2010 Budget and Salary/Compensation Transparency Reporting

Report Date: 05/13/10

INTRODUCTION

Section 18 (2) of the Public Act 94 of 1979, The State School Aid Act, has been amended, which requires each school district and intermediate school district to post certain information on its website within 30 days after a board adopts it annual operating budget or any subsequent revision to that budget. The Annual Budget & Transparency Reporting is an opportunity to communicate our community on how we utilize the resources that are provided to us.

The following information is required to be posted on our website:

1. The annual operating budget and subsequent budget revisions.
2. Using data that has already been collected and submitted to the Michigan Department of Education (MDE), a summary of district or intermediate district expenditures for the most recent fiscal year for which they are available, expressed in the following two (2) pie charts which were provided for the general fund of the district or intermediate district by the Center for Educational Performance and Information (CEPI):
    - (a) A chart of personnel expenditures broken down into the following subcategories:
        - (1) Salaries and Wages
        - (2) Employee benefit costs, including, but not limited to, medical, dental, vision, life, disability, and long term care benefits.
        - (3) Retirement benefits costs
        - (4) All other personnel costs
    - (b) A chart of all district expenditures, broken into the following subcategories:
        - (1) Instruction
        - (2) Support Services
        - (3) Business and administration
        - (4) Operations and Maintenance
3. Links to all of the following:
    - (a) The current collective bargaining agreement for each bargaining unit
    - (b) Each health care benefits plan, including, but not limited to, medical, dental, vision, disability, long-term care, or any other type of benefits that would constitute health care services, offered to any bargaining unit or employee in the district
    - (c)The audit report of the audit conducted for the most recent fiscal year for which it is available.
4. The total salary and a description and cost of each fringe benefit included in the compensation package for the superintendent of the district or intermediate district and for each employee of the district whose salary exceeds $100,000
5. The annual amount spent on dues paid to associations
6. The annual amount spent on lobbying services

Section 1 - Annual Operating Budget and Subsequent Revisions

Fiscal Year 2010-2011 Board Approved Budget

Section 2a and 2b - Summary of Expenditures - Expressed in Pie Charts

Fiscal Year 2008-2009 Personnel Expenditures

Fiscal Year 2008-2009 District Expenditures

Section 3a, 3b and 3c - Listing of the Collective bargaining Agreements, Health Care Plans and Audit Report

Current Collective Bargaining Agreements

Health Care Benefits Plans

Links to Audit Report

Section 4 - Salary and Benefit Description of Superintendent and Employees with Salary Exceeding $100,000

Link to List of Qualifying Employees

Section 5 - Annual Amount Spent on Dues paid to Associations

Link to List of Qualifying Expenditures

Section 6 - Annual Amount Spent on Lobbying or Lobbying Services

Leslie Public Schools has not spent any funds on lobbying or lobbying services in 2008-09 or 2009-10

2010-11 GENERAL APPROPRIATIONS ACT

RESOLUTION FOR ADOPTION BY THE BOARD OF EDUCATION OF LESLIE PUBLIC SCHOOLS

GENERAL FUND

RESOLVED, that this resolution shall be the general appropriations act of Leslie Public Schools for the fiscal year 2010-11; AN ACT to make appropriations; to provide for the expenditure of the appropriations; and to provide for the disposition of all income received by Leslie Public Schools.

BE IT FURTHER RESOLVED, that the total revenues, which include 17.0617 mills of ad valorem property taxes to be levied on non-homestead property, and unappropriated fund balance estimated to be available for appropriations in the General Fund of the Leslie Public Schools for fiscal year 2010-11 are as follows:

Revenue		
Local		$ 765,081
State		9,298,390
Federal		471,702
Incoming Transfers and Other Transactions		661,443
Total Revenue		$ 11,196,616
Estimated Fund Balance, July 1, 2010	$ 822,876	
Less Appropriated Fund Balance	-0-	
Fund Balance Available to Appropriate		$ 822,876
Total Available to appropriate – General Fund		$ 12,019,492

BE IT FURTHER RESOLVED, that $ 12,019,492 of the total available to appropriate in the General Fund is hereby appropriated in the amounts and for the purpose set forth below:

Expenditures	
Instruction	$ 7,164,779
Support Services	4,500,094
Outgoing and Inter-fund Transfers	195,042
Total Appropriated - General Fund	$ 11,859,915

Projected 6/30/2011 General Fund Balance - $159,577

FURTHER RESOLVED, that no Board of Education member or employee of the school district shall expend any funds or obligate the expenditure of any funds except pursuant to appropriations made by the Board of Education and in keeping with the budgetary policy statement hitherto adopted by the Board. Changes in the amount appropriated by the Board shall require approval by the Board.

BE IT FURTHER RESOLVED, that the Superintendent is hereby charged with general supervision of the execution of the budget adopted by the Board and shall hold the department heads responsible for performance of their responsibilities within the amounts appropriated by the Board of Education and in keeping with the budgetary policy statement hitherto adopted by the Board.

This act is to take effect July 1, 2010.

Ayes:

Nays:

Resolution declared adopted. Date:

2010-11 GENERAL APPROPRIATIONS ACT

RESOLUTION FOR ADOPTION BY THE BOARD OF EDUCATION OF LESLIE PUBLIC SCHOOLS

FOOD SERVICE FUND

RESOLVED, that this resolution shall be the general appropriations act of Leslie Public Schools for the fiscal year 2010-11; AN ACT to make appropriations; to provide for the expenditure of the appropriations; and to provide for the disposition of all income received by Leslie Public Schools.

BE IT FURTHER RESOLVED, that the total revenues and unappropriated fund balance estimated to be available for appropriations in the Food Service Fund of the Leslie Public Schools for fiscal year 2010-11 are as follows:

Revenue		
Local		$ 290,450
State		$ 32,000
Federal		$ 225,950
Total Revenue		$ 548,400
Estimated Fund Balance, July 1, 2010	$ 14,452	
Less Appropriated Fund Balance	-0-	
Fund Balance Available to Appropriate		$ 14,452
Total Available to appropriate – Food Service Fund		$ 562,852

BE IT FURTHER RESOLVED, that $ 562,852 of the total available to appropriate in the Food Service Fund is hereby appropriated in the amounts and for the purpose set forth below:

Expenditures	
Food Service	552,363
Total Appropriated – Food Service Fund	$ 552,363

Projected 6/30/2011 Food Service Fund Balance - $10,489

FURTHER RESOLVED, that no Board of Education member or employee of the school district shall expend any funds or obligate the expenditure of any funds except pursuant to appropriations made by the Board of Education and in keeping with the budgetary policy statement hitherto adopted by the Board. Changes in the amount appropriated by the Board shall require approval by the Board.

BE IT FURTHER RESOLVED, that the Superintendent is hereby charged with general supervision of the execution of the budget adopted by the Board and shall hold the department heads responsible for performance of their responsibilities within the amounts appropriated by the Board of Education and in keeping with the budgetary policy statement hitherto adopted by the Board.

This act is to take effect July 1, 2010.

Ayes:

Nays:

Resolution declared adopted. Date:

2010-11 GENERAL APPROPRIATIONS ACT

RESOLUTION FOR ADOPTION BY THE BOARD OF EDUCATION OF LESLIE PUBLIC SCHOOLS

ATHLETIC FUND

RESOLVED, that this resolution shall be the general appropriations act of Leslie Public Schools for the fiscal year 2010-11; AN ACT to make appropriations; to provide for the expenditure of the appropriations; and to provide for the disposition of all income received by Leslie Public Schools.

BE IT FURTHER RESOLVED, that the total revenues, which include 17.0617 mills of ad valorem property taxes to be levied on non-homestead property, and unappropriated fund balance estimated to be available for appropriations in the Athletic Fund of the Leslie Public Schools for fiscal year 2010-11 are as follows:

Revenue		
Local		$ 85,930
Incoming Transfers and Other Transactions		156,097
Total Revenue		$ 242,027
Estimated Fund Balance, July 1, 2010	-0-	
Less Appropriated Fund Balance	-0-	
Fund Balance Available to Appropriate		$ 0
Total Available to appropriate – Athletic Fund		$ 242,027

BE IT FURTHER RESOLVED, that $ 242,027 of the total available to appropriate in the Athletic Fund is hereby appropriated in the amounts and for the purpose set forth below:

Expenditures	
Athletics	242,027
Total Appropriated - Athletic Fund	$ 242,027

Projected 6/30/2011 Athletic Fund Balance - $0

FURTHER RESOLVED, that no Board of Education member or employee of the school district shall expend any funds or obligate the expenditure of any funds except pursuant to appropriations made by the Board of Education and in keeping with the budgetary policy statement hitherto adopted by the Board. Changes in the amount appropriated by the Board shall require approval by the Board.

BE IT FURTHER RESOLVED, that the Superintendent is hereby charged with general supervision of the execution of the budget adopted by the Board and shall hold the department heads responsible for performance of their responsibilities within the amounts appropriated by the Board of Education and in keeping with the budgetary policy statement hitherto adopted by the Board.

This act is to take effect July 1, 2010.

Ayes:

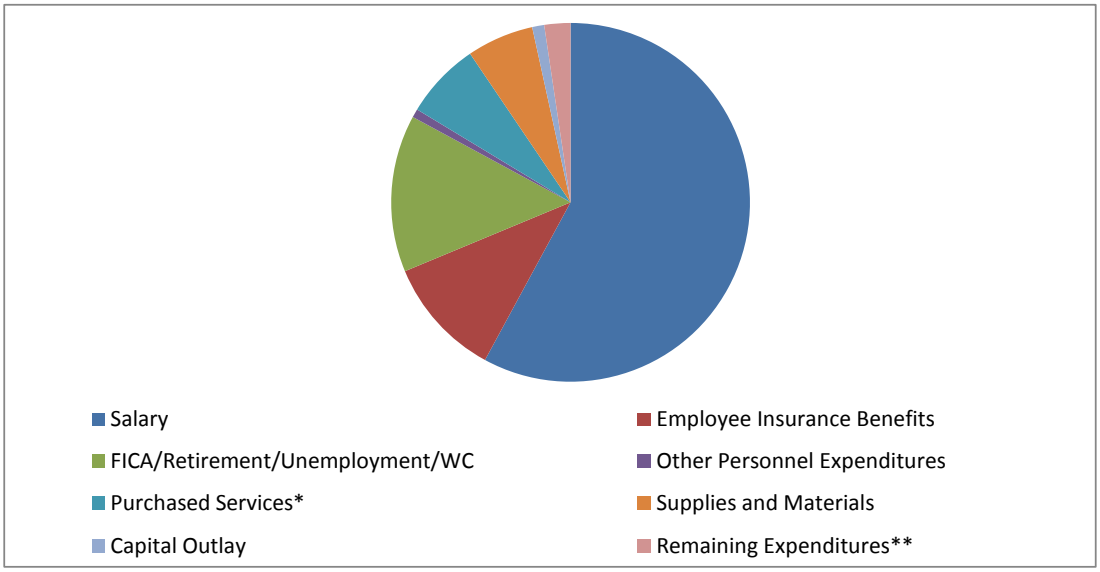
Nays:

Resolution declared adopted. Date:

Leslie Public Schools (33100)

FY 2009 General Fund

Budget Transparency Reporting: Personnel Expenditures



Personnel Expenditures		
Salary (1xxx)	$6,822,700	57.91%
Employee Insurance Benefits (21xx)	$1,273,903	10.81%
FICA/Retirement/Unemployment/WC (28xx)	$1,668,729	14.16%
Other Personnel Expenditures (22xx-24xx, 29xx)	$90,278	0.77%
Total Personnel Expenditures	$9,855,610	83.66%

Remaining Expenditures		
Professional and Technical Purchased Services (31xx)	$301,586	2.56%
Client/Pupil Transportation Purchased Services (33xx)	$85	0.00%
Other Purchased Services (32xx, 34xx - 4xxx)	$508,822	4.32%
Supplies and Materials (5xxx)	$710,116	6.03%
Capital Outlay (6xxx)	$127,529	1.08%
Other Expenditures (7xxx)	$92,397	0.78%
Payments to Other Public School Districts (82xx)	$0	0.00%
Fund Modifications (81xx)	$184,893	1.57%
Other Transactions (83xx - 89xx)	$0	0.00%
Total General Fund Expenditures	$11,781,039	100.00%

* For charting purposes, Purchased Services is defined as object codes 3xxx-4xxx and 82xx.
** For charting purposes, Other Expenditures is defined as object codes 7xxx, 81xx and 83xx-89xx.

Report based on district's 2009 Financial Information Database (FID) submission.

Caution should be used when using these financial data. Sound conclusions can only be drawn when the data elements are used in proper context. As one example; many districts outsource some or all educational functions to other entities. As a result, the district may not incur direct employee salary and benefits for certain functions. The costs instead will appear in the purchased service category. While a district that hires its entire staff as district employees will include all the associated costs under a combination of salary and benefit accounts.

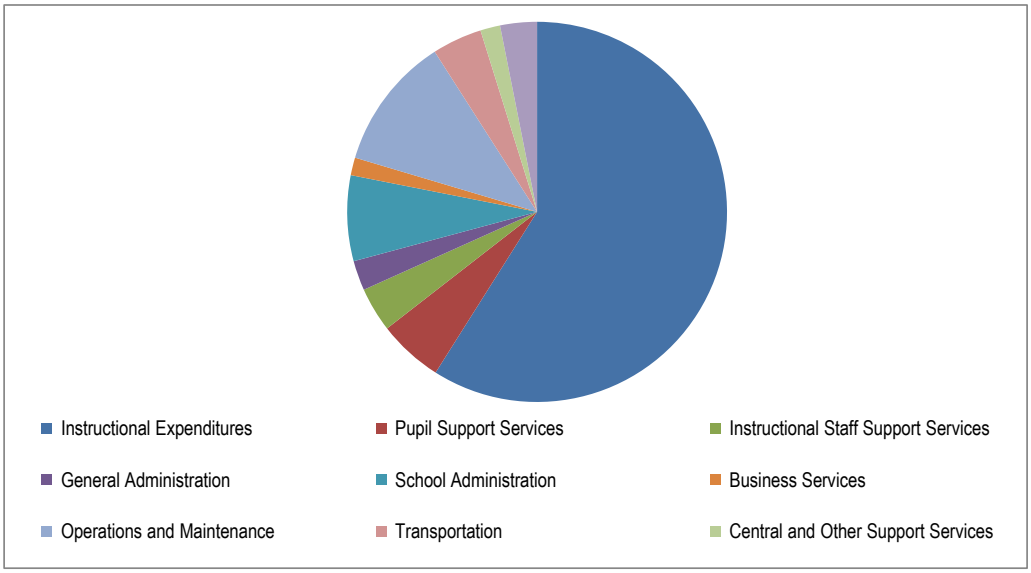
The personnel expenditure costs reported to the charts above are based on object codes as submitted to the Financial Information Database (FID). Districts are required by law (MCL 380.1281) to follow a common chart of accounts published as the Michigan Public School Accounting Manual when reporting financial data. Definitions for each of the object codes listed in the charts above may be found in the Manual available at: http://www.michigan.gov/documents/appendix_33974_7.pdf

Additional district financial information can be found on-line at www.michigan.gov/cepi.

Leslie Public Schools (33100)

FY 2009 General Fund

Budget Transparency Reporting: Operating Expenditures



Operating Expenditures		
Instructional Expenditures (1xx, 293)	$6,946,679	58.96%
Pupil Support Services (21x)	$650,469	5.52%
Instructional Staff Support Services (22x)	$446,600	3.79%
General Administration (23x)	$299,314	2.54%
School Administration (24x)	$858,175	7.28%
Business Services (25x)	$177,317	1.51%
Operations and Maintenance (26x)	$1,336,242	11.34%
Transportation (27x)	$499,446	4.24%
Central and Other Support Services (28x, 291, 292, 295, 299)	$198,483	1.68%
Total Current Operating Expenditures	$11,412,726	96.87%

Remaining Expenditures		
Community Services (3xx)	$20,982	0.18%
Facilities Acquisitions (45x), Debt Service (51x) and Capital Outlay	$162,439	1.38%
Other Transactions (41x-44x, 49x)	$0	0.00%
Fund Modifications (6xx)	$184,893	1.57%
Total General Fund Expenditures	$11,781,039	100.00%

*For charting purposes, Remaining Expenditures is defined as function codes 3xx through 6xx.

Report based on district's 2009 Financial Information Database (FID) submission.

Caution should be used when using these financial data. Sound conclusions can only be drawn when the data elements are used in proper context. The operational expenditure costs reported to the charts above are based on function codes as submitted to the Financial Information Database (FID). Districts are required by law (MCL 380.1281) to follow a common chart of accounts published as the Michigan Public School Accounting Manual when reporting financial data. Definitions for each of the object codes listed in the charts above may be found in the Manual available at: http://www.michigan.gov/documents/appendix_33974_7.pdf

Please note that Capital Outlay, an object category, was extracted from functional categories and reported with Facilities Acquisitions and Debt Service.

