participants and beneficiaries, within the time permitted by law, include but may not be limited to upon request, application, open enrollment, renewal, special enrollment, and change in coverage between application and effective date of coverage.
2. *Delivery to Agent.* Group agrees that if it has an Agent for renewal, BCBSM can deliver the SBC to Agent electronically or in print form, and such delivery to the Agent will be delivery to Group.
3. *Updated Information.* In advance of the next renewal year, within the time period designated by BCBSM, Group shall provide BCBSM with all necessary benefit information to enable BCBSM to provide Group applicable SBCs as required by this Agreement.
4. *Updated SBC with Notice of Material Modification.* Group agrees that it will provide an updated SBC to its participants and beneficiaries in accordance with the requirements set forth in the statutes and regulations where there is a Notice of Material Modification.
5. *Notice of Failure to Deliver.* Group will notify BCBSM immediately if it fails to deliver the SBC to participants and beneficiaries.
6. *Correction of Known Violation.* Group agrees that it will correct any known violation of the SBC rules as soon as practicable if it has information to do so; and, if it does not have the information necessary to make the correction, communicates with participants and beneficiaries regarding any violation and take steps to prevent future violations.
7. *Electronic Distribution of SBC.* Group agrees to promptly register for Group Secured Services website by visiting **bcbsm.com** and completing the registration process. Group consents to and agrees that delivery of any applicable SBC by BCBSM may be through Group's Secured Services website. BCBSM will provide a print copy of any applicable SBC to Group free of charge upon request. SBCs posted by BCBSM to Group's Secured Services website will be updated as required and previous versions may be removed by BCBSM.
8. *Group Internal Intranet Website.* Group agrees that if it provides participants and beneficiaries access in an electronic medium to BCBSM SBCs through Group's internal intranet or by similar means that electronic access will be to a "read-only" SBC but in a readily accessible form which can be retained and printed, and that it will timely post updated SBCs as may be provided by BCBSM and to timely remove previous versions which have been updated.
9. *Group Receipt of SBC.* Group acknowledges that SBCs for applicable BCBSM coverage have been provided either prior to or concurrently with BCBSM's delivery of this Agreement for signature by Group.
10. *Indemnity.* Group shall indemnify and hold BCBSM harmless against loss, claim or action, including costs, penalties and reasonable attorney fees, arising from Group's failure to deliver the SBCs as described above.
11. *Notice of Material Modification.* Group has sole responsibility to provide written notice to enrollees of any material modification in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, and Group agrees that such notice will be provided not later than 60 days prior to the date on which the modification will become effective.

29. Copayments - BlueCard Program.
BCBSM will give Group notice with a new Exhibit 1, which will automatically become part of this Agreement sixty (60) days after notice has been given.

Exhibit 1 attached to this Agreement describes the BlueCard Program available through the BCBSA. If the BCBSA revises the disclosure in Exhibit 1,

Continued on Page 8

I. Out-of-Area Services

BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area BCBSM serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to BCBSM for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Agreement are described generally below.

Typically, Members, when accessing care outside the geographic area BCBSM serves, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. BCBSM's payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when Members access covered healthcare services within the geographic area served by a Host Blue, BCBSM will remain responsible to Group for fulfilling BCBSM's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Member's liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to BCBSM by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to BCBSM by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment in effect at the time a claim is processed without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to BCBSM is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, BCBSM would then calculate Member liability in accordance with applicable law.

Value Based Programs

BCBSM has included a factor in premium calculations for Host Blue value based programs when applicable.

Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, BCBSM will include any such surcharge, tax of other fee in determining premiums.

Continued on Page 9

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by claim or prospective basis.

B. Non-Participating Healthcare Providers Outside BCBSM's Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of BCBSM's service area by non-participating healthcare providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph.

