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# **THE VILLAGE OF TINLEY PARK**

**Cook County, Illinois**

**Will County, Illinois**

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## **RESOLUTION NO. 2020-R-132**

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**A RESOLUTION APPROVING A COLLECTIVE BARGAINING  
AGREEMENT WITH THE METROPOLITAN ALLIANCE OF POLICE,  
TINLEY PARK CHAPTER #192 REPRESENTING PATROL OFFICERS**

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**JACOB C. VANDENBERG, PRESIDENT  
KRISTIN A. THIRION, VILLAGE CLERK**

**CYNTHIA A. BERG  
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Board of Trustees**

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Published in pamphlet form by authority of the President and Board of Trustees of the Village of Tinley Park  
Peterson, Johnson, & Murray Chicago, LLC, Village Attorneys  
200 W. Adams, Suite 2125 Chicago, IL 60606

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Will County, Illinois

**RESOLUTION NO. 2020-R-132**

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TINLEY PARK CHAPTER #192 REPRESENTING PATROL OFFICERS**

**WHEREAS**, Section 6(a) of Article VII of the 1970 Constitution of the State of Illinois provides that any municipality which has a population of more than 25,000 is a home rule unit, and the Village of Tinley Park, Cook and Will Counties, Illinois, with a population in excess of 25,000 is, therefore, a home rule unit and, pursuant to the provisions of said Section 6(a) of Article VII, may exercise any power and perform any function pertaining to its government and affairs, including, but not limited to, the power to tax and to incur debt; and

**WHEREAS**, the Village of Tinley Park ("Village") has considered entering into a successor Collective Bargaining Agreement with its Patrol Officers represented by the Metropolitan Alliance of Police, Tinley Park Chapter #192; and

**WHEREAS**, a true and correct copy of said Collective Bargaining Agreement is attached hereto as Exhibit 1; and

**WHEREAS**, the Corporate Authorities of the Village of Tinley Park, Cook and Will Counties, Illinois have determined that it is in the best interest of said Village of Tinley Park and its residents to enter into said Agreement with the Metropolitan Alliance of Police; and

**NOW, THEREFORE, BE IT RESOLVED** BY THE PRESIDENT AND BOARD OF TRUSTEES OF THE VILLAGE OF TINLEY PARK, COOK AND WILL COUNTIES, ILLINOIS, STATE AS FOLLOWS:

**SECTION 1:** The foregoing recitals shall be and are hereby incorporated as finding of fact as if said recitals were fully set forth herein.

**SECTION 2:** That this President and Board of Trustees of the Village of Tinley Park hereby find that it is in the best interest of the Village and its residents that the aforementioned Agreement between the Village and Metropolitan Alliance of Police, Tinley Park Chapter #192 as set forth in Exhibit 1, be entered into and the Village President is hereby authorized to execute and memorialize said Agreement, subject to review and revision as to form by the Village Attorney.

**SECTION 3:** Any policy, resolution, or ordinance of the Village that conflicts with the provisions of this Resolution shall be and is hereby repealed to the extent of such conflict.

**SECTION 4:** That this Resolution shall be in full force and effect from and after its adoption and approval.

**SECTION 5:** That the Village Clerk is hereby ordered and directed to publish this Resolution in pamphlet form, and this Resolution shall be in full force and effect from and after its passage, approval, and publication as required by law.

PASSED THIS 15<sup>th</sup> day of December, 2020.

AYES: **Berg, Brady, Brennan, Galante, Glotz, Mueller**

NAYS: **None**

ABSENT: **None**

APPROVED THIS 15<sup>th</sup> day of December, 2020.

ATTEST:

  
VILLAGE CLERK

  
VILLAGE PRESIDENT

# **Exhibit 1**

**COLLECTIVE BARGAINING AGREEMENT**

**WITH THE**

**METROPOLITAN ALLIANCE OF POLICE,**

**TINLEY PARK CHAPTER #192**

**REPRESENTING PATROL OFFICERS**

**THROUGH APRIL 30, 2024**

# **AGREEMENT**

**BETWEEN VILLAGE OF**

**TINLEY PARK AND**

**METROPOLITAN ALLIANCE OF POLICE,  
TINLEY PARK POLICE CHAPTER #192**

**Through April 30, 2024**

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## **PREAMBLE**

This Agreement is entered into by and between the VILLAGE OF TINLEY PARK (hereinafter called the "Village") and the METROPOLITAN ALLIANCE OF POLICE TINLEY PARK CHAPTER #192 (hereinafter called the "Union", or the "Chapter").

This Agreement has as its purpose the promotion of harmonious relations between the Village and the Chapter; the establishment of an equitable and peaceful procedure for the resolution of differences; and the establishment of rates of pay, hours of work and other conditions of employment. It is the intention of this Agreement to provide, where not otherwise mandated by statute, for the salary structure, fringe benefits and employment conditions of the police officers covered by this Agreement, to prevent interruptions of work and interference with the efficient operation of the Police Department, and to provide an orderly and prompt method for handling and processing of grievances;

THEREFORE, the parties agree with each other as follows:

## **ARTICLE I**

### **RECOGNITION AND REPRESENTATION**

The Village recognizes the Union as the sole and exclusive bargaining agent for all probationary and non-probationary Patrol Officers employed by the Police Department of the Village, excluding all department employees of the rank of Sergeant and above and all other Police Department employees and all other employees employed by the Village.

Probationary Patrol Officers shall be covered by the conditions set forth in this Agreement; provided, however, that any disciplinary actions, including suspensions or discharge, shall not be subject to the grievance and arbitration procedure set forth herein.

Whenever the male gender is used in this Agreement, it shall be construed to include male and female employees covered by this Agreement.

## **ARTICLE II**

### **NO DISCRIMINATION**

In accordance with applicable legislation, neither the Village nor the Chapter shall discriminate against any employee in a manner prohibited by law because of race, creed, color, national origin, sex, or union membership or activity.

Any alleged violation of this Article may be processed through Step 4 of the grievance procedure, but no further. Nothing herein shall be construed as a waiver or relinquishment of any employee's right to file any commission or court charge or suit.

## **ARTICLE III**

### **GRIEVANCE PROCEDURE**

#### **Section 3.1. Definition of Grievance.**

A grievance is a difference of opinion between an employee or the Chapter and the Village with respect to the meaning or application of the express terms of this Agreement, or with respect to the inequitable application of rules applicable to the Police Department which may be in effect from time to time.

#### **Section 3.2. Chapter Representation.**

The Chapter shall appoint an Employee Committee of not more than two (2) members to attend grievance meetings scheduled pursuant to Steps 3 and 4. The Chapter may appoint three (3) Stewards to participate in the grievance procedure to the extent set forth in Step 2 of the grievance procedure. The Chapter shall notify the Village Manager in writing of the names of employees serving on the Employee Committee and as Stewards.

#### **Section 3.3. Grievance Procedure.**

Recognizing that grievances should be raised and settled promptly, a grievance must be raised within seven (7) calendar days of the occurrence of the event giving rise to the grievance.

Step 1: Written to Immediate Supervisor. An aggrieved employee, (or a Steward or Union officer on behalf of the Chapter), shall file a written grievance signed by the employee on a form provided by the Village setting forth the nature of the grievance and the contract provision(s) involved. The immediate supervisor shall respond in writing within seven (7) calendar days of this discussion.

Step 2: Appeal to Commander. If the grievance is not settled in Step 1, the Employee Committee may, within seven (7) calendar days following receipt of the immediate supervisor's answer, forward the grievance to the Commander. The Commander, or whomever is the employee's next immediate supervisor in the Department's chain of command, shall give a written answer within seven (7) calendar days after receipt of the written grievance.

Step 3: Appeal to Chief. If the grievance is not settled in Step 2, the aggrieved employee, the Employee Committee may, within seven (7) calendar days from receipt of the Step 2 answer, appeal in writing to the Chief. The Employee Committee and the Chief will discuss the grievance at a mutually agreeable time, within seven (7) calendar days of the Chief's receipt of the grievance. If no agreement is reached in such discussion, the Chief will give his answer in writing, within seven (7) calendar days of the discussion. The Village may join the Step 3 and Step 4 meetings if it so desires, by having in attendance both the Chief and the Village Manager or his designee.

Step 4: Appeal to Village Manager. If the grievance is not settled in Step 3 the aggrieved employee, the Employee Committee may, within seven (7) calendar days after receipt of the Step 3 answer, file a written appeal to the Village Manager. A meeting between the Village Manager, or his designee, and the Employee Committee will be held at a mutually agreeable time within seven (7) calendar days of the Village Manager's receipt of the grievance. If no settlement is reached at such meeting, the Village Manager or his designee shall give his answer in writing within ten (10) calendar days of the meeting.

Step 5: Grievance Arbitration. If the grievance is not settled in accordance with the foregoing procedure; the aggrieved employee, the Employee Committee may appeal the grievance to arbitration by notifying the Village Manager within ten (10) calendar days after receipt of the Village's answer in Step 4. Within ten (10) calendar days of receipt of such request, the Chapter and the Village shall jointly submit the dispute to the Federal Mediation and Conciliation Service (FMCS) and request a panel of arbitrators, each of which shall be a member of the National academy of Arbitrators. If upon receipt of a panel of arbitrators from FMCS, the parties cannot agree on the selection of an arbitrator, the arbitrator shall be selected by having each party strike the name of an arbitrator from the panel until only one remains. First strike shall be determined by a coin toss. Each party retains the right to reject one panel in its entirety, and to request that a new panel be submitted. The arbitrator shall fix the time and place of the hearing, which shall be as soon as possible after his selection, subject to the reasonable availability of Chapter and Village representatives. The arbitrator shall have no right to amend, modify, nullify, ignore, add to or subtract from the provisions of the agreement.

He shall consider and decide only the specific issue submitted to him in writing and shall have no authority to make any decision or recommendation on any other issue not so submitted to him. The arbitrator's decision shall be based solely upon his interpretation of the meaning or application of the specific terms of this agreement to the facts of the grievance presented. The arbitrator shall submit his decision in writing within thirty (30) days following the close of the hearing or submission of briefs by the parties. The decision of the arbitrator shall be binding on the parties. The fees of the arbitrator and that of a court reporter, if requested by either party, shall be divided equally between the Board and the Chapter. All other expenses shall be borne by the party incurring them.

Section 3.4. Time Limits.

No grievance shall be entertained or processed unless it is filed within the time limits set forth above. If a grievance is not appealed within the time limits for appeal set forth above, it shall be deemed settled on the basis of the last answer of the Village, provided that the parties may agree to extend any time limits. If the Village fails to provide an answer within the time limits so provided, such failure to answer shall constitute a proper denial of the grievance on the date the answer was last due and the Association may immediately appeal to the next Step or forego further processing of the grievance.

Section 3.5. Investigation and Discussion.

All grievance discussions and investigations shall take place in a manner which does not interfere with Village operations and at a time when the Grievant and the Steward or other Chapter representative(s) involved are not being compensated by the Village.

Representatives of the Chapter, previously accredited to the Village in writing by the Chapter, shall be permitted to come on the premises of the Village for the purposes of investigating and discussing grievances if they first obtain permission from the Village Manager or his designated representative; such visits shall not interfere with normal Village operations and such permission shall not unreasonably be denied.

### Section 3.6. Civil Service Commission.

It is understood that matters subject to the jurisdiction of the Civil Service Commission such as certification, promotion, discharge, disciplinary suspension of more than five (5) days or a second suspension within any six (6) month period, all as per 65 ILCS 5/10-1-18, are not subject to this grievance procedure.

### Section 3.7 Application of Grievance and Arbitration Procedure to Discipline

No discipline shall be administered without just cause. An Officer who is charged with a disciplinary infraction, or issued discipline, where the penalty may result in termination or suspension has the option of appealing such disciplinary action either before the Civil Service Commission or through the grievance procedure set forth in Section 3.3 above and subject to the procedure described below. An Officer must notify the Village within ten (10) days of receiving written notice of the charge(s) against him or her whether he or she will seek review of the imposed discipline through the grievance procedure or through the Civil Service Commission procedures.

If the Officer elects to appeal the discipline through the arbitration procedure in section 3.3, the following will apply:

1. Notice of intent to appeal will be filed with the Village Manager within ten (10) days of receiving written notice of disciplinary action.
2. The Officer and the Village may agree to extend the time period in which an Officer may file an appeal provided the extension agreement is in writing.
3. The Union and the Village will jointly request a panel of arbitrators from the Federal Mediation and Conciliation Service (FMCS). If upon receipt of a panel of arbitrators from FMCS, the parties cannot agree on the selection of an arbitrator, the arbitrator shall be selected by having each party strike the name of an arbitrator from the panel until only one

remains. First strike shall be determined by a coin toss. Each party retains the right to reject one panel in its entirety, and to request that a new panel be submitted.

4. The arbitrator shall fix the time and place of the hearing, which shall be as soon as possible after his or her selection, subject to the reasonable availability of all parties.
5. Each party shall be afforded the opportunity of an oral argument or briefs, and, as needed supporting witnesses before the arbitrator.

6. Either party may request the opportunity to submit a post-hearing brief to the arbitrator. However, no party shall submit a brief without the agreement of the other. An arbitrator's award shall be final and binding, and any request for judicial review shall be exclusively under and in accordance with the Uniform Arbitration Act (710 ILCS 5/1, et seq.) and Section 8 of the Illinois Public Labor Relations Act (5 ILCS 315/8).

### Section 3.8 Counseling Forms

Officers will be advised and provided a copy of all counseling forms completed by Management and made aware of the deficiency no later than 3 days of issuance of the counseling form.

## **ARTICLE IV**

### **NO STRIKES/NO LOCKOUTS**

During the term of this Agreement, the Chapter, its officers and agents, and the employees covered by this Agreement agree not to instigate, promote, sponsor, engage in or condone any strike, sympathy strike, slowdown, speed-up, blue-flu or other concerted stoppage of work, or any other intentional interruption of operations or other concerted refusal to obey lawful orders of the Chief or other appropriate Village representatives. Any, a few, some or all employees who violate any of the provisions of this Article may be discharged or otherwise disciplined by the Village, at the discretion of the Village. The Village will not lock out any employees during the term of this Agreement as a result of a labor dispute with the Chapter.

## **ARTICLE V**

### **MANAGEMENT RIGHTS**

The Village shall retain the sole right and authority to operate and direct the affairs of the Village and the Police Department in all its various aspects, including, but not limited to, all rights and authority exercised by the Village prior to the execution of this Agreement, except as modified in this Agreement. Among the rights retained is the Village's right to determine its mission and set standards of service offered to the public; to direct the working forces; to assign overtime; to plan, direct, control and determine the operations or services to be conducted in or at the Police Department or by employees of the Village; to assign and transfer employees; to hire, promote, demote, suspend, discipline, or discharge for just cause, or relieve employees due to lack of work or for other legitimate reasons, subject to the statutory jurisdiction of the Civil Service Commission; to make and enforce reasonable rules and regulations; to train employees; to subcontract work; and, to change methods, equipment or facilities; provided, however, that the exercise of any of the above rights shall not conflict with any of the specific provisions of this Agreement.

## **ARTICLE VI**

### **SENIORITY**

#### **Section 6.1. Definition.**

For purpose of this Agreement, seniority shall be defined as an employee's length of continuous full-time service since the employee's last date of hire excluding time off due to layoff or any other unpaid leave of absence which exceeds thirty (30) consecutive days of absence unless otherwise agreed by the Village.

Section 6.2. Seniority List.

The Village shall maintain a current seniority list. This list shall be made available to the Chapter within 30 days after the execution of this Agreement. Any alleged error in the list must be brought to the attention of the Chief of Police within 30 days after the list has been made available to the Union.

