



Charter County of Wayne, Michigan
HEALTH AND WELFARE
BENEFIT PLAN

Effective December 1, 2006

Last Revised: Original Document

Wayne County
2006 HEALTH AND WELFARE BENEFIT PLAN

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Wayne County
HEALTH AND WELFARE BENEFIT PLAN

SECTION 1. DEFINITIONS

Unless otherwise specified and for purposes of this document, the following definitions shall apply:

- A. The “Wayne County Health and Welfare Benefit Plan” effective December 1, 2006 shall be referred to as the **“Benefit Plan.”**
- B. The Charter County of Wayne, Michigan shall be known as the **“Employer.”**
- C. The term **“employee,”** when used without qualification, refers to both active and retired employees of the Charter County of Wayne, Michigan.
- D. The term **“eligible employee,”** when used without qualification, refers to active, full-time, permanent employees and retired employees eligible for benefits under the terms of the applicable labor agreement or retirement ordinance.
- E. The term **“legal dependent”** refers to an employee’s dependent(s) as defined by Internal Revenue Service regulations.
- F. The term **“eligible dependent”** or **“qualified dependent”** refers to an employee’s legal dependent, other than a sponsored dependent, who is appropriately enrolled in a medical, dental and/or vision plan provided by the Employer.
- G. The Wayne County Department of Personnel / Human Resources Benefit Administration Division will be referred to as **“Benefit Administration.”**
- H. The Wayne County Employee Retirement System shall be referred to as **“Retirement.”**
- I. The terms **“health benefits,” “health care benefits,” “health insurance,” “health plan,”** or **“health coverage”** refers to all medical (including hospital and physician, and master medical benefits), dental, and vision/optical coverage.
- J. The term **“labor agreement”** refers to any collective bargaining agreement or executive exempt benefit plan signed into effect by the an authorized agent of the Employer.

SECTION 2. GENERAL PROVISIONS

A. Benefit Administration

- 1. The Benefit Administration Division shall be responsible for the administration of all Employer-provided health, life insurance, long-term disability and workers’ compensation benefits.
- 2. The Director of the Benefit Administration Division shall be designated the Benefit Plan Administrator and may promulgate rules, policies and procedures to effectuate the Benefit Plan. The Benefit Plan Administrator shall have full and final determination as to all issues concerning eligibility for benefits. The Benefit Plan Administrator shall interpret the Benefit Plan and shall decide interpretation and application of the Benefit Plan.

- B. Benefit Effective and Termination Dates:** The effective and termination dates specified below shall apply to all health benefits, life insurance and supplemental life insurance benefits and all flexible spending accounts.
1. Unless otherwise specified, all benefits shall become effective on the first day of the month following date of hire, rehire, transfer into an eligible job classification, or return from leave of absence where benefits were suspended assuming the employee has submitted the appropriate enrollment forms and documentation in a timely manner.
 2. Subject to various provisions of labor agreements including but not limited to, continuation of medical coverage while on workers' compensation, long-term disability, approved leave due to illness, upon the accidental death of an employee, and eligibility for retiree health and life insurance benefits, all benefits shall be terminated on the last day of the month following a voluntary or involuntary termination of employment, retirement, death, a paid or unpaid leave of absence(s), commencement of a disability or layoff.
- C. Labor Agreements Provisions:** Unless otherwise specified by the applicable collective bargaining agreement or other labor agreement, the provisions of this Benefit Plan, as described in the sections below, shall apply to all eligible employees of the Employer.
- D. Insurance Carrier and Third-Party Administrator Policy Provisions:** Benefits paid under insurance programs or self-funded programs shall be subject to the policy provisions of the insurance carriers or third-party administrative service organizations (TPAs) selected to insure or provide administrative claims service for the various plans.
- E. Choice of Insurance Carriers and Third-Party Administrators:** The present choice of insurance carriers and TPAs does not obligate nor limit the Employer to provide insurance or self-insurance programs with these organizations. The employer reserves the right to select insurance carriers and TPAs for any and all programs cited in this Benefit Plan at its discretion and in accordance with the Wayne County Purchasing Ordinance with sixty (60)-day notice to eligible employees so long as there is no reduction in plan benefits.
- F. Cost-Containment Programs:** The Employer reserves the right to implement health care cost containment programs, for example a prescription drug carve-out program. Said cost-containment programs shall not diminish the levels of benefits provided under this plan but may require the insured to follow procedures prescribed by the carrier in order to be eligible for benefits.

SECTION 3. HEALTH BENEFITS

- A. Hospital and Physician Benefits:** Eligible employees may choose from any of the available health benefit plans outlined below.
- 1. PPO Plan Option**
 - a. The Employer shall make available hospital and physician benefits for each eligible employee and their qualified dependents in a PPO plan option of the Employer's choice with minimum benefit levels as described in Appendix A.
 - b. Employee Contribution Toward Health Plan Cost**
 - i. Active employees enrolled in this PPO plan option will be required to pay fifteen percent (15%) of the applicable monthly illustrative rate or premium.

- ii. The illustrative rates or premiums to be used as a basis for this computation will be those provided by the plan TPA or insurance carrier and published annually for the purpose of the annual policy rate renewal. Rates will become effective on the October first of each year. Published rates shall be made available for review upon written request to the Director of Benefit Administration.
- iii. Contributions will be deducted monthly on a pre-tax basis out of the first two (2) pays of each month in equal amounts. Changes in enrollment resulting in a change in the amount of the contribution and deduction will commence with the first pay of the month following the effective date of the event causing the change or the next pay after notice is given to Benefit Administration of the change, whichever is later.
- iv. In the event that an employee who is eligible and enrolled in any health benefit plan requiring a contribution does not have enough payable time or other income to make those contributions, the contribution amount shall be billed to the employee on a monthly basis. Employees failing to make payment within thirty (30) days of receipt of the bill shall be subject to cancellation of benefits effective on the first of the month for which the contribution is owed. Employees who are unable to make payment due to hardship may make written request to the Director of Benefit Administration to have payments deferred until such time as the employee returns to work, retires or is otherwise separated from employment.
- v. The Employer shall implement a premium-recovery Section 125 plan for providing a pre-tax benefit for active employees contributing towards the monthly cost of health care benefits.

