



45TH DISTRICT
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MICHIGAN HOUSE OF REPRESENTATIVES

TOM McMILLIN
STATE REPRESENTATIVE

COMMITTEES:
EDUCATION
FAMILIES AND CHILDREN'S SERVICES
GOVERNMENT OPERATIONS
LABOR

Dear Taxpayer,

Thank you for taking an interest in my office budget.

As a State Representative, I receive a salary of \$79,650. This is determined by the State Officers Compensation Commission (SOCC).

There is an additional \$1,000 per month expense allowance. This allowance can be used at the legislator's discretion. Many who live hours away from Lansing use it for housing in the Lansing area, while others like myself use it for gas and wear and tear on their car. Legislators are also reimbursed up to one round trip per week between their home residence and the Capitol Building. In my case this is \$105.60/week.

My benefits include health insurance, life insurance, and a retirement plan. The health insurance covers medical, prescription drug, dental, and vision expenses. Any state legislator who serves a full six years is entitled to receive health insurance coverage in retirement. This is available upon reaching age 55 and requires the legislator to pay 10% of the cost of the plan. I have formally told the House Business Office I will not accept this benefit, should I serve six years. I have also cosponsored and will fully support legislation to eliminate this benefit. I also have a state 401(k) plan, which the state puts in 4% and matches up to an additional 3%. Details of all my benefits can be found below.

My staff members are Derek Robinson, Josiah Kissling, and Maureen Thalmann. They are paid salaries of \$36,000, \$29,500, and \$12/hour respectively.

You can find my monthly office expenditures at <http://www.house.mi.gov/PublicAllotment/>.

Sincerely,

A handwritten signature in black ink that reads "Tom McMillin".

Tom McMillin
State Representative
45th District

Representative Tom McMillin Benefits Package

BENEFIT:

SELECTIONS:

Medical

BCBSM Community Blue PPO. You have coverage for yourself and any eligible enrolled dependents

Prescription Drugs

BCBSM Standard Prescription Plan. This plan covers a \$10 co-pay for (generic) or a \$20 co-pay for (name brand). You have coverage for yourself and any eligible enrolled dependents.

Dental

Delta Dental Comprehensive Plan. You have coverage for yourself and any eligible enrolled dependents.

Vision

VSP Vision Plan. You have coverage for yourself and any eligible enrolled dependents.

Employee Life

Selected 2 times pay.

Dependent Life

Selected \$25,000 for spouse and \$10,000 for child(ren).

I pay a total of \$500 annually for the above coverage. The benefit package details are contained in the documents below.

I would like to be able to report the cost to the state, and indirectly the taxpayers, of the above benefits. If and when I receive this information as a result of the following request, I will post it here.



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October 20, 2009

Director Tim Bowlin
House Business Office
P.O. Box 30014
Lansing, MI 48909

Dear Director Bowlin,

I respectfully request that you please provide my office with the following information:

What is the cost of the state funded benefit package, before employee contribution, that is provided for members of the Michigan House of Representatives?

This request would include health insurance, life insurance, disability insurance, retirement, or any other benefits that are included in our compensation package. Please break out the costs for each individual benefit.

I appreciate your time and attention in fulfilling this request.

Sincerely,

A handwritten signature in blue ink that reads "Tom McMillin".

Tom McMillin
State Representative
45th District

MICHIGAN HOUSE OF REPRESENTATIVES
BCBSM Community Blue (PPO) Benefits Summary
Effective 10/1/2009

Community Blue - PPO		
	In-Network	Out-of-Network
<u>Delivery System</u>	Nationwide Participating BCBS PPO Provider	Nationwide Participating BCBS Provider
<u>Preventative Services</u>		
	Maximum \$500 per calendar year per member (no max on Well-Baby and Child Care)	
Health Maintenance Exam	Covered - One per calendar year	Not Covered
Annual Gynecological Exam	Covered - One per calendar year	Not Covered
Pap Smear Screening - laboratory services only	Covered - One per calendar year	Not Covered
Well-Baby and Child Care	Covered 6 visits birth through 12 months 6 visits 13 months through 23 months 2 visits 24 months through 35 months 2 visits 36 months through 47 months 1 visit per birth year, 48 months through age 15	Not Covered
Immunizations	Covered - Up through age 15	Not Covered
Fecal Occult Blood Screening	Covered - One per calendar year	Not Covered
Flexible Sigmoidoscopy Exam Screening	Covered - One per calendar year	Not Covered
Prostate Specific Antigen (PSA) Screening	Covered - One per calendar year	Not Covered
<u>Mammography</u>		
Mammography Screening	Covered - 100% - one routine/preventative per calendar year, no age restrictions	Not Covered