Section 6.3. Termination of Seniority.

Seniority and employment shall be terminated when an employee:

- 6.3.1 quits; or
- 6.3.2 is discharged for cause; or
- 6.3.3 is absent for three (3) consecutive days without authorization by the Village; or
- 6.3.4 is laid off for a period in excess of twenty-four (24) months, or length of seniority whichever occurs first; or
- 6.3.5 is laid off and fails to report to the Village his intention to return to work within seven (7) calendar days after recall and to report for duty within two weeks after recall; or
- 6.3.6 does not report to work within seventy-two (72) hours after the termination of an authorized leave of absence; or
- 6.3.7 retires or is retired.

**ARTICLE VII**

**HOLIDAYS, VACATIONS AND LEAVES OF ABSENCE**

Section 7.1. Holidays.

During the term of this Agreement, there shall be eleven paid holidays, as follows:

|                       |                               |
|-----------------------|-------------------------------|
| New Year's Day        | Thanksgiving Day              |
| Good Friday (1/2 Day) | Friday After Thanksgiving Day |
| Memorial Day          | Christmas Eve (1 day)         |

Fourth of July  
Labor Day  
Martin Luther King

Christmas Day  
New Year's Eve (1/2 day)  
President's Day

Inasmuch as the employees covered by this Agreement must fill work shifts each day of the calendar year, remuneration for the above holidays shall be made by separate check which shall be paid on either the first or second Friday of December of each year.

Remuneration for holidays shall be based on eight-eight (88) hours of pay per year or a pro rata share thereof for the number of days sufficient to cover those holiday periods while employed by the Village. In addition, all covered employees shall receive twenty-five (25) hours of compensatory time on May 1 of each year, ten of which will be taken as compensatory time off, the balance of fifteen (15) being paid as holiday pay. Said compensatory time shall be utilized pursuant to the provisions of Section 10.3 of this Agreement. In addition, if a covered employee is ordered in to work on a designated Holiday, such employee shall receive two times his regular hourly rate of pay or compensatory time for all hours so worked.

Section 7.2. Vacation Schedule.

In accordance with applicable ordinances, Patrol Officers covered by this Agreement shall be entitled to a vacation as follows:

| <u>Years of Continuous Service</u> | <u>Length of Vacation</u> |
|------------------------------------|---------------------------|
| 1 year but less than 2 years       | 1 week                    |
| 2 years but less than 7 years      | 2 weeks                   |
| 7 years but less than 11 years     | 3 weeks                   |
| 11 years but less than 15 years    | 4 weeks                   |
| 15 years or more                   | 5 weeks                   |

In order to be eligible for full vacation benefits under this Section, a Patrol Officer shall have worked at least sixteen hundred (1,600) hours during the twelve (12) month period preceding January 1 of the vacation year. except if unable to so work because of an on-the job injury, or in the event that the Patrol Officer began employment during said twelve (12) month period, he

shall have worked a pro rata portion of sixteen hundred (1,600) hours. Any Patrol Officer with a continuous length of service with the Village of more than one (1) year who would be otherwise entitled to a vacation but who is not eligible for full vacation benefits because he has not worked at least sixteen hundred (1,600) hours during the twelve (12) month period immediately preceding January 1 of the vacation year, where such failure is not the result of an on-the-job injury, shall be entitled to a vacation of one (1) week so long as he worked at least one thousand (1,000) hours during the twelve (12) month period immediately preceding January 1 of the vacation year.

Insofar as practical, vacation will be scheduled at the times requested. It is understood, however, that because of the nature of the work, it may be necessary to limit the number of Patrol Officers who are authorized to take vacation during any particular period of time or on any particular day. Vacation must be approved by the Division Commander and shall be scheduled in accordance with the procedures set forth herein below.

7.2.1 During the month of January, all Patrol Officers will submit their vacation requests to their respective Division Commanders.

7.2.2 No vacation shall be allowed in excess of three (3) consecutive weeks unless the Chief of Police determines that there are extenuating circumstances and grants approval. Vacations may not be taken in time periods of less than one-half (1/2) of a full day.

7.2.3 All vacation days must be taken prior to the end of the calendar year unless a vacation starts prior to the end of the calendar year and extends into the next year.

7.2.4 Requests for vacations submitted in January shall be honored based upon seniority. The senior officer assigned to each shift/watch shall take his first

choice, all officers by seniority shall follow. This procedure shall be repeated until all then desired vacation weeks/days have been requested. The vacation weeks/days requested in January pursuant to this procedure shall be submitted to the Division Commander for approval by February 1 of each year. The Division Commander shall review the requests and post a vacation schedule on or before March 1. Once the list is posted, any floating vacation as provided in 7.2.5 below shall not be used to bump scheduled vacation time regardless of seniority. On or before May 31, of each year, every employee covered by this Agreement shall have committed no less than the following amounts of vacation: (a) employees with two weeks entitlement, one week, (b) employees with three weeks entitlement, two weeks, (c) employees with four weeks entitlement, two weeks, (d) employees with five weeks entitlement, three weeks. Once committed and approved by the Division Commander, the committed vacation will be added to the posted vacation schedule. Any floating vacation shall not be used to bump scheduled vacation time regardless of seniority. Nothing herein prohibits an officer from taking a vacation between January 1 and March 1. A request for such a vacation must be submitted no later than the first day of the month preceding the month in which the vacation is to be taken.

- 7.2.5 Vacation weeks or days not selected in January or not committed by May 31 shall be floating vacation. Floating vacation shall be taken on a time-available basis. Requests for one day of floating vacation must be submitted to the Division Commander no less than three working days in advance provided, however, that the Division Commander may in his discretion for extenuating circumstances

grant requests without such notice. Requests for two or more consecutive days of floating vacation must be submitted to the Division Commander no later than the 1st day of the month preceding the month in which the vacation days are to occur. These vacation requests may be approved on a first requested basis provided that conflicts which arise in vacation requests submitted on the same day shall be resolved based upon seniority. All floating vacation weeks/days must be requested no later than November 1 of each year. Floating vacation not requested by that date will be lost and no longer available.

- 7.2.6 In the case of extenuating circumstances as determined by the Chief of Police, the Division Commander may cancel and reschedule any or all previously approved and scheduled vacation. In the event that a previously approved and scheduled vacation is canceled by order of the Chief or Division Commander under this subsection, then the Village shall reimburse the officer for any forfeited travel/lodging/tour or like deposits or expenses that the officer has paid. The reimbursement shall be made upon request of the officer and presentment to the Village of proper verification that the officer has incurred and paid the expense.
- 7.2.7 An officer may request to cancel and reschedule vacation. To do so, a written request to cancel and reschedule vacation must be submitted at least 18 days prior to the start of the scheduled vacation. These requests will not be unreasonably denied but in no event shall such requested change conflict with a scheduled vacation of another officer assigned to the same shift.

### Section 7.3. Personal Leave Days.

All officers shall be granted three (3) days of leave for personal business during each year of this Agreement (May 1 through April 30) without loss of pay. Request for this leave must be made to the appropriate supervisor as far in advance as possible but not less than 48 hours prior to the commencement of the leave. Use of personal leave shall be subject to the same limitations as are applicable to use of vacation time. Unused personal business leave does not accumulate, provided, however, that those employees with less than seven (7) years of continuous service may accumulate unused personal business leave to a maximum of four (4) days. Newly hired officers will be entitled to the use of one personal leave day immediately upon being hired, and will be entitled to three (3) days on the following May 1.

### Section 7.4. Funeral Leave.

When a death occurs in an employee's immediate family (i.e., employee's mother, father, mother-in-law, father-in-law, spouse, brother, sister, child or grandparents, step mother, step father, step child), an employee covered by this Agreement, upon request, shall be excused for up to three (3) days for the purpose of mourning; when a death occurs to an employee's grandfather in-law or grandmother in-law, that employee shall be excused for up to two (2) days for the purpose of mourning; one (1) day of funeral leave shall be granted for mourning some other member of the family. An eligible employee shall be paid his normal daily rate of pay for any day or days on which he is excused and but for such excuse would have been scheduled to work. An otherwise eligible employee will not receive funeral pay when it duplicates pay received for time not worked for any other reason e.g. funeral leave is available only for scheduled work days and cannot be used in conjunction with any scheduled day off.

Section 7.5. Military Leave.

Military leave shall be granted in accordance with applicable law, and this leave shall not be charged against vacation or sick leave. The employee will be compensated by the Village for the difference between his/her military compensation and his/her normal salary, less normal payroll deductions, for up to two (2) weeks per year.

Section 7.6. Combination of Leaves.

Affected employees may combine the use of compensatory time, trade days, personal days and vacation days, provided that no employee may use combined leave days for a period in excess of 21 consecutive calendar days at one time.

## **ARTICLE VIII**

### **INSURANCE AND DEATH BENEFITS**

#### **Section 8.1. Insurance.**

Employees may elect to participate in any health and hospital insurance plan(s) selected and made available from time to time by the Village. Such plan(s) shall include dental coverage as selected by the Village and group term life insurance in the amount of \$50,000. Each employee who participates in a Village selected plan must contribute toward the cost of such insurance in the monthly amounts set forth in APPENDIX A1. The parties acknowledge that the Union has agreed to contribute towards the payments of insurance premiums on a percentage basis commencing the Plan year 2020 as set forth in Appendix A1. The Village agrees that the actual monthly premium contribution will be based on the percentage defined in Appendix A1. At no time will the actual monthly contributions exceed 8% of the prior calendar year's monthly contribution rate.

The Village shall pay the remaining premium costs. The Village retains the sole right to select the health/hospital plan made available to employees. However, if during the life of this Agreement the Village intends to select a health/hospital plan that does not provide reasonably comparable benefits, it shall advise the Chapter and the parties will negotiate regarding the provision of this Section.

The parties agree that the Orthodontic Child Lifetime Benefit will increase WILL REMAIN \$1250 at no additional cost to covered employees.

Section 8.2. Health Insurance Review Committee.

The parties shall meet a minimum of twice per calendar year to discuss issues regarding health insurance coverage and costs, unless both parties agree that such meetings are not necessary. Each party will create their own committee of up to two (2) persons, upon request of either party, a meeting shall be set on a mutually agreeable date, with a proposed written agenda for topics of discussion to be sent by the party.

Section 8.3. Retirees Health Insurance.

All full time police officers of the Village of Tinley Park hired on or before May 1, 2013, upon obtaining twenty (20) years of service with the Village's Police Department and upon obtaining the age of fifty (50) years of age and who are retired, regardless of their age at the time of retirement, from the Tinley Park Police Department, and who are without the benefit of any group health and accident insurance coverage, whether public or private, shall be eligible upon retirement from the Village to apply for coverage under the Village's group health insurance plan.

Retired full time police officers, who have become covered by health and accident coverage, whether public or private, other than the coverage offered by the Village, shall be eligible, without objection by the Village, to return to the current Village group health insurance plan, if allowed by the plan. However, it is understood that the retired full time police officers shall need to meet all of the following criteria, and obtain the approval of the Village's health insurance carrier, to be eligible to return to the Village's group health insurance plan:

1. The retired full time police officer must meet the criteria, as described in Ordinance No. 77-O-015, specifically being that he or she (1) has retired, regardless of age at the time of retirement, (2) has 20 years of credible service with the Village of Tinley Park; (3) has attained the age of fifty (50) years; and (4)

is without the benefit of any group health and accident insurance coverage, whether public or private;

2. The retired full time police officer must have had continuous health and accident coverage for the entire period of time he or she was not covered by the Village's group health insurance plan or provide certificate of eligibility (physical). The Village reserves the right to request evidence of said coverage;
3. The retired full time police officer shall provide the Village six (6) months of advanced notice of his or her intention to return to the Village's group health insurance plan when possible. The retired full time police officer must provide notice of his or her intention to return to the Village's group health insurance plan a minimum of thirty (30) days when unforeseen circumstances have occurred. The notification of the retired officers intention to return to the plan shall be in writing and submitted directly to the Village Manager.
4. It is understood that the retired full time police officer, if allowed coverage by the Village's insurance carrier, shall be provided the same coverage options as provided in the most current collective bargaining agreement between the Village and the Union. This includes the option to change coverage during open enrollment.
5. The retired full time police officer shall be required to pay the sum of one-half ( $\frac{1}{2}$ ) of the costs to the Village to provide health and accident coverage to the retired full time police officer.
6. In addition, until the retiree is eligible for AARP coverage, the Village shall contribute, in addition to 50% of the premium cost, \$60 per month toward the

retiree's cost for health insurance for those covered officers retiring with at least 20 years of service and 50 years of age.

7. When any such retired full time police officer is eligible for Medicare or Medicaid or similar health and accident insurance programs, then such officer shall not be entitled to any of the benefits of this Section 8.3, except for participation in a supplemental plan as allowed by Ordinance No. 77-O-015.

#### Section 8.4. Killed In The Line Of Duty Benefits.

In the event that any police officer is killed in the line of duty or suffers a catastrophic injury while on duty or in the performance of duty, or while performing a police function, the Village shall pay to the officer or the officer's family all benefits as provided by current state law including burial expenses up to \$7,500.00 and provide his dependents including widow/widower and all minor children who are without the benefit of health/hospital insurance, with the opportunity to continue participation in the Village selected health and hospital insurance plan on the same basis and under the same terms and conditions as would have existed had the officer not been killed and continued in the employ of the Village, provided that such participation is not prohibited by the terms of the plan. In the event that participation in the Village plan is prohibited, the Village shall pay to the deceased officer's eligible dependents a sum equal to that which the Village would have paid for dependent health/medical insurance had the officer not been killed and continued in the employ of the Village.

"In the line of duty" or "while performing a police function" is understood to include the performance of duty outside the officer's normal work shift and while not being compensated by the Village, whether or not the officer is in uniform. These situations include, but are not limited

to, providing assistance in locating criminal subjects, motorist assistance, and providing additional police assistance when needed for the Village of Tinley Park.

## **ARTICLE IX UNIFORM**

### **ALLOWANCE**

#### **Section 9.1. Uniform Allowance.**

A uniform allowance in the amount of One Thousand Two Hundred and no/100 Dollars (\$1,200.00) per year shall be paid to the individual officers in the month of May of each contract year, as set forth below:

Patrol Officers shall use such funds to obtain among other items the following items which may be changed from time to time by the Chief:

|                                                              |                       |
|--------------------------------------------------------------|-----------------------|
| Plastic flashlight                                           | Tie                   |
| Badge                                                        | Jacket (chill chaser) |
| Silver or gold hat cord                                      | Rain coat             |
| Bullets                                                      | Fur cap               |
| Off duty holster                                             | Garrison belt         |
| Off duty star                                                | Holster               |
| Long sleeve shirt                                            | Belt keeper           |
| Short sleeve shirt                                           | Handcuff case         |
| Trousers                                                     | Ammo magazine pouch   |
| Jacket                                                       | Handcuffs             |
| Baton                                                        | Baton Ring            |
| 5 Star uniform hat                                           | Plastic whistle       |
| Name tags for shirt and jacket                               | Rain cover            |
| Necessary repairs or alterations on required uniform apparel | Ticket book holder    |

Patrol Officers assigned on a continuing basis, to special duty, i.e., investigative services, crime prevention, support services, etc., shall not be limited to those items of purchase enumerated above.

In the event that during the term of this Agreement the Village requires a major uniform change for all officers to take effect on a date certain rather than at the time of when replacement would be necessary or should the Village require officers to obtain a new uniform item or equipment item not required in the Department prior to May 1, 1994, then the Village shall, in addition to the clothing allowance provided for herein, pay the cost of the ordered major uniform change or new item.

Section 9.2. Body Armor Vests.