2. HMO Plan Option

- a. The Employer shall make available hospital and physician benefits for each eligible employee and their qualified dependents in an HMO plan option of the Employer's choice with minimum benefit levels as described in Appendix B.
- b. **Employee Contribution Toward Health Plan Cost:** Active employees enrolled in the HMO plan option will be required to pay fifteen percent (15%) of the applicable monthly premium. Contributions will be taken in accordance with the terms and procedures outlined in Section 3(A)(1)(b)(ii) through (v).

3. Traditional Indemnity Plan Option

- a. The Employer shall make available a Traditional Indemnity plan option for each eligible employee and their qualified dependents in a traditional indemnity plan of the Employer's choice with benefit levels as described in Appendix C.
- b. **Employee Contribution Toward Health Plan Cost:** Active employees enrolled in the Traditional Indemnity Plan Option as described in Section 3(A)(3)(a) above will be required to contribute fifteen percent (15%) of the average applicable monthly premium of the health plan options described in Section 3(A)(1)(a) and Section 3(A)(2)(a) plus the monthly rate difference between the average cost of those plans and the Traditional plan. Contributions will be taken in accordance with the terms and procedures outlined in Section 3(A)(1)(b)(ii) through (v).

B. Prescription Drug Benefits

- 1. Unless otherwise specified in this Benefit Plan, the Employer shall provide a prescription drug benefit as described in Appendix D to eligible employees and their qualified dependents that have elected medical benefits in any plan described in Section 3(A).

2. **Employee Contribution Toward Prescription Drug Plan Cost:** Active employees enrolled in prescription drug plan option described in Section 3(B)(1) above will be required to pay fifteen percent (15%) of the applicable monthly illustrative rate or premium. Contributions will be taken in accordance with the terms and procedures outlined in Section 3(A)(1)(b)(ii) through (v).

C. Dental Benefits: The Employer shall provide the following dental plan options that include Class I (diagnostic and preventative services), II (restorative services), III (specialty services including endodontic, prosthodontic, and periodontic services) and IV (orthodontic services) dental benefits for each eligible active employee and their qualified dependents.

1. **Traditional Indemnity Dental Plan Option:** The Employer shall make available a Traditional Indemnity dental plan option as described in Appendix E.
2. **Dental Maintenance Organization (DMO) Dental Plan Option:** The Employer shall make available a DMO dental plan option as described in Appendix F.
3. **Alternate Dental Plan:** The Employer, at its discretion, may make available a dental PPO plan option to be offered to employees.

D. Vision Benefits

1. Optical Reimbursement Program

- a. The Employer shall provide, at its expense, optical reimbursement benefits up to a maximum amount every two (2) years for each eligible employee and each of their qualified dependents. The maximum amount for each active employee shall be one hundred seventy-five dollars (\$175.00) and the maximum amount for each retired employee shall be seventy-five dollars (\$75.00). Retired employees and their legal dependents shall not be entitled to additional seventy-five dollar (\$75.00) reimbursements when changing status from an active employee to a retiree.
- b. Benefits shall be limited to prescription lenses, including contact lenses, eyeglass frames and vision examinations by licensed optometrists, opticians and ophthalmologists. Eligible employees and their qualified dependents may obtain optical services from any licensed optometrist, optician or ophthalmologist.
- c. The optical reimbursement benefit amount will be restored on October first of every odd numbered year.
- d. To receive reimbursement for optical services, the employee must submit to Benefit Administration a completed Optical Reimbursement Form with a paid receipt. The receipt must clearly indicate what items and services were purchased.

2. **Alternative Vision Plan:** The Employer reserves the right to replace the optical reimbursement program with an insured or self-insured plan administered through an insurance carrier or TPA at its discretion. If implemented, benefit limits under the alternate plan shall match or exceed those described in Section 3(D)(1) above.

E. Reduction in Health Benefits Programs: All eligible employees may choose to enroll in the Health Benefit Opt-Out Program instead of the medical coverage provided in Section 3 (A)(1) or its alternatives and prescription drug coverage in provided in Section 3 (B)(1), or waive Employer-sponsored health benefits.

1. Health Benefit Opt-Out Program

- a. Employees who are covered by other health insurance and provide proof of other coverage may choose to opt-out of all medical and prescription drug coverage provided by the Employer. "Other health insurance" means another employer-sponsored plan of group health insurance that provides primary medical coverage to the employee as a spouse of an active employee of another employer or as a retiree of another employer. An employee married to another employee also working for the Employer or retiree of the Employer is not eligible to participate in the Health Benefit Opt-Out Program.
- b. Employees who elect and are eligible to opt out of medical benefits shall receive a cash rebate equal to fifteen percent (15%) of the average annual premium at the applicable coverage tier of the medical plans as described in Section 3(A)(3)(a) and (b). All rules regarding dependent eligibility shall apply.
- c. An employee who wishes to opt-out shall certify to the Employer in writing that he or she is covered by other health insurance. The notice shall include the name of the group health plan, the name of the other employee, in what capacity the employee is covered, and the name of the insurer or payer of the other plan. The Employer's coverage shall terminate as of the end of the month following receipt of the notice.
- d. Once elected in writing by the employee, the opt-out is irrevocable until the next health insurance open enrollment unless the other health coverage is lost.
- e. An employee who loses the other health insurance and wishes to enroll in Employer-sponsored health coverage must certify in writing of the reason why coverage was lost. If an employee is eligible to re-elect Employer coverage due to the loss of other coverage, the employee will automatically be placed in the medical plan of the Employer's choice until the next open enrollment period, unless otherwise agreed by the parties. Following re-enrollment, coverage provided by the Employer shall be effective on the first day of the month following notice to the Employer. Notice of loss of other coverage must be provided to the Employer within thirty (30) days.
- f. Notice is considered received by the Employer upon receipt by Benefit Administration of the appropriate written notice on a form authorized for this purpose by Benefit Administration.
- g. Employees electing to enroll in the Health Benefit Opt-Out Program will receive the cash rebate paid in arrears. The benefit will be paid as a taxable earning in the first pay after October first after having opted out of benefits through September of each year. The gross opt-out earning will be equal to the full rebate amount specified above or the prorated share of the same representing the number of months since October first of the previous year that the employee was eligible for health benefits if less than twelve (12) months.
- h. The implementation of the Health Benefit Opt-Out Program shall be at the sole discretion of the Employer.