**MICHIGAN HOUSE OF REPRESENTATIVES
BCBSM Community Blue (PPO) Benefits Summary
Effective 10/1/2009**

Community Blue - PPO		
	In-Network	Out-of-Network

Physician Services

Office Visits	Covered - \$10 copay	Covered - 70% after deductible must be medically necessary
Outpatient and Home Visits	Covered - 90% after deductible	Covered - 70% after deductible
Office Consultations	Covered - \$10 copay	Covered - 70% after deductible
Inpatient Consultations	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Medical Care	Covered - 90% after deductible	Covered - 70% after deductible
Anesthesia	Covered - 90% after deductible	Covered - 70% after deductible
Surgery (including sterilization)	Covered - 90% after deductible	Covered - 70% after deductible

Emergency Medical Care

Hospital Emergency Room	Covered - \$75 copay, waived if admitted or for an accidental injury	Covered - \$75 copay, waived if admitted or for an accidental injury
Physician's Office	Covered - \$10 copay	Covered - 70% after deductible
Urgent Care Center	Covered - \$10 copay	Covered - 70% after deductible; must be medically necessary
Ambulance Services - medically necessary	Covered - 90% after deductible	Covered - 90% after deductible

MICHIGAN HOUSE OF REPRESENTATIVES
BCBSM Community Blue (PPO) Benefits Summary
Effective 10/1/2009

Community Blue - PPO		
	In-Network	Out-of-Network
<u>Diagnostic Services</u>		
Laboratory and Pathology Tests	Covered - 90% after deductible	Covered - 70% after deductible
Diagnostic Tests and X-rays	Covered - 90% after deductible	Covered - 70% after deductible
Radiation Therapy	Covered - 90% after deductible	Covered - 70% after deductible
<u>Maternity Services Provided by a Physician</u>		
Pre-Natal and Post-Natal Care	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care	Covered - 90% after deductible	Covered - 70% after deductible
<u>Hospital Care</u>		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies, Specialty Care Units	Covered - Unlimited days - 90% after deductible	Covered - 70% after deductible
Chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible
<u>Alternatives to Hospital Care</u>		
Skilled Nursing Facility	Covered - 90% after deductible	Covered - 90% after deductible <i>Combined 120 days per calendar year</i>
Custodial Care	Not Covered	Not Covered
Hospice Care	Covered - 100% <i>Limited to the lifetime dollar maximum which is adjusted annually</i>	Covered - 100%
Home Health Care	Covered - 90% after deductible	Covered - 90% after deductible <i>Unlimited visits</i>

MICHIGAN HOUSE OF REPRESENTATIVES
BCBSM Community Blue (PPO) Benefits Summary
Effective 10/1/2009

Community Blue - PPO		
	In-Network	Out-of-Network

Human Organ Transplants

Liver, Heart, Lung, Pancreas and Heart-lung	Covered - 100% \$1 million maximum per transplant Approved facility required	Covered in designated facilities only
Kidney, Cornea, Skin and Bone Marrow	Covered - 90% after deductible	Covered - 70% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Inpatient Substance Abuse Care	Covered - 80% after deductible	Covered - 80% after deductible
<i>Unlimited days, \$15,000 annual, \$30,000 lifetime maximum per member</i>		
Outpatient Mental Health Care Private Practice	Covered - 80% up to 20 visits per calendar year	Covered - 50% after deductible, up to 20 visits per calendar year
Facility and Clinic	Covered - 80% after deductible up to 20 visits per calendar year	Covered - 50% after deductible, up to 20 visits per calendar year
Outpatient Substance Abuse Care		
Physician	Covered - 80% after deductible	Covered - 80% after deductible
Facility	Covered - 80% after deductible	Covered - 80% after deductible
<i>Up to the state-dollar annual amount which is adjusted annually (\$3671) Benefit period of April 1 through March 31</i>		

Other Services

Hearing Aid Testing/Treatment	Covered - 100 % Approved providers	Covered - 100 % Approved providers
Allergy Testing and Therapy	Covered - 100%	Covered - 70% after deductible

