COUNCIL STUDY SESSION AGENDA

Monday, November 16, 2026
6:00 PM

Albion City Hall
Council Chambers
112 W. Cass Street
Albion, MI 49224

PLEASE TURN OFF CELL PHONES DURING MEETING

I. CALL TO ORDER

II. PLEDGE OF ALLEGIANCE

III. ROLL CALL

IV. ITEMS FOR INDIVIDUAL DISCUSSION

A. Discussion-FY 2027 Budget

B. Discussion - Letter of Understanding between the City of Albion and Albion Command Officers Association, Police Officer Association of Michigan, Albion Department of Public Works (TPOAM), Albion Clerical Alliance
2026 City Manager Memo - BCBS 2027 LOU.pdf
2027 Medical Insurance LOU rev 11.12.26.docx
2027 BCBS 3500-7000 Benefits at a Glance.pdf
2027 BCN 2500-5000 Benefits at a Glance.pdf
BCBS Jeneene Evans email 11-4-2026.png

C. Discussion of 2027 Budget Study Session Dates and Public Hearing
2026 City Manager Memo - 2027 Budget Dates.pdf

V. PUBLIC COMMENTS
(Persons addressing the Council shall limit their comments to no more than three (3) minutes. Proper decorum is required.)

VI. CITY MANAGER REPORT

VII. MAYOR AND COUNCIL MEMBER COMMENTS

VIII. ADJOURN

CITY COUNCIL STUDY SESSION COUNCIL STUDY SESSION

AGENDA ITEM REPORT

Subject:	Discussion - Letter of Understanding between the City of Albion and Albion Command Officers Association, Police Officer Association of Michigan, Albion Department of Public Works (TPOAM), Albion Clerical Alliance
Meeting:	CITY COUNCIL STUDY SESSION COUNCIL STUDY SESSION - November 16, 2026
Department:	City Manager's Department

ATTACHMENTS:

2026 City Manager Memo - BCBS 2027 LOU.pdf
2027 Medical Insurance LOU rev 11.12.26.docx
2027 BCBS 3500-7000 Benefits at a Glance.pdf
2027 BCN 2500-5000 Benefits at a Glance.pdf
BCBS Jeneene Evans email 11-4-2026.png

CITY OF ALBION
Office of The City Manager
Dr. Sheryl L. Theriot

112 West Cass Street ♦ Albion, MI 49224
517.629.7172 ♦ stheriot@cityofalbionmi.gov
www.cityofalbionmi.gov

MEMO

TO: Mayor Snyder and Albion City Council Members
FR: Dr. Sheryl Theriot, City Manager
RE: Approve Letter of Understanding between the City of Albion and Albion Command Officers Association, Police Officer Association of Michigan, Albion Department of Public Works (TPOAM), Albion Clerical Alliance
DA: November 16, 2026

Purpose & Executive Summary

This memorandum accompanies the proposed Letter of Understanding (LOU) entered into between the City of Albion and all four recognized collective bargaining units: the Albion Command Officers Association (ACOA), the Police Officers Association of Michigan (POAM), the Albion Department of Public Works Association (TPOAM), and the Albion Clerical Alliance (ACA).

Faced with steep, unexpected cost increases at our annual renewal, administration engaged union leadership in collaborative negotiations to restructure our health coverage for calendar year 2027. The proposed agreement replaces the current high-cost plan with a modern high-deductible health plan (HDHP), provides an optional HMO alternative, maintains the contractual 90/10 premium cost-share, and continues the City's practice of fully pre-funding employee Health Savings Accounts (HSAs) to mitigate out-of-pocket exposure.

Council approval of this LOU is recommended to preserve fiscal sustainability while honoring our commitment to employee wellness.

Background & Market Realities

During our renewal cycle for the health plan year, the City was informed that maintaining our existing medical plan—**Blue Cross Blue Shield (BCBS) Simply Blue HSA PPO $2,000/$4,000 (0% coinsurance)**—would result in an unsustainable **35.97% premium increase**.