The Village shall upon the request of an officer, provide said officer with a body armor vest of the officer's own choosing provided, however, that if the cost of any vest selected by the officer is more than ten (10) percent higher than the cost of a level IIA vest from the Village vendors, the officer shall pay the additional cost beyond ten (10) percent. The Village shall replace existing vests every five (5) years. Vests will be provided at the Village's expense to those officers making a request pursuant to this section. Officers obtaining vests pursuant to this section shall be required by the Village to wear said vests while on duty. Nothing herein prohibits management from ordering the wearing of body armor vests in any high risk situation.

Section 9.3. Purchase of New Uniforms.

The Village shall make a one time purchase of new uniforms for a newly hired employee as outlined in APPENDIX "G".

## ARTICLE X

### HOURS OF WORK AND OVERTIME

#### Section 10.1. Work Period/Normal Workweek and Workday.

The Village established a regularly recurring period of seven (7) consecutive days as the regular work period for each Patrol Officer. The beginning date of this regular work period may be changed provided the change is intended to be permanent at the time that it is made. Within an established work period, the normal workweek shall consist of forty (40) hours per week subject to the last paragraph of this Section 10.1. The normal workday may consist of ten (10) hours, eight (8) hours, or some other combination as determined by the Chief of Police to be in the best interests of the Village and the Department. The normal workweek shall commence at the start of the first regularly scheduled duty day in any seven (7) consecutive day period (168 consecutive hours) which may begin on any day of the calendar week and enter into the next calendar week. Where there is a change in shifts and/or scheduled off duty days, the commencement of the first regularly scheduled duty day of the new workweek shall terminate the preceding workweek.

Preferred Division and Shift selection shall be offered to patrol officers by descending seniority until the designated divisions and shifts have been staffed to the proper levels. This does not preclude the right to adjust and balance the selections in this process based upon the levels of experience of the officers on a particular shift and/or division.

#### 10.1.5 Ten Hour Workday.

Notwithstanding the paragraphs above, the Village agrees to maintain the current forty (40) hour work week based upon a four (4) day, ten (10) hour schedule for the duration of this contract. The four/ten (4/10) schedule will only be applicable to those divisions/units that operate on such a schedule on the date this agreement is executed by both parties. This language

does not apply to any division which operates on a different work schedule. Officers assigned to replace manpower shall work the zone assignment of the officer they are replacing, IF such zone assignment is already designated on the schedule at the time the replacement is made.

#### Section 10.2. Overtime Pay.

Each Patrol Officer covered by this Agreement shall be paid one and one-half (1-1/2) times his regular straight time hourly rate of pay for all hours of work in excess of forty (40) in a regular 7-day work period. Hours of work include all time that a Patrol Officer is required to be on duty whether scheduled or unscheduled provided, however, that time worked as the result of "trading time" pursuant to the provisions of Section 10.6 below shall not be considered hours of work for the purpose of overtime pay. Paid absences from work, excluding, however, sick leave, shall be considered as "hours of work" for purposes of calculating overtime pay. Unpaid absences are not "hours of work" for purposes of overtime pay.

Overtime assignments for which there is more than one and one-half hours' notice shall be offered by seniority to covered officers. Any assignments not filled by a volunteer shall be assigned by reverse seniority. Nothing herein shall be construed to require the Village to fill any vacancy that may from time to time occur. The Village possesses the absolute right to assign overtime work and Patrol Officers must work overtime as assigned by the Village. The Village will not order a patrol officer to fill a vacancy created by the absence of a Sergeant. (These provisions are to implement the overtime assignment procedure in effect as of May 1, 1998).

#### Section 10.3. Compensatory Time.

A Patrol Officer may elect to have earned overtime credited to a compensatory time-off account rather than to be paid for such overtime. No Patrol Officer shall be allowed to accumulate over seventy-five (75) hours of compensatory time. Compensatory time shall be paid at the rate of one and one-half (1-1/2) hours for each overtime hour of work over 40 in any

regular 7-day work period. Compensatory time off may be taken only with the approval of the Patrol Officer's supervisor based upon existing manpower needs. Requests for compensatory time must be made at least 24 hours in advance unless the supervisor grants approval without such notice. Requests for use of compensatory time may not be made more than six (6) months in advance of the dates requested for use. Requests for use of compensatory time off shall not be unreasonably withheld. Compensatory hours may be carried over from year to year.

#### Section 10.4. Court Time.

Time spent in court (including travel to and from court) pursuant to job duties shall be compensated in the same manner as scheduled on-duty time. Covered officers shall be compensated for a minimum of two (2) hours for time spent at the Bridgeview or Markham Court Houses. Covered officers shall be compensated for a minimum of two and one-half (2-1/2) hours for time spent at the Will County Court House.

Normal travel time to court in Joliet is 1/2 hour each way. Normal travel time to court at the Daley Center or 26th and California is 1 hour each way.

When a Patrol Officer is subpoenaed for a civil case and when such subpoena arises directly from the performance of job duties as an officer in the Tinley Park Police Department, the Patrol Officer shall be paid at the regular rate for all court time spent in response to the subpoena. It is understood that any extraordinary expenses incurred by the Officer will be reimbursed by the Village upon proper submittal of receipts documenting such extraordinary expenses, i.e., transportation costs, parking fees, etc. It is understood that reimbursement of expenses will be viewed in a limited manner and will not be extended to such items as meals or any other expenses that would normally arise in an Officer's performance of his duties. Further, it is understood that Officers will submit all witness fees to the Village that result from their participation in court-related matters. If such fees are not timely submitted, no court-time

payment will be made by the Village provided, however, if the subpoena fee exceeds the payment to be made by the Village, the Patrol Officer shall have the option to retain the subpoena fee in lieu of the payment provided for herein.

Section 10.5. Training Time.

Patrol Officers covered by this Agreement who are required to attend a training program shall be considered at work while engaged in such training and accordingly, they shall be compensated for such hours of training in the same manner as other hours of duty.

Section 10.6. Trading of Work Shifts.

Patrol Officers shall have the right to request trading of work shifts on a limited basis. A Patrol Officer may initiate unlimited trades, provided that the officer may not trade more than four (4) consecutive shifts with the same person. Responsibility for the trade is with the officer who is to work the shift. Once an officer agrees to work a trade shift, any failure to completely fulfill such an obligation will result in discipline of the officer who accepted the trade request. All such requests shall be made in writing and approved by both the Patrol Officer's Supervisors. The written request must normally be submitted no less than three (3) working days prior to the day upon which the first trade is to occur provided, however, that the Officer's Supervisors may, in extenuating circumstances, approve the trade without such notice. It is understood that these requests will be given due consideration by the Supervisors and denial must be based on legitimate departmental manpower needs. It is further understood that once a trade has been made, the party accepting the trade will be held totally responsible for covering the shift that he has agreed to cover. Trading of duty shifts under the provisions of this section is voluntary as between the Patrol Officers involved and is permitted for the benefit and convenience of the officers. The Village shall maintain a record of all such trades. Any shift traded hereunder may be paid back within twelve (12) months but in all cases, the day must be traded back no later than the last day of the calendar year in which the trade was initiated.

Section 10.7. No Pyramiding.

This Article is intended to define the normal hours of work, the regular work period and provide the basis for overtime calculation. It shall not be construed as a guarantee of hours of work per day or per week or per regular work period. Compensation shall not be paid more than once for the same hours under any provision of this Article or Agreement.

Section 10.8. Call Back.

A call-back is defined as an official assignment of work which does not continuously precede or follow an officer's regularly scheduled work hours. Employees who are required to work a call-back assignment shall be compensated at the officer's applicable overtime or straight-time rate of pay for all hours worked, with a minimum of two (2) hours compensated.

## **ARTICLE XI GENERAL**

### **PROVISIONS**

Section 11.1. Right to Join or Not to Join.

Employees included in the appropriate bargaining unit set forth in Article 1 of this Agreement shall have the right to join or refrain from joining the Association. The Village and the Chapter agree not to interfere with the rights of employees to become or not become members of the Chapter and, further, that there shall be no discrimination or coercion against any employee because of Chapter membership or non-membership. Nothing contained in this Agreement shall be construed to prohibit individual employees from presenting grievances to the Village; provided, however, that the settlement of any such grievance shall not be inconsistent with the terms of this Agreement.

Section 11.2. Personnel Files.

Upon appropriate request, an employee may inspect his personnel file subject to the following:

- A. Inspection shall occur at a time and in a manner mutually acceptable to the employee and the Village. Upon request, an employee who has a written grievance on file who is inspecting his personnel file with respect to said grievance may have an association official present during such inspection.
- B. Copies of materials in his personnel file shall be provided an employee upon request if such materials are to be used in the processing of a grievance at the third step. The employee shall bear the cost of duplication.
- C. An employee shall be provided a copy of the evaluation form used for the purpose of evaluating him at no cost to the employee.
- D. Pre-employment information, e.g., reference checks and responses, or information provided the Village with the specific request that it remain confidential shall not be subject to inspection or copying.

Written reprimands shall remain in an Officer's personnel file for the length of time commensurate with the offense as set forth in Appendix B. Written reprimands shall be removed based on the schedule attached hereto as Appendix B.

#### Section 11.3. Bulletin Board.

The Village shall provide, within the Patrol Officer's squad room, twenty-four inch by twenty-four inch space for a Chapter-provided bulletin board to be used exclusively for the posting of official notices. Such notices, which shall be non-political and non-inflammatory in nature, shall be delivered to the Chief for his approval prior to posting. The Chief shall not unreasonably withhold approval of notices which are in compliance with this Article.

#### Section 11.4. Probationary Period.

All new employees and those hired after loss of seniority shall be considered probationary until they have completed a probationary period of twelve (12) months of work, excluding time spent in school. Time absent from duty that is not credited for seniority purposes shall not apply toward satisfaction of the probationary period. During an employee's probationary period, the employee may be suspended, laid off or terminated in accordance with procedures established by the Civil Service Commission, without cause at the sole discretion of

the Village. Such probationary employee shall have no recourse to the grievance procedure or to the Civil Service Commission to contest such a suspension, layoff or termination. An employee is not required to comply with the Village residency policy until the employee has completed the probationary period.

Section 11.5. Light Duty.

Covered employees suffering from a duty or non-duty-related injury or illness may be assigned to light duty pursuant to the terms and conditions of the existing Village of Tinley Park Modified Duty Policy. However, no covered officer shall be required to work a light duty shift other than that to which he/she was assigned prior to the injury or illness requiring light duty assignment, unless said officer voluntarily accepts said assignment.

Section 11.6. Residency.

All employees covered by this Agreement shall, as a condition of employment and continued employment, be required to reside within a 30-mile radius measured from any border or village limit of Tinley Park within 12 months of employment date. . Employees who choose to reside within the Village limits will have the benefit of Project 75. Residency in Indiana is not permitted. Waivers to this requirement may be approved by the Village Board. If the Village waives the residency requirement for any other employee group after the effective date of this Agreement, it will waive it for the employees covered by this Agreement as well.

Section 11.7. Part Time Officers.

The Village agrees that all part time officers hired by the Village will be covered by the terms and conditions set forth in Appendix C, attached hereto and made a part hereof, for the duration of this Agreement.

#### Section 11.8. Community Service Officers

The parties agree that Community Service Officer (CSO) shall be permitted to perform administrative duties and shall not be permitted to perform criminal investigations, criminal reports or traffic crash reports.

### **ARTICLE XII**

#### **FAIR SHARE AND DUES DEDUCTION**

##### Section 12.1. Dues Deduction.

Upon receipt of lawful written authorization from employees covered by this Agreement, the Village agrees to deduct from their salary the regular uniform Union membership dues during the term of this Agreement. A copy of the dues deduction authorization that is to be utilized is attached hereto as Appendix D. Signing of the dues deduction authorization is voluntary with the individual employee and any dues deduction authorization which is signed shall be revocable at any time by the employee. The dues shall be forwarded to the individual designated by the Union to receive such deductions. The regular uniform Union membership dues to be deducted will be certified in writing by the Union to the Village.

##### Section 12.2. Indemnity.

The Chapter agrees to indemnify and hold the Village harmless against any and all claims, suits, orders or judgments brought or issued against the Village as a result of any action taken or not taken by the Village under any of the provisions of this Article, except if the Village initiates or prosecutes such action.

## ARTICLE XIII

### WAGES

#### Section 13.1. Salary Schedule.

The minimum monthly salary effective from May 1, 2016 through April 30, 2024, is as follows:

Effective:

|                 | Base  | 5/1/2020<br>(2.0%) | 5/1/2021<br>(2.0%) | 5/1/2022<br>(2.25%) | 5/1/2023<br>(2.55%) |
|-----------------|-------|--------------------|--------------------|---------------------|---------------------|
| Start           | 35.12 | 35.82              | 36.54              | 37.36               | 38.31               |
| End of 1st Year | 37.43 | 38.18              | 38.94              | 39.82               | 40.83               |
| End 2nd Year    | 39.92 | 40.72              | 41.53              | 42.47               | 43.55               |
| End 3rd Year    | 42.54 | 43.39              | 44.26              | 45.25               | 46.41               |
| End 4th Year    | 45.35 | 46.26              | 47.18              | 48.24               | 49.47               |
| End 5th Year    | 48.32 | 49.29              | 50.27              | 51.40               | 52.71               |

### Section 13.2. Investigator Compensation.

In addition to the above, all Patrol Officers assigned to the Investigative Division shall receive an additional stipend of \$2,000.00 during each contract year of this Agreement. This additional remuneration will be paid on a bi-weekly basis and will be discontinued immediately upon the Patrol Officers no longer being assigned to the Investigative Division or when such Patrol Officer is on assignment to some other organization.

In the event the scheduled standby week is vacant without a normally scheduled Investigator, all Investigators who are assigned to the standby rotation list will take one day of the week by seniority until the week is filled. In the event that standby days are not filled, the Investigator assigned to the standby rotation list with the least seniority will be assigned the remainder of the unfilled days.

### Section 13.3. Service Longevity.

For employees hired prior and subsequent to the effective date of this Agreement, salary and wage recognition will be accorded each such employee on the basis of service longevity independent of, but in addition to, that accorded as base pay or merit pay as follows:

#### Effective May 1, 2009 and thereafter:

| <u>Period of Employment</u> | <u>Increment for Service Longevity</u> |
|-----------------------------|----------------------------------------|
| 5- 9 years of employment    | \$80.00 per month                      |
| 10 - 15 years of employment | \$140.00 per month                     |
| 15 - 18 years of employment | \$200.00 per month                     |
| 19+ years of employment     | \$260.00 per month                     |

#### Effective May 1, 2014 and thereafter:

| <u>Period of Employment</u> | <u>Increment for Service Longevity</u> |
|-----------------------------|----------------------------------------|
| 5- 9 years of employment    | \$85.00 per month                      |
| 10 - 15 years of employment | \$145.00 per month                     |
| 15 - 18 years of employment | \$205.00 per month                     |
| 19+ years of employment     | \$265.00 per month                     |

Section 13.4. Educational Incentive Compensation.

Employees who presently hold, or who subsequently obtain, college course credits as described below in police-related subjects approved in advance by the Chief of Police shall receive annual educational incentive compensation, which shall not be cumulative, as follows:

Effective May 1, 2009 and thereafter:

| Completion of:             | Compensation for Month |
|----------------------------|------------------------|
| BA/BS Degree               | \$220.00               |
| 60 hours of college credit | \$160.00               |
| 45 hours of college credit | \$100.00               |
| 30 hours of college credit | \$80.00                |
| 15 hours of college credit | \$40.00                |

Section 13.5. Extra Compensation for Marksmanship Proficiency.