**MICHIGAN HOUSE OF REPRESENTATIVES
BCBSM Community Blue (PPO) Benefits Summary
Effective 10/1/2009**

Community Blue - PPO		
	In-Network	Out-of-Network
<u>Other Services - Continued</u>		
Chiropractic Spinal manipulation	Covered - \$10 copay	Covered - 70% after deductible <i>24 visits per calendar year</i>
Outpatient Physical, Speech and Occupational Therapy		
Facility and Clinic	Covered - 90% after deductible	Covered - 90% after deductible
Physician's Office - excludes speech and occupational therapy	Covered - 100%	Covered - 70% after deductible
		<i>A combined 60-visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician's office</i>
Durable Medical Equipment	Covered - 90% after deductible	Covered - 90% after deductible
Prosthetic and Orthotic Appliances	Covered - 90% after deductible	Covered - 90% after deductible
Private Duty Nursing	Covered - 50%	Covered - 50% copay
Health Education and Counseling	Covered via Nurse Call Line	Covered via Nurse Call Line
Dermatology	Covered - \$10 copay	Covered - 70% after deductible
Family Planning	Not covered	Not covered
Infertility Counseling	Not covered	Not covered
Nutritional Education	Not Covered	Not Covered

**MICHIGAN HOUSE OF REPRESENTATIVES
BCBSM Community Blue (PPO) Benefits Summary
Effective 10/1/2009**

Community Blue - PPO		
	In-Network	Out-of-Network
<u>Deductible, Copays and Dollar Maximums</u>		
Deductible: Annual	\$100 per member, \$200 per family	\$250 per member, \$500 family
Fixed Copay	\$10 for office visits and \$75 for emergency room visits	\$75 for emergency room visits
Percent Copay	10% copay for general services 20% copay for substance abuse care and private duty nursing	30% copay for general services 20% copay for substance abuse care and private duty nursing
Fixed Copay Dollar Maximums	None	None
Percent Copay Dollar Maximums (excludes in-patient mental health care, substance abuse and private duty nursing copays)	\$500 per member, \$1,000 family, per calendar year	\$1,500 per member, \$3,000 family, per calendar year
Dollar Maximums	\$5 million lifetime per member for all covered services. Within this maximum:	
	\$500 annually for all preventive care (preventive care is not covered out-of-network)	
	\$15,000 annual, \$30,000 lifetime for all mental health care combined, including inpatient substance abuse care	
	Specified organ transplants: Additional \$1,000,000 per transplant	



Delta Dental PPO (Point-of-Service) Summary of Dental Plan Benefits

House of Representatives

This Summary of Dental Plan Benefits should be read in conjunction with your Dental Care Certificate. Your Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. In the event that you seek treatment from a dentist that does not participate in any of Delta Dental's programs, you may be responsible for more than the percentage indicated below.

Control Plan – Delta Dental of Michigan

Benefit Year – October 1 through September 30

Covered Services -

	PPO Dentist	Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays
Class I Benefits			
Diagnostic and Preventive Services - includes exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	90%	90%	90%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	90%	90%	90%
Class II Benefits			
Major Restorative Services - includes crowns	90%	90%	90%
Minor Restorative Services - includes fillings	90%	90%	90%
Periodontic Services - to treat gum disease	90%	90%	90%
Endodontic Services - includes root canals	90%	90%	90%
Oral Surgery Services - extractions and dental surgery	90%	90%	90%
Relines and Repairs - to bridges and dentures	90%	90%	90%
Other Basic Services - misc. services	90%	90%	90%
Class III Benefits			
Prosthetic Services - includes bridges and dentures	50%	50%	50%
Implants - endosteal implants to replace missing teeth	50%	50%	50%
Class IV Benefits			
Orthodontic Services - includes braces	50%	50%	50%
Orthodontic Age Limit -	No Age Limit	No Age Limit	No Age Limit

Orthodontic benefits for eligible dependents will be paid to the age of 25. The orthodontic age limitations are hereby waived for eligible subscribers and spouses.

- Three oral exams are payable in any period of 12 consecutive months.
- Three prophylaxes (cleanings) are payable in any period of 12 consecutive months.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.
- Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- People with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

Having Delta Dental coverage makes it easy for our enrollees to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to the AXA Assistance USA, Inc. worldwide network of dentists and dental clinics. English-speaking AXA Assistance operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,500 per person total per benefit year on all services except Orthodontics. \$2,000 per person total per lifetime on Orthodontic Services.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered on the first day of the month following the date of hire.

Eligible People – All full-time employees of the Contractor who choose the high option plan. All full-time employees of the contractor shall include employees on temporary leaves of absence and/or voluntary reduction in working hours.

Also eligible are your legal spouse, your dependent children to the end of the calendar year in which they turn 19, and your dependent unmarried children who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application card and as a dependent on your spouse's application card. Your dependent children may be enrolled on both application cards as well. Delta Dental will coordinate benefits. The Contractor pays the full cost of this plan.

Benefits will cease on the last day of the month in which the employee is terminated.