2. Waiver of Health Benefits

- a. An employee who is not otherwise qualified to opt out of medical benefits, as described in Section 3(E)(1) above, may elect to waive these benefits. There shall be no cash rebate given for waiving medical benefits in this case.
- b. An employee may choose to waive dental and/or vision / optical benefits for him/herself and his/her dependents. There shall be no cash rebate given for waiving dental or vision/optical benefits.

- c. Employees that elect to waive medical, dental and/or vision benefits must wait until the next health insurance open enrollment period to enroll themselves and their eligible dependents into an available plan(s).

F. Eligible Dependents

1. Spouses

a. Legal Spouses

- i. Legally married employees and retirees, as defined by the laws of the State of Michigan, shall be entitled to enroll their spouses on the plan(s) of participation. The employee shall provide proof of marriage to the Employer.
- ii. Spouses who are eligible for primary medical coverage through another employer shall not be eligible for primary coverage through Wayne County. Failure to provide accurate information to the Employer within thirty (30) days of coverage under the Employer's plan becoming effective for a spouse or the effective date of primary coverage for a spouse may result in disciplinary action up to and including termination. Reasonable premiums, fees and/or claim costs incurred due to this failure will be deducted from the employee's pay by whatever means available to the Employer.

b. Divorce / Ex-Spouses

- i. The ex-spouses of legally divorced employees and retirees shall not be entitled to continuation of benefits other than those benefits required under the Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA) beyond the first of the month following the date of the divorce.
- ii. Failure by the employee to remove an ex-spouse within sixty (60) days of the date of divorce from the employee's health plan by providing appropriate documentation to the Employer will result in disciplinary action up to and including termination. Reasonable premiums, fees and/or claim costs incurred due to this failure will be deducted from the employee's pay by whatever means available to the Employer. Retirees failing to provide documentation of divorce within sixty (60) days of the date of the divorce shall be assessed reasonable premiums, fees and/or claim costs incurred due to this failure.

2. Dependent Children

- a. Dependent children may be covered under the employee's plan(s) of participation until the end of the year in which they have reached age nineteen (19). Dependent children are defined as children by birth, adoption, marriage, guardianship or court order. The employee shall provide proof of dependent status to the Employer.
- b. **Disabled Children:** Permanently disabled/handicapped dependent children over the age of nineteen (19) will be covered, so long as the child meets the terms and conditions of Public Act 275 of 1966 and any other applicable Federal or State statute, and as long as the employee remains eligible for health benefits. It is the employee's responsibility to notify Benefit Administration of the child's disability before the end of the year in which the child reaches the age of twenty-five (25). Proof of permanent disability from a licensed physician shall be required.
- c. **Children Aged 19 to 24:** Dependent children between the ages of nineteen (19) and twenty-four (24), inclusive, who are still the employee's legal dependents may remain enrolled until the end of the

year in which they reach the age of twenty-five (25) only if the employee certifies annually the child's dependent status by notarized affidavit or other means as may be requested by the Employer.

- i. **Full-Time Students:** If the child is a full-time student, actively enrolled in college, university or technical school and provides appropriate documentation from the school's registrar's office or an agent thereof verifying full-time attendance, that child's enrollment will be covered without additional charge to the employee.
 - ii. **Not Full-Time Students:** If the dependent child is not a full-time student, the dependent may continue coverage with a contribution from the employee of one hundred dollars (\$100.00) per month on a pre-tax basis paid by payroll deduction. The contribution will be deducted in equal amounts from the first two (2) pays of each month.
- d. **Children Over Age 25:** Dependent children over the age of twenty-five (25) may be covered under the employee's plan(s) of participation as "sponsored dependents" if that child meets the requirements as set forth in Section 3(G)(3) below.
- e. Failure by the employee to remove a dependent that becomes ineligible for coverage from the employee's health plan within sixty (60) days of the event causing ineligibility by providing appropriate documentation to the Employer will result in disciplinary action up to and including termination. Reasonable premiums, fees and/or claim costs incurred due to this failure will be deducted from the employee's pay by whatever means available to the Employer. Retirees failing to provide documentation of divorce within sixty (60) days of the date of the divorce shall be assessed reasonable premiums, fees and/or claim costs incurred due to this failure.

3. Sponsored Dependents

- a. An employee may cover legal dependents, other than those described in Section 3(G)(1) and (2) above, as sponsored dependents under the employee's medical plan. To be considered for enrollment as a sponsored dependent, the dependent must also have been claimed as a dependent on the employee's most recent federal income tax return, proof of which must be provided upon enrollment of the sponsored dependent and every year thereafter while enrolled.
- b. Sponsored dependents shall not be covered for master medical, dental or vision / optical benefits.
- c. Employee's covering sponsored dependents shall be responsible for one hundred percent (100%) of the monthly cost for this continued coverage. The cost for this coverage will be determined on a sound actuarial basis, consistently applied, using a per-covered-sponsored-dependent approach. The monthly premium cost will be assessed as a payroll deduction.

G. Enrollment

1. New Hires

- a. All new employees and their eligible dependents, with or without prior service with the Employer, shall be enrolled in the plan(s) of the Employer's choice for at least one (1) year. Participation will begin the first of the month following the effective date of active service and will continue for at least one (1) year.
- b. Employees may, after one year in the mandatory plan and during the next available open enrollment period following one (1) year, choose among the various health insurance plans offered by the Employer.