- **Current Monthly Premium (Base Plan):** $100,917.10 (approx. $1.21 million annualized across 63 enrolled contracts).
- **Quoted Renewal Monthly Premium (Same Plan):** $137,216.51 (approx. $1.65 million annualized).
- **Net Projected Increase:** Over **$435,500 annually** if no structural modifications were made.

Under PA 152 of 2011 and existing collective bargaining agreements, health care costs are shared 90% by the City and 10% by employees. An unmitigated 36% jump would have severely strained the General Fund and imposed a burdensome cost hike on employees' monthly paychecks.

Collaborative Negotiations & Plan Design Changes

Recognizing these mutual challenges, City administration initiated discussions with leadership and business representatives across all bargaining units. Through productive, good-faith dialogue, the parties are considering an agreement that controls premium escalation while insulating employees from catastrophic medical expenses.

Effective **January 1, 2027 through December 31, 2027**, the health care structure will be modified as follows:

1. **New Base Plan – BCBS Simply Blue HSA PPO $3,500/$7,000 (Option 3):**
    - **Deductible:** $3,500 single / $7,000 family (with 0% coinsurance after deductible).
    - **Monthly Premium:** $114,841.59 (approx. $1.38 million annualized).
    - **Fiscal Impact:** Reduces the renewal premium by **$22,374.92 per month** (over **$268,000 in annualized premium savings** compared to staying on the old deductible tier).
    - **Embedded Deductible Protection:** Confirmed by Blue Cross Blue Shield of Michigan, this plan incorporates an individual deductible cap of $3,500. No single family member will ever have to satisfy more than $3,500 out-of-pocket before benefits begin paying for that individual, providing vital financial security to covered families.
2. **Voluntary Alternative Plan – Blue Care Network (BCN) $2,500/$5,000 HMO (Option 1):**
    - Employees may elect coverage under a lower-deductible BCN HMO plan during open enrollment, offering greater flexibility for employees who prefer an HMO network model at competitive composite rates.
3. **Maintenance of 90/10 Cost-Sharing:**
    - The City and bargaining units preserve the existing 90% employer / 10% employee premium cost-sharing allocation for the duration of 2027.

City Commitment to Full HSA Funding & Funding Schedule

To offset the increased deductible threshold from $2,000/$4,000 to $3,500/$7,000, the City has committed to **fully funding the increased deductible** for all participating eligible employees into their Health Savings Accounts (HSAs).

- **City Funding Amount:** The City will deposit the full applicable deductible amount ($3,500 for single; $7,000 for family/two-person) to eligible employee HSA accounts.

- **Funding Date (On or before January 15, 2027):** In past years, HSA contributions were released on January 1. Due to January 1, 2027 falling on a Friday immediately preceding a holiday weekend, combined with typical holiday banking processing schedules and the substantial financial and administrative reconciliation involved in issuing expanded contribution levels, the LOU provides that HSA funding will be deposited in one full installment on or before **January 15, 2027**.

- **Separation Clause:** As established in past practice, employees who separate prior to December 31 without fully reimbursing their 10% employee-share advance will have outstanding balances reconciled against their final paycheck.

Alignment with Total Compensation Goals

This negotiated health care solution is a critical piece of the City's broader workforce strategy:

- **Wage Growth Support:** By curbing health premium inflation by over $268,000, the City preserves budgetary capacity to fund planned, competitive workforce wage increases averaging approximately **5%** across departments.
- **Employee Protection:** Rather than passing higher deductible risk directly onto workers, the City's full HSA pre-funding absorbs the out-of-pocket exposure up front, enabling employees to pay qualifying medical expenses tax-free.
- **Future Negotiations:** The LOU explicitly covers calendar year 2027. Health coverage for plan years beginning January 1, 2028 will be renegotiated during successor contract bargaining, and nothing in the LOU waives or impairs the City's statutory rights under PA 152 of 2011 moving forward.