2. Exceptions

In some exception cases, BCBSM may pay claims from non-participating healthcare providers outside of BCBSM's service area based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a participating provider, as determined by BCBSM in BCBSM's sole and absolute discretion or by applicable state law. In other exception cases, we may pay such a claim based on the payment we would make if BCBSM were paying a non-participating provider inside of BCBSM's service area, as described elsewhere in this Agreement, where the Host Blue's corresponding payment would be more than BCBSM's in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and payment BCBSM will make for the covered services as set forth in this paragraph.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

New Group - Part B

Group Exec Initials

Federal Tax ID Number: 46-1628814

Sponsored Plan Acronym

Customer ID(BCBSM), Group ID(BCN)

SubGroupID

ClassID

BCBSM Group Number

Group Division

Leasing Company Acronym

Leasing Company Name

Effective Date: 01/01/2017

Company Name: Michigan Municipal Services

Phone: 517-618-9616

Physical Address: PO Box 120120

County: Ingham

City: Lansing

State: MI

Zip Code: 48918-

Primary Nature Of Business

Doing Business As: DBA Michigan Municipal Servic

Company Fax

Check here if this group is ERISA Exempt [ ]

Are you currently in bankruptcy? [ ] Yes [X] No

Do you have any leased employees? [ ] Yes [X] No

Does this group have subsidiaries, offices, or branches located at other physical locations? [ ] Yes [X] No If yes, submit multiple location report

Is Work Force Unionized? [ ] Yes [X] No

Number of Employees Represented

Local Number

Contract Expiration Date

National/International Name

Local Representative Name

Retiree Group: Is there a surviving spouse option? [ ] Yes [X] No

Employer Monthly Contribution:

Medical [ ] $ [X] % 100.00

Dental [ ] $ [X] % 100.00

Vision [ ] $ [X] % 100.00

A. To be eligible for coverage an employee must work a minimum of 30 hours per week.

B. Eligible Dependent coverage will be effective on date of event, e.g., spouse, newborn, if written notification is received within 31 days thereof with billing prorated. If after 31 days, coverage will be effective at group's next annual reopening date.

C. Enter appropriate BCBSM/BCN code selected from the New Hire/Rehire options table for newly hired full-time employees, or part-time employees who become full-time. Any requests that do not comply with BCBSM/BCN guidelines require underwriting review and approval, such as requests from large employers related to compliance with the employer mandate provisions of IRC 4980H:

BCBSM Code: S3-60

BCN Code

ID cards will be mailed directly to the subscriber unless the box below is checked.

Mail to group [ ] Yes

D. Employees hired with an active BCBSM/BCN contract may transfer to this group without regard to above schedule (Item C, above).

E. Exceptions: Rehired employees are to be effective Date of rehire

Managing Agent Name: 03_Action Benefits

MA Code: 03

Agent Code: 17274

Agent Name: (first and last) KIMBERLY A WIXSON

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

New Group - Part B

Group Exec Initials

Federal Tax ID Number: 46-1628814

Previous or existing BCBSM/BCN Coverage? [ ] Yes [ ] No If Yes, Plan Year (MM/DD) ___/___

If yes, Former Group Number

Previous Carrier

BCBSM/BCN Cancellation Date ___/___/____

Workers Comp Information

Workers Comp Carrier: BENCHMARK INSURANCE COMPANY

Workers Comp Policy Number: GRBWC5000057504

Workers Comp Renewal Date: 09/05/17

Billing Contact Information

Billing Contact - First Name: Kristen Last Name: Delaney Billing Phone Number: 517-618-9616 Billing Contact - Job Title: Assistant

TPA or Billing Address-If other than Physical Address: PO Box 12012

Billing Address County: Ingham

City: Lansing State: MI Zip Code: 48901-

Administrative Contact Information

Administrative Contact Person - First Name: Robert Last Name: Bruner Contact Person's Phone Number: 517-618-9616 Administrative Contact Job Title: CEO

Mailing Address: PO Box 12012

Mailing Address County: Ingham

City: Lansing State: MI Zip Code: 48901-

Chief Executive Contact Information

Chief Executive - First Name: STACIE Last Name: BEHLER Chief Executive's Phone Number: 616-791-5851

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Group Exec Initials

Federal Tax ID Number: 46-1628814

New Group - Part B

The person named below has full legal authority to execute agreements on behalf of your company and is authorized to delegate access to all of your group's information available through our website.