More district financial information can be found on-line at www.michigan.gov/cepi.

Current Bargaining Agreements and Employer Sponsored Health Care Plans

	Support Staff	Teachers	Administrators
Bargaining Agreement	Ingham Clinton Education Association/MEA/NEA	Ingham Clinton Education Association/MEA/NEA	**N/A**
Health	Blue Cross Blue Shield Flexble Blue PPO (Plan 2)	MESSA Super Care 1* MESSA Choices II	Blue Cross Blue Shield Flexble Blue PPO (Plan 2)
Dental	Set Seg	MESSA	Delta Dental
Vision	N/A	MESSA-VSP	MESSA-VSP
Life Insurance	Sunlife	MESSA	MESSA
Long Term Disability	N/A	MESSA	MESSA

* MESSA Super Care 1 is no longer an option for new hires. Employees that were already in this plan are able to keep the plan.

Master Agreement

between the

Leslie Board of Education

and the

Michigan Education Association/NEA

July 1, 2006 – June 30, 2008

TABLE OF CONTENTS

AGREEMENT

This Agreement is entered into between the Leslie Public Schools, hereinafter referred to as the "Employer" and the Michigan Education Association/NEA, hereinafter referred to as the "Association."

ARTICLE 1: RECOGNITION

A. Pursuant to and in accordance with all applicable provisions of Act 379 of the Public Acts of 1965, as amended, the Employer does hereby recognize the Michigan Education Association/NEA as the exclusive representative for the purpose of collective bargaining with respect to rates of pay, wages, hours of employment, and other conditions of employment for the term of this Agreement for all regular non-teaching employees including office and clerical employees, cooks and cafeteria employees, custodial employees, maintenance employees, crossing guards, hall monitors, library clerks, aides, bus drivers, mechanics, and noon hour workers, but excluding supervisors, administrators, substitutes, the Superintendent's secretary and payroll employees.

B. The Employer agrees not to negotiate with any organization other than the Association for the duration of this Agreement.

ARTICLE 2: EMPLOYER RIGHTS

A. 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 the Constitutions of the State of Michigan, and of the United States, including, but without limiting the generality of the foregoing, the right:

1. To the executive management and administrative control of the school system, its properties and facilities, and the occupational activities of its employees;

2. To assign and direct the work of its personnel, determine the number of shifts and hours of work, the starting times and the scheduling of all the foregoing and to establish, modify or change any work or business hours or days, but not in conflict with the specific provisions of this Agreement;

3. To direct the work force, including the right to hire, promote, suspend and discharge employees, transfer employees, evaluate employees, assign work, to determine the size of the work force and to lay off employees;

4. To determine the services, supplies and equipment necessary to continue its operation and to determine the methods, schedules and standards of operation, the means, methods, and processes of work including the automation thereof or changes therein;

5. To adopt reasonable rules and regulations;

6. To determine the location or relocation of its facilities, including the establishment or relocation of new schools, buildings, departments, divisions or subdivisions thereof and the relocation or closing of offices, departments, divisions or subdivisions, buildings or other facilities;

7. To determine the placement of operations, production, services, maintenance or distribution of work, and the source of materials and supplies;

8. To determine the financial policies, including all accounting procedures, and all matters pertaining to public relations;

9. To determine the size of the management organization, its function, authority, amount of supervision and the table of organization.

B. The exercise of the foregoing powers, rights, authority, duties, and responsibilities by the Board, the adoption of policies, rules, regulations and practices in furtherance thereof, the use of judgment 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.

ARTICLE 3: ASSOCIATION RIGHTS

A. The Association and its representatives shall have the right to use school buildings and facilities subject to existing Board policy.

B. Duly authorized representatives of the Association shall be permitted to transact official Association business on school property provided that this shall not interfere with or interrupt normal school operations.

C. The Association shall have the right to reasonable use of the Employer's office equipment at reasonable times, when such equipment is not otherwise in use, and subject to existing Board policy.

D. The Employer will provide bulletin board space in each building which may be used by the Association for posting official Association notices.

E. The Employer agrees to notify the Association President of the hiring of any new bargaining unit member and provide his/her name, rate of pay, classification and work location.

F. The Employer agrees to furnish to the Association in response to written requests, public information which the Association requires to administer this Agreement and to formulate contract proposals.

G. The Association President will be provided with copies of modified or new job descriptions established by the Employer within five (5) working days of the change or establishment.

ARTICLE 4: EMPLOYEE RIGHTS

A. The Employer will not discipline or discharge any non-probationary bargaining unit member for other than just cause. Discipline, by way of illustration and not by limitation, may include suspension, with or without pay, written reprimand and oral reprimand.

1. The specific grounds for disciplinary action shall be presented to the bargaining unit member in advance of the imposition of discipline.

2. The Employer will advise a bargaining unit member that he/she has the right to have an Association Representative present when being investigated which may lead to discipline. Upon request, the bargaining unit member will be allowed to meet with the Association President or a representative of the bargaining unit member's choice prior to the beginning of a scheduled interview. The Employer will make an area available where the bargaining unit member may meet with their representative before the interview

3. The Employer agrees to promptly notify the Association President and the Steward in the District of any bargaining unit member who is disciplined except in the case of an oral reprimand.

4. Should the discipline of a non-probationary bargaining unit member be considered improper, either the Association or the non-probationary bargaining unit member may grieve the matter beginning at Step II of the Grievance Procedure.

B. At his/her request, a bargaining unit member shall be entitled to review his/her official personnel file.

C. Documents of an evaluative and/or disciplinary nature that will be inserted into the personnel file shall be signed and dated by the bargaining unit member.

1. The bargaining unit member's signature shall not be interpreted to mean agreement with the content of the material, but shall be understood to indicate awareness of the material.

2. Should the bargaining unit member disagree with the content of the material being placed in the personnel file, he/she may have his/her written statements attached to the file copy of said material.

D. Records of a warning, reprimand, and/or other disciplinary action in a bargaining unit member's personnel file which do not relate to a recurring incident within a four (4) year period from the date of such discipline, shall be removed from the personnel file at the written request of the bargaining unit member and the concurrence of the Superintendent.

The parties recognize that the decision to permit the removal of disciplinary records which do not relate to recurring incidents is discretionary with the Superintendent. Each request for the removal of a disciplinary record will be reviewed on a case-by-case basis with a determination made based upon the merits of the request. The Superintendent will not arbitrarily or capriciously deny a request for the removal of said materials.

E. Any bargaining unit member subject to the terms of the Omnibus Transportation Employee Testing Act will be discharged following the conclusion of an investigation resulting in the following:

1. A verified drug or alcohol test as established under the Act and its procedures.

2. During the process of re-verification of a split sample as a result of a positive drug test, the bargaining unit member will be considered as on unpaid suspension, however, his/her Employer-paid insurance premium contributions shall be continued. If the medical review officer finds through the split sample re-verification process that the bargaining unit member was free from drugs, the employee will be reinstated without loss of pay or benefits.

3. Refusing to submit to testing.

4. Possession of alcohol or drugs (as defined in the Act) while on the job.

5. Time spent associated with testing procedures will be paid at the bargaining unit member's regular hourly rate of pay.

6. The Association President will be provided with a copy of the annual reports required to be submitted to the federal government.

F. The Employer shall provide all employees who are hired into the bargaining unit with a copy of the Master Agreement.

G. The Employer agrees not to discriminate against or between bargaining unit members because of race, creed, religion, color, national origin, age, sex, marital status or physical characteristics.

ARTICLE 5: DUES, FEES AND PAYROLL DEDUCTIONS

A. Bargaining unit members shall, as a condition of employment, pay a Service Fee in an amount established by the Association. Dues and Service Fees will be payroll deducted pursuant to MCLA 408.477; MSA 17.277 (7). The Employer shall deduct one-tenth of such dues from the second regular paycheck of the bargaining unit member each month for ten (10) months, beginning in September and ending in June of each year.

B. Bargaining unit members who work less than full time shall be assessed on a pro-rata basis as determined by the number of hours they are normally scheduled to work. Bargaining unit members who are hired during the course of the school year will be assessed on a pro-rata basis as determined by their starting date and the months remaining in the school year.

C. With respect to all sums deducted by the Employer pursuant to MCLA 408.477; MSA 17.277(7) whether for membership dues or the Service Fee, the Employer agrees to promptly remit said sums to the Michigan Education Association, 1216 Kendale Blvd., East Lansing, MI 48823, accompanied by an alphabetical list of bargaining unit members for whom such deductions have been made categorizing them as to membership or non-membership in the Association, and indicating any changes in the list previously furnished. The Association agrees to advise the Employer of all members of the Association in good standing and to furnish any other information needed by the Employer to fulfill the provisions of this Article, and not otherwise available to the Employer.

D. The Association agrees to assume the legal defenses of any suit or action brought against the Employer, including individual Board members and their agents, regarding this Article of the collective bargaining agreement. The Association further agrees to indemnify the Employer for any costs, damages, or back pay which may be assessed against the Employer as the result of said suit or action subject, however, to the following conditions:

1. The damages have not resulted from the negligence, misfeasance, or malfeasance of the Employer or its agents.

2. After consultation with the Employer, the Association has the right to decide whether to defend any said action or whether or not to appeal the decision of any court or other tribunal regarding the validity of the action or the defense which may be assessed against the Employer by any court or tribunal.

3. Since the Association is obligated for all legal costs involved in enforcing this Article, it has the right to choose the legal counsel to defend any said suit or action.

4. The Association shall have the right to compromise or settle any claim made against the Employer under this section.

E. Upon appropriate written authorization from the bargaining unit member, the Employer shall deduct from the salary of any bargaining unit member and make appropriate remittance for annuities, The Educators and Employees Credit Union in Jackson and the Capital Area

School Employees Credit Union in Lansing, savings bonds, charitable donations, MESSA and MEAFS programs as jointly approved between the Employer and the Association and any other plans or programs that may be jointly approved between the Employer and the Association.

The Employer agrees to make payroll deductions available to IDS, Horace Mann, Prudential, Northwestern National Life, VALIC, Waddell and Reed, Kemper Group/ Mutual Service and Shearson, Lehman and Hutton.

F. Should the provision for mandatory payroll deduction of dues or service fees, as referenced in section A above, be found contrary to law, the parties agree to negotiate procedures requiring the submission of written authorizations for the deduction of dues or service fees as a condition of continued employment within thirty (30) calendar days of such determination.

ARTICLE 6: STEWARD SYSTEM

A. There shall be one (1) steward for each of the following employee groups: custodial/maintenance, secretarial/clerical, non-instructional aides, instructional aides transportation and food services. The names of said stewards will be provided to the Superintendent in writing at the beginning of each school year and at any time that there is a change thereafter.

1. The steward may present grievances to the Employer during his/her working hours and without loss of time or pay.

2. Normally, the investigation of grievances will be conducted outside of the steward's assigned hours of work. Grievances which require the steward's immediate attention may be investigated during working hours and without loss of time or pay provided it does not interfere with the normal operation of the school or require overtime or additional personnel to compensate for said time.

3. The steward who acts on behalf of the Association as set forth in sections 1 and 2 above, shall notify his/her immediate supervisor of his/her departure from and return to the work site.

B. Upon the request of either party, the Association President and the Employer shall arrange for a special conference.

1. No more than four (4) representatives of the Association may be present at such meetings unless mutually agreed otherwise.

2. Arrangements for a special conference, including those who are to attend shall be made in advance.

3. An agenda of the matters to be taken up during the meeting shall be presented at the time the conference is requested.

4. Conferences shall be scheduled at mutually acceptable times. The parties will make a reasonable attempt to schedule such special conferences so as not to interfere with the normal operation of the District.

5. Bargaining unit members shall not lose time or pay for any time spent in a special conference.

6. Association Representatives may meet on the Employer's property for up to one-half hour preceding a special conference provided a written request has been made.

ARTICLE 7: GRIEVANCE PROCEDURE

A. A grievance shall be defined as a complaint by a bargaining unit member based on an event or condition alleged to be an expressed violation of this Agreement. The Employer will respond in writing to any grievance presented in writing by the Association.

B. Every effort will be made to file written grievances as soon as possible, but shall be presented in writing to the immediate supervisor by the Steward within ten (10) days of its occurrence.

C. Days, as set forth herein, shall be defined as Monday through Friday excluding holidays.

D. Nothing contained herein will be construed as limiting the right of any bargaining unit member having a grievance to discuss the matter informally with the appropriate administrator/supervisor and having the grievance adjusted without the intervention of the Association, provided the adjustment is consistent with the terms of this Agreement and provided further, that the Association has been notified of such adjustment.

E. STEP I.

1. A bargaining unit member alleging a grievance shall discuss same with the Steward.

2. The Steward and/or bargaining unit member may discuss the grievance with the immediate supervisor.

3. Should the Steward and/or bargaining unit member elect to discuss the grievance with the immediate supervisor and the same is not resolved, the Steward or the bargaining unit member shall, within five (5) days of the discussion with the immediate supervisor, submit the grievance to the immediate supervisor in writing.

4. Should the Steward and/or bargaining unit member elect to waive the right to discuss the grievance with the immediate supervisor, the Steward or bargaining unit member

shall, within ten (10) days of its occurrence, submit the grievance to the immediate supervisor in writing.

5. A written grievance, as referenced herein, shall contain the following:

   a. It shall be signed by the grievant(s) or by the authorized representative of the unit if it is an Association grievance;

   b. It shall contain a synopsis of the facts giving rise to the alleged violation;

   c. It shall cite the section or subsections of this Agreement alleged to have been violated;

   d. It shall specify the relief requested.

6. Any written grievance not in accordance with the above requirements may be returned to the Association without action.

7. The immediate supervisor shall respond to a grievance in writing within five (5) days.

F. STEP II

If the grievance is not resolved, the Association President shall present same, in writing, to the Superintendent within five (5) days after the response at STEP I is due. The Superintendent shall meet with the grievant and/or his/her Association Representative within five (5) days of receipt of the grievance. The Superintendent shall respond to the grievance in writing within five (5) days of said meeting.

G. STEP III

1. No individual bargaining unit member shall have the right to process a grievance to arbitration.

2. In the event the Association decides to pursue the matter further, it shall, within thirty (30) days from the date of the Employer's STEP II response, meet with the Employer and/or its representatives for the purpose of attempting to settle the grievance before proceeding to arbitration except when there is a continuing back pay liability in which case the parties shall meet as set forth herein within ten (10) days from the date of the Employer's STEP II response.

3. If, subsequent to such a meeting the Association is not satisfied with the disposition of the grievance, it may within five (5) days of the meeting referenced in section 2 of STEP III, request the selection of an arbitrator either through mutual agreement or from the following panel of arbitrators:

David T. Borland
Barry C. Brown
Mark J. Glazer
Patrick A. McDonald

4. Should it be necessary to use the foregoing panel of arbitrators, each party shall, on alternating cases, be the first to strike the name of an arbitrator. Thereafter, each party will alternately strike a name until one name remains. The parties shall jointly notify the arbitrator and request available hearing dates.

H. The powers of the arbitrator shall be as follows:

1. He/she shall have no power to interpret state or federal law.

2. He/she shall have no power to rule on the discharge of a probationary bargaining unit member.

3. The decision of the arbitrator shall be final and binding on the Association and its members, the bargaining unit members involved, and the Employer.

4. The arbitrator shall base his/her judgment on the expressed terms of this Agreement, and shall have no authority to add to or subtract from any of the terms of this Agreement.

5. No claim for back pay shall exceed the amount that the bargaining unit member would have otherwise earned.

6. It is expressly understood that the arbitration provisions shall not apply to those areas for which state or federal law prescribes a procedure or authorizes a remedy (i.e., EEOC, MERC).

I. General

1. The arbitration hearing shall be conducted in accordance with the rules and procedures of the American Arbitration Association.

2. Neither party shall be permitted to assert in any arbitration proceeding, any ground, or to rely on any evidence, not previously disclosed to the other party.

3. Each party shall bear the expense of providing its own witnesses except that regularly employed bargaining unit members will be released from their normal responsibilities without loss of pay or leave time for such time as is necessary to serve as a witness in an arbitration hearing.

4. The expenses of the arbitrator shall be shared equally between the Employer and the Association.

5. A grievance may, at any time, be withdrawn without prejudice.

6. No grievance shall be filed for or by any bargaining unit member after the effective date of his/her resignation except in the case of severance benefits.

7. Any grievance not appealed within the specified time limits shall be deemed settled on the basis of the last response.