2. **Newly-Acquired Dependents:** Dependents of eligible employees not in existence or not eligible at the time of hire/rehire, such as a new spouse or child, must be enrolled within thirty (30) days of becoming eligible dependents.
3. **Open Enrollment:** An open enrollment for health benefits will be held once each year, during the last quarter of the fiscal year, to allow eligible employees to elect from the available health plans offered by the Employer and to enroll dependents in the employee's plan(s) of participation that were not previously enrolled. Changes made during the open enrollment period shall be effective on the first day of the fiscal year.
4. Health plan enrollees shall be responsible for providing appropriate notice to Benefit Administration, within the specified time period or within a reasonable time if no time period is specified, all information necessary for enrollment or changes in enrollment for the enrollee and his/her qualified dependents.

H. Coordination of Benefits

1. The Employer shall provide only one (1) health care benefit option per employee or dependent. This applies to all coverages (i.e., medical, dental, and vision / optical) provided by the Employer regardless of the source of coverage. An employee who is also the qualified dependent of another active or retired employee of the Employer may not be covered under more than one (1) Employer-sponsored health benefit plan. An employee or retiree married to another employee or retiree covered under this Benefit Plan may elect coverage separate from his/her spouse. In this case that married employees elect separate coverage, however, the eligible dependents will only be covered under one plan, not both.
2. The Employer shall coordinate all health care benefits with the insurance carriers of the employee's covered dependents and/or with Medicare. Employees are required to provide Benefit Administration with current information regarding changes in marital, employment and insurance status including Medicare eligibility and enrollment information.
3. Coordination of benefits under self-funded plans will be conducted under the policy known as "Pursue and Pay."

I. Continuation of Benefits

1. An employee leaving employment with the Employer shall not be entitled to continuation of benefits for him/herself or his/her dependents other than provided under the Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA) beyond the first of the month following separation of service with the Employer.

2. Survivor Health Care Benefits

- a. Surviving dependents shall be defined as the employee's spouse who was legally residing with the employee at the time of death and the employee's legally dependent children.
- b. Survivors of active employees entitled to retiree health care benefits at the time of the employee's death shall be entitled to retiree health care benefits if death occurs after ten (10) years of service or if death occurs in the line of duty.
- c. **Death Occurring in the Line of Duty:** In the event of the death of an employee with less than ten (10) years of service resulting from the performance of his/her duties, the Employer shall provide health benefits for surviving legal dependents if the employee was entitled to the health benefits at the time of death and will continue to provide health benefits for up to three (3) years at the Employer's expense under the provisions of COBRA.

- i. An employee's legal dependents will be determined eligible for these benefits only if survivors qualify for Workers' Compensation as a result of the employee's death.
- ii. Employer-paid coverage will be discontinued upon the remarriage of the employee's spouse if remarriage occurs prior to the completion of the COBRA period. The remarried spouse will maintain rights to continuation of coverage under the provisions of COBRA at their own expense through the remainder of the COBRA period.

SECTION 4. POST-RETIREMENT HEALTH CARE

- A. Active employees, hired on or before the effective date of this Benefit Plan, who are eligible for health care benefits upon retirement shall, upon retirement, participate in the same medical benefit plan options at the same coverage levels, including deductibles and co-payments, as active employees covered under this benefit plan.
 - 1. Eligible retirees shall make monthly contributions towards the cost of medical and prescription drug benefits until the retiree and all covered dependents are eligible for Medicare. If one or more covered members is not eligible for Medicare at the time the first person on the retiree's policy becomes eligible for Medicare, then the applicable monthly rate for the purpose of applying the retiree contribution will be determined by the number of persons remaining on the retiree's health insurance policy who are not eligible for Medicare. For example, a retiree who has a family contract with three (3) members, only one of which is Medicare-eligible, will pay the contribution based on the monthly rate for a two-person policy instead of a family policy.
 - a. **PPO and HMO Plan Contributions:** Retirees electing to enroll in either a PPO or HMO plan option shall be required to make a monthly contribution in the amount of ten percent (10%) of the applicable monthly premium or illustrative rate.
 - i. The illustrative rates or premiums to be used as a basis for this computation will be those provided by the plan TPA or insurance carrier and published annually for the purpose of the annual policy rate renewal. Rates will become effective on first of October of each year. Published rates shall be made available for review upon written request to the Director of Benefit Administration.
 - ii. Contributions shall be assessed in the month prior to the month for which the contribution is being made. Where possible, the contribution amount shall be deducted from the retiree's monthly pension payroll. In situations where there is no pension payroll due to the retiree, the contribution amount shall be billed directly to the retiree. Changes in enrollment resulting in a change in the amount of the contribution will commence with the payment due for the month in which the change becomes effective.
 - iii. Retirees failing to make a payment within thirty (30) days of the contribution being due shall be subject to cancellation of benefits effective on the first of the month for which the contribution is owed. Retirees who are unable to make payment due to hardship may make written request to the Director of Benefit Administration to make alternate payment arrangements.
 - b. **Traditional Plan Contributions:** Retirees electing to enroll in a Traditional Indemnity plan option shall be required to make a monthly contribution in the amount of ten percent (10%) of the average applicable monthly premium of the PPO and HMO plan options plus the monthly rate difference between the average cost of those plans and the Traditional plan option. Contributions will be assessed in accordance with the terms and procedures outlined in Section 4(A)(1)(a)(i) through (iii).

