SUPERVISORS

AGREEMENT
BETWEEN

THE BAY CITY BOARD OF EDUCATION
AND
THE ASSOCIATION OF
SUPERVISORY PERSONNEL
OF
THE BAY CITY PUBLIC SCHOOLS

2017-2018
2018-2019

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AGREEMENT BETWEEN
THE BAY CITY BOARD OF EDUCATION
and
THE ASSOCIATION OF SUPERVISORY PERSONNEL
OF THE BAY CITY PUBLIC SCHOOLS

THIS AGREEMENT, entered into this first day of July, 2017, by and between the Board of Education of the School District of the City of Bay City, Michigan, hereinafter called the "Board", and the Association of Supervisory Personnel of the Bay City Public Schools, hereinafter called the "Association".

WITNESSETH

WHEREAS, the Board and the Association recognize and declare that providing the supportive services necessary to provide a quality education for the children of the Bay City School District is their mutual aim; and

WHEREAS, Supervisors are qualified to assist in suggesting and developing policies and programs to improve the supportive services; and

WHEREAS, the parties, following deliberate professional negotiations, reached some certain understanding which they desire to incorporate into this Agreement;

NOW THEREFORE, in consideration of the mutual covenants and benefits to be derived, the parties respectively agree to the following articles and/or provisions:

ARTICLE I

RECOGNITION

Section 1.01

The Bay City Board of Education recognizes the Association of Supervisory Personnel of the Bay City Public Schools as the sole and exclusive representative of all supervisory personnel.

Section 1.02

Such representation of the Association shall cover all employees whose role or function is that which is normally performed by supervisory personnel.

Section 1.03

The term of "Supervisor" as used in this Agreement shall be a person who supervises, manages, directs, assumes responsibility, or has jurisdiction over personnel, records, events, programs, or property that is owned or that which the Board is the lessor, or leased or being used by the Bay City Public School District.

Section 1.04

For purposes of this agreement, Supervisors included in this contract include, but are not limited to, the following: Supervisor of Maintenance/Warehouse, Supervisor of Maintenance/Custodial Services, Supervisor of Maintenance/Technical Support Services, Supervisor of Maintenance/Asbestos and Special Projects, Supervisor of Maintenance/Grounds and Custodial Services, Supervisor of Intermediate Attendance, Food Service Managers and the District Volunteer Coordinator. Other supervisory positions will be included in the Association provided such positions are deemed to be essentially in the normal categories included herein by the parties hereto.

Section 1.05

Excluded from this classification are those certified employees serving as student instructors, counselors, or administrators who are members of the Bay City Public Schools Administrative Association, Bay City Education Association, or other similar organizations.

ARTICLE II

ENCOURAGEMENT AND SUPPORT OF SUPERVISORS

Section 2.01

The Board hereby agrees to render to its Supervisors full encouragement and support when they are acting within the scope of their employment.

Section 2.02

The Parties recognized that as jobs change and as new methods of operation are developed it is to the advantage of the employee and the employer that identified training programs may be utilized to improve supervisory skills and training. Employees sent to programs for inservice or education shall be at District expense and at no loss of regular compensation.

Section 2.03

The District may allow up to twenty-one (21) days in each calendar year, upon the prior approval of the Director of Personnel & Employee Relations and subject to scheduling and budgeting allowance, for the express purpose of improving the Supervisors' specific job skills through professional development. Additional days may be granted at the discretion of the Director of Personnel & Employee Relations.

Unit members are encouraged to share with the Director of Personnel & Employee Relations the known dates and costs of programs which might be considered for member participation.

ARTICLE III

RIGHTS OF THE BOARD OF EDUCATION

Section 3.01

It is recognized by all parties hereto that the Board, on its own behalf and on behalf of the electors of the District, hereby retains and reserves unto itself, without limitation, all powers, rights, authority, duties and responsibilities conferred upon and vested in it by the laws and Constitution of the State of Michigan and of the United States. It is further recognized that the exercise of said powers, rights, authority, duties and responsibilities by the Board, the adoption of policies, rules, regulations and practices in furtherance thereof, and the use of judgement and discretion in connection therewith shall be limited only by the specific and express terms of this Agreement and then only to the extent such specific and express terms hereof are in conformance with the Constitution and laws of the State of Michigan and the Constitution and laws of the United States.

Section 3.02

An emergency manager appointed under the Local Government and School District Fiscal Accountability Act is authorized to reject, modify, or terminate this Agreement as provided in the Local Government and School District Fiscal Accountability Act.

This clause is included in this agreement because it is legally required by state law. It is noted the union does not agree or acknowledge this provision as binding and reserves all rights to assert this clause as unenforceable.

ARTICLE IV

SUPERVISORS RIGHTS AND RESPONSIBILITIES

Section 4.01

The provisions of this Agreement and the wages, hours, terms and conditions of employment shall be applied without regard to race, creed, religion, color, national origin, age, gender, or membership in, or association with, the activities of any employee organization. The Board and the Association pledge themselves to seek to provide the supportive services to extend the advantages of public education to every student without regard to race, creed, religion, color, age, gender, marital status, national origin, height, weight, physical or mental handicap.

Section 4.02

Duly authorized representatives of the Association, and representatives of an affiliated organization if any, shall be permitted to transact official Association business on school property, provided that such activities do not interfere with normal school business and/or operations of the management responsibilities of the Supervisors involved, and prior approval is granted by the Director of Personnel & Employee Relations or Immediate Supervisor.

Section 4.03

This Association and its representatives shall be permitted to use office facilities and equipment of the school district, provided such use does not interfere with normal school business, and prior approval is granted by the Director of Personnel & Employee Relations or Immediate Supervisor.

Section 4.04

The Association shall be informed of any new or modified fiscal, budgetary or tax programs, construction programs or major revisions in supportive services policies affecting the Association, which are proposed, and the Association shall be given the opportunity to provide input with respect to said matters prior to their adoption and/or general publication.

ARTICLE V

PAYROLL DEDUCTIONS

Section 5.01 Deductions

The Board will provide that, whenever duly authorized by any Supervisor on a form or forms approved by the Board, payroll deductions on behalf of such employee shall be made from the salary check as directed by the Supervisor to the extent authorized by law. The Board will provide that any payroll deduction sanctioned by the School District will be authorized.

ARTICLE VI

SUPERVISOR'S EVALUATIONS

Section 6.01

The Board recognizes that a Supervisor's effectiveness is dependent on a clear understanding between the Supervisor and his/her Immediate Supervisor regarding specific criteria by which his/her effectiveness shall be evaluated. The Board, therefore, assigns each Supervisor's Immediate Supervisor the responsibility of conducting an evaluation, such evaluation to be completed not later than May 15 of each year. The evaluation shall be based solely upon the performance of duties set forth in the job description of the Supervisor being evaluated.

Section 6.02

In order that each Supervisor may be aware of his/her strengths and deficiencies, the evaluation shall be written and such evaluation will include: (a) a statement of strengths and/or deficiencies, (b) a statement of the improvement desired, and (c) a reasonable time period within which specific improvements are expected to be realized.

Section 6.03

No supervisor shall be disciplined, suspended, reduced in classification or pay, or dismissed except for just cause. By way of illustration, just cause shall include the following conduct: willful disregard of Board policies or the terms of this Agreement, dishonesty, incompetence, insubordination, or unprofessional conduct.

Section 6.04

If the Board determines that it shall not continue to employ a Supervisor in his/her position as Supervisor, the Board shall give written notice to the individual and the Association of such determination and shall provide, in writing, within seven (7) calendar days of the notice, the basis for its determination. In the event that such determination is based upon unacceptable performance of the individual Supervisor, such determination shall be based solely upon performance following previous evaluations. The parties acknowledge that reductions in the supervisory staff may be the result of, or due to, a decline in the overall fiscal standing of the District. In those instances, such reductions shall not be tied to an individuals performance other than as contained in the criteria stated in Article XII.

Each Supervisor shall have the right, upon request, to review the contents of his/her own personnel file. A representative of the Association may, at the Supervisor's request, accompany the Supervisor in conducting such a review. The review will be made in the presence of the Director of Personnel & Employee Relations or his/her designee. The Supervisor may challenge any materials in the file and if the accuracy or completeness of the file is contested by the Supervisor, he/she may provide a written statement and any other relevant material and ask that these be added to his/her personnel file. Any materials added to the personnel file shall be signed and dated by the Supervisor.

Section 6.05

Actions taken for the purpose of observing, monitoring or evaluating the performance of the Supervisor shall be conducted with full knowledge of the Supervisor.

Section 6.06

The Supervisor shall be promptly notified of any complaints of a serious nature brought by a citizen, other employees, or a member of the Board of Education.

ARTICLE VII

GRIEVANCE PROCEDURE

Section 7.01

The term "grievance" is hereby defined to mean a complaint by a Supervisor or a group of Supervisors based on an alleged violation of this Agreement, or a dispute involving the meaning, interpretation, or application thereof.