Patrol Officers covered by this Agreement shall receive, in addition to any other payments, marksmanship proficiency payments payable as a lump sum payment on or before April 15 of each year for obtaining a verified shooting score annually under Village supervision as follows:

| <u>Score</u>                                               | <u>Compensation Per Month</u> |
|------------------------------------------------------------|-------------------------------|
| Seventy percent (70%)<br>on the applicable course of fire. | \$ 6.00                       |
| Eighty percent (80%)<br>on the applicable course of fire.  | \$ 8.00                       |
| Ninety percent (90%)<br>on the applicable course of fire.  | \$10.00                       |

This applicable course of fire shall be the "Illinois State Training Standard Qualification."

#### Section 13.6. Officer in Charge.

When that employee is required to serve as an acting supervisor, the employee will receive additional pay equal to the existing low base pay for sergeants or 5 percent of the employee's base hourly rate, whichever is higher, provided, however, that when an employee is assigned to serve as an acting supervisor and does so serve for a period in excess of four consecutive weeks, the employee will receive additional pay equal to the existing low base pay for sergeants or 10 percent of the employee's base hourly rate for that period of time during which he is, without interruptions, so assigned to act as a supervisor, whichever is higher. Acting pay will be given only for hours worked as an "acting supervisor" and shall be calculated to the nearest full hour. Additional pay hereunder shall be accumulated and paid annually in the holiday payroll check as provided for in Section 7.1 of this Agreement. Officers in Charge shall be selected by the supervisor or designee reasonably taking into consideration the candidate's seniority, overall experience and competency.

#### Section 13.7. Field Training.

A field training officer shall receive additional pay of five (5) hours at 1.5 times his regular rate of pay for each eighty (80) hours of time spent in field training another officer. Affected officers who work less than eighty (80) hours shall be paid for all hours worked on a pro rata basis. This additional compensation shall be paid as part of the officer's regular payroll check.

#### Section 13.8. Canine Officer.

The Village, the Village's Police Department and the Union:

- have investigated the amount of time it takes an employee assigned to Canine or K-9 officer duties to provide daily canine care;
- have developed a reasonable estimate of the time reasonably required by a Canine or K-9 Officer to provide daily care for his or her assigned canine by analyzing

the actual amount of time per day it takes a Canine or K-9 Officer to feed, groom, exercise, walk, train and perform other canine care duties;

- and seek to memorialize the manner in which the Canine or K-9 Officer will be reasonable compensated for providing daily care for his or her assigned canine.

The Village and the Union agree and acknowledge that it takes one (1) hour per day for a Canine or K-9 Officer to care for his or her assigned canine. This care includes, but is not limited to, feeding, grooming, exercising, walking and training the assigned canine.

The Village and the Union further agree and understand that whenever practical, and subject to departmental needs, one (1) hour of each shift that the Canine Officer is on duty will be used for the care of the canine. This care includes, but is not limited to, feeding, grooming, exercising, walking and training the assigned canine, as well as maintenance of the vehicle and kennel assigned to the Canine or K-9 Officer. Emergencies and calls for service will always take precedence over this provision at the direction of the Canine or K-9 Officer's supervisors.

The foregoing provision will also be in effect when the Canine or K-9 Officer is on any paid leave, including, but not limited to, compensatory time, vacation time, personal leave time or sick time, unless the canine is being boarded.

The Village and the Union further agree that the Canine or K-9 Officer will be paid one (1) hour at the Canine Officer's current rate of pay for every non-duty day he is assigned as a Canine Officer. This payment is intended to compensate the Canine or K-9 Officer for one hour of dog care responsibilities during his or her non-duty day.

In addition to any normal recordkeeping requirements during on-duty time, the Canine or K-9 Officer will also keep a detailed log of all canine care activities and responsibilities that are carried out beyond his on-duty time, complete with dates and times the duties were performed. If the time required for such duties extends beyond the Officer's normal duty day, or exceeds the one (1) hour allotted for off-duty dog care, the Village shall compensate the Canine Officer for

such time at his current rate of pay, provided that the duties were necessary and within the scope of the Canine or K-9 Officer's assignment, and the Canine or K-9 Officer has tendered to the Village a detailed log outlining the additional canine care activities performed during that pay period. The aforementioned log will be submitted along with the Officer's corresponding time sheet for that pay period.

In addition to the foregoing reasonable compensation, the Village and the Union agree that the Canine or K-9 Officer will be further reasonably compensated by the Village for canine care as follows:

- a. provision of a specially equipped department K-9 motor vehicle which may be used to transport the canine to and from the Officer's home and the Tinley Park Police Department, as well as any other locations necessary for the care or training of the canine;
- b. provision of all gasoline, insurance, equipment and maintenance for the canine vehicle;
- c. payment for any expenses related to the care of the canine, including but not limited to, veterinary care, necessary boarding or kennel fees, food, toys, canine equipment and training supplies;
- d. payment for all expenses related to the necessary training and certification of the canine; and
- e. provision and installation of a kennel at the home of the Canine or K-9 Officer for the care and convenience of the canine. This kennel will remain Village property at all times, and can be recovered or replaced at the Village's discretion.

The Village and the Union finally agree and acknowledge that the assigned Canine or K-

9 Officer will be required to enter into a separate written agreement with the Village acknowledging and memorializing the foregoing Canine or K-9 Officer compensation package and the reasonableness thereof.

Section 13.9. Extra Duty.

Pursuant to Section 7(p)(1) of the Fair Labor Standards Act, the Village administers the extra duty employment of bargaining unit members by certain separate and independent employers. A list of such extra duty employers is attached hereto as Appendix F. Extra duty assignments are performed solely at the option of the officer during off-duty hours. These extra duty assignments may include sporting events and extracurricular activities of those employers listed in Appendix F. Compensation for extra duty assignments performed by members of the bargaining unit is at the rate of \$30.00 per hour. The Village shall bill the independent employers for service provided, and establish procedures for the officers to receive their pay through the Village payroll system. Officers wishing to work extra duty assignments may place their names on the extra duty roster from which extra duty assignments may be made. While on extra duty assignments, all officers are required to observe their normal standards of conduct and shall be subject to disciplinary action for their failure to do so. Members of the bargaining unit shall be offered at least fifty (50) per cent of all extra duty assignments offered by independent employers. Extra duty assignments will be offered (by seniority) to all bargaining unit employees who have placed their names on the extra duty roster. All Bargaining Unit members are entitled to work these extra duties.

Section 13.10. Retroactivity.

Those employees employed by the Village on the date the Agreement is signed by both parties, and any employee who shall have retired from the Village of Tinley Park during the term of negotiations, shall receive the wage increases described in this Agreement on a retroactive

basis to May 1, 2020. Retroactive wage increases will be paid to each eligible employee for all hours worked and compensated between May 1, 2020, and the date of the execution of this Agreement within forty-five (45) days of the signing of this Agreement.

## **ARTICLE XIV**

### **EMPLOYEE DRUG AND ALCOHOL TESTING**

#### **Section 14.1. Statement of Policy.**

It is the policy of the Village that the public has the absolute right to expect persons employed by the Village in its Police Department will be free from the effects of drugs and alcohol. The Village, as the employer, has the right to expect its employees to report for work fit and able for duty and to set a positive example for the community. The purpose of this policy shall be achieved in such manner as not to violate any established constitutional rights of the officers of the Police Department.

#### **Section 14.2. Prohibitions.**

Officers shall be prohibited from:

- (a) Consuming or possessing alcohol at any time during or just prior to the beginning of the workday or anywhere on any Village premises or job sites, including Village buildings, properties, vehicles and the officer's personal vehicle while engaged in Village business, except as may be necessary in the performance of duty as authorized by the Chief or his designee.
- (b) Possessing, using, selling, purchasing or delivering any illegal drug at any time and at any place except as may be necessary in the performance of duty as authorized by the Chief or his designee.
- (c) Failing to report to the employee's supervisor any known adverse side effects of medication or prescription drugs which the employee may be taking.

Section 14.3. Drug and Alcohol Testing Permitted.

Where the Village has reasonable suspicion to believe that: (a) an officer is being affected by the use of alcohol; or (b) has abused prescribed drugs; or (c) has used illegal drugs, the Village shall have the right to require the officer to submit to alcohol or drug testing as set forth in this Agreement. The foregoing shall not limit the right of the Village to conduct any tests it may deem appropriate for persons seeking employment as police officers prior to their date of hire, or upon promotion or reassignment to another position within the Department.

Section 14.4. Order to Submit Testing.

Within twenty-four (24) hours of the time the officer is ordered to testing authorized by this Agreement, the Village shall provide the officer with a written notice setting forth the facts and interferences which form the basis of the order to test. Refusal to submit to such test may subject the employee to discipline, but the officer's taking of the test shall not be construed as a waiver of any objection or rights that he or she may possess.

Section 14.5. Test to be Conducted.

In conducting the testing authorized by this Agreement, the Village shall:

- (a) Use only a clinical laboratory or hospital facility which is certified by the State of Illinois to perform drug and/or alcohol testing, or use a licensed breathalyzer operator who is not a member of the bargaining unit.
- (b) Establish a chain of custody procedure for both the sample collection and testing that will ensure the integrity of the identity of each sample and test result.
- (c) If a blood, urine, or hair test, collect a sufficient sample of the same bodily fluid or material from an officer to allow for initial screening, a confirmatory test, and a sufficient amount to be set aside reserved for later testing if requested by the officer.

(d) Collect samples in such a manner as to preserve the individual officer's right to privacy while insuring a high degree of security for the sample and its freedom from adulteration. Officers shall not be witnessed by anyone while submitting a sample except in circumstances where the laboratory or facility does not have a "clean room" for submitting samples or where there is reasonable suspicion that the officer may attempt to compromise the accuracy of the testing procedure.

(e) Confirm any blood, urine, or other sample that tests positive in initial screening for drugs by testing the second portion of the same sample by gas chromatography/mass spectrometry (GC/MS) or an equivalent or better scientifically accurate and accepted method that provides quantitative data about the detected drug or drug metabolites.

(f) Provide the officer tested with an opportunity to have the additional blood, urine, or other sample tested by a clinical laboratory or hospital facility to the officer's choosing, at the officer's own expense; provided the officer notified the Village within seventy-two (72) hours of receiving the results of the test.

(g) Require that the laboratory or hospital facility report to the Village that a blood, urine, or other sample is positive only if both the initial screening and confirmation test are positive. The parties agree that should any information concerning such testing or the results thereof be obtained by the Village inconsistent with the undertakings expressed herein (e.g., billings for testing that reveal the nature or number of tests administered), the Village will not use such information in any manner or form adverse to the officer's interests.

(h) Require that with regard to alcohol testing, for the purpose of determining whether the officer is under the influence of alcohol, test results showing an alcohol concentration of .020 or more based upon the grams of alcohol per 100 millimeters of blood be

considered positive (NOTE: The foregoing standard shall not preclude the Village from attempting to show that test results between .000 and .019 demonstrate that the officer was under the influence, but the Village shall bear the burden of proof in such cases).

(i) Provide each officer tested with a copy of all information and reports received by the Village in connection with the testing and the results.

(j) Insure that no officer is the subject of any adverse employment action except emergency temporary reassignment or relief of duty during the pendency of any testing procedure.

Section 14.6. Right to Contest.

If disciplinary action is not taken against an employee based in whole or in part upon the results of a drug or alcohol test, the Chapter and/or the officer, with or without the Chapter, shall have the right to file a grievance concerning any testing permitted by this Agreement, contesting the basis for the order to submit to the test, the right to test, the administration of the tests, the significance and accuracy of the test, or any other alleged violation of this Agreement. Such grievances shall be commenced at Step 2 of the grievance procedure. Further, if disciplinary action is taken against an officer based in part upon the results of a test, then the Chapter and/or the officer, with or without the Chapter, shall have the right to file a grievance concerning any portion of the test if the discipline is not so extreme as to invoke the jurisdiction of the Village of Tinley Park Board of Police Commissioners. If the discipline is sufficiently extreme as to invoke the jurisdiction of the Village's Board of Police Commissioners, then the Chapter and/or the officer, with our without Chapter, shall have the right to contest any testing permitted by this Agreement before the Board of Police Commissioners.

#### Section 14.7. Voluntary Request for Assistance.

The Village shall take no adverse employment action against any officer who voluntarily seeks treatment, counseling, or other support for an alcohol or drug related problem not involving or related to criminal activity because of the officer's voluntary actions, other than the Village may require reassignment of the officer with pay if he is unfit for duty in his current assignment. The foregoing is conditioned upon:

(a) The officer was not under investigation for illegal drug use or abuse o alcohol, or in such a circumstance that such investigation was imminent.

(b) The officer agreeing to appropriate treatment as determined by the physician(s) involved.

(c) The officer discontinues his use of illegal drugs or abuse of alcohol.

(d) The officer completes the course of treatment and aftercare prescribed by the attending medical authority(s), including an "after-care" group for a period of up to twelve (12) months.

(e) The officer agrees to submit to suspicionless testing during hours of work during the prescribed period of treatment and aftercare discussed in (d) above.

Officers who do not agree to or act in accordance with the foregoing, or for whom there exists independent evidence of improper activity, shall be subject to discipline, up to and including discharge. This Article shall not be construed as an obligation on the part of the Village to retain an officer on active status throughout the period of rehabilitation if it is appropriately determined by the attending medical authority(s) that the officer's current use of alcohol or drugs prevents such individual from performing the duties of a police officer or whose continuance on active status would constitute a direct threat to the property and safety of others.

Such officer shall be afforded the opportunity, at his option, to use accumulated paid leave or take an unpaid leave of absence pending treatment.

## **ARTICLE XV**

### **BILL OF RIGHTS**

All members of the bargaining unit are entitled to the rights provided by the Uniform Peace Officers Disciplinary Act (commonly known as Peace Officers Bill of Rights), 50 ILCS 725/1 et seq, provided, however, that this clause shall have no effect if said Act is repealed or declared invalid. Any alleged violation of this article shall not be subject to the grievance procedure unless and until the grieving and an authorized representative of the Chapter each voluntarily executes a binding waiver of any right to sue the Village in any administrative forum or court of law alleging a violation of Chapter 85 Section 2551 et seq., arising from the events giving rise to the grievance. It is the express intent of the parties that any alleged violation of the Peace Officers Bill of Rights be subject to determination only by one forum. In addition, all employees covered by this Agreement are hereby informed that they have the right to Union representation in any interview or interrogation that they reasonably believe could result in disciplinary action against them, commonly known as Weingarten rights.

## **ARTICLE XVI**

### **ENTIRE AGREEMENT**

The parties acknowledge that during the negotiations which resulted in this Agreement, each had the unlimited right and opportunity to make demands and proposals with respect to any subject or matter not removed by law from the area of collective bargaining, and that the understandings and agreements arrived at by the parties after the exercise of that right and opportunity are set forth in this Agreement. Therefore, the Village and the Chapter, for the duration of this Agreement, each voluntarily and unqualifiedly waives the right, and each agrees

that the other shall not be obligated to bargain collectively with respect to any subject or matter referred to or covered in this Agreement, or with respect to any subject or matter not specifically referred to or covered in this Agreement, even though such subjects or matters may not have been within the knowledge or contemplation of either or both of the parties at the time they negotiated or signed this Agreement.

## **ARTICLE XVII**

### **SAVINGS CLAUSE**

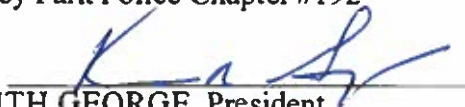
If any provision of this Agreement is subsequently declared by legislative or judicial authority to be unlawful, unenforceable or not in accordance with applicable statutes or orders, all other provisions of this Agreement shall remain in full force and effect for the duration of this Agreement.