- c. **Prescription Drug Plan Contributions:** Retirees electing to enroll in a prescription drug plan option shall be required to make a monthly contribution in the amount of ten percent (10%) of the applicable monthly premium or illustrative rate. Contributions will be assessed in accordance with the terms and procedures outlined in Section 4(A)(1)(a)(i) through (iii).
 - 2. Employees may elect to permanently waive any rights to retirement health benefits. Once waived, the employee shall not be allowed to regain retirement health benefits at any time during the employee's term of continuous service.
 - 3. Employee electing to permanently waive their rights to retirement health benefits may elect to participate in the Employee Health Care Benefit Trust described in Section 4(B)(a)-(d) below.
- B. The Employer shall establish an Employee Health Care Benefit Trust (Trust) on or after the effective date of this Benefit Plan to be used for the sole purpose of paying for health care expenses post-employment. Employees hired, rehired, reemployed or reinstated on or after the establishment of the Trust shall not be eligible for retirement health care benefits regardless of eligibility for any other retirement benefits.

1. Trust Funding and Vesting

- a. **Employee Contribution:** The Employee shall be required to contribute funds into the Trust on a bi-weekly basis in an amount equal to two percent (2%) of the employee's base wage rate. Funds shall be deducted on a pre-tax basis.
- b. **Employer Contribution:** The Employer shall contribute funds into the Trust on a bi-weekly basis in an amount equal to five percent (5%) of the employee's base wage rate.
- c. All funds contributed by the Employee and the Employer and all investment earnings shall be accounted for on an individual basis.
- d. Employees shall be entitled to receive one hundred percent (100%) of the funds contributed by the Employer at such time as the employee has attained thirty (30) years of credited service. If the employee fails to attain thirty (30) years of credited service, the following terms shall apply.
 - i. Employees with at least ten (10) years of participation in the Trust shall be entitled to one hundred percent (100%) of the employee's own contributions plus fifty percent (50%) of the Employer's contribution including any investment earnings.
 - ii. Employees with more than ten (10) years of participation in the Trust shall be entitled to an additional two and one-half percent (2.5%) of the Employer's contribution including any investment earnings for each full year of participation in the Trust thereafter.
 - iii. Employees with less than ten (10) years of participation in the Trust shall only be entitled to one hundred percent (100%) of the employee's own contributions.
- e. Upon separation from the County, all funds for which the employee is vested as described in Section 4(B)(1)(c) above shall be returned to the employee. Funds distributed to employees may only be used in accordance with the appropriate IRS rules and regulations.
- f. The County shall allow Trust participants who leave County service and who would be otherwise eligible for retirement to enroll in any health insurance plan available to retirees of the County. Trust participants will be responsible for paying the full monthly premium cost or illustrative rate for the plan(s) in which the participant elects to enroll.

2. **Waiver of Participation in Trust:** Employees may elect to waive participation in the Trust as described in Section 4(B)(1) above only under the following conditions.
 - a. Employee must show proof of enrollment in or eligibility for coverage under another group retirement health insurance plan.
 - b. Waiver of participation in the Trust must be in writing.
 - b. Once waived, Employer contributions into the Trust will be discontinued.
 - c. Employee's wishing to resume participation in the Trust may not elect to do so until the first pay of the next fiscal year.

SECTION 5. LIFE INSURANCE

- A. The Employer shall provide, at its expense, for each eligible active employee, group life insurance with volumes set in accordance with the terms and conditions provided in each employee's applicable collective bargaining agreement or other labor agreement; and for each eligible retired employee, group life insurance with a volume of five thousand (\$5,000).
- B. The Employer may make supplemental life insurance available for purchase by employees. The life insurance carrier shall determine the amount of the supplemental life insurance available for any individual and the life insurance policy provisions.

SECTION 6. WORKERS' COMPENSATION

- A. The Employer shall comply with the provisions of the Michigan Workers' Compensation Act.
- B. The Employer may assign job duties to an employee who is receiving workers' compensation benefits that are within the physical ability of the employee to perform.

C. Restricted Duty Positions

1. The Employer may utilize positions for restricted duty assignments for employees receiving workers' compensation benefits.
 - a. **Temporary Restrictions:** The Employer may provide transitional / light duty work assignments to enable employees with temporary duty restrictions to return to work immediately. The Employer will make every effort to reassign work among other employees to accommodate an employee with temporary restrictions.
 - b. **Permanent Restrictions:** The Employer may place an employee with permanent restrictions into a permanent position consistent with the employee's restrictions. If it is not possible to place an employee with permanent restrictions into a permanent position, the Employer will make every effort to place the employee in a restricted duty assignment. The Employer will make every effort to place an employee into a temporary part-time position whenever such a position would be consistent with the employee's restrictions.
2. The Director of Personnel / Human Resources shall have the authority to file a written application for disability retirement on behalf of all employees.

3. If an applicant for disability retirement is disqualified, the Director of Personnel / Human Resources shall have the authority to place the disqualified applicant into a restricted duty position.
- D. Employees who are receiving workers' compensation and who are unable to return to work after eighteen (18) consecutive months of workers' compensation leave shall not be entitled to health benefits or life insurance effective on the first of the month following the expiration of those eighteen (18) months.

SECTION 7. LONG-TERM DISABILITY INCOME PROTECTION PLAN

- A. The Employer shall provide, at its expense, for each eligible active employee a long-term disability (LTD) income protection plan that pays the employee sixty percent (60%) of the employee's gross salary up to a dollar per month maximum as specified in the applicable collective bargaining agreement or other labor agreement for non-work-related injuries and illnesses. An employee, who is otherwise eligible for sick leave, shall qualify for LTD benefits after sixty (60) calendar days of illness or disability or after the use of all sick time, whichever ever occurs last.
- B. LTD benefits shall be administered according to the "County of Wayne, Michigan Long-Term Disability Income Benefit Plan."
- C. Employees receiving LTD benefits must cooperate in efforts to receive treatment and/or rehabilitation for continued benefits under the plan. Failure to cooperate may result in termination of LTD benefits.
- D. Health benefits and life insurance, as described in previous sections, will continue for employees receiving LTD benefits so long as the employee remains actively employed but not for more than eighteen (18) months beginning with the first of the month following the original date of disability. Employees who are receiving LTD benefits and who are unable to return to work after eighteen (18) consecutive months of leave under LTD shall not be entitled to health benefits or life insurance effective on the first of the month following the expiration of those eighteen (18) months.
- E. Payment of workers' compensation benefits precludes payment of benefits under the LTD plan. If long-term disability payments have been made prior to favorable adjudication of a workers' compensation claim, the Employer shall deduct the dollar amount received under the LTD plan during the overlapping disability period for workers' compensation benefits from any future workers' compensation payments.