Blue Vision Benefits at-a-Glance – Michigan House of Representatives

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation.

	VSP Network Doctor	Non-VSP Provider
Eye Exam		
Covers a complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered – \$5 copay	Reimbursement up to \$35 less a \$5 copay
	Once every 12 consecutive months	
Lenses		
Covers standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. Note: Additional pairs of prescription glasses and non-covered lens options are discounted when obtained from a VSP doctor.	Covered – \$7.50 copay (one copay applies to both lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay
	One pair every 12 consecutive months	
Frames		
Covers standard eyeglass frames. A wide selection of frames is available at each VSP network doctor location.	Covered – \$7.50 copay (one copay applies to both lenses and frames) \$120 maximum	Reimbursement up to \$45, less a \$7.50 copay
	One frame every 12 consecutive months	
Contact Lenses: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.		
Covers medically necessary contact lenses (that meet medically necessary criteria)	Covered – \$7.50 copay No maximum	Reimbursement up to \$210 after a \$7.50 copay (member responsible for difference)
	Once every 12 consecutive months	
Covers elective contact lenses that improve vision (prescribed, but do not meet medically necessary criteria)	Covered – \$120 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	Covered – \$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Once every 12 consecutive months	
Copays		
• Eye exam	\$5 copay	\$5 copay applies to charge
• Lenses and/or frames or medically necessary contact lenses	A combined \$7.50 copay	Member responsible for difference between approved amount and provider's charge, less a \$5 copay

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.



Key Features

Category	401(k) Defined Contribution Plan	401(k) Plan	457 Plan
Maximum Employee Contributions*	The lesser of \$16,500 or 100% of compensation for both pre-tax and Roth contributions combined		The lesser of \$16,500 or 100% of compensation
Mandatory Employer Contributions	4% of compensation	Not applicable	Not applicable
Employer Matching Contributions	Dollar-for-dollar up to 3% of compensation	Not applicable	Not applicable
Loan Provisions	YES — a minimum of \$1,000 and a maximum of 50% of vested account balance or \$50,000		NO
Catch-Up Provisions			
<i>Age 50+ Catch-Up</i>	Anyone age 50 or over can contribute an additional \$5,500		Anyone age 50 or over can contribute an additional \$5,500, but not in the same year as Traditional Catch-Up
<i>Traditional Catch-Up</i>	Not applicable	Not applicable	Increases maximum contributions to twice the annual limit — must meet eligibility requirements
Service Credits for Defined Benefit Plans	Not applicable	You may be eligible to purchase or reinstate service credits	You may be eligible to purchase or reinstate service credits
Vesting (ownership of employer contributions)	50% after 2 years of service 75% after 3 years of service 100% after 4 years of service	Not applicable	Not applicable
Rollover / Transfer OUT of Plan	Rollover to IRA or other plan that allows transfers in		Rollover to IRA or other plan that allows transfers in
Rollover / Transfer FROM Another Plan	YES — from Traditional IRAs, SEP-IRAs, 401(k), 401(a), and 403(b) plans		YES — from 457 plans only
Early Withdrawal Penalty	Pre-tax and employer contributions — 10% of amount withdrawn before age 59½. Some exceptions apply. Roth contributions — the earnings portion becomes taxable and a 10% penalty is assessed for withdrawals if taken before age 59½ and account has been held for less than five years.		NO
Over Age 59 ½ Withdrawal	Anyone over age 59 ½ can take distributions from their account. Such distributions are taxable as ordinary income unless being rolled over.		Not applicable
Taxability of Distributions	Employer contributions and employee first 3% of contributions exempt from State of Michigan taxes.	Taxable to Federal and State of Michigan	Taxable to Federal and State of Michigan
	No taxes on qualified withdrawals from Roth 401(k) if age 59½ or older and money has been held in Roth account for at least 5 years		

* The maximum annual contribution may be contributed to both the 401(k) and 457 plans each year. Dollar amounts are for 2009.

MICHIGAN LEGISLATIVE RETIREMENT SYSTEM ACT (EXCERPT)
Act 261 of 1957

38.1079 Health insurance coverage.

Sec. 79. (1) A former qualified participant may elect health insurance benefits in the manner prescribed in this section if he or she meets both of the following requirements:

(a) The former qualified participant is vested in health benefits under section 75(2).

(b) The former qualified participant meets 1 of the following requirements:

(i) He or she meets or exceeds the benefit commencement age employed in the actuarial present value calculation under section 62 and the service requirements that would have applied to that former participant under Tier 1 for receiving health insurance coverage under section 50b, if that former participant was a member of Tier 1.