## **ARTICLE XVIII**

### **TERM OF AGREEMENT**

This Agreement shall become effective as of the first day after it is signed by both parties, and shall terminate at 11:59 p.m. on April 30, 2024. Either the Village or the Chapter may give written notice to the other party of its desire to modify or terminate this Agreement and to renegotiate an agreement for subsequent years. Said notice shall be given at least ninety (90) days prior to the termination of the agreement. In the event that this notice is not so given, this contract shall be deemed automatically renewed for an additional year and from year to year thereafter until such written notice is given. This Agreement shall remain in full force and effect after any expiration date while negotiations or resolution of impasse procedures are continuing for a new agreement, or part thereof, between the parties.

Metropolitan Alliance of Police,  
Tinley Park Police Chapter #192

By: 

KEITH GEORGE, President  
Metropolitan Alliance of Police

  
RAYMOND VIOLETTO, President  
M.A.P. Tinley Park Chapter #192

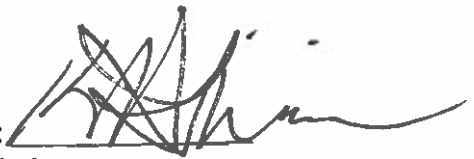
DATED: 12/22/20

Village of Tinley Park, Illinois

By: 

MICHAEL GLOTZ,  
Village Mayor Pro-tem

DATED: \_\_\_\_\_

ATTEST:   
Village Clerk

## APPENDIX A1

| Plan | HMO                       | PPO                       | Blue Advantage            |
|------|---------------------------|---------------------------|---------------------------|
|      |                           |                           |                           |
| 2020 | 10% Employee contribution | 10% Employee contribution | 10% Employee contribution |
| 2021 | 11% Employee contribution | 11% Employee contribution | 11% Employee contribution |
| 2022 | 12% Employee contribution | 12% Employee contribution | 12% Employee contribution |
| 2023 | 12% Employee contribution | 12% Employee contribution | 12% Employee contribution |

**APPENDIX A2**  
**(SUMMARY PLAN BENEFIT SHEETS)**

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-892-2803 or at <https://policy-srv.box.com/s/w71ouzewdncpu30mc26gy9n6sj97zjs6>.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other undefined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-855-756-4448 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | For In-Network:<br>\$500 Individual/\$1,500 Family<br>For Out-of-Network:<br>\$1,500 Individual/\$4,500 Family                                                                           | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.                                                                                                                         |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Certain preventive care, services that charge a copay, and prescription drugs are covered before you meet your deductible.                                                          | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                   |
| <b>Are there other deductibles for specific services?</b>          | Yes. \$300 deductible for Out-of-Network hospital admission. There are no other specific deductibles.                                                                                    | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.                                                                                                                                                                                                                                                                                                                             |
| <b>What is the out-of-pocket limit for this plan?</b>              | For In-Network:<br>\$1,000 Individual/\$3,000 Family<br>For Out-of-Network:<br>\$3,000 Individual/\$6,000 Family<br>Prescription drug expense limit<br>\$1,000 Individual/\$3,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.                                                                                                                                                                                                                         |
| <b>What is not included in the out-of-pocket limit?</b>            | Premiums, balanced-billed charges, and healthcare this plan doesn't cover.                                                                                                               | Even though you pay these expenses, they don't count toward the out-of-pocket limit.                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-892-2803 for a list of network providers.                                                                      | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | No.                                                                                                                                                                                      | You can see the specialist you choose without a referral.                                                                                                                                                                                                                                                                                                                                                                                                            |

 **All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

| Common Medical Event                                          | Services You May Need                            | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                   |
|---------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                          |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness | \$25 copay/visit; deductible does not apply     | 40% coinsurance                                    | Virtual Visits: \$25 copay/visit; deductible does not apply. See your benefit booklet* for details.<br><br>Services or supplies that are not ordered by your Primary Care Physician or Women's Principal Health Care Provider, except emergency or routine vision exams are not covered. |
|                                                               | Specialist visit                                 | \$50 copay/visit; deductible does not apply     | 40% coinsurance                                    | None                                                                                                                                                                                                                                                                                     |
|                                                               | Preventive care/screening/immunization           | No Charge; deductible does not apply            | 40% coinsurance                                    | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.                                                                                                                                |
|                                                               | Diagnostic test (x-ray, blood work)              | 20% coinsurance                                 | 40% coinsurance                                    | None                                                                                                                                                                                                                                                                                     |
| <b>If you have a test</b>                                     | Imaging (CT/PET scans, MRIs)                     | 20% coinsurance                                 | 40% coinsurance                                    | None                                                                                                                                                                                                                                                                                     |

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/w71ouzawdncpu30mc26gy9n6sj97zjs6>.

| Common Medical Event                                                                                                                                                                         | Services You May Need                          | What You Will Pay                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                   | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                              |                                                | In-Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                               | Out-of-Network Provider<br>(You will pay the most)                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p><b>If you need drugs to treat your illness or condition</b><br/>More information about prescription drug coverage is available at <a href="http://www.bcbsil.com">www.bcbsil.com</a>.</p> | Generic drugs                                  | <p><u>\$15 copay/prescription (retail)</u><br/> <u>\$30 copay/prescription (mail order); deductible does not apply</u><br/> <u>\$40 copay/prescription (retail)</u><br/> <u>\$80 copay/prescription (mail order); deductible does not apply</u><br/> <u>\$60 copay/prescription (retail)</u><br/> <u>\$120 copay/prescription (mail order); deductible does not apply</u></p> | <p><u>\$15 copay/prescription (retail); deductible does not apply</u><br/> <u>\$40 copay/prescription (retail); deductible does not apply</u><br/> <u>\$60 copay/prescription (retail); deductible does not apply</u><br/> <u>\$60 copay/prescription (retail); deductible does not apply</u></p> | <p><u>Rx Out-of-Pocket Expense Limit</u><br/> <u>\$1,000 Individual/\$3,000 Family</u><br/> <u>30-day supply at Retail</u><br/> <u>90-day supply at Mail Order</u></p> <p>For <u>Out-of-Network</u> drug provider, you are responsible for 25% of the eligible amount after the <u>copay</u>.</p> <p>Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.</p> |
|                                                                                                                                                                                              | Specialty drugs                                | <p><u>\$60 copay/prescription (retail); deductible does not apply</u></p>                                                                                                                                                                                                                                                                                                     | <p><u>\$60 copay/prescription (retail); deductible does not apply</u></p>                                                                                                                                                                                                                         | <p><u>Specialty drugs</u> coverage based on group policy. <u>Specialty retail</u> limited to 30-day Supply. Prior <u>authorization</u> may be required.</p>                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                              | Facility fee (e.g., ambulatory surgery center) | <p><u>20% coinsurance</u></p>                                                                                                                                                                                                                                                                                                                                                 | <p><u>40% coinsurance</u></p>                                                                                                                                                                                                                                                                     | <p><u>Preauthorization</u> may be required.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                              | Physician/surgeon fees                         | <p><u>20% coinsurance</u></p>                                                                                                                                                                                                                                                                                                                                                 | <p><u>40% coinsurance</u></p>                                                                                                                                                                                                                                                                     | <p><u>None</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                              | Emergency room care                            | <p><u>\$250 copay/visit</u></p>                                                                                                                                                                                                                                                                                                                                               | <p><u>\$250 copay/visit</u></p>                                                                                                                                                                                                                                                                   | <p><u>Copay</u> waived if admitted.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p><b>If you need immediate medical attention</b></p>                                                                                                                                        | Emergency medical transportation               | <p><u>20% coinsurance</u></p>                                                                                                                                                                                                                                                                                                                                                 | <p><u>20% coinsurance</u></p>                                                                                                                                                                                                                                                                     | <p><u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet for details.</p>                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                              | Urgent care                                    | <p><u>20% coinsurance</u></p>                                                                                                                                                                                                                                                                                                                                                 | <p><u>40% coinsurance</u></p>                                                                                                                                                                                                                                                                     | <p><u>None</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/w71ouzawdncpu30mc26g9n6s97zjs6>.

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                          |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | \$300 deductible per admission <u>Out-of-Network providers</u> . <u>Preauthorization</u> required. See your benefit booklet* for details.                                                                                                                                                                |
|                                                                           | Physician/surgeon fees                    | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                     |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$25 copay/visit; deductible does not apply     | 40% <u>coinsurance</u>                             | Virtual Visits: \$25 copay/visit; deductible does not apply. PCP copay applies to psychotherapy only. <u>Preauthorization</u> required. See your benefit booklet* for details.                                                                                                                           |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | \$300 deductible per admission <u>Out-of-Network providers</u> . <u>Preauthorization</u> required.                                                                                                                                                                                                       |
| If you are pregnant                                                       | Office visits                             | \$25 copay/visit; deductible does not apply     | 40% <u>coinsurance</u>                             | Copay applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                          |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | \$300 deductible per admission <u>Out-of-Network providers</u> .                                                                                                                                                                                                                                         |

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/w71ouzewdncpu30mc26gy9n6sj97zjs6>.

| Common Medical Event                                           | Services You May Need            | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                  |
|----------------------------------------------------------------|----------------------------------|-------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                         |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | <u>20% coinsurance</u>                          | <u>40% coinsurance</u>                             | <u>\$300 deductible per admission Out-of-Network providers. Preauthorization may be required.</u>                                                                                                                       |
|                                                                | <u>Rehabilitation services</u>   | <u>20% coinsurance</u>                          | <u>40% coinsurance</u>                             | Limited to 70 visits per benefit period for occupational therapy, 45 visits per benefit period for speech therapy, and 65 visits per benefit period for physical therapy. <u>Preauthorization may be required.</u>      |
|                                                                | <u>Habilitation services</u>     | <u>20% coinsurance</u>                          | <u>40% coinsurance</u>                             |                                                                                                                                                                                                                         |
|                                                                | <u>Skilled nursing care</u>      | <u>20% coinsurance</u>                          | <u>40% coinsurance</u>                             | <u>\$300 deductible per admission Out-of-Network providers. Preauthorization may be required.</u>                                                                                                                       |
|                                                                | <u>Durable medical equipment</u> | <u>20% coinsurance</u>                          | <u>40% coinsurance</u>                             | <u>Referral required. Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price). Preauthorization may be required.</u> |
|                                                                | <u>Hospice services</u>          | <u>20% coinsurance</u>                          | <u>40% coinsurance</u>                             | <u>\$300 deductible per admission Out-of-Network providers. Preauthorization may be required.</u>                                                                                                                       |
| If your child needs dental or eye care                         | Children's eye exam              | Not Covered                                     | Not Covered                                        | None                                                                                                                                                                                                                    |
|                                                                | Children's glasses               | Not Covered                                     | Not Covered                                        | None                                                                                                                                                                                                                    |
|                                                                | Children's dental check-up       | Not Covered                                     | Not Covered                                        | None                                                                                                                                                                                                                    |

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/w71ouzewdncpu30mc26gy9n6sj97zjs6>.

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- |                    |                            |                                                                               |
|--------------------|----------------------------|-------------------------------------------------------------------------------|
| • Acupuncture      | • Dental care (Adult)      | • Routine foot care (with the exception of person with diagnosis of diabetes) |
| • Cosmetic surgery | • Long term care           | • Weight loss programs                                                        |
| • Custodial care   | • Routine eye care (Adult) |                                                                               |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |                                                              |                                                                                                              |                                                                               |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| • Bariatric surgery                                          | • Hearing aids                                                                                               | • Non-emergency care when traveling outside the U.S.                          |
| • Chiropractic care (limited to 30 visits per calendar year) | • Most coverage provided outside the United States. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> . | • Private-duty nursing (with the exception of inpatient private duty nursing) |
| • Infertility treatment                                      |                                                                                                              |                                                                               |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit [www.bcbsil.com](http://www.bcbsil.com), or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.gov>.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

**Spanish (Español):** Para obtener asistencia en Español, llame al 1-800-892-2803.

**Tagalog (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.

**Chinese (中文):** 如果需要中文的帮助, 请拨打这个号码 1-800-892-2803.

**Navajo (Dine):** Dinekehgo shika atohwol nininisingo, kwijigo holne' 1-800-892-2803.

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

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/w71ouzewdncpu30mc26gy9n6sj97zjs6>.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$500
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:  
Specialist office visits (prenatal care)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (ultrasounds and blood work)  
Specialist visit (anesthesia)

| Total Example Cost              | \$12,800 |
|---------------------------------|----------|
| In this example, Peg would pay: |          |
| Cost Sharing                    |          |
| Deductibles                     | \$500    |
| Copayments                      | \$0      |
| Coinsurance                     | \$500    |
| What isn't covered              |          |
| Limits or exclusions            | \$60     |
| The total Peg would pay is      | \$1,060  |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$500
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:  
Primary care physician office visits (including disease education)  
Diagnostic tests (blood work)  
Prescription drugs  
Durable medical equipment (glucose meter)

| Total Example Cost              | \$7,400 |
|---------------------------------|---------|
| In this example, Joe would pay: |         |
| Cost Sharing                    |         |
| Deductibles                     | \$500   |
| Copayments                      | \$500   |
| Coinsurance                     | \$0     |
| What isn't covered              |         |
| Limits or exclusions            | \$60    |
| The total Joe would pay is      | \$1,060 |

**Mia's Simple Fracture**  
(in-network emergencyroom visit and follow up care)

- The plan's overall deductible \$500
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:  
Emergencyroom care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

| Total Example Cost              | \$1,900 |
|---------------------------------|---------|
| In this example, Mia would pay: |         |
| Cost Sharing                    |         |
| Deductibles                     | \$500   |
| Copayments                      | \$400   |
| Coinsurance                     | \$100   |
| What isn't covered              |         |
| Limits or exclusions            | \$0     |
| The total Mia would pay is      | \$1,000 |

The plan would be responsible for the other costs of these EXAMPLE covered services.