Section 7.02

If the Association or employee(s) presents a grievance, it shall be consistent with the provisions of this Agreement. The Association or employee(s) shall be permitted to be heard at each level of the procedure under which the appeal shall be considered.

Section 7.03

Notwithstanding the provisions of Section 7.05, an appeal that affects more than one Supervisor not reporting to the same Immediate Supervisor may be submitted, in writing, to the Director of Personnel & Employee Relations directly, and the processing of such an appeal shall be commenced at Level Two.

Section 7.04

Failure at any level of this procedure to communicate the decision of an appeal within the specified time limits to the aggrieved employee, and to the chairperson of the professional appeal committee, shall permit the aggrieved party or parties to proceed to the next level.

Section 7.05

LEVEL ONE: An informal settlement between the aggrieved Supervisor and his/her immediate Supervisor, or designated representative of the Board if his/her Supervisor is a member of the Association, shall be attempted.

LEVEL TWO: A Supervisor with a grievance, with or without the chairperson of the professional grievance committee or its designee, shall present the appeal in writing to his/her immediate Supervisor, or a designated representative of the Board if his/her Supervisor is a member of the Association, within twenty (20) calendar days, of the occurrence of the knowledge of the event upon which the grievance is based.

LEVEL THREE: (a) In the event that the grievance shall not have been disposed of to the satisfaction of the aggrieved employee at Level Two, or in the event that no decision has been reached within ten (10) calendar days of filing an appeal at Level Two, it shall be referred to the Director of Personnel & Employee Relations.

(b) The Director of Personnel & Employee Relations or his/her designee shall represent the Board at this level of the grievance procedure. Within fifteen (15) calendar days after the receipt of the written grievance by the Director of Personnel & Employee Relations, he/she shall meet with the aggrieved employee and the designated representative of the Association in an effort to settle the grievance.

LEVEL FOUR: In the event that the grievance shall not have been satisfactorily disposed of at Level Three, or in the event that no decision has been rendered within fifteen (15) calendar days after the Level Three meeting, the Association may within fifteen (15) calendar days, refer the unsettled grievance to arbitration. The arbitrator shall be selected by an agreement between both parties. If the parties are unable to agree upon an arbitrator, the selection shall be made by the American Arbitration Association, in accordance with its Rules and Regulations. The Board and the Association shall not be permitted to assert, in such arbitration proceedings, any grounds, or to rely on any evidence not previously disclosed to the other party as part of or during the proceedings at Levels One, Two, or Three. The arbitrator shall be without power or authority to make any decision prohibited by law, or to add to, alter or modify this Agreement. The decision of the arbitrator shall be in writing and shall set forth his/her findings of fact, reasoning, and conclusions of the issues submitted. The decision shall be final and binding on both parties. The costs of the services of the arbitrator shall be borne by both parties equally.

ARTICLE VIII

WORK YEAR - HOLIDAYS AND VACATION DAYS

All Supervisors shall be twelve (12) month employees unless a shorter work period is defined in the individual Supervisor's job description. The term of each employment year shall be July 1 through June 30.

Section 8.01 Holidays - Legal

July 4th
Thanksgiving Day
Friday after Thanksgiving Day
Christmas Day (December 25th) and:
December 24th, if Christmas is on Tuesday
December 26th, if Christmas is on Thursday
December 24th, if Christmas is on Saturday
(in lieu of Christmas Day)
December 26th, if Christmas is on Sunday
(in lieu of Christmas Day)
New Year's Day (January 1st) and:
December 31st, if New Year's Day is on Tuesday
January 2nd, if New Year's Day is on Thursday
December 31st, if New Year's is on Saturday
(in lieu of New Year's Day)
January 2nd, if New Year's is on Sunday
(in lieu of New Year's Day)

Good Friday
Memorial Day
Labor Day

The Christmas and New Year's holiday break for twelve (12) month Supervisors and the District Volunteer Coordinator will be the same schedule as the custodians.

Section 8.02 Worked Holiday and Weekend Catering Events

When it is necessary for a Supervisor to work on a holiday as listed above, said Supervisor shall be allowed to reschedule that day off at a later date, such date to be scheduled with the approval of their immediate Supervisor. Additionally should the Director of Nutrition Services determine the need for a Supervisor to work a catering event on a Saturday or Sunday, said Supervisor shall be allowed to schedule the time off at a later date (at a rate of time and one-half hours), such date to be scheduled with the approval of their immediate Supervisor.

Section 8.03 Vacation Accumulation

Vacation days for new employees shall begin with twelve (12) days per full work year. On July 1 of each successive year, two (2) additional vacation days shall be granted until a maximum of twenty five (25) vacation days for 52 week employees have been earned and twenty (20) vacation days for less than 52 week employees have been earned. Said vacation days are exclusive of holidays.

Section 8.04 Vacation Scheduling

Each Supervisor shall be entitled to schedule and take his/her earned vacation allotment during the year in which said days are granted. Supervisors working less than 52 weeks, other than the District Volunteer Coordinator, shall take vacation days when students are not in session. The remaining vacation days must be taken with the permission of their Immediate Supervisor.

Vacation days may not be carried over to another year unless written permission is granted by the Director of Personnel & Employee Relations. The decision by the Director of Personnel & Employee Relations is final and not subject to the appeal procedure. No more than one (1) year may be carried over under any circumstances. Members may request to move up to five (5) unused vacation days into their personal sick leave account on an annual basis. Such request shall be made to the Director of Personnel & Employee Relations.

ARTICLE IX

COMPENSATION

Section 9.01

The employees covered by this Agreement shall be paid in accordance with the Salary Schedule attached to this agreement and identified as Appendix "A". All staff will be compensated through Direct Deposit and/or Pay Card option.

For the 2015-2016 school year, the salary schedule will reflect a 1/2% salary schedule increase with a freeze on steps/longevity as reflected at the end of the 2014-2015 school year. For the 2016-2017 school year, the salary schedule will reflect an additional 1/2% increase with a freeze on steps/longevity as reflected at the end of the 2014-2015 school year. For the 2016-2017 school year, there shall be a wage reopener.

Section 9.02

The Salary Schedule is based upon a normal five (5) day work week and the annual compensation shall be paid in twenty-six (26) bi-weekly installments, or pro-rated for those Supervisors who work less than fifty-two (52) weeks.

Section 9.03 Mileage

Upon presentation of proper documentation by the Supervisor to his/her Immediate Supervisor, approved school related mileage expenses shall be reimbursed at the rate established by the Board, but shall not be less than twenty-six (26) cents per mile.

Section 9.04 Apparel

The parties acknowledge that, as part of their day-to-day duties, the Association members in the Maintenance Department are called upon to perform duties outdoors and exposed to the elements. As it is often necessary that, in the most severe of weather the Supervisors must be outdoors to effectively oversee the work being undertaken, the Board shall provide appropriate clothing and outerwear to protect employees from the elements. Such items of clothing shall be provided at such times and in such manner and style as the Director of Maintenance determines to be appropriate given the nature of the position held by the Supervisor.

Section 9.05 Tuition

Tuition for college coursework, undergraduate and/or graduate, shall be paid for by the Board for up to a maximum of six (6) credit hours per contract year for members

of the Association upon proof of registration. An additional three (3) college credit hours per year may be granted by the Superintendent.

Prior approval of coursework shall be required through the office of the Director of Personnel & Employee Relations. Courses shall be taken beyond the "normal" workday. Exceptions to this may be appealed to the Director of Personnel & Employee Relations. Decisions of the Director of Personnel & Employee Relations shall be final.

Tuition costs will be reimbursed to the Association member and may be prepaid by the Board. Documentation of satisfactory completion of the course (a grade of "C" or higher) will be required of the employee or money paid to the Association member shall be reimbursed to the District.

If an employee is interested in out-of-state tuition, up to a maximum of $100 per credit hour shall be allowed for the employee with a limit of six (6) credit hours per contract year.

The cost of class required textbooks shall be reimbursed by the District. Receipts shall be turned in to the Director of Personnel & Employee Relations prior to reimbursement. Reimbursement for required textbooks shall be subject to the requirement of successful completion of the related course as stated above.

Supplemental textbooks, materials, mileage, and incidental costs are the responsibility of the employee, and shall not be reimbursed by the District.

Section 9.06 Longevity

A longevity payment shall be paid for years of service in the Bay City School District according to the following schedule:

On the 10th, 11th, 12th, 13th and
14th year of service .... 1% of unit member's current step and level per Appendix A.

On the 15th, 16th, 17th, 18th and
19th year of service .... 2% of unit member's current step and level per Appendix A.

On the 20th, 21st, 22nd, 23rd, and
24th year of service .... 3% of unit member's current step and level per Appendix A.

On the 25th, 26th, 27th, 28th, and
29th year of service and thereafter.......4% of unit member's current step and level per Appendix A.