F. Restricted Duty Positions

1. The Employer may utilize positions for restricted duty assignments for employees receiving LTD benefits.
 - a. **Temporary Restrictions:** The Employer may provide transitional / light duty work assignments to enable employees with temporary duty restrictions to return to work immediately. The Employer will make every effort to reassign work among other employees to accommodate an employee with temporary restrictions.
 - b. **Permanent Restrictions:** The Employer may place an employee with permanent restrictions into a permanent position consistent with the employee's restrictions. If it is not possible to place an employee with permanent restrictions into a permanent position, the Employer will make every effort to place the employee in a restricted duty assignment. The Employer will make every effort to place an employee into a temporary part-time position whenever such a position would be consistent with the employee's restrictions.
2. The Director of Personnel / Human Resources shall have the authority to file a written application for disability retirement on behalf of all employees.

3. If an applicant for disability retirement is disqualified, the Director of Personnel / Human Resources shall have the authority to place the disqualified applicant into a restricted duty position.

SECTION 8. SUPPLEMENTAL / VOLUNTARY BENEFIT PROGRAMS

- A. **Flexible Spending Accounts:** The Employer may, at its option and at its own cost, implement flexible spending accounts (FSA) for eligible expenses incurred by active employees. Accounts may include unreimbursed health care, dependent care, adoption, parking and/or commuter transit assistance during the term of this agreement. The FSA shall comply with Sections 125 and 132 of the Internal Revenue Code, and will provide employees with a voluntary program to achieve income tax savings on unreimbursed qualifying expenses.
- B. The Employer may, at its option, implement supplemental / voluntary employee benefit plans for the purpose of providing a group savings for active employees. Enrollment in these plans will be solely at the employee's discretion and cost. These group plans may include but will not be limited to:
 - a. Cancer Insurance
 - b. Disability Insurance
 - c. Long-Term Care Insurance
 - d. Supplemental Employee and Dependent Life Insurance
 - e. Accidental Death and Dismemberment Insurance
 - f. Pre-Paid Legal Benefits
 - g. Identity Theft Protection & Prevention Benefits
- C. All plans provided for under this section will be administered through Benefit Administration at the discretion of the Director of Benefit Administration.

SECTION 9. RETIREE-SPECIFIC BENEFIT STIPULATIONS

A. Health Benefits

1. The Employer shall continue to provide medical and prescription drug benefits to eligible retirees and their legal dependents. Retired employees shall not be eligible for Master Medical and dental plan benefits unless elected under the provisions of COBRA or purchased through a supplemental / voluntary benefit program.
2. Eligible retired employees shall be entitled to select from available health plans during the annual health care open enrollment period.
3. The Employer reserves the right to modify, amend, replace and/or discontinue any health benefit provisions applicable to retired employees retired prior to the effective date of this Benefit Plan.

B. Eligibility for Health Benefits and Life Insurance

1. Employees in retirement plans #1 through #6 may be eligible for health care benefits and life insurance upon retirement if they have met all the age and service requirements of the applicable retirement plan.
2. All employees hired or rehired on or after December 1, 1990 shall not be eligible for health care benefits and life insurance upon retirement unless they retire with thirty (30) or more years of credited service.

3. Employees, who, on or after December 1, 1990, elect to receive a deferred retirement option upon separation from the Employer's service, shall not be eligible to receive health benefits and life insurance upon normal age and service requirements for a deferred retirement pension.

C. Medicare Coordination of Benefits

1. For eligible retired employees and their covered dependents, eligible for Medicare benefits due to age or disability, all Employer-provided health care benefits shall be coordinated with Medicare.
2. Proof of enrollment in Medicare Parts A and B for each Medicare-eligible retired employee or covered dependent shall be required upon becoming eligible for the same unless proof of enrollment in another group health plan(s) for active employees covering the retired employee and each covered dependent is provided.

3. Failure to Provide Appropriate Documentation:

- h. **Retired Employee:** Retired employees failing to provide documentation as described in Section 9(C)(2) for themselves within ninety (90) days of becoming eligible will have their benefits cancelled for themselves and any covered family member until such time as documentation is provided.
- i. **Covered Dependent(s):** Failure to provide documentation for covered dependents eligible for Medicare Parts A and B within ninety (90) days of dependent becoming eligible will cause that dependent to be cancelled from the County retirement health plan until such time as documentation is provided.
- j. If health benefits are cancelled due to circumstances as described in Section 9(C)(3)(a) or (b) above, health benefits will be reinstated on the first of the month following the date the appropriate documentation is provided.

4. Medicare Part B Premium Reimbursement

- a. The Employer will partially reimburse Medicare Part B premiums for both retired employees and their spouses beginning at age sixty-five (65) if they are enrolled in both Medicare Part A and Medicare Part B and have provided the appropriate documentation of such. Medicare Part B reimbursement shall be no more than twenty-nine dollars and ninety cents (\$29.90) per person per month.
- b. Active employees and their spouses shall not be eligible for Medicare Part B reimbursement.
- c. Employees retiring on or after the effective date of this Benefit Plan and their spouses shall not be eligible for the partial reimbursement of Medicare Part B premiums as described in Section 9(C)(4) above.

D. After-Acquired and Surviving Retiree Dependents

1. After-Acquired Dependents

- a. **Spouse:** If an eligible retired employee marries after retirement, the after-acquired spouse shall be eligible for health care benefits and/or reimbursement for Medicare Part B premiums but only during the lifetime of the retired employee.
- b. **Children:** If an eligible retired employee acquires an additional child(ren) after retirement, the after-acquired child(ren) shall be eligible for health care benefits if the child qualifies as an eligible dependent.