**If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.**

|                          |                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| عربية<br>Arabic          |                                                                                                                                                                                                                                                                                                                                                                                                    |
| 繁體中文<br>Chinese          | 如果您或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，並沒有會員卡，請致電 855-710-6984。                                                                                                                                                                                                                                                                                               |
| Français<br>French       | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.                        |
| Deutsch<br>German        | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.                              |
| Ελληνικά<br>Greek        | Εάν εσείς ή κάποιος που βοηθάτε έχει ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς κόστος. Για να μιλήσετε σε έναν διαγλωσσικό καλόγηγο των ομοεθνών, καλέστε τον αριθμό εξυπηρέτησης πελάτη που αναγράφεται στο πίσω μέρος της κάρτας μέλους ή της κάρτας μέλους. Εάν δεν είστε μέλος, καλέστε τον αριθμό 855-710-6984.                                     |
| ગુજરાતી<br>Gujarati      | જો તમારે અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દલાલિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો. જો આપ સભ્યપદ નથી ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો.                                                                                                                                              |
| हिंदी<br>Hindi           | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए साहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।                                                                                  |
| Italiano<br>Italian      | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.                                                              |
| 한국어<br>Korean            | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984으로 전화 주십시오.                                                                                                                                                                                                                                               |
| Diné<br>Navajo           | T'áá ní, éí dootagoo ha' da bítáá anánítwo't'ígíí, na' 'dóót'idéego, ts'í'áá bee ná áhóó't'i; 't'áá mǫ́k'e o' nílká a' 'doolwoł. Án'a' balné'e 'i bich'i 'i' hodeesdzih náínizingo éí kwe' é da' 'iníishgi áłká wánítaalwo' 'ígíí bich'i 'i' hódíilíní, bee néshóníini bíne dé'é' bítáá'. Kojí aanah naalisoos ná hadít' dégoó éí dootagoo bee néshóníinigíí áńíngoo kojí' hódíilíní 855-710-6984. |
| Polski<br>Polish         | Jedli Ty lub osoba, ktorej pomagasz, masz jakiegokolwiek pytanie, moze prawdo do uzyskania bezplatnej informacji i pomocy we własnym języku. Aby porozumieć z tłumaczem, zadzwoni pod numer podany na odwrocie karty członkowskiej. Jeżeli nie jesteś członkiem lub nie masz przy sobie karty, zadzwoni pod numer 855-710-6984.                                                                    |
| Русский<br>Russian       | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию на русском языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов указанного на обратной стороне вашей карты членства номера. Если вы не являетесь членом или не имеете при себе карту членства, позвоните по телефону 855-710-6984.                 |
| Español<br>Spanish       | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.                                                |
| Tagalog<br>Tagalog       | Kung ikaw, o ang isang taong iyong tinutulong ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wikang nang walang bayad. Upang makipag-usap sa isang tagasaal-wika, lumawag sa numero ng serbisyo para sa kasamang sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, lumawag sa 855-710-6984.                          |
| Urdu                     | اگر آپ ہی، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش آئے تو، آپ کی اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ ممبرم سے بات کرنے کے لیے، ممبر کارڈ پر دی گئی ویلن کا نمبر، گو کہ وہ بھی ہونے ہوگی، پر کال کریں جو کہ 855-710-6984 ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کی پاس کارڈ نہیں ہے، تو 855-710-6984 پر کال کریں۔                                                    |
| Tiếng Việt<br>Vietnamese | Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984. hàng năm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.                                                                            |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p align="center"><b>Health care coverage is important for everyone.</b></p> <p>We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.</p>                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                      |
| <p>To receive language or communication assistance free of charge, please call us at 855-710-6984.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                      |
| <p>If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a <u>grievance</u>.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                               | <p>Office of Civil Rights Coordinator<br/>300 E. Randolph St.<br/>35th Floor<br/>Chicago, Illinois 60601</p> <p>Phone: 855-664-7270 (voicemail)<br/>TTY/TTDD: 855-661-6965<br/>Fax: 855-661-6960<br/>Email: <a href="mailto:CivilRightsCoordinator@hscs.net">CivilRightsCoordinator@hscs.net</a></p> |
| <p>You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at</p> <p>U.S. Dept. of Health &amp; Human Services<br/>200 Independence Avenue SW<br/>Room 509F, HHH Building 1019<br/>Washington, DC 20201</p> <p>Phone: 800-368-1019<br/>TTY/TTDD: 800-537-7697<br/>Complaint Portal: <a href="https://ocrportal.hhs.gov/ocrportal/lobby.jsf">https://ocrportal.hhs.gov/ocrportal/lobby.jsf</a><br/>Complaint Forms: <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a></p> |                                                                                                                                                                                                                                                                                                      |

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-892-2803 or at <https://policy-srv.box.com/s/05vblugleupr6ih3o16qd1g119wi3ka>.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-855-756-4448 to request a copy.

| Important Questions                                         | Answers                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible?                             | \$0                                                                                                                       | See the Common Medical Events chart below for your costs for services this plan covers.                                                                                                                                                                                                                                                                                                                                                                              |
| Are there services covered before you meet your deductible? | No.                                                                                                                       | You will have to meet the deductible before the plan pays for any services.                                                                                                                                                                                                                                                                                                                                                                                          |
| Are there other deductibles for specific services?          | No.                                                                                                                       | You don't have to meet deductibles for specific services.                                                                                                                                                                                                                                                                                                                                                                                                            |
| What is the out-of-pocket limit for this plan?              | \$1,500 Individual/\$3,000 Family<br>Prescription drug expense limit:<br>\$1,000 Individual/\$2,000 Family                | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.                                                                                                                                                                                                                         |
| What is not included in the out-of-pocket limit?            | Premiums, balanced-billed charges, and healthcare this plan doesn't cover.                                                | Even though you pay these expenses, they don't count toward the out-of-pocket limit.                                                                                                                                                                                                                                                                                                                                                                                 |
| Will you pay less if you use a network provider?            | Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-892-2803 for a list of participating providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a Referral to see a specialist?                 | Yes.                                                                                                                      | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a Referral before you see the specialist.                                                                                                                                                                                                                                                                                                                  |

**! All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

| Common Medical Event                                                                                                                                                                  | Services You May Need                            | What You Will Pay                                                         |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                       |                                                  | Participating Provider<br>(You will pay the least)                        | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                |
| If you visit a health care provider's office or clinic                                                                                                                                | Primary care visit to treat an injury or illness | \$30 copay/visit                                                          | Not Covered                                           | Services or supplies that are not ordered by your <u>Primary Care Physician</u> or <u>Women's Principal Health Care Provider</u> , except emergency and routine vision exams, are not covered. |
|                                                                                                                                                                                       | <u>Specialist visit</u>                          | \$50 copay/visit                                                          | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                      |
|                                                                                                                                                                                       | <u>Preventive care/screening/immunization</u>    | No Charge                                                                 | Not Covered                                           | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your plan will pay for.               |
| If you have a test                                                                                                                                                                    | <u>Diagnostic test</u> (x-ray, blood work)       | No Charge                                                                 | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                      |
|                                                                                                                                                                                       | <u>Imaging</u> (CT/PET scans, MRIs)              | No Charge                                                                 | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                      |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.bcbsil.com">www.bcbsil.com</a> . | Generic drugs                                    | \$10 copay/prescription (retail)<br>\$20 copay/prescription (mail order)  | Not Covered                                           | Dispensing limit may apply to certain drugs.<br>34-day retail/90-day mail.<br>RX Out-of-Pocket Expense Limit: \$1,000 Individual/\$2,000 Family.                                               |
|                                                                                                                                                                                       | Preferred brand drugs                            | \$40 copay/prescription (retail)<br>\$80 copay/prescription (mail order)  | Not Covered                                           | Self-injectable drugs covered at \$50 per prescription.                                                                                                                                        |
|                                                                                                                                                                                       | Non-preferred brand drugs                        | \$60 copay/prescription (retail)<br>\$120 copay/prescription (mail order) | Not Covered                                           | Certain women's <u>preventive services</u> will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.                |
|                                                                                                                                                                                       | <u>Specialty drugs</u>                           | \$60 copay/prescription (retail)                                          | Not Covered                                           | <u>Specialty drug</u> coverage based on group policy. Prior <u>authorization</u> may be required. <u>Specialty retail</u> limited to 30-day supply.                                            |

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/05vblugleupr6in3o16qd1g119wi3ka>.

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                                  |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                    |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | No Charge                                          | Not Covered                                           | <u>Referral required.</u>                                                                                                                                                                                                                                                          |
|                                                                           | Physician/surgeon fees                         | No Charge                                          | Not Covered                                           | <u>Referral required.</u>                                                                                                                                                                                                                                                          |
|                                                                           | Emergency room care                            | \$150 copay/visit                                  | \$150 copay/visit                                     | <u>Copay waived if admitted.</u>                                                                                                                                                                                                                                                   |
| If you need immediate medical attention                                   | Emergency medical transportation               | No Charge                                          | No Charge                                             | Ground transportation only.                                                                                                                                                                                                                                                        |
|                                                                           | Urgent care                                    | \$30 copay/visit                                   | Not Covered                                           | Must be affiliated with member's chosen medical group or <u>referral required.</u>                                                                                                                                                                                                 |
|                                                                           | Facility fee (e.g., hospital room)             | No Charge                                          | Not Covered                                           | <u>Referral required.</u>                                                                                                                                                                                                                                                          |
| If you have a hospital stay                                               | Physician/surgeon fees                         | No Charge                                          | Not Covered                                           | <u>Referral required.</u>                                                                                                                                                                                                                                                          |
|                                                                           | Outpatient services                            | \$30 copay/visit                                   | Not Covered                                           | Unlimited visits. <u>Referral required.</u>                                                                                                                                                                                                                                        |
|                                                                           | Inpatient services                             | No Charge                                          | Not Covered                                           | Unlimited days. <u>Referral required.</u>                                                                                                                                                                                                                                          |
| If you need mental health, behavioral health, or substance abuse services | Office visits                                  | \$30 copay/visit                                   | Not Covered                                           | <u>Copay</u> applies for the 1st prenatal visit only. <u>Cost sharing</u> does not apply for <u>preventive</u> services. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services      | No Charge                                          | Not Covered                                           |                                                                                                                                                                                                                                                                                    |
|                                                                           | Childbirth/delivery facility services          | No Charge                                          | Not Covered                                           | <u>Referral required.</u>                                                                                                                                                                                                                                                          |

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/05vblugleupr6ih3o16qd1g119wi3ka>.

| Common Medical Event                                           | Services You May Need      | What You Will Pay                                  |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                            |
|----------------------------------------------------------------|----------------------------|----------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                            | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                   |
| If you need help recovering or have other special health needs | Home health care           | No Charge                                          | Not Covered                                           | Referral required.                                                                                                                                                                |
|                                                                | Rehabilitation services    | No Charge                                          | Not Covered                                           | 60 visits combined for all therapies.                                                                                                                                             |
|                                                                | Habilitation services      | No Charge                                          | Not Covered                                           | Referral required.                                                                                                                                                                |
|                                                                | Skilled nursing care       | No Charge                                          | Not Covered                                           | Excludes custodial care. Referral required.                                                                                                                                       |
|                                                                | Durable medical equipment  | No Charge                                          | Not Covered                                           | Referral required.<br>Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price). |
| If your child needs dental or eye care                         | Hospice services           | No Charge                                          | Not Covered                                           | Referral required.                                                                                                                                                                |
|                                                                | Children's eye exam        | No Charge                                          | Not Covered                                           | Limited to one exam every 12 months at participating providers.                                                                                                                   |
|                                                                | Children's glasses         | Not Covered                                        | Not Covered                                           | None                                                                                                                                                                              |
|                                                                | Children's dental check-up | Not Covered                                        | Not Covered                                           | None                                                                                                                                                                              |

#### Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) |                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Custodial care</li> <li>Dental care (Adult)</li> </ul>                          | <ul style="list-style-type: none"> <li>Long term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Routine foot care (with the exception of person with diagnosis of diabetes)</li> </ul>                                                                        |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)                     |                                                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Chiropractic care</li> </ul>                              | <ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Hearing aids</li> <li>Most coverage provided outside the United States. See <a href="http://www.bcbstl.com">www.bcbstl.com</a></li> <li>Routine eye care (Adult)</li> <li>Weight loss programs (except when non-medically supervised)</li> </ul> |

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/05vblugleupr6th3o16qd1g119w13ka>.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit [www.bcbsil.com](http://www.bcbsil.com), or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.gov>.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

#### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-2803.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-892-2803.

Navejo (Dine): Dinekehgo shika a'ohwöl ninisingo, kwijigo holne' 1-800-892-2803.

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

## About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$50
- Hospital (facility) \$0
- Other \$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,800 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing               |       |
|----------------------------|-------|
| Deductibles                | \$0   |
| Copayments                 | \$100 |
| Coinsurance                | \$0   |
| What isn't covered         |       |
| Limits or exclusions       | \$60  |
| The total Peg would pay is | \$160 |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$50
- Hospital (facility) \$0
- Other \$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$7,400 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$0     |
| Copayments                 | \$1,200 |
| Coinsurance                | \$0     |
| What isn't covered         |         |
| Limits or exclusions       | \$60    |
| The total Joe would pay is | \$1,260 |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist copayment \$50
- Hospital (facility) \$0
- Other \$0

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$1,900 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing               |       |
|----------------------------|-------|
| Deductibles                | \$0   |
| Copayments                 | \$300 |
| Coinsurance                | \$0   |
| What isn't covered         |       |
| Limits or exclusions       | \$0   |
| The total Mia would pay is | \$300 |

The plan would be responsible for the other costs of these EXAMPLE covered services.



**If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.**

|                          |                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| عربية<br>Arabic          | اگر آپ کسی بات پر شک ہے، یا کسی مسئلے پر مدد کرنا چاہتے ہیں، تو آپ کو یہاں سوال پوچھ سکتے ہیں۔ اگر آپ کسی بات پر شک ہے، یا کسی مسئلے پر مدد کرنا چاہتے ہیں، تو آپ کو یہاں سوال پوچھ سکتے ہیں۔ اگر آپ کسی بات پر شک ہے، یا کسی مسئلے پر مدد کرنا چاہتے ہیں، تو آپ کو یہاں سوال پوچھ سکتے ہیں۔                                                                                 |
| 繁體中文<br>Chinese          | 如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，並沒有會員卡，請致電 855-710-6984。                                                                                                                                                                                                                                                                        |
| Français<br>French       | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.  |
| Deutsch<br>German        | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenloser Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.       |
| Ελληνικά<br>Greek        | Εάν κατά ή κάποια που βοηθάτε έχει ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς κόστος. Για να μιλήσετε σε έναν έμπειρο, καλέστε τον αριθμό εξυπηρέτησης μελών που αναγράφεται στο πίσω μέρος της κάρτας μέλους ή εάν δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984.                                                               |
| ગુજરાતી<br>Gujarati      | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દ્વારા સહાયતા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો                                                                                                                                    |
| हिंदी<br>Hindi           | यदि आपके या आप जिसकी सहायता कर रहे हैं उससे, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।                                                           |
| Italiano<br>Italian      | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.                    |
| 한국어<br>Korean            | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객 서비스 번호를 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화하십시오.                                                                                                                                                                                                                         |
| Diné<br>Navajo           | T'áí ná, éí doodagoo na'da bílká anánílwo'ígíí, na' ídítikídgo, ts'í'k'á bee ná abóódi'i' t'áí nílk' é' nálk' a' doolwol. An' halne' i' bich'i' hadesadzihi níníizngó éí kwe'e' ka' íníshgí áłtá anílnalwo'ígíí bich'i' hodilniih, bee nééts'oziníí bine' déé' búld'. Kojí atah naalisoos ná hadit'éégóó éí doodago bee nééts'ozinígíí ádinigo kojí' hodilniih 855-710-6984. |
| Polski<br>Polish         | Jedli Ty lub osoba, ktorej pomagasz, masz jakies pytania, moze prawo do uzyskania bezplatnej informacji i pomocy we własnym jezyku. Aby porozumiec z tłumaczem, zadzwon pod numer podany na odwrocie karty członkowskiej. Jezeli nie jestes czlonkiem lub nie masz przy sobie karty, zadzwon pod numer 855-710-6984.                                                         |
| Русский<br>Russian       | Если у вас возникли вопросы, вы можете получить помощь и информацию на русском языке бесплатно. Чтобы поговорить с переводчиком, позвоните по номеру, указанному на обратной стороне вашей карты участника. Если вы не являетесь участником или у вас нет карты участника, позвоните по телефону 855-710-6984.                                                               |
| Español<br>Spanish       | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.                          |
| Tagalog<br>Tagalog       | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa ibang wika nang walang bayad. Upang maiipag-usap sa isang tagasaal-wika, tumawag sa numero ng serbisyo para sa kusotomer sa likod ng ibang hard ng miyembro. O kaya ay walang kard, tumawag sa 855-710-6984.                                      |
| اردو<br>Urdu             | اگر آپ کسی بات پر شک ہے، یا کسی مسئلے پر مدد کرنا چاہتے ہیں، تو آپ کو یہاں سوال پوچھ سکتے ہیں۔ اگر آپ کسی بات پر شک ہے، یا کسی مسئلے پر مدد کرنا چاہتے ہیں، تو آپ کو یہاں سوال پوچھ سکتے ہیں۔ اگر آپ کسی بات پر شک ہے، یا کسی مسئلے پر مدد کرنا چاہتے ہیں، تو آپ کو یہاں سوال پوچھ سکتے ہیں۔                                                                                 |
| Tiếng Việt<br>Vietnamese | Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thành viên văn phòng, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.                                            |

|                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p align="center"><b>Health care coverage is important for everyone.</b></p> <p>We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.</p> |                                                                                                                                                                                                                                                                                                                      |
| <p>To receive language or communication assistance free of charge, please call us at 855-710-6984.</p>                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                      |
| <p>If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a <u><a href="#">grievance</a></u>.</p>                                                                                                                                                 | <p>Office of Civil Rights Coordinator<br/>300 E. Randolph St.<br/>35th Floor<br/>Chicago, Illinois 60601</p> <p>Phone: 855-664-7270 (voicemail)<br/>TTY/TTDD: 855-661-6965<br/>Fax: 855-661-6960<br/>Email: <a href="mailto:CivilRightsCoordinator@hcsc.net">CivilRightsCoordinator@hcsc.net</a></p>                 |
| <p>You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at</p> <p>U.S. Dept. of Health &amp; Human Services<br/>200 Independence Avenue SW<br/>Room 509F, HHH Building 1019<br/>Washington, DC 20201</p>                                        | <p>Phone: 800-368-1019<br/>TTY/TTDD: 800-537-7697<br/>Complaint Portal: <a href="https://ocrportal.hhs.gov/ocrportal/lobby.jsf">https://ocrportal.hhs.gov/ocrportal/lobby.jsf</a><br/>Complaint Forms: <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a></p> |