These years shall be determined by the following method:

1) A Unit member hired during the first half of the school fiscal year, July through December 31, shall have a longevity date as of July 1 of the fiscal year. A Unit member hired during the last half of the school fiscal year, January 1 through June 30, shall have a longevity date of July 1 of the following fiscal year.

2) To find the tenth, fifteenth, twentieth, or twenty-fifth year of service, add nine, fourteen, nineteen or twenty-four to the longevity date year. July 1st of that year will be the date when the 1%, 2%, 3%, or 4% longevity begins as per example.

EXAMPLE:

Longevity	July 1, 1960	July 1, 1960	July 1, 1960	July 1, 1960
Add	9	14	19	24
1%, 2%, 3% or 4% longevity begins	July 1, 1969	July 1, 1974	July 1, 1979	July 1, 1984

ARTICLE X

SEVERANCE AND RETIREMENT

Section 10.01 Severance Pay

At any time a Supervisor having fifteen (15) or more years of service to the District shall leave the employ of the District for reasons other than retirement under Section 10.02, he/she shall receive severance pay of two hundred dollars ($200) for each year of service but not to exceed six thousand dollars ($6,000), plus severance pay prorated at current salary for every day of accumulated sick leave over forty (40) days but not to exceed four thousand five hundred ($4,500) dollars. In the event of the death of a Supervisor, the designated beneficiary(ies) of said Supervisor shall receive all severance pay due said Supervisor.

Section 10.02 Retirement Benefits

A Supervisor who has at least fifteen (15) years of Bay City Public Schools service and who retires under the Michigan Public Schools Employees Retirement System (MPSERS) shall receive a retirement benefit in accordance with the following terms and conditions:

He/she shall notify the Director of Personnel & Employee Relations of an intent to take an early retirement at least thirty (30) days prior to the effective date of retirement unless otherwise waived by the Superintendent.

Section 10.03

An employee who has at least fifteen (15) years of Bay City Public Schools service and who retires under MPSERS shall receive a severance benefit in accordance with the following terms and conditions:

- For each accumulated unused sick leave day up to a maximum of 96 days, the employee shall receive an amount based upon the employee's base rate of pay (less longevity, current improvement, etc.) at the time of retirement.
- For each accumulated unused sick leave day above 96 days, the employee shall receive an amount based upon one-half (1/2) the employee's base rate of pay (less longevity, current improvement, etc.) at the time of retirement.
- The total severance amount may be used to purchase service credit under the guidelines and conditions as established by the Michigan Public Schools Employees Retirement System (MPSERS).

Section 10.04

An employee may only be charged a maximum of ninety-six (96) days of sick leave for serious illness or illnesses during the last five years prior to leaving the District. A serious illness is defined as any illness in excess of ten (10) consecutive sick leave days. (Documentation by a physician is required.) For purposes of calculating severance pay only days used beyond the ninety-sixth (96th) day shall be added back into the final calculation.

ILLUSTRATIVE MODEL:

1999-00	Used a block of 25 consecutive days	25
2000-01	Used 15 non-consecutive days	0
2001-02	Used two blocks of 15 and 25 consecutive days respectively	40
2002-03	Used 60 days including a block of 45 consecutive days	45
2003-04	Used 9 days, consecutive or non-consecutive	0
	TOTAL	110

110 days – 96 = 14 days

Fourteen (14) days would be included in the severance pay final calculation.

(Total sick days for serious illness used in a block during the last five (5) years of employment – maximum capped amount (96 days) = Number of sick days to be added back for severance calculation)

Section 10.05

The retired Supervisor shall receive the amount in equal bi-weekly installments over a five year (5) period. The equal bi-monthly installments shall be remitted to the retired Supervisor beginning with the first pay Friday of the next school year or if the Supervisor's retirement is effective during a school year, the first pay Friday following the first full month after the effective date of retirement. Payment(s) will be deposited into a Paradigm Equity 403(b) account set up for the Member. There is no cash option.

Section 10.06 Beneficiary

In the event a retired Supervisor dies prior to receiving all the installments, the retired Supervisor's beneficiary(ies) shall receive the remaining installments. Upon retiring, the Supervisor shall submit the names(s) of the beneficiary(ies), in writing, to the Personnel office.

ARTICLE XI

CREATION OF NEW SUPERVISORY POSITIONS

Section 11.01

The Board reserves unto itself the right to create new supervisory positions. However, the duties, wages, hours and employment, and other conditions of employment shall be mutually agreed upon by the Board of Education and the Supervisory Association.

Other supervisory positions will be included in the Association, provided such position/s is/are deemed to be essential to the normal categories included herein by the parties hereto. Failure to agree will result in the appeal procedure set forth in Article VII being followed.

Section 11.02

New positions will be filled within ninety (90) calendar days after the Board informs the Association of its desire to create such position(s).

ARTICLE XII

REDUCTION OF STAFF

Section 12.01 Determination Factors

If the Board determines that it is necessary to reduce the number of Supervisors, the Board shall confer with the Association regarding the necessity and feasibility of the reduction and shall present the reasons underlying the decision.

Once the need for reduction of Supervisory force is established, the Board and the Association shall develop an equitable and feasible procedure of lay-off and recall.

The following factors, weighted by priority as to their order of listing, shall be used to determine Supervisor/s to be laid off shall be:

1) Recommendation of the Director of Maintenance or Superintendent's designee

2) Evaluation records

3) Qualifications regarding current position

4) Total experience as a Supervisor with the Bay City Public Schools

5) Total experience as an employee of the Bay City Public Schools

Any lay-offs shall be equivalent to the total number of supervisory positions being reduced. A Supervisor scheduled to be laid off must be notified, in writing, by the Board at least ninety (90) calendar days prior to the lay-off date.

Section 12.02 Allocation of Duties

When reduction of supervisory staff dictates added work load to remaining Supervisors, the duties will be allocated as evenly as possible. The Board and Association shall confer and agree on such matters. In the event the parties cannot agree upon the allocation of duties, the matter shall be resolved pursuant to the appeal process set forth in Article VII.

ARTICLE XIII

SICK LEAVE

Section 13.01 Purpose

The primary purpose of the sick leave allowance is to cover the absence of a Supervisor from work because of personal illness or injury sufficiently severe that would render his/her presence at his/her job inadvisable. Sick leave applies only to absences resulting from illness or injury to the employee.

Section 13.02 Rate of Accumulation

Sick leave accumulates at the rate of six (6) days per semester and shall be unlimited in total accumulation. Accumulated sick leave shall be reported monthly on the payroll forms and a record of total days available will be available in the office of the Immediate Superior.

Section 13.03 Verification of Illness/Injury

If there is a question or concern regarding the illness or injury of an employee, the Superintendent or his/her designee may require a doctor's statement verifying the illness or may require the employee to submit to a medical examination before sick leave pay is allowed or the employee may return to work.

Section 13.04 Worker's Compensation

Any Supervisor who is absent because of an injury or illness compensable under the Michigan Workers' Compensation Law, shall receive from the Board the difference between the allowance under the Workers' Compensation Law and his/her regular salary for the duration of the illness and the difference shall be charged against sick leave until sick leave benefits are exhausted. If the employee continues to be absent as a result of a compensable illness, he/she will continue receiving the allowance provided under Workers' Compensation for the duration of the disability or as otherwise provided under such Act.

ARTICLE XIV

LEAVES OF ABSENCE

Section 14.01 Purpose

Any employee whose personal illness or disability extends beyond the period compensated shall be granted a leave of absence without pay or benefits for such

additional time as may be necessary for complete recovery from such illness. Leave of absence without pay shall not exceed two (2) years. Upon return from leave, the employee shall be assigned to the same position, if available, or substantially equivalent position.

Section 14.02 Criteria - "Chargeable"

Leaves of absence with pay chargeable against sick leave allowance shall be granted annually for the following reasons:

1) A maximum of five (5) days for critical illness in the immediate family living in the same household.

2) A maximum of five (5) days for a critical illness in the immediate family not living in the same household may be granted at the discretion of the Director of Personnel & Employee Relations.

3) Two (2) days to transact business when the Supervisor, through no fault of his/her own, is unable to transact such business except during his/her regular working hours. Application for business days will be made to the Immediate Supervisor and/or the Director of Personnel & Employee Relations at least twenty-four (24) hours in advance. If the urgency of the leave is of such a nature that the request in writing is not practical, verbal notice to the Immediate Supervisor and/or the Director of Personnel & Employee Relations will be sufficient and a Reason for Absence form will be submitted by the Supervisor upon return from leave. Additional days may be granted by the Director of Personnel & Employee Relations. The decision of the Director of Personnel & Employee Relations on the justification of business days will be final and not subject to the Appeal procedure.