8. No claim for back wages shall exceed the amount of wages the bargaining unit member would have otherwise earned nor shall any such claim be retroactive for more than thirty (30) work days prior to the date on which a grievance was filed at Step I of the Grievance Procedure.

J. The grievance form is attached to this Agreement as Appendix C.

ARTICLE 8: WORKING HOURS AND CONDITIONS

A. The normal workweek shall be Monday through Friday not to exceed forty (40) hours for full time bargaining unit members.

B. Except for bus drivers, the workday shall include a duty-free, unpaid, thirty (30) minute lunch period for bargaining unit members who work five (5) or more continuous hours a day.

Should a bargaining unit member be required to perform work during a lunch period, the bargaining unit member shall be paid the appropriate portion of his/her hourly wage rate for all such work during the lunch period or the schedule will be adjusted by an amount of time equal to that worked.

C. Break periods will be established by the bargaining unit member's immediate supervisor.

1. Bargaining unit members who work full time may take a fifteen (15) minute break in the a.m. and also a fifteen (15) minute break in the p.m., or in the first half and second half of their regular shift, whichever may apply.

2. Part-time bargaining unit members who work between three (3) and five (5) hours a day may take a fifteen (15) minute break.

3. The foregoing Section C shall not apply to bus drivers.

D. The first shift is any shift that regularly starts at or after 4:00 a.m. but before 1:00 p.m. The second shift is any shift that regularly starts at or after 1:00 p.m. but before 7:00 p.m. The third shift is any shift that regularly starts at or after 7:00 p.m. but before 4:00 a.m.

E. Bargaining unit members will be informed of the name and telephone number of the person with whom they are to report their unavailability for work.

No bargaining unit member shall be required to secure a substitute for his/her own period of absence.

F. Any bargaining unit member who is assigned to call substitutes shall be paid at his/her regular hourly rate irrespective of whether the responsibilities are executed at or away from his/her normal workstation or outside of his/her regularly assigned hours of work.

G. The Employer agrees to provide parking space for all bargaining unit members during their regularly assigned work hours at no charge.

H. Bargaining unit members who are required to provide tools in connection with their employment, shall have said tools insured for their full replacement value at Employer expense.

I. On weekends and during the summer months when District buildings are to be used, a bargaining unit member from the Custodial/Maintenance Classification shall be on duty provided such use requires building clean-up. The Employer shall determine whether said use will require building clean-up.

J. Except provided for in Articles 9 and 10, the scheduling of overtime shall be subject to the following procedures:

1. Overtime shall be offered and distributed to bargaining unit members within the classification(s) in each building.

2. Overtime will be organized by the use of an overtime chart and will be offered within the building where overtime is available to the most senior bargaining unit member on the seniority rotation list.

3. Bargaining unit members assigned to more than one (1) classification and/or building shall be offered overtime on a rotating basis within each classification; however, bargaining unit members will be eligible for overtime in only one (1) of the buildings to which they are assigned. On or before September 1 of each year, the bargaining unit member will notify the Association Representative responsible for overtime as to the overtime building of his choice. Same shall remain in effect without change until the following September 1.

4. For purposes of maintaining the overtime chart, the refusal of an offer of overtime shall be recorded as if it had been accepted.

5. Upon completion of the probationary period, a bargaining unit member shall be added to the bottom of the seniority rotation list in accordance with his bargaining unit seniority i.e., last date of hire.

6. Overtime work shall be voluntary. Absent a volunteer, the District reserves the right to assign the least seniored bargaining unit member in the classification within the building.

7. The seniority rotation list shall continue in effect from year to year.

8. An extension of the bargaining unit member's shift for purposes of task completion shall not be subject to the overtime rotation.

9. The Association will designate a representative to administer, post and maintain the overtime, extra work and extra trip provisions under this Agreement subject to the provisions below:

   a. Once the work is authorized by the supervisor, the Association Representative will be responsible for providing the names of the bargaining unit members who will perform the work. Communications required to obtain bargaining unit employees to perform the work may be done during the work hours with prior authorization from the supervisor.

   b. In the event of an error or omission in terms of the application of any overtime, extra hours and extra trips, the bargaining unit member bypassed will be placed at the top of the rotation list for the next opportunity to work and in the driver's case will be assigned the next available unassigned trip.

10. When a bargaining unit member works five (5) or more hours in any day, he shall be entitled to a duty-free, unpaid lunch period equal to thirty (30) minutes unless he is notified that he is the only District employee on duty in the building. If he is the only District employee on duty, he will receive a paid lunch period if continuous coverage is necessary during the lunch break.

K. In the event the entire instructional day is cancelled prior to the start of a bargaining unit member's workday due to inclement weather or conditions not within the control of the District, the following procedures will apply:

1. Fifty-two week bargaining unit members and secretaries will report to work and will receive their regular rate for the day. If an individual is directed not to report, the employee will not suffer a loss of pay for the day. If an individual is not able to arrive at their regularly scheduled starting time, the employee may request to arrive up to three (3) hours late and extend their workday accordingly.

2. School year employees shall not be required to report to work.

   In the event the District is not required to make up such day(s) to receive State Aid payments, bargaining unit members will receive their regular rate of pay for the

day(s). If the District is required to make up the day, pay will be issued after the rescheduled day(s) have been worked.

A bargaining unit member who is on paid leave as provided in Article 18 when school is closed for the reasons stated above, shall suffer no loss of leave time nor loss of salary when State Aid is received.

L. In the event a student instructional day is delayed or students are dismissed early due to inclement weather or conditions not within the control of the District, the following procedures will apply:

1. Fifty-two week bargaining unit members who are required to report to work at their regularly scheduled starting time or remain until their regularly scheduled quitting time, shall receive their regular rate of pay for the day.

   Fifty-two week bargaining unit members who are not required to report to work at their regular time or are dismissed early will receive their regular rate of pay for the day.

2. School year employees shall be directed when to report to work and will receive their regular rate of pay for the day.

   Employees covered by Section 2 who are released when students are dismissed early, will receive pay for the balance of the day provided State Aid is received for the reminder of the day.

3. When the Food Service Supervisor determines to deliver the special menu on a delay day, food service employees shall be directed when to report to work and will be paid their regular rate of pay for the day. In the event the Food Service Supervisor determines to deliver the regular menu, food service employees will report at their regular time and will be paid at their regular rate of pay for the day.

M. When a bargaining unit member is assigned to perform routine, scheduled maintenance of a medical apparatus used by a student (e.g. catheter, tracheotomy, etc.), the bargaining unit member will be provided with training regarding the proper procedures to be utilized. The cost of the training will be paid by the Employer and the bargaining unit member will receive his/her regular hourly rate of pay.

1. The Ingham County Intermediate School District plan for the delivery of special education programs and services will be made available for review at the Central Office. Questions regarding the plan should be directed to the Special Education Director or Superintendent.

2. In the event a special education aide is directed to report to an IEPC meeting, the aide will be informed as to the procedures involved by the principal or Special Education Director upon request of the aide.

N. Should an aide be assigned to accompany a class/student on a District-sponsored trip and the trip extends beyond the aide's regularly assigned work hours, said aide shall be paid at his/her regular hourly rate provided said hours do not exceed eight (8) hours a day nor forty (40) hours a week. Hours in excess of eight (8) hours a day or forty (40) hours a week shall be paid in accordance with the overtime provisions of this Agreement.

O. Should a bargaining unit member request and be approved and/or should a bargaining unit member attend a conference or inservice training at the request of the Employer, said bargaining unit member shall be paid at his/her regular hourly rate including travel time provided said hours do not exceed eight (8) hours a day or forty (40) hours a week.

1. Mileage will be paid at the IRS rate(s).

2. Expenses for meals and lodging, if any, shall be reimbursed in accordance with Board policy upon presentation of a receipt.

P. The costs associated with maintaining certification for Interpreter Aides shall be borne by the District.

Q. When the District requires training or inservice for any bargaining unit member, where appropriate, the bargaining unit member(s) occupying the same position (see Appendix D) and bargaining unit members in other positions within the same classification (see Appendix D), will be provided the opportunity to attend the same unless the training or inservice is specific to a particular position within a classification.

R. In the event the Employer elects to change the work schedule for a custodial bargaining unit member's position to incorporate Saturday or Sunday, the following will apply:

1. The Employer will provide five (5) calendar days notice of a bid meeting for bargaining unit members in the affected classification. The notice will contain the date and time of the bid meeting.

2. All positions within the classification will be considered vacant at the meeting and will be bid based upon seniority.

3. The schedule for all positions will be distributed at the meeting. No Sunday shift shall commence before 2:30 p.m.

4. An absent bargaining unit member may bid by proxy through the steward for the classification.

S. The Employer will provide custodial employees with five (5) uniform tops and maintenance, grounds and the mechanic with five (5) uniforms (tops and pants) on an ongoing basis.

1. Bargaining unit members shall be responsible for cleaning and maintaining the uniforms. With the exception of summer months when students are not in attendance and approval is given by the supervisor, uniforms shall be worn at all times while on the job.

2. The supervisor shall be responsible for ordering uniforms. Bargaining unit members in need of replacements will direct their requests to the supervisor.

ARTICLE 9: FOOD SERVICES

A. Should the Employer elect not to have a food service employee on duty to cover an activity outside of regularly scheduled food service hours, food service personnel shall not be responsible for any theft or damage to equipment or facilities.

B. The Food Service Supervisor will not perform bargaining unit work in the kitchen except for instructional or emergency work.

C. The Employer or the Supervisor for Food Services shall train new hires, transferred bargaining unit members, substitutes and students. Should a bargaining unit member be assigned to assist in training, he/she shall be compensated at an additional $.25 an hour.

D. Each year, the Employer will provide up to five (5) uniform tops and three (3) aprons for Food Service employees at the employees request.

1. Bargaining unit members shall be responsible for cleaning and maintaining the tops and aprons. Tops and aprons shall be worn at all times while on the job.

2. The Food Service Supervisor shall be responsible for ordering uniforms. Bargaining unit members in need of replacements will direct their requests to the Supervisor.

E. Extra or additional hours shall be defined as evening or weekend activities or as preparation for such activities outside of the normal daily work schedule and shall be governed by the following:

1. The work will always be offered first to the most senior cook on a seniority-based rotation list.

2. In the event no cook accepts the work, other food service employees will be offered the work from a seniority-based rotation list.

3. For purposes of maintaining the rotation list, the refusal of an offer for extra hours shall be recorded as if it had been accepted.

4. Upon completion of the probationary period, a probationary bargaining unit member will be added to the bottom of the rotation list.

ARTICLE 10: TRANSPORTATION

A. The Employer shall establish the route for each regular bus run. The starting time shall be determined by the route and seasons of the year in which it is run. The length of the day shall be the time it takes to safely drive the entire route.

B. At least seven (7) calendar days prior to the first instructional day in each year, drivers shall meet with the Employer for the purpose of bidding on bus runs. The Employer shall provide written notice of the intended date of said meeting not later than June 1 of the preceding school year.

1. Bus runs will be bid on the basis of seniority with the most senior driver bidding on available runs first.

2. At the annual bid meeting, the Employer will provide written notice of the available runs together with a schedule of hours for each run.

3. Except as set forth in B(3), at a minimum, each driver will first bid on a morning and an afternoon run. In the event there are sufficient regular drivers in attendance (including those submitting proxies under B-4 below) at the bid meeting to cover the morning and afternoon runs, a driver may first select a stand alone run. (i.e. a HUGS, PPI or In-Town Take Home).

4. Drivers shall be permitted to submit their bids by proxy on forms provided by the Employer. Said forms shall be submitted to the immediate supervisor in advance of the bid meeting.

5. Except as provided in Section 4, drivers who miss a bid meeting and fail to submit a proxy, will be assigned to a remaining run(s). Should such assignment be refused, the driver shall be considered a voluntary quit.

6. There shall be no further bidding subsequent to the annual bid meeting except in the event of a reduction in staff. New assignments (any not in yearly bid meeting) will be posted and awarded by seniority as long as it does not conflict with the times of their current assignment.

7. Bid meetings are not considered time worked and are therefore not paid.

8. Vacancies which remain or occur subsequent to any bid meeting shall be governed by Article 12 of this Agreement.

9. The foregoing shall not apply to temporary assignments which shall be governed by Article 14 of this Agreement.

10. The times for special education runs will not be shortened due to the personal absence of the student(s) to be transported, provided the driver is available for duty during that time unless the absence exceeds three (3) consecutive days.

C. A driver will be paid his/her regular rate of pay for all hours worked during the regular runs, including breakdowns and/or other similar forms of downtime while working a regular bus run and for time necessary to clean a school bus or other work, if requested to do so.

D. The Employer shall reimburse each driver or any other bargaining unit member who is required to obtain a chauffeur's license, for the cost of said license. Said payment will be made in accordance with the District's existing accounts payable procedures. In order to receive reimbursement, the bargaining unit member shall submit a receipt to the business office.

E. Drivers who are required by the State of Michigan and/or the Employer to attend classes, a conference or inservice training shall be paid at the extra trip hourly rate.

F. The provisions that follow shall govern extra trips:

1. Extra trips shall be posted on four (4) separate lists and shall be signed by interested drivers at least twenty-four (24) hours prior to the scheduled departure time.

   Trips where the driver will not be held over will be posted as a single trip or as two separate trips at the Employer's sole discretion. Such trips will be paid at a minimum of two (2) hours pay for each trip when posted as two separate trips and four (4) hours minimum when posted as one single trip.

2. Emergency trips shall be defined as any of the above-referenced trips that are posted within twelve (12) hours or less of the scheduled departure time and includes those trips already bid by a driver who is absent on the day of the trip.

3. Each list shall be governed by its own seniority (includes probationary drivers) rotation list which shall continue in effect from year to year.

4. Drivers who sign for an extra trip, but fail to take such trip shall rotate to the bottom of the seniority rotation list.

5. A driver who fails to sign for or refuses an extra trip or who is absent during the posting period shall rotate to the bottom of the seniority rotation list.

6. A driver shall have the right to refuse an extra trip. Should no regular driver agree to take a trip, the trip will be assigned to a probationary employee. If there is no probationary employee, it shall be assigned to the least senior regular driver.

7. Any regular driver who is scheduled for an extra trip and who is notified less than one (1) hour in advance of departure time that the bus is cancelled will be paid two (2) hours of pay at the extra trip rate and will be offered the next available trip.

   If the trip is scheduled for a Saturday, Sunday or holiday and the bus is cancelled with less than sixteen (16) hours notice of the departure time, the driver will also be offered the next available Saturday, Sunday or holiday trip in addition to two (2) hours pay at the overtime rate under Article 20(B)(2).

8. With the exception of substitute drivers and emergency situations involving supervision, no Employee of the District outside of the bargaining unit will drive a school bus to transport students.

9. Should there be an error that is attributable to the Secretary for Transportation in connection with an extra trip thereby creating a violation of this Agreement, the violation will not be subject to the grievance procedure. For purposes of further rotation of extra trip assignments, the bargaining unit member(s) bypassed in error will be entitled to the next available trip.

10. Drivers who occupy a second position within the bargaining unit will not be eligible for extra trips or substitute runs which conflict with the hours of their second position unless there are no substitutes available or other qualified bargaining unit members who are not scheduled to work during the period in question.

G. Drivers who do not have both a morning and an afternoon run or who do not have a noon kindergarten run will have priority status on the substitute list for transportation provided such drivers do not hold another position in the District. Such drivers will be paid at the substitute rate.

ARTICLE 11: EVALUATION

A. It shall be the Administration's responsibility to evaluate the work performance of bargaining unit members.

B. Bargaining unit members shall be evaluated at least once in each three (3) year period.

C. Prior to any formal evaluation, a bargaining unit member will be apprised of the criteria upon which he/she will be evaluated. Said criteria shall be related to the bargaining unit member's job duties and responsibilities.

D. All evaluations shall be reduced to writing and a copy provided to the bargaining unit member within ten (10) calendar days of the final observation. Each written evaluation will be followed by a conference between the bargaining unit member and the immediate supervisor within ten (10) workdays following the issuance of the written evaluation.

E. Should a bargaining unit member disagree with the content of an evaluation, he/she may submit a written response which shall be attached to the file copy of the evaluation.

F. In the event a bargaining unit member's work is unacceptable, the reasons will be set forth in writing together with an identification of the ways in which the bargaining unit member is to improve. In subsequent evaluation reports, failure to again note a continuing deficiency will be construed as evidence of improvement.

G. In the event a bargaining unit member is not continued in employment, the Employer will advise the bargaining unit member of the reason(s) therefore in writing and provide a copy of same to the Association President at the bargaining unit member's request.

H. Evaluations shall include a statement as to whether performance is satisfactory, needs improvement or is unsatisfactory.