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-892-2803 or at

<https://policy-srv.box.com/s/veryturlu2yct0cpheytd3hduk80bhf>.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-855-756-4448 to request a copy.

| Important Questions                                         | Answers                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible?                             | \$0                                                                                                                       | See the Common Medical Events chart below for your costs for services this plan covers.                                                                                                                                                                                                                                                                                                                                                                              |
| Are there services covered before you meet your deductible? | No.                                                                                                                       | You will have to meet the deductible before the plan pays for any services.                                                                                                                                                                                                                                                                                                                                                                                          |
| Are there other deductibles for specific services?          | No.                                                                                                                       | You don't have to meet deductibles for specific services.                                                                                                                                                                                                                                                                                                                                                                                                            |
| What is the out-of-pocket limit for this plan?              | \$1,500 Individual/\$3,000 Family<br>Prescription drug expense limit<br>\$1,000 Individual/\$2,000 Family                 | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.                                                                                                                                                                                                                         |
| What is not included in the out-of-pocket limit?            | Premiums, balanced-billed charges, and healthcare this plan doesn't cover.                                                | Even though you pay these expenses, they don't count toward the out-of-pocket limit.                                                                                                                                                                                                                                                                                                                                                                                 |
| Will you pay less if you use a network provider?            | Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-892-2803 for a list of participating providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a Referral to see a specialist?                 | Yes.                                                                                                                      | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a Referral before you see the specialist.                                                                                                                                                                                                                                                                                                                  |

**! All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

| Common Medical Event                                                                                                                                     | Services You May Need                            | What You Will Pay                                                         |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                          |                                                  | Participating Provider<br>(You will pay the least)                        | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                               |
| If you visit a health care provider's office or clinic                                                                                                   | Primary care visit to treat an injury or illness | \$20 copay/visit                                                          | Not Covered                                           | Services or supplies that are not ordered by your <u>Primary Care Physician</u> or <u>Women's Principal Health Care Provider</u> , except emergency and routine vision exams, are not covered.                |
|                                                                                                                                                          | <u>Specialist visit</u>                          | \$40 copay/visit                                                          | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                                     |
|                                                                                                                                                          | <u>Preventive care/screening/immunization</u>    | No Charge                                                                 | Not Covered                                           | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your plan will pay for.                              |
| If you have a test                                                                                                                                       | <u>Diagnostic test</u> (x-ray, blood work)       | No Charge                                                                 | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                                     |
|                                                                                                                                                          | <u>Imaging</u> (CT/PET scans, MRIs)              | No Charge                                                                 | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                                     |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <u>www.bcbsil.com</u> . | Generic drugs                                    | \$10 copay/prescription (retail)<br>\$20 copay/prescription (mail order)  | Not Covered                                           | Dispensing limit may apply to certain drugs.<br>30-day retail/90-day mail.<br>RX Out-of-Pocket Expense Limit<br>\$1,000 Individual/\$2,000 Family.<br>Self-injectable drugs covered at \$50 per prescription. |
|                                                                                                                                                          | Preferred brand drugs                            | \$40 copay/prescription (retail)<br>\$80 copay/prescription (mail order)  | Not Covered                                           | Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.                                      |
|                                                                                                                                                          | Non-preferred brand drugs                        | \$60 copay/prescription (retail)<br>\$120 copay/prescription (mail order) | Not Covered                                           |                                                                                                                                                                                                               |
|                                                                                                                                                          | <u>Specialty drugs</u>                           | \$60 copay/prescription (retail)                                          | Not Covered                                           | <u>Specialty drug</u> coverage based on group policy. Prior authorization may be required. <u>Specialty retail</u> limited to 30-day supply.                                                                  |

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/yeryturjuz2yct0cpheytd3hduk80bht>.

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                                  |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                |
|---------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                       |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | No Charge                                          | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                                                                                             |
|                                                                           | Physician/surgeon fees                         | No Charge                                          | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                                                                                             |
|                                                                           | Emergency room care                            | \$150 copay/visit                                  | \$150 copay/visit                                     | Copay waived if admitted.                                                                                                                                                                                                                                             |
| If you need immediate medical attention                                   | <u>Emergency medical transportation</u>        | No Charge                                          | No Charge                                             | Ground transportation only.                                                                                                                                                                                                                                           |
|                                                                           | <u>Urgent care</u>                             | \$20 copay/visit                                   | Not Covered                                           | Must be affiliated with member's chosen medical group or <u>referral</u> required.                                                                                                                                                                                    |
|                                                                           | Facility fee (e.g., hospital room)             | No Charge                                          | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                                                                                             |
| If you have a hospital stay                                               | Physician/surgeon fees                         | No Charge                                          | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                                                                                             |
|                                                                           | Outpatient services                            | \$20 copay/visit                                   | Not Covered                                           | Unlimited visits. <u>Referral</u> required.                                                                                                                                                                                                                           |
|                                                                           | Inpatient services                             | No Charge                                          | Not Covered                                           | Unlimited days. <u>Referral</u> required.                                                                                                                                                                                                                             |
| If you need mental health, behavioral health, or substance abuse services | Office visits                                  | \$20 copay/visit                                   | Not Covered                                           | Copay applies for the 1st prenatal visit only. Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services      | No Charge                                          | Not Covered                                           |                                                                                                                                                                                                                                                                       |
|                                                                           | Childbirth/delivery facility services          | No Charge                                          | Not Covered                                           | <u>Referral</u> required.                                                                                                                                                                                                                                             |

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/verytunjlu2yct0cpheytd3hduk80bnf>.

| Common Medical Event                                           | Services You May Need      | What You Will Pay                                  |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                            |
|----------------------------------------------------------------|----------------------------|----------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                            | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                   |
| If you need help recovering or have other special health needs | Home health care           | No Charge                                          | Not Covered                                           | Referral required.                                                                                                                                                                |
|                                                                | Rehabilitation services    | No Charge                                          | Not Covered                                           | 60 visits combined for all therapies.                                                                                                                                             |
|                                                                | Habilitation services      | No Charge                                          | Not Covered                                           | Referral required.                                                                                                                                                                |
|                                                                | Skilled nursing care       | No Charge                                          | Not Covered                                           | Excludes custodial care. Referral required.                                                                                                                                       |
|                                                                | Durable medical equipment  | No Charge                                          | Not Covered                                           | Referral required.<br>Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price). |
| If your child needs dental or eye care                         | Hospice services           | No Charge                                          | Not Covered                                           | Referral required.                                                                                                                                                                |
|                                                                | Children's eye exam        | No Charge                                          | Not Covered                                           | Limited to one exam every 12 months at participating providers.                                                                                                                   |
|                                                                | Children's glasses         | Not Covered                                        | Not Covered                                           | None                                                                                                                                                                              |
|                                                                | Children's dental check-up | Not Covered                                        | Not Covered                                           | None                                                                                                                                                                              |

#### Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) |                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Custodial care</li> <li>• Dental care (Adult)</li> </ul>                    | <ul style="list-style-type: none"> <li>• Long term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine foot care (with the exception of person with diagnosis of diabetes)</li> </ul>                                                                          |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)                     |                                                                                                                                                                                                                                                                                                                                  |
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>                        | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Hearing aids</li> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbstl.com">www.bcbstl.com</a></li> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs (except when non-medically supervised)</li> </ul> |

• For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/yeryturjlu2yct0spheytd3hdutk80bht>.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit [www.bcbsil.com](http://www.bcbsil.com), or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.gov>.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-2803.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-892-2803.

Navejo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijijigo holne' 1-800-892-2803.

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

## About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) \$0
- Other \$0

This EXAMPLE event includes services like:  
Specialist office visits (prenatal care)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (ultrasounds and blood work)  
Specialist visit (anesthesia)

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,800 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing               |       |
|----------------------------|-------|
| Deductibles                | \$0   |
| Copayments                 | \$50  |
| Coinsurance                | \$0   |
| What isn't covered         |       |
| Limits or exclusions       | \$60  |
| The total Peg would pay is | \$110 |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) \$0
- Other \$0

This EXAMPLE event includes services like:  
Primary care physician office visits (including disease education)  
Diagnostic tests (blood work)  
Prescription drugs  
Durable medical equipment (glucose meter)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$7,400 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$0     |
| Copayments                 | \$1,100 |
| Coinsurance                | \$0     |
| What isn't covered         |         |
| Limits or exclusions       | \$60    |
| The total Joe would pay is | \$1,160 |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) \$0
- Other \$0

This EXAMPLE event includes services like:  
Emergency room care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$1,900 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing               |       |
|----------------------------|-------|
| Deductibles                | \$0   |
| Copayments                 | \$300 |
| Coinsurance                | \$0   |
| What isn't covered         |       |
| Limits or exclusions       | \$0   |
| The total Mia would pay is | \$300 |

The plan would be responsible for the other costs of these EXAMPLE covered services.



**BlueCross BlueShield of Illinois**

**If you or someone you are helping have questions, you have the right to get help and information in your language at no cost.**

To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6884.

|                          |                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| العربية<br>Arabic        |                                                                                                                                                                                                                                                                                                                                                                                                    |
| 繁體中文<br>Chinese          | 如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，或沒有會員卡，請致電 855-710-6984。                                                                                                                                                                                                                                                                                              |
| Français<br>French       | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.                                                  |
| Deutsch<br>German        | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenloser Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.                             |
| Ελληνικά<br>Greek        | Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς κόστος. Για να μιλήσετε σε έναν διαμετρητή, καλέστε τον αριθμό εξυπηρέτησης πελατών που αναγράφεται στο πίσω μέρος της κάρτας μέλους σας. Εάν δεν έχετε κάρτα μέλους ή δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984.                                                 |
| ગુજરાતી<br>Gujarati      | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એકબી એમ ફરિયાદિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો.                                                                                                                                                 |
| हिंदी<br>Hindi           | यदि आपको, या आप जिसकी सहायता कर रहे हैं उसके, पता है, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।                                                                                    |
| Italiano<br>Italian      | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.                                                              |
| 한국어<br>Korean            | 만약 귀하 또는 귀하기 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객센터 서비스 번호를 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984으로 전화하십시오.                                                                                                                                                                                                                                              |
| Diné<br>Navajo           | T'la'i ni, éí doodagoo la'da bhiin anaa'niiwo'ígíí, na' ídítik'idágo, is'k'áa bee ná ábbóót'i' t'áa nílk' o' nílk' a' doot'íwól. Aha' habné'e' i' bich'i' badesdzih níniizingo éí kwe'e'é da' í'itishgigi ákáa anáak'al'ho'ígíí bich'i' i' bod'ílnih, bee nééhtozini'gíí bine' déé' bílák'. Kojí atah maaisosó ná hadí't'éégóó éí doodago bee nééhtozini'gíí ádingo kojí." bod'ílnih 855-710-6984. |
| Polski<br>Polish         | Jedli Ty lub osoba, której pomagasz, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwonił pod numer podany na odwrocie karty członkowskiej. Jeżeli nie jesteś członkiem lub nie masz przy sobie karty, zadzwonił pod numer 855-710-6984.                                                                                               |
| Русский<br>Russian       | Если у вас или человека, которому вы помогаете, есть вопросы, то вы имеете право на бесплатную помощь и информацию на своем языке. Чтобы поговорить с переводчиком, позвоните на указанный номер обратной стороны вашей карты участника. Если вы не являетесь участником или у вас нет карты участника, позвоните по телефону 855-710-6984.                                                        |
| Español<br>Spanish       | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.                                                |
| Tagalog<br>Tagalog       | Kung ikaw, o ang isang taong iyong tinutulongan ay may mga tanong, may karapatan kang makatutala ng tulong at impormasyon sa iyong wikang nang walang bayad. Upang makipag-usap sa isang tagasaal-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.                      |
| Urdu                     | اگر آپ کو، یا کسی شخص کی مدد کرنے کے لیے کوئی سوال پیش ہے تو، آپ اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ ممبر سے بات کرنے کے لیے، کھنڈر سروس نمبر پر کل کریں جو آپ کی کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کل کریں۔                                                                                                            |
| Tiếng Việt<br>Vietnamese | Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thành viên dịch vụ, gọi số 855-710-6984. hàng năm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.                                                                    |

|                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p align="center"><b>Health care coverage is important for everyone.</b></p> <p>We provide free communication aids and services for anyone with a disability or who needs language assistance.<br/>We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.</p> |                                                                                                                                                                                                                                                                                                                        |
| <p>To receive language or communication assistance free of charge, please call us at 855-710-6984.</p>                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                        |
| <p>If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a <u>grievance</u>.</p>                                                                                                                                                                     | <p>Office of Civil Rights Coordinator<br/>300 E. Randolph St.<br/>35th Floor<br/>Chicago, Illinois 60601</p> <p>Phone: 855-664-7270 (voicemail)<br/>TTY/TTDD: 855-661-6965<br/>Fax: 855-661-6960<br/>Email: <a href="mailto:CivilRightsCoordinator@hcsc.net">CivilRightsCoordinator@hcsc.net</a></p>                   |
| <p>You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at</p> <p>U.S. Dept. of Health &amp; Human Services<br/>200 Independence Avenue SW<br/>Room 509F, HHH Building 1019<br/>Washington, DC 20201</p>                                            | <p>Phone: 800-368-1019<br/>TTY/TTDD: 800-537-7697<br/>Complaint Portal: <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a><br/>Complaint Forms: <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a></p> |