Fiscal Impact

- **Gross Renewal Premium Cost (Old Plan):** $1,646,598
- **Negotiated Premium Cost (New Base Plan):** $1,378,099
- **Gross Premium Savings: $268,499**
- **Net Position:** Even after accounting for the incremental employer HSA funding required to back the higher deductibles, the restructure yields net operational savings, dampens the trajectory of future rate increases, and keeps health benefit costs predictable.

Recommendation
City administration extends its sincere appreciation to the bargaining representatives of ACOA, POAM, TPOAM, and ACA for their collaboration and pragmatic approach to solving a shared financial challenge.

Action Requested: It is respectfully recommended that the Albion City Council approve the 2027 Medical Insurance Letter of Understanding as presented and authorize the City Manager to execute the final agreement.

LETTER OF UNDERSTANDING

BETWEEN

The City of Albion

AND

Albion Command Officers Association
Police Officer Association of Michigan
Albion Department of Public Works Association (TPOAM)
Albion Clerical Alliance

This Letter of Understanding is entered into by the parties in response to the significant and unanticipated increases in health insurance premiums recently experienced by the City and its employees. The parties share a mutual interest in addressing these rising costs while maintaining comprehensive and sustainable health care coverage for employees. Accordingly, following discussions and in recognition of the need to address these challenges collaboratively, the parties agree as follows:

1. Beginning with the plan year effective January 1, 2027, the current health care coverage plan offered to City employees, i.e. BCBS Simply Blue HSA PPO 2000/4000, will be discontinued and replaced with BCBS Simply Blue HSA PPO 3500/7000, as detailed in the Benefits-at-a-Glance, Attachment 1.

2. As an alternative to the BCBS Simply Blue HSA PPO 3500/7000 plan, employees may, at their option, elect coverage under a Blue Care Network 2500/5000 deductible plan at open enrollment. The alternative Blue Care Network plan is detailed in the Benefits-at-a-Glance, Attachment 2.

3. The City shall continue to provide HSA contributions for 2027 in a manner consistent with its past practice, i.e. full funding in January. The City shall fund the full applicable increased deductible for each eligible employee by contributing funds to their Health Savings Account (HSA) in one installment on or before January 15, 2027. Newly hired employees in each bargaining unit shall likewise continue to receive HSA funding in accordance with the funding practices applicable during the current term of the respective Collective Bargaining Agreement.

4. If an employee separates from employment before December 31 of the calendar year and has therefore not fully repaid the 10% portion of the employee's HSA funding advanced by the City, the outstanding balance shall become immediately due and payable. The City is expressly authorized to deduct the outstanding balance from the employee's final pay. To the extent the outstanding balance exceeds the amount available for deduction from the employee's final pay, the employee shall remain responsible for repayment of the remaining balance.

5. All other existing terms of the applicable Collective Bargaining Agreements shall continue in effect, including but not limited to the 90% employer, 10% employee cost sharing allocation.

6. The health care coverage detailed in Attachment 1 (or the option detailed in Attachment 2, if elected) and the 90%/10% cost sharing allocation shall remain in effect for all collective bargaining unit employees until December 31, 2027. Health care coverage for the plan year beginning January 1, 2028 shall be subject to negotiations between the City and each bargaining unit in negotiations for their successor collective bargaining agreement(s). Nothing in this Letter of Understanding shall be construed to waive or otherwise impair the City's rights under PA 152 of 2011 beginning effective January 1, 2028, including its authority to determine and implement health care cost-sharing allocations in accordance with the Act.