I. All written evaluations shall be placed in the bargaining unit member's personnel file.

J. This Article shall not apply to probationary employees.

ARTICLE 12: VACANCIES, PROMOTIONS AND TRANSFERS

A. A vacancy shall be defined as a bargaining unit position which has been permanently vacated or a newly created position which the Employer intends to fill.

An increase in the number of hours of a position shall not constitute a vacancy.

B. Vacancies shall be posted in the kitchen and the custodial lounge at the High School, in each of the other three (3) school buildings, at the bus garage and at the administration building for five (5) full workdays. During the summer months when school is not in session, postings for vacancies shall be mailed to each bargaining unit member who submits a written request to the Superintendent prior to the last day of school in any year.

1. All postings shall set forth the minimum requirements to perform the job, the hours the applicant(s) will be expected to work and the length of the work year.

2. Should the requirements of the vacancy change during the posting period, the Employer shall repost the vacancy in accordance with the provisions of this Article.

3. Vacancies shall be posted and awarded as set forth herein prior to the recall of any laid off bargaining unit member.

4. During the process of filling a vacancy, the position may be filled with a substitute. No vacancy shall be occupied by a substitute for more than twenty (20) workdays from the close of the job posting without prior consultation with the Association as to the necessity and duration of the extension.

5. Vacancies will not be posted in the food service, custodial or transportation departments until any requirements in Articles 9(A), 10(B) and 12(L) have been fulfilled.

C. Any bargaining unit member who meets the qualifications as set forth on the posting may apply in writing within the posting period.

D. Vacancies will be awarded to applicants in the following order:

1. The most senior qualified bargaining unit member in the same position within the classification where the vacancy arose.

2. The most senior qualified bargaining unit member who is on layoff provided she/he has occupied the same position within that classification.

3. The most senior qualified bargaining unit member from within the same classification where the vacancy arose.

4. Except as set forth in Section 6 below, the most senior qualified bargaining unit member from another classification.

5. For purposes of this Article, the term classification shall be as established in Appendix D.

6. An applicant with greater seniority will not be bypassed for a less seniored or outside applicant hereunder unless it can be demonstrated that the applicant selected is the most qualified.

In the event the bargaining unit member with more seniority under Sections 1-3 above is bypassed, the reasons for the denial shall be provided to the applicant upon request. Should the bargaining unit member disagree with the reasons given, the denial will be subject to the grievance procedure beginning at Step II. Any grievance relating to appointments in the administrative secretarial, maintenance, grounds or instructional aide classifications will terminate at step II.

E. A bargaining unit member selected to fill a vacancy in another classification shall be granted a five (5) workday trial period to determine his/her desire to remain in the job and ability to perform satisfactorily.

1. During the trial period, the bargaining unit member may revert back to his/her former position in which case the bargaining unit member may not apply for another posted vacancy within that classification for a period of six (6) months from the date of return.

2. Should the work of the bargaining unit member be unsatisfactory, he/she shall be provided with written notice stating the reasons and shall be returned to his/her

former position. Should the bargaining unit member disagree, the matter may be appealed through the grievance procedure beginning at Step II.

3. During the trial period, the position vacated by the bargaining unit member may be filled with a substitute.

F. All positions will be awarded within ten (10) calendar days of the end of the posting period.

G. The Association President shall receive a copy of each job posting, a list of the applicants and the name of the bargaining unit member to whom the position was awarded.

H. A bargaining unit member may occupy more than one (1) bargaining unit position provided there is no conflict in hours and provided further that the total number of hours does not exceed eight (8) hours a day.

I. Those positions which become vacant and for which the Employer requires testing, the testing will be administered to the applicants prior to filling any such vacancy.

J. In cases of voluntary transfers, promotions, or reassignments to a new classification, bargaining unit members will be paid the "new hire" rate for the first five (5) work days. Upon satisfactory completion of the trial period, the bargaining unit member shall be paid in accordance with his/her bargaining unit seniority.

1. In cases of reassignment within the same classification, bargaining unit members shall be paid in accordance with their bargaining unit seniority.

2. In cases of involuntary transfer whether into a new classification or within the same classification, bargaining unit members shall be paid in accordance with their bargaining unit seniority.

3. Bargaining unit members who move from one classification to another as provided in Section I shall be paid at the "new hire" rate unless said bargaining unit member has had experience within said classification in which case, he/she shall be given credit for same to determine the appropriate hourly wage.

K. Any bargaining unit member in the aides, custodial/maintenance and secretarial classifications who has a reduction in work hours of at least thirty (30) minutes will be entitled to first consideration for additional regularly scheduled hours within his/her classification subject to the following conditions:

1. The hours reduction referenced transpired subsequent to July 1, 1991.

2. The hours are being reinstituted in the employee's building, are contiguous to the employee's assigned hours, are compatible with the employee's schedule, and the bargaining unit member is qualified.

3. The entitlement shall expire after two (2) years from the effective date of the reduction.

4. The bargaining unit member shall lose his/her rights during the two (2) year period under this Section if she/he does not apply for a position for which he/she is qualified and which equals or exceeds the level of hours prior to the reduction or, if he/she refuses additional regularly assigned hours.

L. The following provisions will apply to custodial and food service classification (See Appendix D) vacancies:

1. When a vacancy occurs, a notice will be posted of a bid meeting in the custodial lounges and kitchens throughout the district and to laid off employees from within the classification at least three (3) weekdays in advance of the bid meeting. The notice will contain the date, time and location of the bid meeting and the location and work schedule of the vacancy.

2. Only employees (including those who are laid off at the time of the bid meeting) within the classification where the vacancy exists may attend the meeting.

3. Only the posted position and any subsequent vacancies occurring at the bid meeting will be available. No bargaining unit member may be involuntarily displaced at the meeting.

4. Bid meetings are not considered time worked and are therefore not paid. Bargaining unit members may submit bids by written proxy on a form provided by the Employer through the supervisor.

5. Positions will be bid on the basis of seniority with the most senior bargaining unit member bidding first. The trial period in Article 12(E) will not apply.

6. The remaining vacancy will be posted and filled under the provisions of Article 12, Section D(4)-(6).

7. Following the completion of the bid meeting, no employee from within the classification may apply for the remaining vacancy.

ARTICLE 13: SUBSTITUTE ASSIGNMENTS

A. Long-term substitute assignments (Operations Department)

The Employer reserves the right to make temporary reassignments of staff within the department prior to implementing Section B below. The employee will receive his/her regular rate of pay.

Custodial staff assigned to a custodial substitute assignment in another building, will be placed on the overtime rotation in the new building assignment and removed from the overtime rotation in their former building for the duration of the substitute assignment.

Absent good cause being shown, appointments will be made on the basis of seniority.

B. Long-term substitute assignments (other than operations department):

1. Long-term substitute assignments are temporary vacancies that are attributable to the absences of a bargaining unit member under the provisions of Article 18 and the duration of which are known by the Employer to exceed ten (10) workdays that the Employer intends to fill.

2. Bargaining unit members who work eight (8) or less hours a day or less than twelve (12) months per year, shall have the first opportunity for substitute assignments in accordance with the following:

   a. On May 1 or the first workday thereafter in each school year, the Employer shall post a form on which bargaining unit members may register their interest in substitute assignments. Said registration form shall be valid for one (1) school year beginning with the first day of work in the following school year.

   b. Said form shall be posted in all the buildings as set forth in Article 12, Section B for ten (10) full calendar days.

   c. A bargaining unit member who is interested in substitute assignments may register said interest with his/her immediate supervisor as provided in Section 1 above.

   d. A newly hired bargaining unit member may sign up within ten (10) calendar days of the completion of his/her probationary period.

   e. Substitute assignments shall be awarded in the following order:

      1. The most seniored employee within the classification (see Appendix D).

      2. The most senior qualified bargaining unit member in another classification (see Appendix D) who meets the requirements for the job.

   A substitute assignment will be denied if the assignment will not result in an increase in gross pay compared to the bargaining unit member's regular assignment.

A substitute assignment may be taken in addition to the bargaining unit member's regular assignment provided said assignment does not interfere with his/her regular job.

f. In the event a bargaining unit member is used as a substitute, he/she shall be paid at the non-union substitute rate for the entire assignment.

g. Any position that is temporarily vacated under the provisions of Section e, above, will be filled by a non-bargaining unit substitute.

h. Registered bargaining unit members who subsequently refuse three (3) substitute assignments in any given school year shall be removed from the registration list for the remainder of the school year except when the bargaining unit member is working in another substitute assignment or if such bargaining unit member is working full time.

i. No bargaining unit member will be involuntarily assigned to a long-term substitute assignment.

j. The Employer reserves the right to deny a substitute assignment to an employee where the employee's position requires special qualifications (i.e. bus driver certification, etc.) or it may impair the operations of the District.

C. Daily substituting

Normally, substitute assignments of ten (10) or less working days will be filled with non-bargaining unit substitutes.

Where the Employer elects to utilize a bargaining unit member to substitute on a daily basis, the employee will be paid his/her regular rate of pay or the new hire rate for the classification, whichever is higher. An employee may refuse a substitute assignment on a different shift.

D. Daily Substituting (Food Service Department):

The Employer reserves the right to use cooks and kitchen assistants to substitute on a daily basis in the absence of regularly assigned cooks and kitchen assistants subject to the following conditions:

1. The bargaining unit member does not have a conflicting assignment outside of the food service classification.

2. This provision will not require the reassignment of cooks or kitchen assistants between buildings.

3. The supervisor shall determine the positions to which bargaining unit members will be reassigned.

4. A bargaining unit member who is assigned to substitute shall be paid at his/her regular rate of pay or the new hire rate for the classification, whichever is higher.

E. No bargaining unit member will be entitled to a substitute assignment in addition to his/her regularly assigned hours if the combination of the substitute assignment and his/her regularly assigned hours will result in overtime.

F. No additional rights or benefits shall accrue to a bargaining unit member during the term of a substitute assignment.

G. Substitute assignments shall not be used to satisfy the probationary period referenced in Article 15.

ARTICLE 14: SEASONAL AND SPECIAL PROJECTS

A. Bargaining unit members who work one hundred and eighty (180) days at eight (8) or less hours a day shall have the first opportunity for seasonal and special project assignments, hereinafter referred to as temporary assignments, in accordance with the following:

1. On May 1 or the first workday thereafter in each school year, the Employer shall post a form on which bargaining unit members may register their interest in temporary assignments. Said registration form shall be valid for one (1) school year beginning with the first day of work in the following school year.

2. Said form shall be posted in all the buildings as set forth in Article 12, Section B for ten (10) full calendar days.

3. A bargaining unit member who is interested in temporary assignments may register said interest with his/her immediate supervisor as provided in Section 1 above.

4. No bargaining unit member will be entitled to a temporary assignment in addition to his/her regularly assigned hours if the combination of the temporary assignment and his/her regularly assigned hours will exceed eight (8) hours a day.

5. Temporary assignments shall be awarded to the most senior qualified bargaining unit member provided said assignment does not interfere with the bargaining unit member's regularly assigned hours.

6. Bargaining unit members who are awarded temporary assignments as provided herein shall be paid at the new hire rate of pay for custodians.

7. Registered bargaining unit members who refuse three (3) temporary assignments in any given school year shall be removed from the registration list for the remainder of the school year except when the bargaining unit member is working in another temporary assignment or if such bargaining unit member is working full time.

8. No additional rights or benefits shall accrue to a bargaining unit member during the term of a temporary assignment.

B. Temporary assignments shall not be used to satisfy the probationary period referenced in Article 15.

C. The "events custodian" position shall be considered a temporary assignment. As such, the position shall be posted as a temporary vacancy on a seasonal basis e.g., basketball season, volleyball season. Accordingly, the assignment will be for the duration of a season except as same may be assigned to a custodian as part of his regular assignment on a day-to-day basis.

ARTICLE 15: SENIORITY

A. Newly hired bargaining unit members shall be on probation for the first sixty (60) days worked. Any scheduled workdays on which the probationary bargaining unit member is absent shall serve to extend the probationary period.

1. No bargaining unit member shall be required to serve more than one (1) probationary period with the Employer unless he/she has severed his/her employment and is later rehired.

2. A probationary bargaining unit member shall have no seniority until the completion of the probationary period at which time seniority shall be established from the last date of hire.

B. Seniority shall be defined as the length of continuous employment in a bargaining unit position and shall accrue on a bargaining unit wide basis from the last date of hire.

1. Last date of hire shall be defined as the first day worked in a bargaining unit position.

2. Should a bargaining unit member permanently transfer to a non-bargaining unit position with the Employer, seniority shall not continue to accrue; however, the bargaining unit member shall retain his/her seniority accrual until such time as he/she may return to the bargaining unit.

3. Relative rankings on the seniority list shall be determined by the last three (3) digits of the bargaining unit members' social security number. The bargaining unit member with the higher number shall be credited with greater seniority.

4. Part-time bargaining unit members shall accrue seniority as if they were employed fulltime.

5. Seniority shall be pro-rated for newly hired bargaining unit members.

6. Seniority shall continue to accrue while on layoff and during an unpaid leave of absence granted pursuant to this Agreement.

C. A bargaining unit member shall lose his/her seniority when:

1. He/she resigns or retires.

2. He/she is discharged and the discharge is not reversed through the grievance procedure set forth in this Agreement.

3. He/she fails to return from an unpaid leave of absence within three (3) working days of the end of said leave.

4. He/she is absent for three (3) consecutive working days without notifying the Employer. Exceptions may be made by the Superintendent.

5. After such absences as listed in Sections 3 and 4 above, the Employer will send written notification to the bargaining unit member at his/her last known address that he/she has lost his seniority, and his/her employment has been terminated. If the disposition of any such case is not satisfactory, the matter may be referred to the grievance procedure.

D. For purposes of implementing Article 16, the Association President shall have superseniority. For purposes of layoff and recall, the Association President will be considered the most seniored bargaining unit member in any classification in which he/she has worked. If there is available work within said classification(s), the Association President shall not be laid off. In the event no such work is available, the Association President shall be considered the most seniored bargaining unit member in any classification in which he/she has worked for purposes of recall to vacancies.

The Association agrees to indemnify and save the District, including individual school board members and their agents, harmless against any and all fees, awards, claims, demands, costs, suits, judgments or other forms of liability which may arise out of or by reason of action taken by the District or its agents in complying with Section D.

E. The Employer shall prepare, maintain and post the seniority list on all Association bulletin boards annually. Posting of said list shall occur on or before October 1 in each year.

1. The seniority list shall include the name, the last three (3) digits of the social security number, date of hire and job title of all bargaining unit members entitled to seniority in the bargaining unit.

2. The bargaining unit member shall have thirty (30) calendar days following the posting of the seniority list in which to challenge the accuracy of said list. Should the bargaining unit member fail to challenge within the period provided above, the seniority credited on that list shall be deemed correct for said school year and not thereafter subject to challenge through the grievance procedure.

3. In the event of a typographical error not identified by the bargaining unit member in a timely fashion, the list will not be subject to change until the next annual posting of the seniority list. Any personnel changes initiated in the interim period in which seniority is utilized shall be based upon the list as posted including the typographical error(s). A challenge to said changes during the interim period which are based upon a typographical error on the seniority list are not subject to challenge through the grievance procedure.

4. Any personnel changes required as a result of correcting a typographical error when the next annual seniority list is posted will be subject to the grievance procedure. Any grievance submitted will be restricted to prospective remedy from the date the new annual list is submitted.

ARTICLE 16: LAYOFF AND RECALL

A. Layoff shall be defined as a reduction in the work force.

B. In the event it becomes necessary to reduce staff, the Employer shall meet with the designated Association Representative(s) at least twenty-one (21) calendar days prior to the effective date of layoff. At such meeting the Employer shall submit a list of the names of bargaining unit members scheduled for layoff and a list of the names of reassigned bargaining unit members, their job title and work location together with a copy of an updated seniority list.

C. Bargaining unit members to be laid off shall be provided with written notice at least fourteen (14) calendar days prior to the effective date of said layoff. Bargaining unit members whose positions have been eliminated shall be notified of either reassignment or layoff. The Association President shall receive a copy of all such notices.

D. In the event of a layoff, the following procedure shall apply:

1. All temporary employees shall be laid off unless there is no qualified bargaining unit member to perform the work.

2. Should further reduction be necessary, probationary bargaining unit members within the affected classification(s) shall be laid off unless there is no qualified, non-probationary unit member to perform the work.

3. Should further reduction be necessary, bargaining unit members shall be laid off in accordance with their seniority status with the least senior bargaining unit members within the affected classification to be laid off first unless there is no other qualified unit member to perform the work.

   a. The Employer will reassign bargaining unit members within the affected classification(s) to facilitate the requirements set forth herein.

      Such reassignment shall entitle the laid off bargaining unit member to displace the least senior bargaining unit member within his/her classification whose annual work hours most closely approximate, but do not exceed the number of annual hours to which the bargaining unit member was assigned prior to layoff.