- i. **Single Retirement Option:** If an eligible retired employee has selected a single retirement option, the after-acquired dependent child(ren) shall be eligible for health care benefits but only during the lifetime of the retired employee.
- ii. **Joint Retirement Option:** If an eligible retired employee who has selected a joint retirement option dies, the after-acquired dependent child(ren) shall be eligible for health care benefits only if the child(ren) qualify as a dependent(s) of the retired employee who is eligible for health benefits.

2. Surviving Dependents

- a. **Single Retirement Option:** If an eligible retired employee has selected a single retirement option dies, neither the surviving spouse nor any dependents shall not be eligible for health benefits.
- b. **Joint Retirement Option:** If an eligible retired employee who has selected a joint retirement option dies, the surviving spouse and dependent children shall continue to be eligible for health benefits and/or reimbursement of Medicare Part B premiums. If the surviving spouse remarries, the second spouse shall not be eligible for health benefits or reimbursement of Medicare Part B premiums. If the surviving spouse acquires an additional child(ren) after retirement, the after-acquired child(ren) shall not be eligible for health benefits.

SECTION 10. DISCLAIMERS

- A. This Benefit Plan is not intended to replace the policy, provision, terms and conditions of the insurance companies, health maintenance organizations and third-party administrative service organizations responsible for paying benefits under the various programs specified in this plan.
- B. This Benefit Plan is not intended to replace conflicting provisions of any collective bargaining agreement or other labor agreement.
- C. This Benefit Plan is not intended to replace conflicting provisions of the Wayne County Retirement Ordinance or any other applicable State, Federal and local statutes, laws, ordinances or binding legislative resolutions. This Benefit Plan is to be viewed in conformity with legal precedents.
- D. This Benefit Plan is not intended to be a complete statement or interpretation and application of health, life insurance and related benefits for employees of the Charter County of Wayne, Michigan.

Last Revised On: 2/26/2009

APPENDIX A

PPO MEDICAL PLAN OPTION

The following table describes the essential features of the health benefit plan in general terms. It is not intended to be a full description of coverage. The complete plans are described in the certificate of coverage issued by the plan provider.

Benefit Description	In-Network	Out-of-Network
MEDICAL SERVICES		
Hospital Care (inpatient and outpatient)	Covered at 90% after deductible	Covered at 70% after deductible
Surgical Services	Covered at 90% after deductible	Covered at 70% after deductible
Emergency Medical Services	\$100 copay	\$100 copay
Ambulance	Covered at 90% after deductible	Covered at 70% after deductible
Physician Office; not including vision and hearing)	\$20 copay for general visit	Not covered
Preventative Services (including well-baby care)	Covered at 100%	Not covered
Diagnostic Services	Covered at 90% after deductible	Covered at 70% after deductible
Maternity Services	Covered at 90% after deductible	Covered at 70% after deductible
Alternatives to Hospital Care (skilled nursing, hospice care & home health care)	Covered at 90% after deductible	Covered at 70% after deductible
Human Organ Transplant	Covered at 90% after deductible	Covered at 70% after deductible
Mental Health and Substance Abuse Treatment	Covered at 50% after deductible	Covered at 50% after deductible
Allergy Testing and Therapy	Covered at 100% after deductible	Covered at 70% after deductible
Chiropractic Spinal Manipulation	Covered at 100% after deductible	Covered at 70% after deductible
Outpatient Physical, Speech and Occupational Therapy	Covered at 90% after deductible	Covered at 70% after deductible
Durable Medical Equipment	Covered at 90% after deductible	Covered at 70% after deductible
Prosthetic and Orthotic Appliances	Covered at 90% after deductible	Covered at 70% after deductible
Private Duty Nursing	Covered at 50% after deductible	Covered at 50% after deductible
DEDUCTIBLES & DOLLAR MAXIMUMS		
Annual Deductible	\$100 per member, \$200 per family per year	\$250per member, \$500 per family per year
Annual Copay Dollar Maximums (out-of-pocket maximums)	\$500 per member, \$1,000 per family per year (excluding mental health and private duty nursing services)	\$1,500 per member, \$3,000 per family per year (excluding mental health and private duty nursing services)
Dollar Maximums (benefit caps)	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted above for individual services.	

APPENDIX B

HMO MEDICAL PLAN OPTION

The following table describes the essential features of the health benefit plan in general terms. It is not intended to be a full description of coverage. The complete plans are described in the certificate of coverage issued by the plan provider.

Benefit Description	In-Network	Out-of-Network
MEDICAL SERVICES		
Hospital Care (inpatient and outpatient)	Covered at 100%	Not covered
Surgical Services	Covered at 100%	Not covered
Emergency Medical Services	\$100 copay	\$100 copay
Ambulance	Covered at 100%	Covered
Physician Office Services (including preventative care services; not including vision and hearing)	\$20 copay for general visit	Not covered
Diagnostic Services (including preventative)	Covered at 100%	Not covered
Maternity Services	Covered at 100%	Not covered
Alternatives to Hospital Care (skilled nursing, hospice care & home health care)	Covered according to plan guidelines	Not covered
Human Organ Transplant	Covered according to plan guidelines	Not covered
Mental Health and Substance Abuse Treatment	Covered according to plan guidelines; office visit copay may apply	Not covered
Allergy Testing and Therapy	Covered at 100%	Not covered
Chiropractic Spinal Manipulation	Not covered	Not covered
Outpatient Physical, Speech and Occupational Therapy	Covered according to plan guidelines	Not covered
Durable Medical Equipment	Covered for authorized equipment	Not covered
Prosthetic and Orthotic Appliances	Covered for authorized equipment according to plan guidelines	Not covered
Private Duty Nursing	Covered according to plan guidelines	Not covered
DEDUCTIBLES & DOLLAR MAXIMUMS		
Annual Deductible	None	Not applicable
Annual Copay Dollar Maximums (out-of-pocket maximums)	None	Not applicable
Dollar Maximums (benefit caps)	None	

APPENDIX C

TRADITIONAL INDEMNITY MEDICAL PLAN OPTION

The following table describes the essential features of the health benefit plan in general terms. It is not intended to be a full description of coverage. The complete plans are described in the certificate of coverage issued by the plan provider.