Section 14.03 Criteria- "Non-Chargeable"

Leaves of absence with pay not chargeable against sick leave allowance shall be granted for the following reasons:

1) A maximum of three (3) days for a death in the immediate family; spouse, father, mother, father-in-law, mother-in-law, brother, sister, and children. Additional time may be granted at the discretion of the Director of Personnel & Employee Relations.

2) One (1) day for the attendance at the funeral service of person whose relationship to the employee warrants such attendance. Additional time may be granted at the discretion of the Director of Personnel & Employee Relations.

3) Absence when called for jury service.

4) Court appearance as a witness in any case connected with the Supervisor's employment of the school or whenever the Supervisor is subpoenaed to attend any proceeding.

5) One (1) day to take the selective service physical examination.

Section 14.04 Child Rearing Leave

In conjunction with the Family and Medical Leave Act, and not in addition thereto, a child rearing leave of a maximum of one (1) year shall be granted without pay or benefits. Extensions may be granted for one (1) year upon application, in writing, ninety (90) calendar days prior to the end of the leave. An employee having been duly granted a child rearing leave must apply for re-employment a minimum of ninety (90) calendar days prior to the time employment is desired.

An employee adopting a child may receive similar leave which shall commence upon entry of an order terminating the rights of the natural parents by the Probate Court.

Section 14.05 Peace Crops

Leave of absence shall be granted up to two (2) years to any employee who enlists in the Peace Corps as a full-time participant. Such employee shall be restored to employment with the District and shall be given the benefits of any increments which would have been credited to him/her had he/she remained in active service with the school system; provided, however, that such Supervisor shall make application for re-employment within the ninety (90) calendar days after discharge from the Peace Corps.

Section 14.06 Military

Military leaves of absence shall be granted to any employee who shall be inducted or shall enlist for military duty to any branch of the Armed Forces of the United States until expiration of the first enlistment of the duration of the national emergency. Such employee shall be restored to employment with the District and shall be given the benefit of any increments; provided however, that such Supervisor shall make application for such re-employment within ninety (90) calendar days after discharge from the Armed Forces and provided further, that such employee reports for his/her assignment immediately following such application. Military leave of absence shall also be granted for National Guard or Reserve duty.

Section 14.07 Public Office

An employee elected or selected for full-time public office which takes him/her from his/her duties with the school system, shall, upon written request, receive a leave of absence without pay or benefits for the term of such office or two (2) years, whichever is less. Unless such employee returns within the time limit hereinbefore

specified, such leave of absence shall terminate unless it has been renewed for a specific period with the approval of the Director of Personnel & Employee Relations.

Section 14.08 Part-time Service

It is recognized that an employee has the right to serve in, or be elected to, public office less than full time. However, such services shall not be permitted to interfere with the employee's service to be rendered to the School District.

Section 14.09 Physical Examination

When an employee returns to work following a leave of absence duly granted for any reason, the Board may require such employee to submit to a physical examination at its expense to make certain such employee is able to return to work.

Section 14.10 Leaves Without Pay

It is the intent that a leave of absence without pay or benefits will be taken only in very unusual circumstances and then, very infrequently. A conference with the Director of Personnel & Employee Relations will be held to consider the reason for such leave and the effect on the operation of the school system.

Section 14.11 Loss of Benefits

Leaves of absence without pay of less than ninety (90) calendar days shall not result in a loss of benefits.

Section 14.12 Leave for Employment within the District

Any member of the Unit who is employed in any other position in the Bay City School District shall be entitled to retain such rights and seniority as she/he may have had under the Supervisor's Union agreement prior to transfer should she/he return. If the employee returns to the Unit, longevity credit will be given for service to the Bay City Public Schools. Procedure for return will be pursuant to seniority and qualificiations with the Supervisors' Union agreement.

ARTICLE XV

INSURANCE PROTECTION

Section 15.01 Establishment

Pursuant to the authority set forth in the School Code of 1955, as amended, the Board agrees to furnish all Supervisors in the Bargaining Unit insurance protection as hereinafter set forth.

Section 15.02 Term Life Insurance

Group term life insurance coverage in the amount of $75,000.00 AD & D, in addition to the coverage provided in Section 15.03. All employees must be actively at work on the effective date of any changes in coverage. Any changes in coverage will be effective the first of the month following ratification of the contract by all parties with the exception of employees not actively at work. Insurance coverage changes for those not actively at work will take place the first of the month following their first day back to work.

Section 15.025 Insurance Benefits

For the term of this Agreement, the Board shall provide complete health care protection on a full twelve (12) month basis with either a single, two-person, or full family benefit status as selected by the employee during the open enrollment period. Upon proper application and acceptance for enrollment by the appropriate insurance underwriter, policyholder and/or third party administrator, the Board shall make premium payments on behalf of the Employee and his/her eligible dependents for the following insurance program to include medical, dental, vision and hospitalization insurance for a full twelve (12) month period:

Beginning July 1, 2015, the District shall contribute 80% of the combined costs for all health insurance programs (all-inclusive costs to the school district including health, dental, vision, life, ACA fees/taxes, etc.) and all "medical benefit plan" costs within the meaning of Public Act 152 of 2011. The District's all-inclusive (health, dental, vision, life, ACA fees/taxes, etc.) contribution shall not exceed 90% of the State statutory cap levels in place pursuant to PA152.

Section 15.03 Health Care

The School District shall provide complete health care protection on a full twelve (12) month basis with either single, two-person, or full family benefit status as selected by the employee during the open enrollment period. Parties have agreed to offer multiple health care coverage options provided in the attached level of benefits. The plan year is July 1st through June 30th.

The following "Base Plan" level of co-pays, deductibles and level of Co-insurance are a 100% expense of the employee. The "Base Plan" (OPT 3) is $1000/$2000 Deductible, 20% Coinsurance Percentage up to a potential Max Paid Out of Pocket $3500/$7000, $30/$50 Office Visit Co-pay, $80 Urgent Care Co-pay, $150 ER Co-pay (See attached benefit level description for the Base Plan (OPT 3) attached to this contract). Included in the "Base Plan" health insurance are prescription benefits that have established co-payment levels of $15/$50 which are the responsibility at 100% paid by the employee based on the prescription category (See attached benefit levels description for prescription coverage).

Should the employee select one of the offered health insurance options other than the "Base Plan" and the option they select is at a higher annual premium cost, the employee is responsible (in addition to their cost outlined above) for 100% of the differential cost between the plan selected and the "Base Plan". Under all health insurance options offered by the Board, all co-pays, levels of deductibles and levels of co-insurance are the responsibility of the employee.

Bi-weekly payments for the employee's portion of insurance benefits costs shall be made through a Section 125 payroll deduction (pre-tax benefit) as established by the District and as allowable based on available compensation level. If the employee elects not to select the payroll deduction via a Section 125 (pre-tax benefit) plan, an election form to deduct on a post-tax basis must be signed by the employee. If the employee's required contribution to pay premiums for the insurance option selected is increased or decreased during the plan year, the payroll deduction will automatically be adjusted to reflect the increase or decrease. The Board shall have the right to recover any unpaid premiums by the employee (in addition to any other remedies provided by law) by deducting the premium amount in arrears from any wages remaining to be paid to the employee. If remedies described above are not available, the District reserves the right to terminate healthcare coverage of the employee who is unable to make their portion of the premium current.

There will be no double insurance coverage allowed. Whenever the employee's spouse and family are covered by a fully-paid hospitalization insurance, this section is void.

In Lieu of Health – Bargaining unit members who qualify for health insurance coverage and who choose not to be provided with such coverage shall receive a cash option payment of $100.00 per month or $100.00 per month under Section 125 of the Internal Revenue Code (403b annuity plan currently payroll deducted by the Board). In addition a fund will be established to share savings related to an employee's decision to select an annuity payment in lieu of selecting District provided health insurance coverage.

An amount equal to 40% of the District's portion of the health insurance premium relinquished by the employee will be added to a fund for any individual that selects

the annuity option over the number of individuals (based upon the current census of June 1, 2015 that had selected the annuity option for the 2015-16 year and based upon the current census of June 1, 2016 for the 2016-17 year. (See attached illustrated example)

Furthermore, the level of health insurance premium used for the calculation will be based on the employee's previous choice of coverage prior to selecting the annuity option, single coverage, two person coverage or full family coverage as defined in the "Base Plan".

Payment of any savings over the fixed monthly annuity payment of $100 dollars per month will be paid in a lump sum amount no later than June 30th of the fiscal year in which the annuity option was selected in a separate check. The member may choose a cash option payment or a 403b annuity governed by Section 125 of the Internal Revenue Code.

If an employee selects the annuity option or requests a change in coverage at a time other than open enrollment, the amount added to the annuity fund will be adjusted to reflect this change.

In the event an individual who has a spouse employed by the District (and who is currently primary insurance holder) moves from the primary insurance holder to the annuity option, this individual will not be included in the annuity savings calculation.

The member will need to complete a declination form when making a decision not selecting insurance coverage.