      If the implementation of reassignments under Section 3(A) results in a bargaining unit member losing their district paid health and dental insurance benefits under Article 21, that bargaining unit member will:

      1. Upon written request to the Superintendent being made within one (1) district business day of receipt of the notice, be reassigned to a classification the employee had been formerly assigned to as a regular employee (excludes Article 13 and 14 assignments) and had successfully completed the trial or probationary period.

      2. Such reassignment shall entitle the laid off bargaining unit member to displace the least senior bargaining unit member within their former classification whose annual work hours most closely approximate, but do not exceed the number of annual hours to which the bargaining unit member was assigned prior to layoff.

   b. A bargaining unit member without sufficient seniority to maintain a position within his/her classification shall be reassigned to a position within another classification provided he/she is otherwise qualified. Such reassignment shall entitle the laid off bargaining unit member to displace the least senior bargaining unit member whose annual work hours most closely approximate, but do not exceed the number of annual hours to which the bargaining unit member was assigned prior to layoff.

   c. A bargaining unit member assigned to more than one (1) position (see Article 12, Section H) shall be considered as occupying separate positions for purposes of reassignment under this Section.

4. With the exception of the bus driver classification, the foregoing procedure will be used in the event of a permanent reduction in hours in excess of thirty (30) minutes a day.

E. For purposes of this Article, classification shall be as defined in Appendix D.

F. The layoff procedures provided in this Article shall not be applied to the bus driver classification until such time as the bid procedures set forth in Article 10 has been effected.

G. Bargaining unit members shall not continue to accrue sick leave, salary steps, longevity credit or vacation credit while on layoff status, but shall have all previously accrued rights restored upon recall.

H. In the event of a layoff, the Association and the Employer may mutually agree to allow individual bargaining unit members to waive their seniority rights for the purpose of layoff.

1. A bargaining unit member may, at his option, request to waive his seniority in the event that the Employer institutes a layoff during the term of this Agreement.

2. Should the bargaining unit member elect to waive his seniority rights, such waiver shall not be construed to be a waiver of the right to be recalled from such layoff.

3. If such an agreement is reached, the Individual Agreement Form which is attached to and incorporated into this Agreement as Appendix B shall be completed by the bargaining unit member and filed by the Employer.

4. It is understood that a bargaining unit member who elects a voluntary layoff shall be recalled to a vacancy as provided in Section I and shall not have the right to displace another bargaining unit member.

5. Bargaining unit members shall not continue to accrue sick leave, salary steps, longevity or vacation credit while on voluntary layoff status, but shall have all previously accrued rights restored upon recall.

6. The denial of a voluntary leave is not subject to the grievance procedure.

I. Laid off bargaining unit members shall be recalled in order of seniority, with the most senior being recalled first, to any position for which he/she is qualified.

1. Notice of recall shall be sent by certified or registered mail to the last known address as shown on the Employer's records. The recall notice shall state the time and date on which the bargaining unit member is to report back to work.

2. A recalled bargaining unit member shall be given ten (10) working days from receipt of notice to report to work.

3. The Employer may fill the position on a temporary basis until the recalled bargaining unit member can report for work, provided the unit member reports within the above ten (10) day period.

4. Bargaining unit members recalled to a position for which they are qualified and the gross earnings for which equal at least ninety percent (90%) of the current regular gross weekly earnings of the classification(s) to which he/she was assigned at the time of layoff are obligated to accept such work. Accordingly, a bargaining unit member who declines recall to such a position shall forfeit his/her seniority and right to recall.

5. Should the bargaining unit member fail to respond within ten (10) working days from receipt of written recall, he shall be considered as having resigned.

6. Recall rights shall terminate two (2) years from the effective date of the bargaining unit member's layoff except in the event of a voluntary layoff in which case the bargaining unit member's recall rights shall terminate three (3) years from the effective date of such voluntary layoff.

ARTICLE 17: MEDICAL EXAMINATIONS

A. The Employer shall require at the time of initial employment, a statement certifying an employee's fitness for work from a physician authorized to practice medicine under the laws of the State of Michigan.

B. In addition, at the time of initial employment, a bargaining unit member shall submit a report of a negative chest x-ray or tuberculin test taken within the past six (6) months. Thereafter, a chest x-ray or tuberculin test shall be required as arranged by the Employer and at no expense to the bargaining unit member. Each bargaining unit member shall have the option of securing an x-ray or tuberculin test elsewhere at his/her own expense.

C. After any extended illness or hospitalization, of five (5) or more workdays, the bargaining unit member shall provide the Superintendent with a statement from his/her physician certifying the bargaining unit member's fitness to return to work.

D. Any physical examination required by the Employer or appropriate State agency or law for continued employment shall be by a physician designated by the Employer and at Employer's expense.

E. The Employer may require a bargaining unit member to submit to a physical and/or psychological examination which shall certify his/her fitness to continue his/her employment. Physical and/or psychological examinations requested by the Employer shall be made by a physician designated by the Employer without cost to the bargaining unit member. The Employer shall provide a list of at least three (3) doctors' names from which the bargaining unit member may select.

ARTICLE 18: LEAVES OF ABSENCE

A. Paid Leave

1. The abuse or misuse of paid leave is reasonable cause for discipline up to and including discharge. Should the Employer have reasonable cause to suspect abuse, a bargaining unit member may be required to provide medical or other verification in connection with the use of paid leave.

2. At the beginning of each contract year or school year whichever is applicable, ten (10) month bargaining unit members shall be credited with ten (10) days of sick leave and twelve (12) month bargaining unit members shall be credited with twelve (12) days of sick leave, the unused portion of which shall accumulate from year to year without limit.

   a. At the beginning of each contract year or school year, whichever is applicable, the Employer shall provide each bargaining unit member with a written statement which sets forth his/her total number of accumulated sick leave days.

   b. The bargaining unit member's accumulated leave time will be charged for the time required to recover from his/her own illness or disability.

   c. The bargaining unit member's accumulated leave time will be charged for up to five (5) days of sick leave for each year for incidents of critical illness or injury among members of the bargaining unit member's immediate family.

      1. Immediate family shall be defined as child, spouse, grandparents, grandchild, parent or other members of the bargaining unit member's immediate household.

      2. An additional five (5) days per year may be used for critical illness or injury or the bargaining unit member's spouse, child or parent.

      3. The bargaining unit member will provide medical verification of the illness or injury.

   d. Sick leave which was earned prior to an unpaid leave of absence or a layoff shall be held in reserve pending the bargaining unit member's return to the bargaining unit.

   e. A bargaining unit member who is absent due to an injury incurred during the course of his/her employment and such injury is compensable under the Worker Disability Compensation Act of 1969, as amended, shall be considered to be on paid leave.

1. The bargaining unit member shall notify his/her immediate supervisor of any such injury immediately, if able. If the bargaining unit member is unable to notify the immediate supervisor at the time of the injury, the immediate supervisor or other representative of the Employer shall be notified within forty-eight (48) hours of such injury.

2. A bargaining unit member whose illness or injury is compensable under the Workers' Compensation Act shall be entitled to use his/her accumulated sick leave on a pro-rata basis to make up the difference between Workers' Compensation benefits and his/her regular daily rate of pay; provided, however, that this differential is not determined by a court or administrative agency of competent jurisdiction to be a required offset under Section 354 of the Workers' Compensation statute.

f. Should a bargaining unit member's employment be severed prior to the end of any work year, the bargaining unit member's final paycheck will be adjusted for any sick leave used in excess of the days earned.

3. At the beginning of each contract year, each bargaining unit member who works four (4) or more hours a day shall be credited with two (2) days of leave to be used for the bargaining unit member's personal business.

At the beginning of each contract year, each bargaining unit member who works less than four (4) hours a day shall be credited with one (1) day of leave to be used for the bargaining unit member's personal business. Bargaining unit members hired during the year shall receive the appropriate pro-rated portion of the foregoing personal business leave.

a. A personal leave day shall be defined as the number of hours the bargaining unit member is regularly scheduled to work.

b. A bargaining unit member planning to use a personal business day(s) shall notify his immediate supervisor at least one (1) day in advance except in cases of emergency. The Superintendent may extend personal business leave at his/her discretion.

c. Personal business leave is to be used only for purposes which require the bargaining unit member's absence to attend to matters which cannot be conducted except during the bargaining unit member's normal working hours.

d. During the school year, personal leave may not be used immediately prior to or immediately after any holiday or vacation period. The Superintendent or his agent may, at his discretion, grant an exception to the above should an emergency arise.

e. Personal leave may not be used to circumvent any other leave provision of this Agreement; to defend a morals charge unless found innocent; nor to fulfill the expectations of another employer.

f. Unused personal leave shall accrue as accumulated sick leave.

4. A bargaining unit member who is summoned for jury duty, or who is subpoenaed to give testimony in court shall, if possible, notify the Administration at least one (1) week prior to the date he/she is to begin serving on jury duty or testifying in court.

a. A bargaining unit member who is summoned and reports for jury duty or for testifying in court, shall be paid the difference between the amount he/she receives from the court and his/her regular rate of pay.

b. It is understood and agreed that a bargaining unit member shall be required to report to work on any and all days he/she is not sitting as a juror or testifying in court.

c. To be eligible for the pay differential, a bargaining unit member shall furnish the Employer with a written statement from the appropriate public official listing the amount and the dates for which he/she received payment from any court.

d. Bargaining unit members who appear before a court of competent jurisdiction or an administrative body on behalf of the Employer shall suffer neither loss of leave time nor loss of salary.

5. A bargaining unit member shall be allowed up to five (5) working days as funeral leave days, not to be deducted from sick leave, for any death in the immediate family. Immediate family shall be defined as: mother, father, sister, brother, wife or husband, son or daughter, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, aunts, uncles, grandparents or grandchildren, step parents or step children, or a member of the bargaining unit member's household.

a. Any bargaining unit member selected to be a pall bearer for a deceased bargaining unit member will be allowed one (1) funeral leave day with pay not to be deducted from sick leave. The Association President or his/her representative shall be allowed one (1) funeral leave day in the event of a death of a member of the bargaining unit for the exclusive purpose of attending the funeral.

b. A bargaining unit member may be granted leave without pay to attend the funeral of any person who is not a member of the bargaining unit member's immediate family or household.

6. For purposes of computing all benefits under this Agreement, paid leave shall be considered as time worked. Pay for leave day(s) shall be defined as the bargaining unit member's regularly assigned work hours.

B. Unpaid Leaves

1. The reinstatement of bargaining unit members who were inducted into any branch of the armed services, whether probationary or non-probationary, shall be in accordance with the Veterans Employment Reinstatement Act.

   a. Bargaining unit members who are interested in accordance with the Universal Military Training Act, as amended, and other applicable laws and regulations, will be granted an unpaid leave of absence for a period not to exceed their seniority in order to attend school fulltime under applicable federal laws in effect on the date of this Agreement.

   b. Bargaining unit members who are in some branch of the Armed Forces Reserve or the National Guard will be paid the difference between their reserve pay and their regular pay with the District when they are on full time active duty in the Reserve or National Guard, provided proof of service and pay is submitted. A maximum of two (2) weeks per year is the limit. The Board, in its discretion, may extend said leave.

2. Upon prior written request from the bargaining unit member, an unpaid leave of absence shall be granted without loss of seniority for a period of one (1) year or, for a period equal to the bargaining unit member's seniority, whichever is less, for the following reasons:

   a. Serving in any elected or appointed position, public or Association.

   b. Maternity leave.

   c. Illness leave (physical or mental).

   d. Prolonged illness in immediate family.

   e. Educational leave.

3. Members of the Association who are elected to attend Association conventions or educational conferences, shall be allowed time off without pay to attend such conferences and/or conventions.

4. A non-probationary bargaining unit member with at least five (5) years of service to the District may be granted time off without pay provided the following conditions are met:

   a. The bargaining unit member shall apply in writing with the Superintendent at least four (4) weeks in advance of the intended time off. The decision of the Superintendent is final and is not subject to the grievance procedure.

   b. The bargaining unit member has used no more than a total of four (4) personal and/or sick leave days within the preceding eight (8) months. Long term illness and/or injury as verified in writing by a physician shall not count as one (1) of the four (4) days.

   c. The period of a leave shall not be more than ten (10) working days.

   d. No bargaining unit member may apply for more than one (1) leave of absence under these provisions in any fiscal year (July 1 to June 30).

   e. The bargaining unit member's absence shall not unduly impair the operation of the District.

5. Bargaining unit members who are eligible for leaves under the Federal Family Medical Leave Act will be afforded leaves in accordance with the following provisions:

   a. In addition to the provisions set forth below, Board Policy and Administrative Procedure will govern leaves authorized under the Family Medical Leave Act of 1993.

   b. In the event the policy and/or administrative procedures are being amended by the Board, the Association will be provided with written notice and the opportunity to negotiate with respect to the changes.

   c. Eligible staff means an employee who has been employed by the District for at least twelve (12) months and who has worked at least 1250 hours during the previous twelve (12) month period.

   d. The Board shall provide up to twelve (12) work weeks of unpaid leave to all eligible staff during any twelve (12) month period for one (1) or more of the following reasons:

      1. The birth or care of a child.

      2. The adoption or foster care of a child.

3. The care of a spouse, son, daughter, or parent if such individual has a serious health condition.

4. A serious health condition of the staff member which disables him/her from performing the responsibilities of his/her position.

   A serious health condition may be an illness, injury, impairment or physical or mental condition that involves in-patient care in a hospital, hospice, or residential medical facility or which requires continuing treatment by a healthcare provider.

e. If a leave is necessitated by the serious health condition of the staff member or his/her family member, and is foreseeable based on planned medical treatment, the staff member shall, whenever possible, provide the Superintendent with thirty (30) calendar days notice and shall schedule the treatment so as not to disrupt the regular operation of the District.

f. When the Superintendent and the staff member agree, such leave may be taken intermittently or on a reduced-schedule leave in the event of birth or adoption. The staff member may take intermittent or reduced-schedule (half-days) leave when medically necessary to care for a spouse, child, or parent who has a serious health condition, or if the staff member has a serious health condition. In both cases, the taking of such leave will result in reducing the twelve (12) week leave period only by the amount of the leave actually taken.

   When the duration of the leave is foreseeable based upon planned medical treatment and leave time will exceed twenty percent (20%) of the total number of workdays within that period, the staff member may be required to take leave in a block of time (not intermittently) or to transfer to an available, alternate position which better accommodates an intermittent leave. Said position shall be equivalent in pay and shall be one for which the staff member is qualified.

g. In the case of a serious health condition of a family member, the Superintendent will obtain medical certification from the physician of the family member. Said statement shall include the date the serious health condition began, the probable duration, appropriate medical facts regarding the condition, a statement that the staff member is needed to care for a family member and an estimate of the amount of time needed for such care.

   Whenever the leave is necessitated by the staff member's own health condition, a statement from his/her physician will be required. The statement shall verify that the staff member is unable to perform the responsibilities of his position.

h. Subject to the limitations set forth in the Master Agreement that correspond to time under the Act for which unpaid time is afforded, the Board does require that all accrued paid medical, sick or personal leave be substituted for the Family Medical Leave described in the policy.

i. During a family medical leave, the Board shall maintain the staff member's current coverage under the District's health insurance program.

j. At the end of any leave, the Board shall restore the staff member to his/her former position or to one that is equivalent in responsibility and compensation.

C. General Leave Provisions

1. Bargaining unit members shall be returned to the position held at the time the leave of absence was granted, or to a position to which his/her seniority entitles him/her.

2. Unpaid leaves of absence granted pursuant to this Agreement may be extended for a period not to exceed one (1) year at the discretion of the Employer.

3. The general leave provisions set forth herein shall not apply to leaves granted under the Family Medical Leave Act.

ARTICLE 19: HOLIDAYS AND VACATION TIME

A. The following days shall be paid holidays for all bargaining unit members: Labor Day, Thanksgiving Day and the Friday following, Christmas Eve Day, Christmas Day, New Years Eve Day, New Years Day, Presidents' Day, Good Friday, Memorial Day and July 4.

1. When the holiday occurs on Sunday, it will be observed on the following Monday. When the holiday occurs on Saturday, it will be observed on the preceding Friday.

2. In order to receive holiday pay, bargaining unit members must work the last workday preceding and the first workday following the holiday provided they are normally scheduled for work on said days and except as otherwise excused.

3. In order to receive holiday pay for July 4, a bargaining unit member must work no less than ten (10) days during the month of July unless he/she is on vacation or other paid leave.