Benefit Description	In-Network	Out-of-Network
MEDICAL SERVICES		
Hospital Care (inpatient and outpatient)	Covered at 100% up to BCBSM approved amount	Covered at 100% up to BCBSM approved amount
Surgical Services	Covered at 100% up to BCBSM approved amount	Covered at 100% up to BCBSM approved amount
Emergency Medical Services	Covered at 100% up to BCBSM approved amount	Covered at 100% up to BCBSM approved amount
Ambulance	Covered at 100% up to BCBSM approved amount	Covered at 100% up to BCBSM approved amount
Physician Office Services (excluding routine/preventative, vision and hearing services)	Covered under Master Medical up to BCBSM approved amount	Covered under Master Medical up to BCBSM approved amount
Well-Baby Care up to age 6	Not Covered	Not Covered
Diagnostic Services (including preventative)	Covered at 100% up to BCBSM approved amount	Covered at 100% up to BCBSM approved amount
Maternity Services	Covered at 100% up to BCBSM approved amount	Covered at 100% up to BCBSM approved amount
Alternatives to Hospital Care (skilled nursing, hospice care & home health care)	Covered at 100% up to plan limits	Covered at 100% up to plan limits
Human Organ Transplant	Covered according to plan guidelines	Covered according to plan guidelines
Mental Health and Substance Abuse Treatment	Covered according to plan guidelines under Basic with additional days under Master Medical	Covered according to plan guidelines under Basic with additional days under Master Medical
Allergy Testing and Therapy	Covered under Master Medical up to BCBSM approved amount	Covered under Master Medical up to BCBSM approved amount
Chiropractic Spinal Manipulation	Covered under Master Medical up to BCBSM approved amount	Covered under Master Medical up to BCBSM approved amount
Outpatient Physical, Speech and Occupational Therapy	Covered according to plan guidelines under Basic with additional days under Master Medical	Covered according to plan guidelines under Basic with additional days under Master Medical
Durable Medical Equipment	Covered under Master Medical up to BCBSM approved amount	Covered under Master Medical up to BCBSM approved amount
Prosthetic and Orthotic Appliances	Covered under Master Medical up to BCBSM approved amount	Covered under Master Medical up to BCBSM approved amount
Private Duty Nursing	Covered under Master Medical up to BCBSM approved amount	Covered under Master Medical up to BCBSM approved amount
DEDUCTIBLES, COPAYMENTS & DOLLAR MAXIMUMS		
Annual Deductible	\$50 per member, \$100 per family per year for Master Medical services	\$50 per member, \$100 per family per year for Master Medical services
Copayment	20% for Master Medical services after deductible has been met	20% for Master Medical services after deductible has been met
Annual Copay Dollar Maximums (out-of-pocket maximums)	\$1,000 per family per year (excluding mental health and private duty nursing services)	\$1,000 per family per year (excluding mental health and private duty nursing services)
Dollar Maximums (benefit caps)	\$1 million lifetime per covered specified human organ transplant type and a separate \$1 million lifetime per member for all Master Medical services and as noted above for individual services.	

APPENDIX D

PRESCRIPTION DRUG PLAN

The following tables describe the essential features of the health benefit plan in general terms. It is not intended to be a full description of coverage. The complete plans are described in the certificate of coverage issued by the plan provider.

For active employees electing medical coverage, the following prescription drug benefit will apply:

Benefit Description	In-Network	Out-of-Network
Generic	\$5	Not covered
Brand-Name Formulary	\$25	Not covered
Brand-Name Non-Formulary	\$40	Not covered
Mail Order	90-day supply: - \$12 generic - \$52 brand-formulary - \$95 brand-non-formulary	Not covered
Annual Copay Dollar Maximums (out-of-pocket maximums)	\$1,500 per member, \$3,000 per family per year	Not applicable
Plan Features	- Mandatory generic program - Mandatory mail order for maintenance drugs - Step-Therapy	

APPENDIX E

TRADITIONAL INDEMNITY DENTAL PLAN OPTION

The following table describes the essential features of the health benefit plan in general terms. It is not intended to be a full description of coverage. The complete plans are described in the certificate of coverage issued by the plan provider.

Benefit Description	At Participating Providers
Diagnostic and Preventative Services	Covered at 100%
Restorative Services	Covered at 100%
Oral Surgery	Covered at 100% when performed by a dentist; covered at 85% when performed by a specialist
Endodontic Services	Covered at 85%
Prosthodontic Care	Covered at 85%
Periodontic Services	Covered at 85%
Orthodontic Services	Covered at 50% to a lifetime maximum of \$1,000 with no age restrictions.
DEDUCTIBLES & DOLLAR MAXIMUMS	
Annual Deductible	None
Annual Benefit Maximum	\$1,000 per calendar year for all services except orthodontic.

APPENDIX F

DMO DENTAL PLAN OPTION

The following table describes the essential features of the health benefit plan in general terms. It is not intended to be a full description of coverage. The complete plans are described in the certificate of coverage issued by the plan provider.

Benefit Description	At Participating Providers
Diagnostic and Preventative Services	Covered at 100%
Restorative Services	Covered at 100%
Oral Surgery	Covered at 100% when performed by a dentist; covered at 85% when performed by a specialist
Endodontic Services	Covered at 85%
Prosthodontic Care	Covered at 85%
Periodontic Services	Covered at 85%
Orthodontic Services	Covered at 100% through age 18; covered at 50% up to a maximum copay of \$1,250 for members age 19 and over.
DEDUCTIBLES & DOLLAR MAXIMUMS	
Annual Deductible	None
Annual Benefit Maximum	None