Section 15.04 Dental

The Board shall provide dental insurance options through either a fully-insured or self-insured program. Options available are full family, single, or two person levels of benefits. The monthly Board paid premium has been identified above. The dental coverage levels of Co-insurance as described in the summary of benefits are 100% the responsibility of the employee. The dental insurance plan is included in the Appendix of the contract.

Bi-weekly payments for the employee's portion of dental insurance benefit costs shall be made through a Section 125 payroll deduction (pre-tax benefit) as established by the District and as allowable based on available compensation level. If the employee elects not to select the payroll deduction via a Section 125 (pre-tax benefit) plan, an election form to deduct on a post-tax basis must be signed by the employee. If the employee's required contribution to pay premiums for the insurance option selected is increased or decreased during the plan year, the payroll deduction will automatically be adjusted to reflect the increase or decrease. The Board shall have the right to recover any unpaid premiums by the employee (in addition to any other remedies provided by law) by deducting the premium amount

in arrears from any wages remaining to be paid to the employee. If remedies described above are not available, the District reserves the right to terminate coverage of the employee who is unable to make their portion of the premium current.

Section 15.05 Duplicate Coverage

If both husband and wife are employed by the District, they may carry only one hospitalization and one dental insurance policy between them.

Section 15.06 Loss of Coverage

Association members may elect hospitalization insurance if his/her spouse, who was previously covered by fully paid MESSA or Blue Cross - Blue Shield or other similar coverage, died, retired, or otherwise lost the benefit of such hospitalization coverage for reasons beyond his/her control. Such Supervisor shall then be permitted to apply for health insurance benefits through the Board on the usual terms and conditions prescribed by the insurance provider(s).

Section 15.07 Liability Coverage

The Board will provide liability insurance to cover losses resulting from litigation against the Supervisor for any actions related to his/her job assignment.

Section 15.08 Supplemental Coverage

The Board will provide assurance of complete compensation over and above the losses covered by the Supervisor's personal insurance for any on-site, job related damage or destruction of personal property, such as 1) personal vehicle, 2) clothing, 3) eyeglasses, 4) timepieces, and 5) any equipment which is frequently used in the normal fulfillment of the Supervisor's administrative duties and which has not been furnished by the District. Total compensation shall not exceed the replacement value of the property.

Section 15.09 Vision

The Board shall provide vision insurance options through either a fully-insured or self-insured program. Options available are full family, single, or two person levels of benefits. The monthly Board paid premium has been identified above. The vision coverage levels of Co-insurance as described in the summary of benefits are 100% the responsibility of the employee. The vision insurance plan is attached to the contract.

Bi-weekly payments for the employee's portion of vision insurance benefit costs shall be made through a Section 125 payroll deduction (pre-tax benefit) as established by the District and as allowable based on available compensation level.

If the employee elects not to select the payroll deduction via a Section 125 (pre-tax benefit) plan, an election form to deduct on a post-tax basis must be signed by the employee. If the employee's required contribution to pay premiums for the insurance option selected is increased or decreased during the plan year, the payroll deduction will automatically be adjusted to reflect the increase or decrease. The Board shall have the right to recover any unpaid premiums by the employee (in addition to any other remedies provided by law) by deducting the premium amount in arrears from any wages remaining to be paid to the employee. If remedies described above are not available, the District reserves the right to terminate coverage of the employee who is unable to make their portion of the premium current.

Section 15.10 Long-Term Disability

The District will provide a Long-Term Disability plan for employees to purchase (See Appendix).

Section 15.15 Flexible Spending Account

A Flexible Spending Account will be available for employee contribution. A copy of the plan is attached to the contract.

ARTICLE XVI

VACANCIES, PROMOTIONS, TRANSFERS

Section 16.01 Appointment to Supervisory Position

The Board and the Association agree that all Supervisory positions as defined in Article I, Section 1.04 of this Agreement shall be staffed by competent and qualified personnel.

In staffing available supervisory positions, qualified and competent applicants shall be given preference in the following order:

1) Members of the Supervisor's Association

2) Other employees of the Bay City Public Schools

3) Persons not employed by the Bay City Public Schools.

Criteria used when considering Association members for other positions shall be:

1) Recommendation of the Director of Maintenance or Superintendent's

designee

2) Evaluation records

3) Qualifications regarding current position

4) Total experience as a Supervisor with the Bay City Public Schools

5) Total experience as an employee of the Bay City Public Schools

ARTICLE XVII

JOB DESCRIPTION

Section 17.01 Availability

A Job Description for each Supervisory position will be available in the office of the Director of Personnel & Employee Relations.

ARTICLE XVIII

DURATION OF AGREEMENT

Section 18.01 Term

This Agreement shall become effective July 1, 2017 and shall continue in full force and effect until June 30, 2019, (the "termination date"), except as outlined below:

Section 18.02 Extension

Notwithstanding the termination date stated above, unless a party to this Agreement provides, at least sixty (60) calendar days prior to the termination date stated herein, a written notice of such intent to terminate, this Agreement shall continue in full force and effect from year to year thereafter, subject to written notice of termination by either party of sixty (60) calendar days prior to the then current year's termination date.

Section 18.03 Amendment

If either party desires to amend or otherwise modify this Agreement, it shall give written notice of such amendment, and such notice set forth the nature of the amendment. If the parties cannot agree to said proposed amendment(s) within a

period of forty-five (45) calendar days from the date of the notice, the proposed amendment will be deemed to have been withdrawn. Said time within which to reach an agreement on the proposed amendment may be extended by mutual consent of both parties, such consent to be in writing and signed by the parties. Any amendments that may be agreed upon shall become and be a part of this Agreement without modifying or changing any of the other terms of the Agreement.

ARTICLE XIX

SALARY SCHEDULE

Section 19.01

For 2017-2018, the Salary schedule will reflect a 2% salary schedule increase. There will be one step allowed for the 2017-2018 year. There will be a freeze on longevity.

For 2018-2019, the Salary schedule will reflect a 0% salary schedule increase. For the 2018-2019 school year an off-schedule payment of $500.00 shall be made on the second payroll Friday of December 2018. There will be no step increase for the 2018-2019 year. There will be a freeze on longevity.

IN WITNESS WHEREOF, the parties hereunto set their hands and seal this 28th day of June, 2017.

BAY CITY PUBLIC SCHOOLS
ASSOCIATION OF
SUPERVISORY PERSONNEL

BY: Courtney Sage
President

BAY CITY BOARD OF EDUCATION

BY: Mark Zanotti
President

Laurie Jeske
Secretary

APPENDIX "A"

Supervisor Salary Schedule 2017-2018

2% on 16/17

LEVEL	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6	STEP 7	STEP 8	STEP 9	STEP 10	STEP 11	STEP 12
A	$30,680	$32,481	$34,301	$36,074	$37,872	$41,463	$43,258	$46,852	$48,651	$51,076	$53,622	$57,938
B	$28,887	$30,683	$32,481	$34,280	$36,074	$37,873	$38,981	$42,218	$44,016	$46,204	$48,509	$55,793
C-44	$25,296	$27,095	$28,887	$30,683	$34,280	$36,074	$36,329	$39,354	$41,149	$42,254	$45,354	$49,151
D-52	$18,597	$20,626	$22,660	$24,693	$26,722	$28,756	$30,785	$32,818	$34,850	$36,881	$38,920	$42,310
D-44	$15,755	$17,559	$19,364	$21,166	$22,970	$24,773	$26,577	$28,380	$30,183	$31,986	$33,796	$36,862
D-42	$15,047	$16,766	$18,491	$20,213	$21,936	$23,656	$25,379	$27,101	$28,823	$30,546	$32,265	$35,237
D-40	$14,337	$15,900	$17,464	$19,027	$20,589	$22,155	$23,717	$25,279	$26,841	$28,405	$29,971	$32,797

A = Maintenance Supervisors
C = District Volunteer Coordinator (44 weeks)
D = Supervisor of Intermediate Attendance (42 weeks)
D = Food Service Managers

A = 52 Week Assignment
B = 52 Week Assignment
C = 44 Week Assignment
D = As Described

APPENDIX "A"

Supervisor Salary Schedule 2018-2019

0% on 17/18

LEVEL	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6	STEP 7	STEP 8	STEP 9	STEP 10	STEP 11	STEP 12
A	$30,680	$32,481	$34,301	$36,074	$37,872	$41,463	$43,258	$46,852	$48,651	$51,076	$53,622	$57,938
B	$28,887	$30,683	$32,481	$34,280	$36,074	$37,873	$38,981	$42,218	$44,016	$46,204	$48,509	$55,793
C-44	$25,296	$27,095	$28,887	$30,683	$34,280	$36,074	$36,329	$39,354	$41,149	$42,254	$45,354	$49,151
D-52	$18,597	$20,626	$22,660	$24,693	$26,722	$28,756	$30,785	$32,818	$34,850	$36,881	$38,920	$42,310
D-44	$15,755	$17,559	$19,364	$21,166	$22,970	$24,773	$26,577	$28,380	$30,183	$31,986	$33,796	$36,862
D-42	$15,047	$16,766	$18,491	$20,213	$21,936	$23,656	$25,379	$27,101	$28,823	$30,546	$32,265	$35,237
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A = Maintenance Supervisors
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D = Food Service Managers