FOR THE CITY

Sheryl Theriot
City Manager

Date

Victoria Garcia-Snyder
Mayor

Date

Jill Domingo
City Clerk

Date

FOR THE ALBION COMMAND OFFICERS ASSOCIATION

Bill Timmons
ACOA

Date

Harry Valentine
Business Representative

Date

[remainder of signatures on following pages]

FOR THE POLICE OFFICERS ASSOCIATION OF MICHIGAN

Aaron Reynolds
POAM

Date

Eric Ronewicz
POAM

Date

FOR THE DEPT. OF PUBLIC WORKS ASSOCIAITION

David Dillard
POAM

Date

Eric Ronewicz
TPOAM

Date

FOR THE ALBION CLERICAL ALLIANCE

Eric Tobin
ACA

Date

Luke Silver
Business Agent

Date



CITY OF ALBION
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Simply Blue℠ HSA PPO with Rx Embedded Cost-Sharing LG
Effective Date: On or after October 2026
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. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Prior authorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, receive prior authorization 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.

Prior authorization 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 prior authorization of the drugs. **If prior authorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

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

Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children**: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26

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

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

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** Two or more members must meet the family deductible. If the one-member deductible has been met, but not the family deductible, we will pay for covered services only for that member who has met the deductible. Covered services for the remaining family members will be paid when the full family deductible has been met.	$3,500 for one member or $7,000 for the family (when two or more members are covered under your contract) each calendar year **(no 4th quarter carry-over)**	$7,000 for one member or $14,000 for the family (when two or more members are covered under your contract) each calendar year **(no 4th quarter carry-over)**
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.	None	20% of approved amount for most covered services
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$6,900 for one member, $13,800 for the family (when two or more members are covered under your contract) each calendar year	$13,800 for one member, $27,600 for the family (when two or more members are covered under your contract) each calendar year
Lifetime dollar maximum	None	

Preventive care services

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

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

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary **Note: Virtual Primary Care** visits by a non-BCBSM selected vendor are not covered.	• 100% after in-network deductible for each office visit (in person or virtual) • 100% after in-network deductible for each **virtual primary care** visit for members 18 years of age or older, by a BCBSM-selected vendor	80% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	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
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

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

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care **Note:** For facility services See "Hospital Care"	100% after in-network deductible	80% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible Unlimited days	80% after out-of-network deductible
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	100% after in-network deductible Limited to a maximum of 90 days per member per calendar year	100% after in-network deductible
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
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 prior authorization - consult with your doctor	100% after in-network deductible	100% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	100% after in-network deductible	80% after out-of-network deductible

Human organ transplants

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

Behavioral Health Services (Mental Health and Substance Use Disorder)

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

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - subject to prior authorization **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	100% after in-network deductible	80% after out-of-network deductible **Note:** Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.

Benefits	In-network	Out-of-network
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a **combined** 12-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 30-visit maximum per member per calendar year	
Durable medical equipment **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **Note:** DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	100% after in-network deductible	80% after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	100% after in-network deductible	80% after out-of-network deductible
Private duty nursing care	100% after in-network deductible	80% after out-of-network deductible

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

CITY OF ALBION
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0070034430004
Simply Blue℠ HSA PPO with Rx Embedded Cost-Sharing LG
Effective Date: On or after October 2026
Benefits-at-a-glance

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

Specialty Pharmaceutical Drugs - The preferred pharmacy for specialty drugs is **Walgreens Specialty Pharmacy**. Specialty drugs are covered only when dispensed through the Walgreens Specialty Pharmacy or through a participating Walgreens retail pharmacy, as long as the drug is available at that location. You may want to call ahead to confirm availability. **If you don't use Walgreens Specialty Pharmacy or a participating Walgreens retail pharmacy, you may be responsible for the full cost of the medication.**

A list of specialty drugs is available on our website at **bcbsm.com/pharmacy**. Click What are specialty drugs, then click Specialty Drug Program Rx Benefit Member Guide. The guide is updated monthly.