Name of Principal Administrator you wish to appoint (could be self): First Name: Robert Last Name: Bruner

Principal Administrator's email address: rbruner@michiganmsa.org

Billing and Contact Email Information for record updates

Chief Executive's email address: STACIE.BEHLER@MEIJER.COM

Billing Contact Person's email address: kdelaney@michiganmsa.org

Administrative Contact Person's email address: rbruner@michiganmsa.org

Designated Mutual Voter Contact Information (BCBSM Only)

Name of Mutual Voter you wish to appoint (could be self): First Name: ROBERT Last Name: BRUNER

Mailing Address

Mailing Address County

City

State

Zip Code -

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

BCBSM/BCN
New Hire/Rehire Options

New Hire/Rehire Option	BCBSM Code*	BCN Code*
The employee coverage will be effective the date of hire/rehire.	S2	01
The employee coverage will be effective the first billing date following the date of hire/rehire.	S4	16
The employee coverage will be effective the first billing date following thirty (30) days from the date of hire/rehire.	S30	17
The employee coverage will be effective the 31st day from the date of hire/rehire	S3-30	02
The employee coverage will be effective the first billing date following sixty (60) days from the date of hire/rehire.	S60	18
The employee coverage will be effective the 61st day from the date of hire/rehire	S3-60	08
The employee coverage will be effective the 91st day from the date of hire/rehire	S3-90	10

*** Enter appropriate code for New Hire/Rehire Options in item C on the first page of part B**

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

2017 Small Group Menu
New Business
Part C

Group Exec Initials

Federal Tax Id 461628814

Order IDs? [X] Yes [ ] No

Requested Effective Date 01/01/2017

Group Name (Full Legal Name) Michigan Municipal Services Authoriy

Group Number

Suffix Number

Simply Blue HSA Gold $1450 0% w/ EA	**Elective Abortion**				
	100% after in-network deductible/80% after out-of-network deductible				

Notes

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

2017 Small Group Menu
New Business
Part C

Group Exec Initials

Federal Tax Id 461628814

Order IDs? [X] Yes [ ] No

Requested Effective Date 01/01/2017

Group Name (Full Legal Name) Michigan Municipal Services Authoriy

Group Number

Suffix Number

SG BDPPO Plus 100/80/50	**SG Dental Annual Max**				
	$1000 per member no Ortho/$1000 per member no Ortho				

Notes

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

2017 Small Group Menu
New Business
Part C

Group Exec Initials

Federal Tax Id 461628814

Order IDs? [X] Yes [ ] No

Requested Effective Date 01/01/2017

Group Name (Full Legal Name) Michigan Municipal Services Authoriy

Group Number

Suffix Number

Blue Vision 12-12-12 $5/$10					

Notes

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Medical Loss Ratio Reporting & Enrollment Attestation

Federal Tax Id: 46-1628814

Customer name	Customer contact email	Renewal date	Effective date
Michigan Municipal Services Authoriy	RBRUNER@MICHIGANMSA.ORG	01/01/2018	01/01/2017

Common control
Do you have multiple employer groups or common control? ☐ Yes ☒ No

If yes, please provide a letter from your group's CPA or tax attorney (on his or her letterhead) certifying that your companies meet the Internal Revenue Service definition of a controlled group, the relationship between the companies along with percentage of ownership for each company.

Where the rebate should be mailed, if applicable:
☒ Current company mailing address ☐ Other mailing address

Street address

City State Zip

Sole proprietor status: Please check one of the following:

- ☒ I am not a sole proprietor (or a sole shareholder).
- ☐ I am a sole proprietor (or sole shareholder) and my employees are enrolled in medical health care coverage that I sponsor (with BCBSM, BCN or another carrier) in the medical health care coverage that I sponsor.
- ☐ I am a sole proprietor (or sole shareholder) and my employees are not enrolled (with BCBSM, BCN or another carrier) in the medical health care coverage that I sponsor.
- ☐ I am a partnership with no employees.

Group Health Plan Type. Your group health plan status will fall into one of the following three options. Please check the appropriate option. If you are an ERISA-exempt church plan (as described below) you must also choose one of the rebate distribution options:

- ☐ My group's health plan is an employee benefit plan established or maintained by an employer or an employee organization (such as a union) that provides medical, surgical or hospital care for participants or their dependents directly or through insurance reimbursement.
- ☒ My group's health plan is a nonfederal government plan established or maintained for employees by state government, political subdivision of state government, or any agency or instrument of any of these.
- ☐ My group's health plan is an ERISA-exempt church plan (a plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches exempt from tax under section 501 of Title 26 (29 USC 10025 (33)(A)).