A = 52 Week Assignment
B = 52 Week Assignment
C = 44 Week Assignment
D = As Described

Supervisors Calendar

2017-2018

July

M	T	W	T	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

August

M	T	W	T	F
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	[24]	25v
[28/]	29	30	31v	

September

M	T	W	T	F
				1v
4H	<5>	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

October

M	T	W	T	F
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

November

M	T	W	T	F
		1v	2	3
6	7	8	9	10
13	14	15	16	17
20	21*	22v	23H	24H
27	28	29	30	

December

M	T	W	T	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22v
25H	26H	27v	28v	29v

January

M	T	W	T	F
1H	2H	3	4	5
8	9	10	11	12
15	16	17	18	19
22v	23	24	25	26
29	30	31		

February

M	T	W	T	F
			1	2
5	6	7	8	9
12	13	14	15	[16]
19	20	21	22	23
26	27	28		

March

M	T	W	T	F
			1	2
5	6	7	8	9*
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30H

April

M	T	W	T	F
2v	3v	4v	5v	6v
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27v
30				

May

M	T	W	T	F
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25v
28H	29	30	31	

June

M	T	W	T	F
				1
4	5	6	7	8
11	12	13	<14>*	15
18	19	20	21	22
25	26	27	28	29

Symbols

Symbol	Meaning
_	Non work days - non paid
H	Holidays (9)
[]	Professional Development Meetings
< >	First Day of School
< >	Last Day of School
v	Vacation Days
/	Welcome Back Meeting - 8/28/17
*	Half Days - Students Attend a.m. (3)

42 Weeks

186 work days (5 unscheduled vac. days)
17 scheduled vacation days
3 Professional Development Days
9 Holidays
215 Total Paid Days

Should the Director of Nutrition Services determine the need for Supervisors to work on August 25 and/or August 31, the scheduled vacation days can be rescheduled on a day to be determined between the Director of Nutrition Services and the Supervisor.

Base Plan
Option # 3

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

Bay City Schools

Simply Blue^{SM} PPO 1000

Coverage Period: Beginning on or after 07/01/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual / Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsm.com or by calling 866-588-2150.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$1,000 Individual /$2,000 Family	$2,000 Individual /$4,000 Family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses? (May include a co-insurance maximum)	$6,350 Individual /$12,700 Family	$12,700 Individual /$25,400 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No		The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.bcbsm.com or call 866-588-2150.		If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see	No		You can see the specialist you choose without permission from this plan.

a specialist?		
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay	40% co-insurance after deductible	-- none --
	Specialist visit	$50 co-pay	40% co-insurance after deductible	-- none --
	Other practitioner office visit	$30 co-pay for Chiropractic and osteopathic manipulative therapy	40% co-insurance after for Chiropractic and osteopathic manipulative therapy	Limited to a **combined** maximum of 12 visits per member per calendar year
	Preventive care/screening/ immunization	No charge	Not covered	-- none --
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you need drugs to treat your illness or condition Some plans may have a separate out of pocket maximum for	Generic or prescribed over-the-counter drugs	$15 co-pay	$15 co-pay **plus** 25% of approved amount	30-day supply. 90-day retail and mail order copays are 2x standard retail copays. 90-day supply not covered out-of-network. For information on women's contraceptive coverage, contact your plan administrator.
	Preferred brand-name drugs	$50 co-pay	$50 co-pay **plus** 25% of approved amount	30-day supply. 90-day retail and mail order copays are 2x standard retail copays. 90-day supply not covered out-of-network.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Out-of-Network Provider	Limitations & Exceptions
prescription drug coverage, for more information please contact your plan administrator.	Nonpreferred brand-name drugs	$70 or 50% (whichever is greater) max $100	$70 or 50% (whichever is greater) max $100 **plus** 25% of approved amount	30-day supply. 90-day retail and mail order copays are 2x standard retail copays. 90-day supply not covered out-of-network.
	Generic and preferred brand-name specialty drugs	20% co-insurance up to $200	20% co-insurance up to $200 **plus** 25% of approved amount	30-day supply maximum. May require preapproval. BCBSM reserves the right to limit the initial quantity to less than 30 days.
	Nonpreferred brand-name specialty drugs	25% co-insurance up to $300	25% co-insurance up to $300 **plus** 25% of approved amount	30-day supply maximum. May require preapproval. BCBSM reserves the right to limit the initial quantity to less than 30 days.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you need immediate medical attention	Emergency room services	$150 co-pay	$150 co-pay	Co-pay waived if admitted
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible	-- none --
	Urgent care	$60 co-pay	40% co-insurance after deductible	-- none --
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Physician/surgeon fee	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Your cost share may be different for services performed in an office setting
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Substance use disorder outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you are	Prenatal and postnatal care	Prenatal: No charge;	40% co-insurance after	-- none --

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
pregnant		Postnatal: 20% co-insurance after deductible	deductible	
	Delivery and all inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	20% co-insurance after deductible	-- none --
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Physical, Occupational, Speech therapy is limited to a **combined** maximum of 30 visits per member per calendar year
	Habilitation services	20% co-insurance after deductible for Applied Behavioral Analysis; 20% co-insurance after deductible for Physical, Speech and Occupational Therapy	20% co-insurance after deductible for Applied Behavioral Analysis; 40% co-insurance after deductible for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	20% co-insurance after deductible	20% co-insurance after deductible	Limited to a maximum of 120 days per member per calendar year
	Durable medical equipment	20% co-insurance after deductible	20% co-insurance after deductible	-- none --
	Hospice service	No charge	No charge	-- none --
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-- none --
	Glasses	Not covered	Not covered	-- none --
	Dental check-up	Not covered	Not covered	-- none --

Excluded Services & Other Covered Services:

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

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

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

• Bariatric surgery • Chiropractic care	• Non-Emergency care when traveling outside the U.S. • Coverage outside of the U.S., see http://provider.bcbs.com	• Private-duty nursing

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

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

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services

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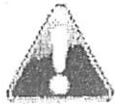
SPANISH (Español): Para ayuda en español, llame al número de servicio al cliente que se encuentra en este aviso ó en el reverso de su tarjeta de identificación.
TAGALOG (Tagalog): Para sa tulong sa wikang Tagalog, mangyaring tumawag sa numero ng serbisyo sa mamimili na nakalagay sa likod ng iyong pagkakakilanlan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

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

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

Please note: Coverage Examples are calculated based on individual coverage and calculations may not include a co-insurance maximum.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,120
- **You pay** $2,420

Sample care costs:

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

Patient pays:

Deductibles	$1,000
Co-pays	$20
Co-insurance	$1,250
Limits or exclusions	$150
Total	**$2,420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,380
- **You pay** $2,020

Sample care costs:

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

Patient pays:

Deductibles	$1,000
Co-pays	$750
Co-insurance	$190
Limits or exclusions	$80
Total	**$2,020**

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Buy-up Plan
Option 1

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

Bay City Schools

Simply Blue℠ PPO 250

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 07/01/2015
Coverage for: Individual / Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsm.com or by calling 866-588-2150.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$250 Individual /$500 Family	$500 Individual /$1,000 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses? (May include a co-insurance maximum)	$6,350 Individual /$12,700 Family	$12,700 Individual /$25,400 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No		The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.bcbsm.com or call 866-588-2150.		If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see	No		You can see the **specialist** you choose without permission from this plan.

a specialist?		
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	40% co-insurance after deductible	-- none --
	Specialist visit	$40 co-pay	40% co-insurance after deductible	-- none --
	Other practitioner office visit	$30 co-pay for Chiropractic and osteopathic manipulative therapy	40% co-insurance after for Chiropractic and osteopathic manipulative therapy	Limited to a **combined** maximum of 12 visits per member per calendar year
	Preventive care/screening/ immunization	No charge	Not covered	-- none --
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you need drugs to treat your illness or condition Some plans may have a separate out of pocket maximum for	Generic or prescribed over-the-counter drugs	$15 co-pay	$15 co-pay **plus** 25% of approved amount	30-day supply. 90-day retail and mail order copays are 2x standard retail copays. 90-day supply not covered out-of-network. For information on women's contraceptive coverage, contact your plan administrator.
	Preferred brand-name drugs	$50 co-pay	$50 co-pay **plus** 25% of approved amount	30-day supply. 90-day retail and mail order copays are 2x standard retail copays. 90-day supply not covered out-of-network.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
prescription drug coverage, for more information please contact your plan administrator.	Nonpreferred brand-name drugs	$70 or 50% (whichever is greater) max $100	$70 or 50% (whichever is greater) max $100 **plus** 25% of approved amount	30-day supply. 90-day retail and mail order copays are 2x standard retail copays. 90-day supply not covered out-of-network.
	Generic and preferred brand-name specialty drugs	20% co-insurance up to $200	20% co-insurance up to $200 **plus** 25% of approved amount	30-day supply maximum. May require preapproval. BCBSM reserves the right to limit the initial quantity to less than 30 days.
	Nonpreferred brand-name specialty drugs	25% co-insurance up to $300	25% co-insurance up to $300 **plus** 25% of approved amount	30-day supply maximum. May require preapproval. BCBSM reserves the right to limit the initial quantity to less than 30 days.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you need immediate medical attention	Emergency room services	$150 co-pay	$150 co-pay	Co-pay waived if admitted
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible	-- none --
	Urgent care	$60 co-pay	40% co-insurance after deductible	-- none --
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Physician/surgeon fee	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Your cost share may be different for services performed in an office setting
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Substance use disorder outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you are	Prenatal and postnatal care	Prenatal: No charge;	40% co-insurance after	-- none --