(ii) He or she is 55 years of age or older.

(2) A former qualified participant who is eligible to elect health insurance coverage under subsection (1) may elect health insurance coverage in a health benefit plan or plans as authorized by section 50b. A former qualified participant who is eligible to elect health insurance coverage under subsection (1) may also elect health insurance coverage for his or her health benefit dependents, if any. A surviving health benefit dependent of a deceased former qualified participant who is eligible to elect health insurance coverage under subsection (1) may elect health insurance coverage to begin at the death of the deceased former qualified participant in the manner prescribed in this section.

(3) An individual who elects health insurance coverage under this section shall become a member of a health insurance coverage group authorized pursuant to section 50b.

(4) For a former qualified participant who is eligible to elect health insurance coverage under subsection (1) and who is vested in those benefits under section 75(2)(a) or (c), and for his or her health benefit dependents, this state shall pay a portion of the health insurance premium as calculated under this subsection on a cash disbursement method. An individual described in this subsection who elects health insurance coverage under this section shall pay to the retirement system the remaining portion of the health insurance coverage premium not paid by this state under this subsection. The portion of the health insurance coverage premium paid by this state under this subsection shall be 90% of the payments for health insurance coverage under section 50b. If the individual elects the health insurance coverage provided under section 50b, this state shall transfer its portion of the amount calculated under this subsection to the health insurance fund created by section 22c.

(5) For a former qualified participant who is eligible to elect health insurance coverage under subsection (1) and who is vested in those benefits under section 75(2)(b), and for his or her health benefit dependents, this state shall pay a portion of the health insurance premium as calculated under this subsection on a cash disbursement method. An individual described in this subsection who elects health insurance coverage under this section shall pay to the retirement system the remaining portion of the health insurance coverage premium not paid by this state under this subsection. The portion of the health insurance coverage premium paid by this state under this subsection shall be equal to the premium amounts paid on behalf of retirants of Tier 1 for health insurance coverage under section 50b. If the individual elects the health insurance coverage provided under section 50b, the state shall transfer its portion of the amount calculated under this subsection to the health insurance fund created by section 22c.

(6) If the department of management and budget receives notification from the United States internal revenue service that this section or any portion of this section will cause the retirement system to be disqualified for tax purposes under the internal revenue code, then the portion that will cause the disqualification does not apply.

History: Add. 1996, Act 486, Eff. Mar. 31, 1997;—Am. 1998, Act 501, Imd. Eff. Jan. 5, 1999;—Am. 2006, Act 614, Imd. Eff. Jan. 3, 2007.

Compiler's note: Section 2 of Act 486 of 1996 provides:

“Section 2. If any section or part of a section of this act is for any reason held to be invalid or unconstitutional, the holding does not affect the validity of the remaining sections of this act or the act in its entirety.”

MICHIGAN LEGISLATIVE RETIREMENT SYSTEM ACT (EXCERPT)
Act 261 of 1957

38.1075 Tier 2; vesting requirements and schedule; health care coverage; vesting requirements.

Sec. 75. (1) A qualified participant is immediately 100% vested in his or her contributions made to Tier 2. A qualified participant shall vest in the employer contributions made on his or her behalf to Tier 2 according to the following schedule:

- (a) Upon completion of 2 years of service, 50%.
- (b) Upon completion of 3 years of service, 75%.
- (c) Upon completion of 4 years of service, 100%.

(2) A qualified participant is vested in the health insurance coverage provided in section 79 if the qualified participant meets 1 of the following requirements:

(a) The qualified participant has completed 6 years of service as a qualified participant and was not a member, deferred vested member, or former nonvested member of Tier 1.

(b) The qualified participant was a member, deferred vested member, or former nonvested member of Tier 1 who made an election to participate in Tier 2 pursuant to section 61, and who has met the service requirements he or she would have been required to meet in order to vest in health benefits under section 50b.

(c) The qualified participant meets all of the following requirements:

(i) Was not a member, deferred vested member, or former nonvested member of Tier 1.

(ii) Was first elected to fill a vacancy in the house of representatives for a period less than the full term but more than 1/2 of the term of office.

(iii) Has completed 5 years of service as a qualified participant.

History: Add. 1996, Act 486, Eff. Mar. 31, 1997;—Am. 1998, Act 501, Imd. Eff. Jan. 5, 1999.

Compiler's note: Section 2 of Act 486 of 1996 provides:

“Section 2. If any section or part of a section of this act is for any reason held to be invalid or unconstitutional, the holding does not affect the validity of the remaining sections of this act or the act in its entirety.”