4. Presidents' Day will be a paid holiday only when school is not in session.

5. In the event Good Friday is scheduled for instruction, an alternate date will be established.

B. Bargaining unit members who are scheduled to work 2,080 hours in any year shall be credited with paid vacation time in accordance with the following schedule:

1. Upon employment and through the bargaining unit member's second year of employment, he/she shall be credited with vacation time at the rate of 5/6 of a day each month not to exceed eighty (80) hours in any year. Unused vacation time may accumulate from year to year up to a maximum of one hundred sixty (160) hours.

2. On the bargaining unit member's third anniversary, he/she shall be credited with vacation time at the rate of 1 1/4 days each month not to exceed one hundred twenty (120) hours in any year. Unused vacation time may accumulate from year to year up to a maximum of two hundred forty (240) hours.

3. On the bargaining unit member's fifth anniversary and every year thereafter, he/she shall be credited with vacation time at the rate of 1 2/3 days each month not to exceed one hundred sixty (160) hours in any year. Unused vacation time may accumulate from year to year up to a maximum of three hundred twenty (320) hours.

C. Bargaining unit members who are twelve (12) month employees and are scheduled to work less than 2,080 hours (except 230 day special education bus drivers) in any year shall be credited with paid vacation time based upon their years of employment as set forth in Section B and computed in accordance with the following formula:

1. Add all the work hours regularly scheduled for a contract year. (July 1 to June 30).

2. Divide the total regularly scheduled work hours arrived at in item #1 above by 2080 hours.

3. Multiply the resulting percentage times the eligible vacation award as if for a full-year, full-time bargaining unit member. (20 days vacation equals 8 hours x 20 days = 160 Total Vacation Hours.)

Examples:

a. Bargaining unit members who are scheduled to work 40 hours a week for 40 weeks during the school year = 1600 hours
and 30 hours/week for 12 weeks during summer = 360 hours
Total 1960 hours

$\frac{1960 \text{ total hours regularly scheduled}}{2080} = .9419 \times 160 \text{ hrs} =$ 150 3/4 vacation hours or 18 7/8 vacation days

b. A Special Education driver who is scheduled for 5 hours a day for 230 special education days
5 hours x 230 days = 1150 hours

In addition during the regular school year an additional bus run is in his/her schedule of 2 hours in length.
2 hours x 180 days = 360 hours Total 1510 hours regularly scheduled

The driver therefore has

$\frac{1510 \text{ Total hours}}{2080} = .7260 \times 160 \text{ hrs} =$ 116 1/4 vacation hours or 14 1/2 vacation days

D. Unless good cause can be shown by the employee, vacation requests must be submitted at least seven (7) calendar days ahead of the date(s) requested. The requests are subject to the approval of the supervisor.

E. Vacation time may only be used in full or half day increments.

F. Bargaining unit members on approved vacation will receive holiday pay for any paid holiday which falls during his/her scheduled vacation.

G. A vacation may not be waived by a bargaining unit member so as to receive extra pay for work during that period.

H. If a bargaining unit member becomes ill and is under the care of a physician during his/her vacation, the vacation time will be rescheduled for that portion of vacation time under a doctor's care. In the event his/her incapacity continues through the year, he/she will be awarded payment in lieu of vacation.

I. If a bargaining unit member's paycheck is normally due during a scheduled vacation period, he/she may request the check prior to the vacation leave. Requests made no less than two (2) weeks prior to the requested date of receipt shall be honored.

J. If a bargaining unit member is laid off, retired, or severs employment, he/she will receive pay for unused accrued vacation credit. Should a bargaining unit member's employment be severed prior to the end of any work year, the bargaining unit member's final paycheck will be adjusted for any vacation days used in excess of the days earned.

K. While on vacation bargaining unit members will be paid their current pay rate based upon their regularly scheduled day and will receive credit for any fringe benefits provided in this Agreement.

ARTICLE 20: COMPENSATION AND LONGEVITY PAY

A. The wages of bargaining unit members covered by this Agreement are set forth in Appendix A which is attached to and incorporated into this Agreement.

1. Bargaining unit members who work the second or third shift shall receive an additional thirty-five cents ($.35) an hour.

2. The mechanic will receive an additional sixty cents ($.60) an hour provided he possesses and maintains Heavy Duty Truck and Diesel Motor Vehicle Mechanics Certificate(s).

3. When a bargaining unit member is assigned to fill in for a maintenance employee or for the mechanic for one (1) hour or more, she/he shall be paid at the maintenance/custodial or the mechanic rate in accordance with his/her years of seniority.

B. A bargaining unit member shall be paid for overtime in accordance with the following:

1. Rate of pay shall be at time and one-half of the appropriate hourly rate for all work performed in excess of ten (10) hours in any workday (Monday through Friday) and forty (40) hours in any work week.

2. The rate of pay for time worked on Saturday shall be time and one-half of the appropriate hourly rate of pay. The rate of pay shall be double the appropriate hourly rate for all work performed on Sunday and holidays (except for those drivers with runs to the ISD) as set forth in Article 19 of this Agreement. Double time on holidays shall be in addition to holiday pay.

3. When a shift extends beyond 12:00 midnight, it will not require the automatic payment of time and one-half on Saturday or double time on Sunday. Time and one-half will be paid for all hours worked on the sixth day of the employee's work week and double time for all hours worked on the seventh day of the employee's work week.

4. Where a bargaining unit member's regular work week involves Saturday or Sunday, the requirement for overtime pay as set forth above will apply for the sixth and seventh day of the bargaining unit member's work week.

5. Paid time off regardless of its origins, shall not count for purposes of computing overtime.

C. A bargaining unit member who, at the Employer's request, reports for duty which is outside of his regular shift shall be guaranteed at least two (2) hours of pay at the rate of time and one half, excluding time worked continuously into the regular shift and continuously after the regular shift.

D. Should it be determined that a bargaining unit member has received compensation in excess of that earned, the Board will deduct the overpayment from the bargaining unit member's salary pursuant to MCLA 408.477; MSA 17.277(7). Said payroll deduction(s) shall be made for the same number of pay periods as the overpayment was permitted to accrue (maximum of one [1] year unless the Board and Association concur that due to the amount in question, a longer period of time is appropriate) except in the event of a layoff or an unpaid leave of absence pursuant to this Agreement. In the event of a layoff or an unpaid leave of absence, the overpayment will be deducted in equal installments, as nearly as may be, from the bargaining unit member's remaining paychecks.

E. An annual longevity bonus will be paid to bargaining unit members on the first pay period following their anniversary date according to the following schedule:

Anniversary	06-07	07-08
Upon completion of ten (10) years	$126	$129
Upon completion of fifteen (15) years	$296	$302
Upon completion of twenty (20) years	$465	$474
Upon completion of twenty-five (25) years	$636	$649

F. Bargaining unit members required in the course of their work to drive their personal automobile shall be reimbursed for mileage at the rate allowed by the IRS.

G. In appreciation for services to the District, a terminal leave payment of fifty dollars ($50) per year of service will be paid upon retirement provided the bargaining unit member shall have been employed in the District for ten (10) years and provided further that the bargaining unit member has accrued at least one hundred (100) days of sick leave at retirement.

ARTICLE 21: INSURANCE BENEFITS

A. Except as set forth at Section K of this Article, the Employer shall provide full premiums for non-probationary bargaining unit members regularly scheduled to work at least six (6) hours a day (30 hours or more a week) toward the health and dental insurance plans outlined in this Article.

1. Bargaining unit members with more than one (1) position within the bargaining unit are not eligible to combine hours of employment for purposes of insurance benefit eligibility.

2. Subject to the provisions of Section B premiums will be paid for a full twelve (12) month period.

3. Bargaining unit members hired after June 30, 2006 must be regularly scheduled to work at least 1600 hours per year to qualify for benefits.

B. An eligible bargaining unit member is responsible for the completion of all necessary documents and for fulfilling any other requirements set forth by the insurance underwriters/administrators.

C. A bargaining unit member shall report changes in family status to the Personnel Office within thirty (30) days of such change. The bargaining unit member shall be responsible for any overpayment of premiums made by the Board on his behalf for failure to comply with this provision.

Sponsored dependents or others not falling within the insurance underwriters and/or insurance administrator's definition for single, two (2) party or full family coverage, will not be eligible for benefits; however, same will be made available through payroll deduction for the bargaining unit member to purchase at his/her expense.

D. Eligible bargaining unit members may enroll in Blue Cross/Blue Shield Flex 2 Health Reimbursement Plan with a $1,250 single and $2,500 two party and full family annual deductible funded by the district for in-network services.

E. A bargaining unit member who is eligible for hospitalization insurance but does not enroll, will be eligible to receive $203.58 per month in cash, which in the alternative may be utilized toward those programs set forth in Article 5, Section E.

F. Eligible bargaining unit members will be covered by a dental plan which will provide in general, 50% basic with incentive, 50% major, $50.00 lifetime deductible, $1,000.00 annual maximum.

G. Bargaining unit members who are regularly scheduled to work ten (10) hours or more per week will receive premium payments toward $15,000 in group term life insurance coverage with AD&D. The Employer reserves the right to change life insurance carriers provided the benefit level is the same.

H. Bargaining unit members who are not eligible for paid insurance premiums may be allowed to join the group plan at the group rates provided the carrier allows same and provided the bargaining unit member's payment is in the business office seven (7) days prior to the first day of each month.

I. Except as provided in Article 18, Section B.4, benefit coverages will cease upon resignation, retirement, discharge, layoff and during an approved, unpaid leave of absence.

1. Unpaid days off which are in excess of ten (10) days in any fiscal year (July 1 to June 30) will result in a per diem deduction of insurance premiums beginning with the eleventh (11th) day.

2. Any per diem deductions due under this provision will be payroll deducted.

J. It is understood by both parties that the entire hospitalization plan, including, but not limited to eligibility, coverage, payment, liability, and benefits, are subject to the terms, provisions and conditions of the carrier. In the event any portion of this Article does not meet the terms, provisions and/or conditions of the carrier, at any time, that portion of the Article shall be voided to the extent it does not comply and the Employer shall not be held liable for any claims, coverage, liability, payments or benefits due to said change.

1. The foregoing waiver shall apply to any matter described above whether challenged by the Association, individuals, or a group of individuals.

2. If the insurance carrier changes its terms, or conditions during the term of this agreement in such a fashion that this article no longer meets with the terms, provisions or conditions of the carrier, the impact of the change shall be subject to negotiation.

K. In the event there is no successor agreement by expiration date of this Agreement, any premium increases on July 1, will be assumed by the employees during further negotiations.

L. The Employer will formally adopt a qualified plan document including a salary reduction agreement which complies with Section 125 of the Internal Revenue Code. The cost associated with establishing the initial plan document(s) and for fulfilling future reporting requirements will be assumed by the Employer.

ARTICLE 22: NEGOTIATION PROCEDURES

A. This Agreement constitutes the sole and entire Agreement between the parties and supersedes all prior practices, whether oral or written, and expresses all obligations of, and restrictions imposed upon, the Employer and the Association. This Agreement is subject to amendment, alteration or additions, only by a subsequent written agreement between, and executed by, the Employer and the Association. The waiver of any breach, term or condition of this Agreement by either party shall not constitute a precedent in the further enforcement of all its terms and conditions.

B. Sixty (60) days prior to the expiration of this Agreement either party may submit written notice to the other of the intent to amend this Agreement.

C. There shall be no less than four (4) signed copies of this Agreement. Two (2) such copies shall be retained by the Employer and two (2) such copies shall be retained by the Association.

D. When a new job is placed in the bargaining unit and cannot be properly placed in an existing classification and/or wage rate, the matter shall be subject to negotiation between the parties within thirty (30) calendar days of such placement.

E. Up to five (5) bargaining unit members will be released from their normal responsibilities without loss of pay or leave time when the parties to this Agreement mutually agree to enter into collective bargaining during the established business hours.

F. Except for those rights which are reserved to the Board in this Agreement, when the Board is considering the adoption or a change in policy or administrative rules which affect a mandatory topic of bargaining under PERA, the Association President will be notified in writing. In the event the Association wants to negotiate relative to the impact of such changes, the Association President will notify the Superintendent in writing within seven (7) calendar days of receipt of such notice.

ARTICLE 23: MISCELLANEOUS PROVISIONS

A. If any provision of this Agreement or any application of this Agreement to any bargaining unit member shall be found contrary to law, then such provision or application shall be deemed null and void, but all other provisions of such law shall supersede, to the extent of the conflict, the provisions of this Agreement and govern the relationship of the parties hereto. Should any provision or application be deemed null and void, the parties shall negotiate a suitable replacement for such provision or application upon request by the Association.

B. It is the intent of the parties to this Agreement that the Grievance Procedure as set forth herein shall serve as the means for peaceful settlement of all disputes that may arise between them. In recognition of this fact, the Association agrees that during the term of this Agreement, neither the Association, its agents, nor its members will authorize, instigate, aid or engage in a work stoppage, slowdown or a strike against the Employer. The Employer agrees that during the term of this Agreement there will be no lockout. A lockout shall not be interpreted to include periods when bargaining unit members are sent home due to a strike by another bargaining unit.

C. Programs which are conducted through the facilities of the Leslie School District, but under the auspices of some other agency or in which the District does not have complete budgetary control, may deviate from the aforementioned compensation and benefits when the other agencies have a prescribed rate of pay differing from that established in this Agreement. The Headstart and summer recreational programs are cited to exemplify the types of situations intended for this provision wherein a cook and bus drivers are employed by those programs. It is understood that these assignments are voluntary and not a condition of employment.

ARTICLE 24: DURATION OF AGREEMENT

This Agreement shall be effective upon Board ratification and shall continue in full force and effect through June 30, 2008.

In Witness thereof, the parties to this Agreement have caused its execution.

For the Employer:

Board President

Board Secretary

10/4/06
Date

For the Association

10/4/06
Date

Leslie Educational Support Personnel Master Agreement

Appendix A: CLASSIFICATIONS AND HOURLY WAGE RATES

Effective July 1, 2006-June 30, 2007
Reflects a 2.25% increase over 2005-2006

Position	New Hires	90 Days	1 Year	2 Years	3 Years	4 Years
Mechanic	$17.05	$18.63	$19.06	$19.42	$19.71	$20.00
Maintenance	$15.51	$15.80	$16.71	$16.99	$17.23	$17.55
Interpreter Aide	$15.03	$15.44	$16.12	$16.39	$16.67	$16.94
Bus Driver	$14.64	$14.87	$15.78	$16.06	$16.32	$16.57
Custodian	$12.58	$12.86	$13.60	$13.91	$14.10	$14.37
Grounds	$13.10	$13.38	$14.12	$14.43	$14.62	$14.89
Administrative Secretary	$13.26	$13.51	$14.28	$14.51	$14.82	$15.16
Instructional Aides	$11.88	$12.09	$12.88	$13.12	$13.37	$13.64
Cook	$11.57	$11.79	$12.61	$12.77	$13.07	$13.30
Kitchen Assistant	$10.26	$10.76	$11.18	$11.45	$11.76	$12.00
*Non-Instructional Aides	$10.26	$10.76	$11.18	$11.45	$11.76	$12.00
Extra Trip Rate=	$13.00					

* For job titles within these classifications, see Appendix D

Leslie Educational Support Personnel Master Agreement

Appendix A: CLASSIFICATIONS AND HOURLY WAGE RATES

Effective July 1, 2007-June 30, 2008

Position	New Hires	90 Days	1 Year	2 Years	3 Years	4 Years
Mechanic	$17.39	$19.00	$19.94	$19.81	$20.10	$20.40
Maintenance	$15.82	$16.12	$17.04	$17.33	$17.57	$17.90
Interpreter Aide	$15.33	$15.75	$16.44	$16.72	$17.00	$17.28
Bus Driver	$14.93	$15.17	$16.10	$16.38	$16.65	$16.90
Custodian	$12.83	$13.12	$13.87	$14.19	$14.38	$14.66
Grounds	$13.36	$13.65	$14.40	$14.72	$14.91	$15.19
Administrative Secretary	$13.53	$13.78	$14.57	$14.80	$15.12	$15.46
Instructional Aides	$12.12	$12.33	$13.14	$13.38	$13.64	$13.91
Cook	$11.80	$12.03	$12.86	$13.03	$13.33	$13.57
Kitchen Assistant	$10.47	$10.98	$11.40	$11.68	$12.00	$12.24
*Non-Instructional Aides	$10.47	$10.98	$11.40	$11.68	$12.00	$12.24
Extra Trip Rate=	$13.00					

* For job titles within these classifications, see Appendix D.

Appendix B: INDIVIDUAL AGREEMENT FORM

The undersigned hereby agrees to voluntarily waive his seniority for the purposes of the Leslie Public Schools impending institution of a layoff under this Agreement.

This waiver pertains solely to the order in which said bargaining unit member might be laid off during the period of this Agreement.