**APPENDIX B**  
**REMOVAL OF DISCIPLINE FOR SPECIFIC OFFENSES**

|          |                                                                                 |
|----------|---------------------------------------------------------------------------------|
| 1.5.2.1  | Permanent                                                                       |
| 1.5.2.2  | 60 mos.                                                                         |
| 1.5.2.3  | Permanent                                                                       |
| 1.5.2.4  | Permanent                                                                       |
| 1.5.2.5  | 12 mos.                                                                         |
| 1.5.2.6  | Permanent                                                                       |
| 1.5.2.7  | 12 months                                                                       |
| 1.5.2.8  | 36 months                                                                       |
| 1.5.2.9  | Permanent                                                                       |
| 1.5.2.10 | 24 months                                                                       |
| 1.5.2.11 | 12 months                                                                       |
| 1.5.2.12 | 24 months                                                                       |
| 1.5.2.13 | 12 months                                                                       |
| 1.5.2.14 | 12 months                                                                       |
| 1.5.2.15 | 12 months                                                                       |
| 1.5.2.16 | 12 months                                                                       |
| 1.5.2.17 | All removed after 12 except Item #17/8 which will be struck after 24 mos.       |
| 1.5.2.18 | Permanent                                                                       |
| 1.5.2.19 | 12 months                                                                       |
| 1.5.2.20 | 12 months                                                                       |
| 1.5.2.21 | 24 months                                                                       |
| 1.5.2.22 | 12 months                                                                       |
| 1.5.2.23 | Permanent                                                                       |
| 1.5.2.24 | 12 months                                                                       |
| 1.5.2.25 | 12 months                                                                       |
| 1.5.2.26 | Permanent                                                                       |
| 1.5.2.27 | Permanent                                                                       |
| 1.5.2.28 | 24 months                                                                       |
| 1.5.2.29 | Permanent                                                                       |
| 1.5.2.30 | 12 mos. This clause will be reworded to reflect "cell phone or home phone line" |
| 1.5.2.31 | Permanent                                                                       |
| 1.5.2.32 | 24 months                                                                       |
| 1.5.2.33 | 24 months                                                                       |
| 1.5.2.34 | 36 mos.                                                                         |
| 1.5.2.35 | 60 mos.                                                                         |
| 1.5.2.36 | 24 months                                                                       |
| 1.5.2.37 | Permanent                                                                       |
| 1.5.2.38 | Permanent will reword..."complainant in a 'criminal case', suspect....."        |
| 1.5.2.39 | Permanent                                                                       |
| 1.5.2.40 | Permanent                                                                       |
| 1.5.2.41 | 12 months                                                                       |
| 1.5.2.42 | 24 months                                                                       |
| 1.5.2.43 | 12 months                                                                       |
| 1.5.2.44 | Permanent                                                                       |
| 1.5.2.45 | 12 months                                                                       |
| 1.5.2.46 | 12 months                                                                       |

|          |           |
|----------|-----------|
| 1.5.2.47 | 24 months |
| 1.5.2.48 | 12 months |
| 1.5.2.49 | 36 mos    |
| 1.5.2.50 | 12 months |
| 1.5.2.51 | 12 months |
| 1.5.2.52 | 36 mos    |
| 1.5.2.53 | Permanent |
| 1.5.2.54 | Permanent |
| 1.5.2.55 | 24 months |
| 1.5.2.56 | 24 mos.   |
| 1.5.2.57 | 12 months |
| 1.5.2.58 | 12 months |
| 1.5.2.59 | 12 months |
| 1.5.2.60 | 24 months |
| 1.5.2.61 | 12 months |
| 1.5.2.62 | 12 months |
| 1.5.2.63 | 24 months |
| 1.5.2.64 | 24 months |
| 1.5.2.65 | Permanent |

**APPENDIX C**  
**PART- TIME**  
**OFFICERS**

- A. Minimum staffing requirements will only apply to Full-Time officers. Exceptions being if a Part-Time officer has signed up for unfilled posted street overtime in accordance with general order 3.1.3 (8)(b) as in effect on May 1, 2008. The Village agrees to make available first to Chapter members, the right to sign up for overtime postings of street patrol and special enforcement programs and details in which the Chapter members take the primary enforcement role. The Village also agrees to make available first to the Chapter members, details which are funded through governmental grant programs. Part-time officers will only be allowed to sign up for street overtime or full-time officers hireback slots after the posting has gone unfilled by full-time officers during the posting period (72 hours). Part-time officers shall be permitted to serve in a secondary role on the above details (i.e. traffic control, crowd control, or support function) in accordance with past practice.
- B. Chapter members will be designated as primary enforcement officers at the outdoor music theatre and supported by part-time officers, as necessary. "Enforcement officer" shall be defined as those officers designated as an arrest team, concourse team, crowd control, and in the venue security office assignment. However, part time officers will be assigned traffic control, and parking duties, in addition to assisting full-time officers, as necessary. In the event that any slots for full time officers go unfilled, part time officers will be permitted to sign up for that assignment.
- C. Pursuant to Police Department General Order 3.1.2-Allocation and Distribution of Personnel, the Village has established "Specialty Assignments" within the Department. The Village will not assign any part time officer to a "specialty assignment" except as provided in sub-paragraph D herein.
- D. The Village retains the right to train and assign part time officers to supplement the full time officer staffing in the specialty of Bicycle Officer. Part time officers will only be assigned to bicycle patrol details involving bar checks, parades, festivals and other details which have been the responsibility of part-time officers as per past practice. Regular patrol duties of bicycle officers shall be limited to full time bicycle officers only.
- E. Consistent with the Civil Services Rules of the Village of Tinley Park, part-time officers will not be eligible for attaining rank within the police department. Additionally, no full time officer shall be subordinate to any part time officer at any time, regardless of assignment or seniority.

**APPENDIX D**  
**DUES DEDUCTION AUTHORIZATION**

**TINLEY PARK PATROLMEN'S ASSOCIATION**

I hereby authorize the Village of Tinley Park to deduct each month \$\_\_\_\_\_ as certified by the Metropolitan Alliance of Police Tinley Park Police Chapter #192 as the current rate of dues or an amount as may hereafter be established by the Metropolitan Alliance of Police Tinley Park Police Chapter #192 as monthly dues. This deduction is to be turned over to the Metropolitan Alliance of Police Tinley Park Police Chapter #192 whose address is \_\_\_\_\_. The authorization of this deduction is entirely voluntary on my part. I understand that I may cancel this authorization at any time.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

**APPENDIX F**  
**EXTRA DUTY EMPLOYERS**

Andrew High School

Central Junior High School

Convention Center

Grissom Jr. High School

Frankfort Park District

Prairie View Jr. High School

Tinley Park Block Party

Tinley Park High School

Tinley Park Park District

Walker Middle School

APPENDIX "G"  
EQUIPMENT ISSUE CHECKLIST - FULL TIME OFFICER

| Officer:                                 | Issued by: | Received by:                                   | Date |
|------------------------------------------|------------|------------------------------------------------|------|
| Uniforms Trousers                        |            | Handcuffs                                      |      |
| (2 pair) Long sleeve                     |            | Double Magazine Case                           |      |
| shirt (2) Short sleeve                   |            | O.C. Spray currently issued by the Village     |      |
| shirt (2) Clip Tie (2)                   |            | O.C. holster                                   |      |
| Winter Jacket w/removable lining         |            | ASP (21")                                      |      |
| Rain coat                                |            | ASP holster                                    |      |
| Trouser belt                             |            | Radio w/shoulder mic & belt holder             |      |
| Knit Hat                                 |            | Traffic vest Traffic                           |      |
| 5-Star hat                               |            | flashlight Water                               |      |
| Hat rain cover                           |            | throw bag Ticket                               |      |
| Hat badge                                |            | book holder Slim-                              |      |
| Uniform badge (2)                        |            | Jim                                            |      |
| Off-duty wallet badge                    |            | Gas mask                                       |      |
| Nametags (2)                             |            | Gas mask pouch                                 |      |
| Time in service pin (Serving since ####) |            | Riot helmet                                    |      |
| Soft body armor vest                     |            | Disaster tool                                  |      |
| WMT Polo shirt                           |            | Biohazard mess kit                             |      |
| Duty                                     |            | Disposable blankets                            |      |
| Duty belt                                |            | antibacterial hand gel/lotion currently issued |      |
| Belt keepers                             |            | by the Village                                 |      |
| Holster                                  |            | Range ear protection                           |      |
| Handcuff case                            |            | Range eye protection                           |      |
| Dress Blouse                             |            | Shotgun (remains property of Village)          |      |

## APPENDIX H

### **POLICY 304 - OFFICER INVOLVED SHOOTING AND DEATHS**

To committee

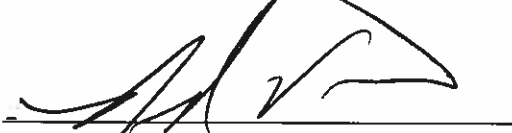
## APPENDIX I

### **Global Positioning and Electronic Monitoring Software**

The GPS system may ONLY be used to discipline an officer when a complaint or issue has been brought against an officer, or when an officer is involved in an accident.

## NON-CONTRACT AGREEMENTS

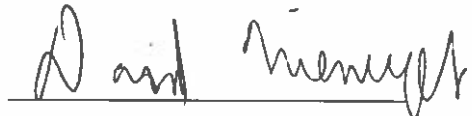
- (1) A policy will be developed to establish departmental meetings for the purpose of reviewing new policies, programs, etc., to allow for Patrol Officers input. These meetings will be scheduled on training days and will occur no less than twice each year. The Police Chief and all Supervisory personnel and all employees covered by this Agreement will attend these meetings. They will be scheduled for a timeframe of approximately 1-1/2 to 2 hours. The Village Manager will attend these sessions on an as needed basis. Nothing herein shall prohibit additional departmental meetings.
- (2) A policy will be developed to provide for better Patrol Officer notification of job related training, seminars, schools, etc., and the policy will indicate that every effort will be made to free up time to attend these training sessions. Special attention will be given to paying for training sessions on off-duty time if the Patrol Officer is willing to go to school on his own time.
- (3) As of the date of execution of this Agreement, the Village has no present intention to abolish or change the Village Ordinance that provides certain health plan benefits to retirees. Covered retired individuals shall also be entitled to maintain dental coverage following retirement, with the Village contributing fifty percent (50%) of the premium for said coverage. In addition, until the retiree is eligible for AARP coverage, the Village shall contribute, in addition to 50% of the premium cost, and \$60 per month toward the retiree's cost for health insurance for those covered officers retiring with at least 20 years of service and 50 years of age. The Village agrees that it will not abolish or change the Ordinance as to bargaining unit members without prior notice to and discussion with the Chapter.
- (4) The Village has no present intention of changing the sick leave or disability leave benefits as they exist in policy as of May 1, 1998. The Village agrees that it will not change those policies as to bargaining unit members without prior notice to and discussion with the Chapter.
- (5) The Chapter agrees that upon request of either the Chapter Executive Board or Police Administration, information sharing meetings will be held on a regular basis. The purpose of the meetings will be to communicate and discuss miscellaneous, non-bargaining issues, which arise between department meetings.
- (6) The Department will require both full time and part time officers in field training to refrain from wearing his/her uniform in public unless on duty, in training or during an assignment by which the officer in training is in the company of another full time or part time officer as a partner.

  
\_\_\_\_\_  
President - Tinley Park Chapter

Date: 12/22/2020

Village Manager

Date: December 18, 2020

  
\_\_\_\_\_

**SIDE LETTER OF AGREEMENT**  
**DRUG TESTING FOLLOWING OFFICER INVOLVED SHOOTINGS**

The Village of Tinley Park ("Village"), the Metropolitan Alliance of Police Tinley Park Police Chapter #192, referred to herein as the ("Union") hereby agree to the following policy to be implemented in accordance with 50 ILCS727/1-25:

1. The Union agrees that its members shall be required to abide by the Village's Policy regarding "Officer Involved Shooting and Death" including the section that requires each officer who is involved in an officer involved shooting to submit to drug and alcohol testing, so long as such testing is required by 50 ILCS727/1-25 or any similar state law.
2. For the purpose of clarity, the parties agree that a person "involved in" an officer involved shooting is defined to mean any officer who discharged a firearm thereby causing injury or death to a person or persons. If multiple officers discharged their firearm and it is unclear whose bullet struck the person or persons, then all officers who discharged their firearm in the direction of the subject shall be required to submit to drug and alcohol testing.
3. The parties agree that the term "involved in" an officer-involved shooting does not include officers who did not discharge their weapon, even if they were providing other forms of support and assistance during the call. Nor does the term "involved in" include officers who discharged their weapons when it is undeniably clear their projectiles did not actually strike any person or persons.
4. The parties agree that the provisions of the collective bargaining agreement regarding drug testing and standards for discipline shall regulate the drug testing procedures and the consequences for any positive drug test results.
5. The parties agree that any drug or alcohol test required pursuant to this Agreement shall be considered a compelled, non-voluntary drug or alcohol test under threat of disciplinary

action. Such testing shall only be done by urinalysis or breathalyzer. Blood tests shall only be administered with a warrant, unless the officer otherwise consents. This does not limit the Village's right to obtain test results via other available legal process.

**Metropolitan Alliance of Police Tinley Park  
Chapter #192**

**Village of Tinley Park, Illinois**

By: K. A. S.

By: Dan Menn

Date: 12/11/2024

Date: 12-11-20

## SUPPLEMENTAL STIPEND SIDE AGREEMENT

This Supplemental Stipend Side Agreement (this "Agreement") is entered into as of the date written below by and among the Metropolitan Alliance of Police ("MAP") and the Village of Tinley Park, IL (the "Village") (collectively referenced herein as the "Parties.")

**WHEREAS**, MAP and the Village are parties to a Collective Bargaining Agreement regarding representation of Patrol Officers employed by the Village (the "CBA"); and

**WHEREAS**, subject to certain terms and conditions, officers assigned to Investigations and who are on the active standby rotation list are eligible for an annual stipend in accordance with the below; and

**WHEREAS**, the Parties acknowledge that the number of officers assigned to Investigations who have been on the standby rotation list has been reduced from a typical number, resulting in those currently assigned to Investigations and part of the standby rotation experiencing a greater standby obligation than would be typical; and

**WHEREAS**, the Parties desire to maintain amicable relations and resolve matters in a mutually beneficial manner;

**NOW THEREFORE**, in consideration of the mutual promises set forth below and for good and valuable consideration, the sufficiency of which is hereby acknowledged, the Parties hereby agree as follows:

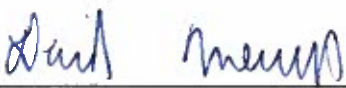
1. Any officer assigned to Investigations as a rotating detective will be assigned and part of the active standby rotation immediately upon such an assignment.
2. The Village will subsidize those officers who were assigned to Investigations and part of the active standby rotation as of December 1, 2020 with an additional \$500 stipend (the "2020 Supplemental Stipend").
3. The 2020 Supplemental Stipend will be a payment for officers who were assigned to Investigations and part of the active standby rotation list experiencing a greater number of standby assignments than would be typical from May 1, 2020 through April 30, 2021.
4. Additionally, the Village will subsidize those officers assigned to Investigations and part of the active standby rotation on May 1, 2021 with an additional \$500 stipend (the "2021 Supplemental Stipend").
5. Should the number of officers assigned to Investigations and who are part of the standby rotation continue to remain below a typical number as of May 1, 2022, the parties agree to negotiate an additional supplemental stipend (the "2022 Supplemental Stipend").
6. Upon returning to the typical number of officers assigned to Investigations and who are part of the standby rotation list to the typical number, the Village will cease to have any obligation to engage in negotiations with the Union regarding the 2022 Supplemental Stipend.

7. Payment of the 2020 Supplemental Stipend shall occur through regular payroll processing within 30 days of the effective date of this agreement.
8. Payment of the 2021 Supplemental Stipend shall occur through regular payroll processing no later than June 1, 2022.
9. MAP agrees to this Agreement on a non-precedential basis.
10. MAP agrees this Agreement does not require the Village to have, maintain or guarantee any specific number of officers assigned to Investigations and/or assigned to the standby rotation.
11. This Agreement may be executed in multiple or duplicate copies, and each such executed copy shall be deemed to be an original.
12. All terms and conditions of the CBA shall remain in full force and effect during the stated contract term applicable to each.

SUPPLEMENT STIPEND SIDE AGREEMENT SIGNATURE PAGE

AGREED:

Village of Tinley Park, IL

By: 

Its: Village Manager

Date: December 10, 2020

Metropolitan Alliance of Police,

By: 

Its: President

Date: 12/22/2020