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
pregnant		Postnatal: 20% co-insurance after deductible	deductible	
	Delivery and all inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	20% co-insurance after deductible	-- none --
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Physical, Occupational, Speech therapy is limited to a **combined** maximum of 30 visits per member per calendar year
	Habilitation services	20% co-insurance after deductible for Applied Behavioral Analysis; 20% co-insurance after deductible for Physical, Speech and Occupational Therapy	20% co-insurance after deductible for Applied Behavioral Analysis; 40% co-insurance after deductible for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	20% co-insurance after deductible	20% co-insurance after deductible	Limited to a maximum of 120 days per member per calendar year
	Durable medical equipment	20% co-insurance after deductible	20% co-insurance after deductible	-- none --
	Hospice service	No charge	No charge	-- none --
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-- none --
	Glasses	Not covered	Not covered	-- none --
	Dental check-up	Not covered	Not covered	-- none --

Excluded Services & Other Covered Services:

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

- **Acupuncture**
- **Cosmetic surgery**
- **Dental Care (Adult)**
- **Hearing aids**
- **Infertility treatment**
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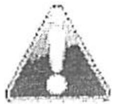

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See the next page for important information about these examples.

Please note: Coverage Examples are calculated based on individual coverage and calculations may not include a co-insurance maximum.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,720
- **You pay** $1,820

Sample care costs:

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

Patient pays:

Deductibles	$250
Co-pays	$20
Co-insurance	$1,400
Limits or exclusions	$150
Total	**$1,820**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,040
- **You pay** $1,360

Sample care costs:

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

Patient pays:

Deductibles	$250
Co-pays	$800
Co-insurance	$230
Limits or exclusions	$80
Total	**$1,360**

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Buy-up Plan
Option 2

Blue Cross Blue Shield of Michigan

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

Bay City Schools

Simply Blue℠ PPO 500

Coverage Period: Beginning on or after 07/01/2015

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsm.com or by calling 866-588-2150.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$500 Individual /$1,000 Family	$1,000 Individual /$2,000 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses? (May include a co-insurance maximum)	$6,350 Individual /$12,700 Family	$12,700 Individual /$25,400 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No		The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.bcbsm.com or call 866-588-2150.		If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see	No		You can see the **specialist** you choose without permission from this plan.

Group Number 000000000-0000

Questions: Call 866-588-2150 or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 866-588-2150 to request a copy.

a **specialist**?		
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	40% co-insurance after deductible	-- none --
	Specialist visit	$40 co-pay	40% co-insurance after deductible	-- none --
	Other practitioner office visit	$30 co-pay for Chiropractic and osteopathic manipulative therapy	40% co-insurance after for Chiropractic and osteopathic manipulative therapy	Limited to a **combined** maximum of 12 visits per member per calendar year
	Preventive care/screening/ immunization	No charge	Not covered	-- none --
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you need drugs to treat your illness or condition Some plans may have a separate out of pocket maximum for	Generic or prescribed over-the-counter drugs	$15 co-pay	$15 co-pay **plus** 25% of approved amount	30-day supply. 90-day retail and mail order copays are 2x standard retail copays. 90-day supply not covered out-of-network. For information on women's contraceptive coverage, contact your plan administrator.
	Preferred brand-name drugs	$50 co-pay	$50 co-pay **plus** 25% of approved amount	30-day supply. 90-day retail and mail order copays are 2x standard retail copays. 90-day supply not covered out-of-network.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Out-of-Network Provider	Limitations & Exceptions
prescription drug coverage, for more information please contact your plan administrator.	Nonpreferred brand-name drugs	$70 or 50% (whichever is greater) max $100	$70 or 50% (whichever is greater) max $100 **plus** 25% of approved amount	30-day supply. 90-day retail and mail order copays are 2x standard retail copays. 90-day supply not covered out-of-network.
	Generic and preferred brand-name specialty drugs	20% co-insurance up to $200	20% co-insurance up to $200 **plus** 25% of approved amount	30-day supply maximum. May require preapproval. BCBSM reserves the right to limit the initial quantity to less than 30 days.
	Nonpreferred brand-name specialty drugs	25% co-insurance up to $300	25% co-insurance up to $300 **plus** 25% of approved amount	30-day supply maximum. May require preapproval. BCBSM reserves the right to limit the initial quantity to less than 30 days.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you need immediate medical attention	Emergency room services	$150 co-pay	$150 co-pay	Co-pay waived if admitted
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible	-- none --
	Urgent care	$60 co-pay	40% co-insurance after deductible	-- none --
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Physician/surgeon fee	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Your cost share may be different for services performed in an office setting
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Substance use disorder outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you are	Prenatal and postnatal care	Prenatal: No charge;	40% co-insurance after	-- none --

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Out-of-Network Provider	Limitations & Exceptions
pregnant		Postnatal: 20% co-insurance after deductible	deductible	
	Delivery and all inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	-- none --
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	20% co-insurance after deductible	-- none --
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Physical, Occupational, Speech therapy is limited to a **combined** maximum of 30 visits per member per calendar year
	Habilitation services	20% co-insurance after deductible for Applied Behavioral Analysis; 20% co-insurance after deductible for Physical, Speech and Occupational Therapy	20% co-insurance after deductible for Applied Behavioral Analysis; 40% co-insurance after deductible for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	20% co-insurance after deductible	20% co-insurance after deductible	Limited to a maximum of 120 days per member per calendar year
	Durable medical equipment	20% co-insurance after deductible	20% co-insurance after deductible	-- none --
	Hospice service	No charge	No charge	-- none --
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-- none --
	Glasses	Not covered	Not covered	-- none --
	Dental check-up	Not covered	Not covered	-- none --

Excluded Services & Other Covered Services:

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

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

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

• Bariatric surgery • Chiropractic care	• Non-Emergency care when traveling outside the U.S. • Coverage outside of the U.S., see http://provider.bcbs.com	• Private-duty nursing

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

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

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services

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

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Please note: Coverage Examples are calculated based on individual coverage and calculations may not include a co-insurance maximum.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,520
- **You pay** $2,020

Sample care costs:

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

Patient pays:

Deductibles	$500
Co-pays	$20
Co-insurance	$1,350
Limits or exclusions	$150
Total	**$2,020**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,830
- **You pay** $1,570

Sample care costs:

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

Patient pays:

Deductibles	$500
Co-pays	$770
Co-insurance	$220
Limits or exclusions	$80
Total	**$1,570**

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

PO Box 610
Southfield, MI 48037
248-901-3705

BAY CITY PUBLIC SCHOOLS Vision Benefits Plan — Group #9833

The Plan-at-a-Glance	Benefit Year – July 1 through June 30
Vision Examination	Covered at 100% of Reasonable & Customary (R&C) Following $10.00 Copay
Spectacle Lenses (Pair): Single Vision, Bifocal, Trifocal, Lenticular	Covered at 100% of R&C Following $10.00 copay According to Limits & Exclusions
Frames	Covered Up to $130.00
Contact Lenses (Pair) Cosmetic/Elective (Includes Vision Exam and Fitting)	Covered Up to $200.00

Extra Lens Features – Tinted, Photochromatic, Polarization, Oversize and Blended Lenses

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. The additional cost of progressive lenses
10. Charges for cosmetic (elective) contact lenses, including the exam, prescription and fitting fee, that exceed the annual plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges during the benefit year for each insured person.