Signature_____ Date_____
Bargaining Unit Member

Signature_____ Date_____
Association Representative

Signature_____ Date_____
Employer Representative

Appendix C: GRIEVANCE REPORT FORM

Grievance # _____

GRIEVANCE REPORT

Distribution of Form
1. Superintendent
2. Principal/Supervisor
3. Association
4. Grievant(s)

Building | Classification | Name of Grievant | Date Filed

STEP I

A. Date Cause of Grievance Occurred _____

B. 1. Statement of Grievance _____

2. Contract Violation(s)_____

3. Relief Sought_____

_____ / _____
Signature Date

C. Disposition by Principal/Supervisor_____

_____ / _____
Signature Date

If additional space is needed, attach an additional sheet.

(Note: Continued)

D. Position of Grievant and/or Association_____

_____

_____

_____

_____/_____

Signature Date

STEP II

A. Date Received by Superintendent or Designee_____

B. Disposition of Superintendent or Designee_____

_____

_____

_____

_____/_____

Signature Date

C. Position of Grievant and/or Association_____

_____

_____

_____

_____/_____

Signature Date

Appendix D: CLASSIFICATIONS

A. For the purposes of Article 16 (Layoff and Recall) and Article 12 (Vacancies, Promotions and Transfers) bargaining unit classifications shall be as follows:

Classification	Position(s) in the Classification
Bus Driver	All Bus Driver positions
Food Service	All Food Service positions (including Kitchen Assistants)
Non-Instructional Aides	Hall Monitor, Bus Aide, Noon Hour Workers, Clerk/Typists
Administrative Secretaries	All Secretarial positions
Instructional Aides	Reading Aides, Math Aides, Special Education Aides, Library Clerk
Mechanic	Mechanic position
Maintenance	All positions
Custodial	All positions
Grounds	All positions
Interpreter Aides	Interpreter Aides

B. An interpreter aide may be qualified for positions within the instructional and non-instructional classifications; however, instructional and non-instructional aides shall not be qualified for an interpreter aide position unless they have acquired and possess the appropriate certification.

Letter of Agreement

between the

Leslie Public Schools Board of Education

and the

Leslie Educational Support Personnel Association/MEA

It is hereby agreed by the parties set forth above as follows:

1. The former "separate" rate of pay for hall monitors has been eliminated. Except as set forth in this Letter of Agreement, Hall Monitors will be paid at the "Non-Instructional Aide" rate set forth in Appendix A of the 2000-2003 Master Agreement.

2. Terri Jo Humphrey will be paid on the following schedule:

	Step 4
2006 – 2007	$12.86
2007 – 2008	$13.12

This schedule applies only to Terri Jo Humphrey and only for as long as she remains continuously assigned as a hall monitor.

Robert E. Hoag 10/3/06
For the Board Date

Geraldine Craddock 10/3/06
For the Association Date

TA on Remaining Issues
August 10, 2009

Notes— The out-of-pocket deductions currently in place will not be reduced to the level outlined below until the transition to the amended health plan which is anticipated not later than October 1, 2009. The former deductible and RX provisions will remain in effect until the change in plans.

ARTICLE 21: INSURANCE BENEFITS

A. Except as set forth at Section K of this Article, the Employer shall provide full premiums for non-probationary bargaining unit members regularly scheduled to work at least six (6) hours a day (30 hours or more a week) toward the health and dental insurance plans outlined in this Article.

1. Bargaining unit members with more than one (1) position within the bargaining unit are not eligible to combine hours of employment for purposes of insurance benefit eligibility.

2. Subject to the provisions of Section B premiums will be paid for a full twelve (12) month period.

3. Bargaining unit members hired after June 30, 2006 must be regularly scheduled to work at least 1600 hours per year to qualify for benefits.

B. An eligible bargaining unit member is responsible for the completion of all necessary documents and for fulfilling any other requirements set forth by the insurance underwriters/administrators.

C. A bargaining unit member shall report changes in family status to the Personnel Office within thirty (30) days of such change. The bargaining unit member shall be responsible for any overpayment of premiums made by the Board on his behalf for failure to comply with this provision.

Sponsored dependents or others not falling within the insurance underwriters and/or insurance administrator's definition for single, two (2) party or full family coverage, will not be eligible for benefits; however, same will be made available through payroll deduction for the bargaining unit member to purchase at his/her expense.

D. Eligible bargaining unit members may enroll in Blue Cross/Blue Shield **FLEX 3** ~~**Flex 2**~~ Health Reimbursement Plan with a **$2,000** ~~**$1,250**~~ single and **$4,000** ~~**$2,500**~~ two party and full family annual deductible funded by the district for in-network services.

E. A bargaining unit member who is eligible for hospitalization insurance but does not enroll, will be eligible to receive $203.58 per month in cash, which in the alternative may be utilized toward those programs set forth in Article 5, Section E.

F. Eligible bargaining unit members will be covered by a dental plan which will provide in general, 50% basic with incentive, 50% major, $50.00 lifetime deductible, $1,000.00 annual maximum.

G. Bargaining unit members who are regularly scheduled to work ten (10) hours or more per week will receive premium payments toward $15,000 in group term life insurance coverage with AD&D. The Employer reserves the right to change life insurance carriers provided the benefit level is the same.

H. Bargaining unit members who are not eligible for paid insurance premiums may be allowed to join the group plan at the group rates provided the carrier allows same and provided the bargaining unit member's payment is in the business office seven (7) days prior to the first day of each month.

I. Except as provided in Article 18, Section B.4, benefit coverages will cease upon resignation, retirement, discharge, layoff and during an approved, unpaid leave of absence.

1. Unpaid days off which are in excess of ten (10) days in any fiscal year (July 1 to June 30) will result in a per diem deduction of insurance premiums beginning with the eleventh (11th) day.

2. Any per diem deductions due under this provision will be payroll deducted.

J. It is understood by both parties that the entire hospitalization plan, including, but not limited to eligibility, coverage, payment, liability, and benefits, are subject to the terms, provisions and conditions of the carrier. In the event any portion of this Article does not meet the terms, provisions and/or conditions of the carrier, at any time, that portion of the Article shall be voided to the extent it does not comply and the Employer shall not be held liable for any claims, coverage, liability, payments or benefits due to said change.

1. The foregoing waiver shall apply to any matter described above whether challenged by the Association, individuals, or a group of individuals.

2. If the insurance carrier changes its terms, or conditions during the term of this agreement in such a fashion that this article no longer meets with the terms, provisions or conditions of the carrier, the impact of the change shall be subject to negotiation.

K. **DURING THE TERM OF THIS AGREEMENT, ELIGIBLE EMPLOYEES WILL MAKE THE FOLLOWING CONTRIBUTION TOWARD HEALTH CARE EACH MONTH (OR EQUIVALENCE DEPENDING UPON PAYROLL OPTIONS:**

SINGLE	**$47.65**
TWO PARTY	**$91.54**

FULL FAMILY	**$84.84**
FAMILY CONTINUATION (PER PERSON)	**$26.07**

In the event there is no successor agreement by expiration date of this Agreement, any premium increases on July 1, will be assumed by the employees during further negotiations.

L. The Employer will formally adopt a qualified plan document including a salary reduction agreement which complies with Section 125 of the Internal Revenue Code. The cost associated with establishing the initial plan document(s) and for fulfilling future reporting requirements will be assumed by the Employer.

ARTICLE 24: DURATION OF AGREEMENT

This Agreement shall be effective upon Board ratification and shall continue in full force and effect through June 30, ~~2008.~~ **2010.**

In Witness thereof, the parties to this Agreement have caused its execution.

For the Employer:	For the Association
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Date	Date

Appendix A: CLASSIFICATIONS AND HOURLY WAGE RATES

2008-2009 **Wage freeze**

2009-2010 **Wage freeze**

LETTER OF AGREEMENT
BETWEEN THE
LESLIE PUBLIC SCHOOLS BOARD OF EDUCATION
AND THE
LESLIE EDUCATIONAL SUPPPORT PERSONNEL ASSOCIATION/MEA/NEA

IN CONJUNCTION WITH THE SETTLEMENT OF THE 2008-2010 MASTER AGREEMENT, THE PARTIES AGREE THAT NOT LATER THAN THE PAYROLL PRECEDING THE DECEMBER 2009 BREAK, EACH BARGAINING UNIT MEMBER ACTIVELY EMPLOYED OR ARE ON A PAID LEAVE OF ABSENCE IN DECEMBER 2009, SHALL RECEIVE A ONE-TIME OFF SCHEDULE PAYMENT OF $250.

FOR THE BOARD **DATE** **FOR THE ASSOCIATION** **DATE**

MASTER AGREEMENT

BETWEEN

LESLIE PUBLIC SCHOOLS
BOARD OF EDUCATION

AND

INGHAM CLINTON EDUCATION ASSOCIATION/MEA/NEA

JULY 1, 2007 – JUNE 30, 2011

TABLE OF CONTENTS

AGREEMENT

This Agreement made and entered into by and between the Board of Education of the Leslie School District, Leslie, Michigan, hereinafter called the "Board", "District" or the "Employer" and the Ingham Clinton Education Association, MEA/NEA, hereinafter called the "Association."

WITNESSETH

WHEREAS, the Board has recognized, as of May 23, 1978, the ICEA-MEA/NEA as the representative of its teaching personnel with respect to hours, wages, terms and conditions of employment; and

WHEREAS, the parties, following extended and deliberate professional negotiations, have reached certain understandings which they desire to memorialize;

In consideration of the following mutual covenants, it is hereby agreed as follows:

ARTICLE 1: BOARD RIGHTS

A. 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 the Constitutions of the State of Michigan, and of the United States, including, but without limiting the generality of the foregoing, the right:

1. To the executive management and administrative control of the school system, its properties and facilities, and the occupational activities of its employees;

2. To hire all employees and subject to the provisions of law, to determine their qualifications and the conditions for their continued employment, or their dismissal or demotion; and to promote, and transfer all such employees;

3. To establish grades and courses of instruction, including special programs, and to provide for athletic, recreational and social events for students, all as deemed necessary or advisable by the Board;

4. To decide upon the means and methods of instruction, the selection of textbooks and other teaching materials, and the use of teaching aids of every kind and nature;

5. To determine class schedules, the hours of instruction, and the duties, responsibilities, and assignments of teachers and other employees with respect thereto, and with respect to administrative and non-teaching activities, and the terms and conditions of employment;

6. To establish school policies, copies of which shall be made available for reference to the Association and to the bargaining unit members in each building.

B. The exercise of the foregoing powers, rights, authority, duties and responsibilities by the Board, the adoption of policies, rules, regulations and practices in furtherance thereof, and the use of judgment 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.

C. The Board recognizes the opportunities for improvement in operation through employee suggestions and recommendations and encourages the presentation of such to the properly designated administrative personnel.

ARTICLE 2: RECOGNITION

A. The Board hereby recognizes the Association as the exclusive bargaining representative, as defined in Section II of Act 379, Public Acts of 1965, for all certified professional personnel, including personnel on tenure and probation, classroom teachers, guidance counselors, social workers, psychologists and librarian; employed or to be employed by the Board on a contract basis (whether or not assigned to a public school building), and

certified professional personnel employed as long-term substitutes, but excluding supervisory and executive personnel and office and clerical employees.

1. The term "teacher", when used hereinafter in this Agreement, shall refer to all employees represented by the Association in the bargaining unit as above defined, and references to male teachers shall include female teachers.

2. The term "long-term substitute" shall mean any teacher employed in one specific teaching position for sixty (60) days or more or who is contracted to replace a teacher on a leave of absence for that same period of time.

3. The term "bargaining unit," where used in this Agreement, shall refer to the local affiliate organization of the Association, its officers and members as defined in Paragraph A above.

B. The Board agrees not to negotiate with any organization other than the Association for the duration of this Agreement. Nothing contained herein shall be construed to prevent any individual bargaining unit member from presenting a grievance and having the grievance adjusted without the intervention of the Association, if the adjustment is not inconsistent with the terms of this Agreement, and provided that the Association has been given an opportunity to be present at such adjustment.

C. The Employer shall offer long term substitute positions to laid off bargaining unit members first. The most senior member who is certified and qualified shall be offered said position first.

D. A teacher employed as a substitute teacher with an assignment to one (1) specific position after sixty (60) days of service shall be granted leave time and other privileges granted to regular bargaining unit members under this Agreement, including a salary of not less than the minimum salary on the current salary schedule. He shall be subject to the provisions of Article 4.

E. Teachers hired as full year replacements shall become members of the bargaining unit and subject to the provisions of Article 4.

F. The Board will not be required to offer future employment to term substitutes. In the event a term substitute is offered and accepts a regular teaching position at a later date, no seniority will be credited for the time served as a term substitute.

ARTICLE 3: ASSOCIATION AND BARGAINING UNIT MEMBER RIGHTS

A. Pursuant to Act 379 of the Public Acts of 1965, the Board hereby agrees that every employee of the Board shall have the right freely to organize, join and support the Association for the purpose of engaging in collective bargaining and other concerted activities for mutual aid and protection. As a duly elected body exercising governmental power under color of law of the State of Michigan, the Board undertakes and agrees that it will not directly or indirectly discourage or deprive or coerce any bargaining unit member in the enjoyment of any rights conferred by Act 379 or other laws of Michigan or the Constitutions of Michigan and the United States.

B. The Board specifically recognizes the right of its employees appropriately to invoke the assistance of the Michigan Employment Relations Commission (MERC), or a mediator from such public agency.

C. The Association and its members shall have the right to use school building facilities at all reasonable hours for meetings, subject to the same policies affecting any other organization in the District.

D. No bargaining unit member shall be prevented from wearing insignias, pins or other identification of membership in the ICEA-MEA/NEA on school premises. Bargaining unit members may not attach or glue types of membership insignia to any part of the building structure.

E. Space on bulletin boards in each building and use of school mail services, mail boxes and the intercom shall be made available to the Association and its members subject to the approval of the building administrator.

F. In response to reasonable requests from time to time, the Board agrees to make available to a designated officer of the Association all available information, subject to the Freedom of Information Act (MCLA 15.231 et seq., as amended), concerning the financial resources of the District, tentative salary requirements and allocations and such other financial information as will assist the Association in developing intelligent, accurate, informed, and constructive programs on behalf of the Association together with records which may be necessary for the Association to process any grievance or complaint. If such records involve a bargaining unit member's personnel file, a written statement granting permission of access shall be required from the bargaining unit member.

G. Nothing contained herein shall be construed to deny or restrict to any bargaining unit member, rights he may have under the Michigan laws and regulations. The rights granted to bargaining unit members hereunder shall be deemed to be in addition to those provided elsewhere.

H. The Board agrees to consult with bargaining unit members concerning adequate provisions for the following facilities in future building:

1. Faculty dining area.
2. Faculty restroom and lavatory facilities.
3. Faculty lounge.
4. Faculty work area.
5. Team and individual planning rooms.

I. Telephone facilities with a reasonable degree of privacy shall be available to bargaining unit members in each building.

J. Parking facilities shall be made available for exclusive use by faculty and administrative personnel.

K. Notwithstanding their employment, bargaining unit members shall be entitled to full rights of citizenship and no religious or political activities or the lack thereof shall be grounds for

any discipline or discrimination with respect to the professional employment of such bargaining unit members unless such action violates their oath to uphold the Constitution of the State of Michigan or of the United States. The private and personal life of any bargaining unit member is not within the appropriate concern or attention of the Board unless it affects his job and image as a professional person.

L. The provisions of this Agreement shall be applied without regard to race, creed, religion, color, national origin, age, sex, and marital status or to membership in or activities connected with any employee organization.

M. The Board of Education is committed to attempting to provide physical working conditions which do not endanger the health and safety of the staff. When mechanical conditions arise which unfavorably affect the normal school environment, temporary arrangements will be made which meet with the approval of the appropriate public regulating agencies.

N. Bargaining unit members will be informed of telephone numbers and procedures for reporting their absences.

O. Upon request, the Association shall be advised by the Board of fiscal, budgetary, and tax programs affecting the District.

P. Should the Employer decide to grant a charter to a public school academy, the Association shall be notified in writing prior to taking final action to grant the charter.

ARTICLE 4: PROFESSIONAL DUES OR FEES AND PAYROLL DEDUCTIONS

A. Bargaining unit members shall, as a condition of employment, pay either dues or a Service Fee in an amount established by the Association. Dues and Service Fees will be payroll deducted pursuant to MCLA 408.477; MSA 17.277(7). The Employer shall, at the bargaining unit member's option, either deduct the full amount of such dues/fees from the second regular paycheck in September or deduct one twentieth (1/20) of such dues/fees from twenty (20) paychecks beginning in September and ending in June of each year.