If you have additional questions, you can 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 Blue Cross defines as a "specialty pharmaceutical". We may make exceptions if a member requires more than a 30-day supply. Blue Cross reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay or coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

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

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until 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 following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum

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

Benefits		90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Generic or select prescribed over-the-counter 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

206050%CRXCMLG;ADM PLANYR OCT;BLUE VISION;BVFL;BVPP CHOICE NET;HSADOPME$69KLG;SBD HSA-E LG;SBD-HSA-EA-1 LG;SBDHSA-D-E3500;SBDHSAC0IN20ONL

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Benefits		90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	31 to 83-day period	No coverage	After deductible is met, you pay $40 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay	No coverage	No coverage
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 83-day period	No coverage	After deductible is met, you pay $120 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $120 copay	After deductible is met, you pay $120 copay	No coverage	No coverage
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 copay 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 83-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
	84 to 90-day period	After deductible is met, you pay $160 or 50% of the approved amount (whichever is greater), but no more than $200	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
Generic specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** After deductible is met, you pay $20 copay **Note:** No coverage for 31-90 day supply.			
Preferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** After deductible is met, you pay $60 copay **Note:** No coverage for 31-90 day supply.			
Nonpreferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** After deductible is met, you pay $80 or 50% of the approved amount (whichever is greater), but no more than $100 **Note:** No coverage for 31-90 day supply.			

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

Covered services				
Benefits	**90-day retail network pharmacy**	**In-network mail order provider***	**In-network pharmacy (not part of the 90-day retail network)**	**Out-of-network pharmacy**
FDA-approved drugs	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
Prescribed over-the-counter drugs - when covered by BCBSM	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
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	80% of approved amount
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs 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

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Benefits	90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **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 plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

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

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Generic drug tier** - This tier includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Preferred brand-name drug tier** - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive then generic and members pay more for them. • **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs.
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. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require prior authorization or step therapy are available online site at **bcbsm.com/pharmacy.**
Maximum allowable cost drugs	For maximum allowable cost (MAC) Drugs, if you have a prescription filled by an in-network pharmacy, and the pharmacist fills it with a generic equivalent drug, you are required to pay only the copayment and/or deductible, if applicable. If you obtain a brand name drug when a generic equivalent drug is available, you must pay the difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug plus your copayment and/or deductible, if applicable. **Note:** If your physician requests and receives authorization for a brand name drug from BCBSM's Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your copayment and/or deductible, if applicable.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Blue Cross Blue Shield of Michigan

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CITY OF ALBION
A1VYD4
0070034430004
Vision Coverage
Effective Date: On or after October 2026
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. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance ***plus*** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
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

Benefits	VSP network doctor	Non-VSP provider
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 $45 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

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Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
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.	$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, in any period of 12 **consecutive** months	
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 $70 less $10 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
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)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	
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)	$105 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 up to the allowance in any period of 12 **consecutive** months	

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



Benefits-at-a-Glance
High Deductible Health Plan
00115149 CITY OF ALBION
0001/0001
Effective Date: 10/01/2026

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

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

Note: A list of services that require approval **before** they are provided is available online at **https://bcbsm.com/priorauth**.

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

Benefits	
Deductible **Note:** The Deductible will apply to all services except preventive services	$2,500 per member/$5,000 per family per calendar year (no 4th quarter carry-over)
The deductible is combined for both medical and prescription drug coverage.	The deductible is aggregate. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.
Coinsurance **Note:** Coinsurance applies once the deductible has been met	50% for select services as noted below
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$4,000 per member/$8,000 per family per calendar year The out-of-pocket maximum is aggregate. For a two-person or family contract, one person on the contract can meet the entire family out-of-pocket maximum.

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%

Preventive services (continued)

Benefits	
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits	100% after deductible
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor **Note:** Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	100% after deductible
Referral Physician Visits	100% after deductible

Emergency medical care

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

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100% after deductible
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% after deductible

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care	100% after deductible

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery	100% after deductible

Alternatives to hospital care

Benefits	
Skilled Nursing Care	100% after deductible Up to 45 days per calendar year
Hospice Care	100% after deductible
Home Health Care	100% after deductible