PO Box 610
Southfield, MI 48037
248-901-3705

BAY CITY PUBLIC SCHOOLS Dental Benefits Plan

Group #9833

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year July 1 through June 30**
Annual Maximum	$1300 per eligible individual for covered class I, II and III services.
Lifetime Maximum	$1300 per eligible individual for covered class IV services
Class I Preventive Services – 80%	
Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year
Topical Application of Fluoride	Once per plan year to age 19
Bitewing X-Rays	Twice per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 36 months
Sealants	Once per permanent molar per lifetime, ages 6 - 19
Space Maintainers	Up to age 19
Class II Restorative Services – 80%	
Other X-Rays	Maximum of 12 films
Composite and Amalgam fillings	
Root Canal Therapy	
Periodontal Maintenance	Once per 6 months, following active treatment
Periodontal Root Planing	Once per quadrant per 6 months
Occlusal Guards	Once per 36 months
General Anesthesia or IV Sedation	With covered oral surgery or medically necessary
Non-Surgical Extractions	
Class III Major Services – 80%	
Inlays, Onlays, Crowns	Once per tooth per 60 months
Oral, Endodontic & Periodontal Surgery	
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per arch per 60 months
Denture Repair and Adjustment	
Denture Reline	Once per plan year
Denture Rebase	Once per arch per 36 months
Addition of Teeth to Partial Dentures	
Class IV Orthodontic Services – 80%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	
Implants and Restorations over Implants	TMJ/TMD Treatment; Cosmetic Services

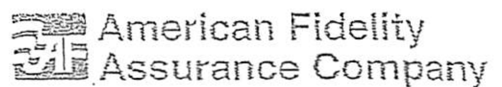
Deductible – None
Missing Tooth Clause – Yes
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Prosthetics are considered on delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $200.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

SOLUTIONS THAT SIMPLIFY

American Fidelity Educational Services



Our Family, Dedicated To Yours.™

NATIONAL

AMERICAN FIDELITY ASSURANCE COMPANY

We Believe

American Fidelity Assurance Company (American Fidelity) has more than 50 years of experience supporting employers, and we understand that maintaining a competitive program within the ever-changing benefits landscape can be overwhelming. This is why we believe employee benefit design and delivery should be simple. Our goal is to provide employers and employees with benefits and services that add value, while also helping employers control costs.

We have built a team of customer care professionals who are conveniently located, available, and committed to ensuring each customer's needs are met. From our local account managers to our dedicated home office colleagues, we believe it is our responsibility to help provide financial security solutions to education employees while providing simplicity and ease to our employer groups.

What We Do

Our experience in delivering expense management benefit plans and services can help offset employer costs of providing important employee benefits. We offer a variety of tools to make utilizing our benefit plans a simple and positive experience for employees, such as Health Flexible Spending Account (Health FSA) cards to access Health FSA funds and our mobile app.

Central to our business philosophy is the belief that our products and services should benefit the education community and those individuals who shape the minds of future generations. We specialize in providing employee benefit administrative services specifically designed to help employers and employees save money today. We also provide supplemental insurance that helps protect your employees in the future.

How We Do It

At American Fidelity, we take a unique approach to the way we support employers and employees. We have local, salaried account managers, not contract enrollers or commissioned brokers, who are dedicated to helping year-round. Our focus on providing top quality customer care demonstrates our commitment to fostering long-term relationships. Resting upon our foundation of financial strength, American Fidelity provides assurance we will be here today and for years to come.

Niche Market Focus

Customers are served best when solutions are tailored for them. Our benefit plans and services are designed with education associations, employers, and employees in mind. Because of our expertise in these niche markets, we are able to quickly identify the needs of employers and provide solutions. We are dedicated to continually looking at the latest trends in the market to ensure we are providing the most effective and competitive benefits and services to our customers.

Salaried, Career Account Managers

Our highly-trained salaried, career account managers are available year-round to assist employers and employees. We focus on educating employers on employee benefit legal changes and best practices, assisting with plan implementation, and communicating plan changes to employees in one-on-one enrollment discussions.

Customer Care

As a team committed to providing quality customer care, we work hard to ensure every customer experience is a positive one. Whether it is with one of our salaried, career account managers, speaking with one of our home office team members, or using our online services, we continuously put our customers first.

Financial Strength

Employers and employees rely on American Fidelity when they need us. Since 1982, American Fidelity has been rated "A+" (Superior)[1] by A.M. Best Company. Considered one of the nation's leading insurance company rating services, A.M. Best bases its ratings on an analysis of the financial condition and operating performance of insurance companies.

[illegible] being the highest.)

Dependent Day Care Flexible Spending Account

How It Works

A Dependent Day Care Flexible Spending Account (Dependent Day Care FSA) is used to reimburse yourself, with tax-free funds, for eligible dependent care expenses incurred while you are working. Your contribution is withheld from your paycheck before tax, which in turn reduces your overall tax burden. You may allocate up to $5,000 pre-tax per calendar year for reimbursement of dependent care expenses or $2,500 if you are married and file a separate tax return.

Who May Participate

Any employee who meets certain eligibility requirements and who has a qualifying dependent may participate in a Dependent Day Care FSA. If you are considering participating, you should be aware that you may be able to take a federal and/or state tax credit instead of participating in the Dependent Day Care FSA. Consult your tax advisor to review your options.

Health Flexible Spending Accounts

How It Works

A Health Flexible Spending Account (Health FSA) may be used for the reimbursement of eligible medical expenses incurred by you, your spouse, or eligible dependents. All eligible employees may participate in a Health FSA, even if you do not have medical coverage through your employer.

When determining your contribution amount, it is important to understand how your employer's plan works and the maximum allowed contribution amount per plan year.

Eligible and Ineligible Expenses

You may use your account to pay for a variety of healthcare products and services for you, your spouse, and your dependents. The Internal Revenue Services (IRS) regulations determine which expenses are eligible for reimbursement. The following are examples of common types of eligible and ineligible expenses.

Examples of Eligible Expenses:

- Copayments and deductibles for medical visits
- Eye exams and eyeglasses
- Lasik
- Orthodontia expenses[2] and other dental expenses
- Prescription drugs and certain eligible over-the-counter medicines (with a prescription)
- Transportation expenses relative to medical care including mileage at IRS allowable rate

Examples of Ineligible Expenses:

- Cosmetic procedures
- Chapstick
- Toothbrushes
- Expenses reimbursed under any other health plan or from any other source
- Insurance premiums
- Vitamins (for general health)

Use or Lose

It is important that you carefully choose your election amount each year. Under IRS regulations, if you don't use your full election amount during the required timeframe, any remaining funds are forfeited. Check with your employer to see if your plan offers a Runoff Period, Carryover Provision, and/or Grace Period.

- Runoff Period - A period after the plan year ends when you are able to submit claims that you incurred during the previous plan year but have not yet submitted.
- Carryover Provision - You are able to carry over up to $500 of unused contributions from one plan year to the next, which may be used to reimburse eligible medical expenses incurred anytime during the next plan year.
- Grace Period - An additional 70 days following the end of the plan year in which you are allowed to incur Health FSA claims and still receive reimbursements.

Visit us at www.americanfidelity.com/FSAtips for more information about your FSA.

ILLUSTRATIVE MODEL "NEW" BIG TABLE GROUP- CALCULATION OF ANNUITY FORMULA

Base: 2014/2015 Number Taking Annuity June 2015	Health Insurance Option	Annual Premium Cost at 100% - Med, RX, D/V	District shall contribute 80% of Premiums - not to exceed 90% of the State Statutory Cap	Gross Savings Amount of employee relinquishing health insurance premium (See note 1 below)	Less any other insurance cost of the District which is provided to employee taking the annuity based on contractual provisions - (less district costs only) Example: Dental/Vision (See note 2 below)	= Net Savings* ILLUSTRATIVE ONLY (See note 3 below)	Illustrative Savings at 40% (***Net Savings * 40% / total # of employees in the pool***)- "Illustration Only" (See note 4 below)	Example Only (subject to change): 10 total people in the pool - Approx. gross paid to each employee
see note 5 below	Single	$ 6,335.64	$ 5,068.51	$ 5,069	*$(if applicable-per contract language)*	$ 5,069	$ 2,027	$ 202.74
see note 5 below	2 Person	$ 14,953.44	$ 11,278.58	$ 11,279	*$(if applicable-per contract language)*	$ 11,279	$ 4,511	$ 451.14
see note 5 below	Full Family	$ 19,108.08	$ 14,708.39	$ 14,708	*$(if applicable-per contract language)*	$ 14,708	$ 5,883	$ 588.34

1.) Annual premium amount based on the Blue Cross Blue Shield, Option 3 (Base Plan), which includes RX, Dental, Vision.
2.) If the employee relinquishing the health insurance premium has dental/vision coverage provided by the District, this cost is deducted from savings.
3.) This amount is illustrative only, and is subject to be either less or more based on all the factors of the equation to calculate the savings.
4.) Net savings x 40% is provided to all employees within the annuity pool on a pro-rated monthly calculation.
5.) The number enrolled in the annuity is as of the June 1, 2015 annuity payment on file with the Benefits/Payroll office, and is used as the base number in calculating any new additions or deletions for 15-16.
6.) If a health insurance change is made between married spouses within the District, no savings is generated for the purposes of the calculation.

The calculation of savings is performed on a monthly basis.