ERISA-exempt church plans rebate options. Please check one of the following:

- ☐ The plan agrees to use any rebate issued for the benefit of the group health plan subscribers in accordance with 45 CFR §158.242. By checking this box, any applicable rebate will be sent to the group. (Note: If we do not receive this attestation, federal law requires Blue Cross and BCN to distribute any rebates directly to the enrollees of the group health plan covered by the policy during the Medical Loss Ratio reporting year. Each enrollee will receive an equal share without regard to how much each enrollee actually paid toward premiums.)
- ☐ The plan does not agree to use any rebate issued for the benefit of the group health plan subscribers.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Medical Loss Ratio Reporting & Enrollment Attestation(continued)

Federal Tax Id: 46-1628814

Most recently completed calendar year 2016

Employee count information

Full time employee equivalents	002	Number of ineligible part-time employees	000	Number of ineligible seasonal employees	000	Number of eligible employees in Michigan	002	Number of eligible employees outside of Michigan	000
Medical loss ratio employee count[1]	002	Number of employees chosing no coverage	001	Number of employees not offered coverage	000	Number of employees covered by an individual health plan	000	Number of employees covered by another group health plan through a spouse, another employer, or retirement plan	001

[1] Provide the average number of active (nonretiree) employees in your company on business days during the most recently completed calendar year.

Current Health Carriers offered to employees

List all health carriers that are offered to your employees and the number of medical contracts enrolled in each.

Carrier	Number of active medical enrolling	Number of active dental enrolling	Number of active vision enrolling	Number of retirees enrolling	Number of cobra enrolling
Blue Cross Blue Shield of MI	001	001	001	000	000
Blue Care Network of MI					

Are you using Health Equity? ☒ Yes ☐ No

HealthEquity is an independent company that provides financial services to Blue Cross Blue Shield of Michigan Customers.

HealthEquity spending accounts

☒ HSA	☐ DC FSA	☐ FSA-SAO
☐ HRA	☐ Limited Purpose HRA	☐ FSA-Ancillary Only
☐ FSA	☐ Limited Purpose FSA	

- BCBSM/BCN will distribute any applicable rebates in good faith based on this attestation. Blue Cross and BCN will be held harmless for any losses that result from action taken based on this group attestation.
- I certify that the group does not provide any contribution or reimbursement of premiums for employees enrolled in an individual plan through Blue Cross, BCN, Health Insurance Marketplace, or other carrier.
- I certify that the employees indicated above who are waiving coverage are not enrolled in other coverage that the group offers to its employees.
- I attest that the employee counts provided above and the group health plan information are complete and accurate and maintain records to support this and will be able to provide the documentation at the request of Blue Cross or BCN Underwriting.
- I am authorized by Michigan Municipal Services Authority sponsor of the group health plan described above. I attest that the employee counts provided above and the group health plan information are complete and accurate.

Stacie Behler		Chair	
Submitted by	Signature	Title	Date

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

IMPORTANT NOTICE OF SMALL GROUP REIMBURSEMENT POLICY

The Patient Protection and Affordable Care Act, as amended (PPACA), and related federal and state regulations require BCBSM's and BCN's underwritten Small Group Products to be filed and approved with specified Actuarial Values (AV) or "metal levels." The AV of such products, including those used with an employer-funded health reimbursement arrangement (HRA) or health savings account (HSA), may be impacted if an employer contributes to a Member's policy, HRA, or HSA an amount that differs from that shown on Part C of the Group Enrollment and Coverage Agreement (Part C). Should an employer do so, BCBSM or BCN may refuse to sell the plan to the employer.

Group may permit employee-funded flexible spending accounts (FSAs) for any plan, provided, however, that Group FSA contributions may not exceed $250 per contract, with the following exceptions: BCBSM's Healthy Blue Achieve and BCN's Healthy Blue Living.

Deductibles, co-insurance or copays for non-HSA or non-HRA plans cannot be reimbursed except as specified in Part C.