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	100% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	50% after deductible
Elective Abortion Services	50% after deductible
Elective Abortion Coverage Limit	Limited to one procedure per two-year period of membership. **Note:** Abortions are not covered if rendered in a location where abortion is not legal.
Human Organ Transplants (subject to medical criteria)	100% after deductible
Reduction Mammoplasty (subject to medical criteria)	50% after deductible
Male Mastectomy (subject to medical criteria)	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	50% after deductible

Behavioral health services (mental health and substance use disorder treatment)

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

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC)	100% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	100% after deductible
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other services

Benefits	
Allergy Testing and Therapy	100% after deductible
Allergy Injections	100% after deductible
Chiropractic Spinal Manipulation - when referred	100% after deductible Limited to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	100% after deductible Limited to 60 visits per calendar year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	50% after deductible (excludes in-vitro fertilization)
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies **Note:** Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	100% after deductible
Hearing Aid	Not Covered

Prescription drugs

Benefits	
Preferred Generic Tier	$10 copay after deductible
Nonpreferred Generic Tier	$30 copay after deductible
Preferred Brand Tier	$60 copay after deductible
Nonpreferred Brand Tier	$80 copay after deductible
Preferred Specialty Tier	20% coinsurance (max $200) after deductible
Nonpreferred Specialty Tier	20% coinsurance (max $300) after deductible
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic- $30 copay after deductible, Preferred Brand- $60 copay after deductible, Non-Preferred Brand - $80 copay after deductible
Drugs for the Treatment of Sexual Dysfunction	50% coinsurance after deductible
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay/coinsurance, 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10 after deductible.

Prescription drugs (continued)

Benefits	
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Custom Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require prior authorization and/or step therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only
Benefits Selected - HDHPLG : 2500HD,4KOMHD,90D3X,P136HD,VACR50

From: Evans, Jeneene <JEvans@BCBSM.com>
Sent: Wednesday, November 4, 2026 7:48 AM
To: Mike Tymkew <mtymkew@sassetmgmt.com>
Subject: RE: insurance question

Mike,

No one person can exceed the single $3500 deductible. But as a family, once in total the $7000 is reached, the plan will start to pay for the family. It would not go beyond the $7000. It just caps at $3500, for an individual if they hit that. Then everyone continues to accumulate towards the reminder of the next $3500. It could be met by one person or combination of 3.

Note: Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage.
Note: Two or more members must meet the family deductible. If the one- member deductible has been met, but not the family deductible, we will pay for covered services only for that member who has met the deductible. Covered services for the remaining family members will be paid when the full family deductible has been met.

I hope this helps.

Jeneene



Jeneene Evans
Client Engagement Manager
West Michigan Region
Blue Cross Blue Shield of Michigan

phone: 616-494-6602
cell: 231-557-3142
email: Jevans@bcbsm.com

CITY COUNCIL STUDY SESSION COUNCIL STUDY SESSION

AGENDA ITEM REPORT

Subject:	Discussion of 2027 Budget Study Session Dates and Public Hearing
Meeting:	CITY COUNCIL STUDY SESSION COUNCIL STUDY SESSION - November 16, 2026
Department:	City Manager's Department

ATTACHMENTS:

2026 City Manager Memo - 2027 Budget Dates.pdf

CITY OF ALBION
Office of The City Manager
Dr. Sheryl L. Theriot

112 West Cass Street ♦ Albion, MI 49224
517.629.7172 ♦ stheriot@cityofalbionmi.gov
www.cityofalbionmi.gov

MEMO

TO: Mayor Snyder and Albion City Council Members
FR: Dr. Sheryl Theriot, City Manager
RE: 2027 Budget Study Sessions and Budget Hearing
DA: November 16, 2026

City Council is requested to approve the following Study Sessions at 6:00pm:

11/16 - Budget Study Session
11/30 - Budget Study Session
12/01 - Budget Study Session

And to approve scheduling and publication of the following dates for the Public Budget Hearing and Adoption of the 2027 Budget:

12/14 - Public Budget Hearing (special session) – 6:00pm
12/21 - Adoption of Budget