B. Bargaining unit members who work less than full time shall be assessed on a pro-rata basis as determined by the Association. Bargaining unit members who are hired during the course of the school year will be assessed on a pro-rata basis as determined by their starting date and the months remaining in the school year as determined by the Association.

C. With respect to all sums deducted by the Employer pursuant to MCLA 408.477; MSA 17.277(7) whether for membership dues or the Service Fee, the Employer agrees to remit said sums promptly on a monthly basis to the Michigan Education Association, 1216 Kendale Blvd., East Lansing, MI 48823, accompanied by an alphabetical list of bargaining unit members for whom such deductions have been made categorizing them as to membership or non-membership in the Association, and indicating any changes in the list previously furnished. The Association agrees to advise the Employer of all members of the Association in good standing and to furnish any other information needed by the Employer to fulfill the provisions of this Article, and not otherwise available to the Employer.

D. The Association agrees to assume the legal defense of any suit or action brought against the Employer, including individual Board members and their agents, regarding this Article of the collective bargaining agreement. The Association further agrees to indemnify the Employer for any costs, damages, or back pay which may be assessed against the Employer as the result of said suit or action subject, however, to the following conditions:

1. The damages have not resulted from the negligence, misfeasance, or malfeasance of the Employer or its agents.

2. The Association, after consultation with the Employer, has the right to decide whether to defend any said action or whether or not to appeal the decision of any court or other tribunal regarding the validity of the action or the defense which may be assessed against the Employer by any court or tribunal.

3. Since the Association is obligated for all legal costs involved in enforcing this Article, it has the right to choose the legal counsel to defend any said suit or action.

4. The Association shall have the right to compromise or settle any claim made against the Employer under this section.

E. Should the provision for mandatory payroll deduction of dues or service fees, as referenced in Section A above, be found contrary to law, the parties agree to negotiate procedures requiring the submission of written authorizations for the deduction of dues or service fees as a condition of continued employment within thirty (30) calendar days of such determination.

F. Upon appropriate written authorization from the bargaining unit member, the Employer shall deduct from the salary of any bargaining unit member and make appropriate remittance for annuities, credit union, savings bonds, charitable donations, MESSA and MEAFS programs as jointly approved between the Employer and the Association and any other plans or programs that may be jointly approved between the Employer and the Association.

G. Annuity monies, whether authorized as a payroll deduction by the bargaining unit member or those that are provided by the Board as set forth in Article 21, shall be remitted to the designated company(s) at least once in each month.

ARTICLE 5: SCHOOL CALENDAR

A. The calendar(s) is attached to and incorporated into this Agreement as Appendix C.

In the event that the provisions in Article 7, Section A or Appendix C create a condition whereby the Employer is not able to meet the number of student instructional hours or days required to receive full state aid payments, the parties will re-negotiate the provision(s) in order to guarantee compliance.

B. There will be six hours of parent teacher conferences in the fall and spring at all buildings. In the event that the high school moves to a trimester schedule, there will be four (4)

hours of conference time per trimester. The specific times will be determined by the administration after consultation with teachers.

ARTICLE 6: PROFESSIONAL COMPENSATION

A. The salaries of bargaining unit members covered by this Agreement are set forth in Appendix A which is attached to and incorporated into this Agreement. Such salary schedule shall remain in effect for the term of this Agreement.

1. The time new teachers spend with mentors and professional development as required by law, will not require supplemental compensation.

2. The time any teacher spends in conjunction with Individual Development Plans will not require supplemental compensation.

B. With the exception of professional development day(s) not designated in the calendar, the salary schedule in Appendix A is based upon an annual assignment of bargaining unit members for the period set forth in Appendix C which is attached to and incorporated into this Agreement.

1. The professional development day(s) not designated in the calendar will be compensated at the hourly rate set forth in Appendix B, Section 6.b. Such day(s) are supplemental workdays and therefore, bargaining unit members must be in attendance to receive the foregoing compensation. Supplemental payments will not be used for professional development days that are required by the State of Michigan.

2. Bargaining unit members will be entitled to appropriate additional compensation only for those additional responsibilities duly designated in Appendix B which is attached to and incorporated into this Agreement. The bargaining unit member shall, at his discretion, be paid the established fee in addition to his base salary on a pro-rated basis as performed or in a lump sum when the responsibility has been completed.

C. Experience acquired outside of the Leslie Public Schools may be credited up to a maximum of seven (7) years.

With the exception of bargaining unit members employed in the District during the 1970-71 school year, any future credit for experience will be based on experience acquired while holding a Bachelor Degree and a provisional or permanent certificate. Non-degree experience will not be recognized.

D. Salary shall be remitted to all less than full time bargaining unit members on a pro-rated basis.

E. The Board shall comply with U.S. and Michigan laws governing retirement.

F. Compensation for any summer professional employment beyond the last contract day in June will be at the substitute rate of pay as set forth at Appendix B, Section 6 for each hour of work.

G. In appreciation for services to the District, a terminal leave payment of $50.00 (fifty dollars) per year of service will be paid upon retirement provided the bargaining unit member shall have been employed in the District for ten (10) years.

H. Bargaining unit members may elect to receive salary in twenty-one (21) or twenty-six (26) installments. Bargaining unit members shall notify the Business Office of their option in writing by August 1 in each year. Should the bargaining unit member decline or withhold a written election in any year, the option authorized in the prior year shall continue in each succeeding year except as the bargaining unit member may change his election in accordance with the notice requirements set forth herein.

I. A bargaining unit member who must travel during the course of his employment responsibilities shall be reimbursed at the IRS rate per mile.

J. Should it be determined that a bargaining unit member has received compensation in excess of that earned, the Board will deduct the overpayment from the bargaining unit member's salary pursuant to MCLA 408.477; MSA 17.277(2). Said payroll deduction(s) shall be made for the same number of pay periods as the overpayment was permitted to accrue (maximum of one [1] year unless the Board and Association concur that due to the amount in question, a longer period of time is appropriate) except in the event of a layoff or he is scheduled for an unpaid leave of absence pursuant to this Agreement. In the event of a layoff or an unpaid leave of absence, the overpayment will be deducted in equal installments, as nearly as may be, from the bargaining unit member's remaining paychecks.

K. An authorized class which is offered outside of the regularly scheduled student instructional day and which is offered without a grade or credit shall be compensated at the hourly rate set forth at Appendix B, Section 7b.

L. If by mutual consent, a bargaining unit member shall teach more than the normal teaching load as set forth at Article 8, he shall receive an additional *1/n* of his annual base salary for the duration of said assignment (*n* equals the total number of class periods in a day).

ARTICLE 7: WORKING CONDITIONS

A. The administration will determine the starting and ending times for the bargaining unit members' workday, within the following guidelines:

1. Normally, the standard workday for each bargaining unit member shall be 7-1/4 hours with a duty-free uninterrupted lunch period of at least thirty (30) minutes within that time.
   a. The normal reporting time shall be ten (10) minutes prior to the first class and the bargaining unit member shall remain at least ten (10) minutes after the last class except in the event of a prearranged conference or staff meetings.

   b. Special requests to leave early on a per diem basis may be honored if such requests are for the purpose of doctor, lawyer, dentist, etc. appointments approved by the building principal.

c. Notwithstanding the foregoing, on Fridays and days before holidays and vacation periods, bargaining unit members shall be permitted to leave the building with the close of the student instructional day.

d. The 7-1/4 hour day for teachers will be extended each year of this Agreement if needed for statutory compliance purposes. A plan will be developed in each building and submitted in writing to the Superintendent and the Association President, or designee, for approval. This will be done by July 1 preceding the start of the next school year. The approved plan will be entered as a Letter of Agreement to the Master Agreement.

2. If by mutual consent, bargaining unit members in grades 7-12 are assigned to a "zero" class period, said bargaining unit members' work days shall be shortened by an equal amount of time except as they may agree to an extra-period assignment. A "zero" class period is defined as a class for which credit is granted and which has been established outside of the regularly scheduled student instructional day.

3. The normal daily load in grades K-12 shall not exceed five (5) hours and fifty (50) minutes of pupil-teacher contact time. Pupil-teacher contact time means classroom teaching time.

a. The normal daily load for classroom teachers in grades 5-12 shall include at least one (1) unassigned conference/preparation period of not less than forty-five (45) consecutive minutes within the student instructional day. In the event collaborative time is scheduled at the middle school, the aforementioned time may be reduced to at least forty (40) minutes.

b. Classroom teachers in grades K-4 and special area teachers shall be provided an average of 225 minutes of released preparation/conference time during the student instructional day each week. For purposes of calculating the foregoing, time bargaining unit members spend on recess supervision (which is normally rotated) shall not be included in the weekly average. Averaging of the released preparation/conference time shall not exceed a normal two (2) week period.

c. Bargaining unit members who teach a morning and an afternoon Kindergarten class shall be guaranteed an average of 185 minutes of released preparation time during the student instructional day each week. Bargaining unit members who teach one (1) Kindergarten class shall be guaranteed an average equal to one-half (1/2) of the above-mentioned released preparation time. For purposes of calculating the foregoing, recess periods shall not be included in the weekly average. Averaging of the released preparation time shall not exceed a two (2) week period.

d. Special area teachers will be provided an average of 25-30 minutes during each instructional day for preparation.

e. In preparing the Master Schedule for traveling teachers, the traveling time allotted will not interfere with the teacher's preparation/conference period

4. Responsibility for monitoring recess time for elementary pupils (grades K-7), shall be shared equally and on a rotating schedule among the building teachers whose pupils participate in recess.

5. Bargaining unit members will be guaranteed a place to work during planning periods.

6. On or before October 1 in each year, the building principal will notify bargaining unit members of the dates/days on which he has scheduled staff meetings throughout the school year.

   a. Building principals shall be responsible for establishing a system whereby bargaining unit members can request items to be placed on the agenda of building level staff meetings.

   b. Staff meetings will normally adjourn within ninety (90) minutes after the close of the student instructional day. Normally there will not be more than twelve (12) staff meetings in any school year.

7. No bargaining unit member shall be required to supervise students outside of the student instructional day for more than fifteen (15) minutes in any day nor for more than thirty (30) minutes in any two (2) week period.

B. Chaperoning of dances and trips is to be distributed among the building staff with no reimbursement involved. The principal of the building shall notify the chaperons within seven (7) calendar days of these extra duties. Each year bargaining unit members shall serve at five (5) chaperoned activities excluding activities stated in Appendix B for which there is extra duty pay. Each bargaining unit member may volunteer for these assignments upon consultation with the principal.

C. Because the pupil-teacher ratio is an important aspect of an effective educational program, the parties agree that class sizes should not exceed the following maxima:

1. Elementary

   a. Kindergarten, First and Second grades and Portables.....25

   b. Third through Eighth grades 27

   c. Special Education 15

   d. The District may exceed the above maxima by no more than three (3) students per class after prior notification to the Association President.

   e. Classes will be balanced within grades 1-6 within an elementary building including students who transfer into the District during the course of the school year. It is understood that this provision will not be implemented if the building principal determines in an individual case, that it is not in the best interest of the student(s) involved.

2. Secondary

a. English Social Studies Math Foreign Language Science Business	*Should not exceed 30 pupils per class; nor one hundred sixty (160) pupils per day, unless otherwise agreed by participating teachers.*

b. Physical education classes should not exceed thirty-five (35) pupils per class nor one hundred and seventy-five (175) pupils per day unless otherwise agreed by participating teachers except when class periods are scheduled to be less than forty-five (45) minutes in duration.

c. Industrial Arts/Technology Education classes should not exceed the number of teaching stations available.

In any work station/classroom where the number of students who are assigned exceeds the number of available teaching stations, the situation will be referred to the principal.

d. Should any choir class in grades seven (7) or eight (8) exceed sixty-five (65) students, such class(es) shall be provided with an aide.

3. Special consideration will be given to students with special needs (IEPC identified) in meeting class size requirements.

D. It is agreed that addressing the implementation of the least restrictive environment mandate is of critical importance. Section D shall apply to special education students who are entering a regular education class/classroom from a special education center program or a special education self-contained classroom program. It shall also apply to students who are identified as students with a handicap who would qualify to be served by either program. Finally, it shall apply to students who are identified as students with a handicap due to accident, trauma, etc., and who would qualify to be served by either program.

1. Except as provided in subsection 2, any bargaining unit member who will be providing instructional or other services to a student with a handicap in a regular education classroom setting shall be invited, in writing, to participate in the Individual Educational Planning Committee (IEPC) which may initially place (or continue the placement of) the student in a regular education classroom. If the IEPC is held during the normal teaching day, the bargaining unit member shall be released from his normal responsibilities to attend.

2. Where the administration and appropriate resource personnel determine that it is not feasible to have each bargaining unit member who will be providing instructional services to a student with a handicap in a regular education classroom setting be a participant in the Individual Educational Planning Committee (IEPC) which may initially place (or continue the placement of) the student in a regular education classroom, the involved bargaining unit members may select representative teacher(s) to attend the IEPC.

3. Should a bargaining unit member, working directly with the student with a handicap, advise the administration in writing of a reasonable basis to believe that a student's current individual educational plan (IEP) report is not meeting the student's unique needs as required by law, the administration shall call an IEPC. The bargaining unit member so advising shall be invited to, and will attend, the IEPC.

4. In order to assure that the student with a handicap can participate in regular education programs and services, the District will provide within its resources, teaching materials and equipment, support personnel and other related services as specified in the IEPC.

5. Where appropriate, the bargaining unit member will be provided inservice training regarding the instruction and behavioral management of the student or students with handicaps in the regular education setting.

6. When there is a request from a bargaining unit member who works directly with a student with a handicap, regarding the assistance needed to implement the least restrictive environment mandate, the request shall be made in writing to the building administrator. The request shall specify the assistance needed. Within ten (10) school days, the parties affected will meet with the building administrator and other appropriate resource personnel to discuss the request.

7. When a general education classroom teacher is assigned a student from a special education program for severely impaired students (POHI, SMI, SXI, TMI, AI), the teacher shall not be expected to perform routine, scheduled maintenance of a medical appliance or apparatus used by the student to sustain his bodily functions nor render routine, scheduled care or maintenance of exceptional bodily functions related to the student's impaired condition. The teacher shall be informed and instructed as to emergency measures which may be necessary on occasion due to the student's impaired condition. It shall be the teacher's responsibility to implement the student's individualized educational plan for attending to the educational needs of the student while in the teacher's class.

8. When appropriate, the administration agrees to arrange for a substitute in the absence of the student's regularly assigned aide.

E. The Board recognizes that appropriate texts, library reference facilities, maps and globes, laboratory equipment, current periodicals, standard tests and questionnaires, and similar materials are tools of the teaching profession. Further, that efforts shall be continued to seek and use textbook and supplementary reading materials which contain the contribution of minority groups to the history, scientific and social development of the United States. The Board agrees to seriously consider all joint decisions made by its representatives and the Association and respond thereto in writing within a reasonable period of time. The Board agrees at all times to keep the schools equipped and maintained.

F. The Board agrees to make available in each school, typing and duplicating facilities to aid teachers in the preparation of instructional material.

G. The Board agrees to provide the following for the opening of the school year:

1. A lockable file cabinet in order to allow the bargaining unit member a place to store instructional materials with security.

2. Closet space for each bargaining unit member to store coats, overshoes, and other personal articles.

3. Attendance books, paper, pencils, pens, chalk, erasers, and other instructional materials necessary for daily teaching effectiveness as determined by the Administration.

4. Copies, exclusively for teacher's use, of all texts (workbooks, etc.) used in each of the courses to which the bargaining unit member is assigned.

5. A reputable desk dictionary in every room. For example: Webster's Seventh New Collegiate Dictionary.

H. When specialist teachers are absent, the Employer will hire substitutes provided appropriate substitutes are available.

ARTICLE 8: VACANCIES, ASSIGNMENTS, TRANSFERS

A. A vacancy shall be defined as a position (including those subject to Appendices A & B) which is presently unfilled or a newly created position which the Employer intends to fill.

B. Whenever any opening in any professional position in the District shall occur, the Board shall publicize the same by giving electronic notice of such opening to the bargaining unit providing for appropriate posting in every building with copy to the Association President. No opening shall be permanently filled until such opening has been posted for at least five (5) working days. Working days shall refer to days when school is in session except that during the summer months, working days shall refer to Monday through Friday excluding holidays. A vacancy shall not be posted when said vacancy is to be filled by the recall of a laid off bargaining unit member. Failure to provide or receive electronic notice shall not be considered a violation of this section.

Positions covered by Appendix B which are occupied by non-bargaining unit members will be posted annually.

C. Any bargaining unit member may apply for a vacancy by submitting a written application to the Superintendent.

1. In reviewing said applications, the Board shall give due weight to seniority, the professional background and attainments of all applicants.

2. An applicant with no service or less service in the bargaining unit shall not be awarded a vacancy unless his qualifications are substantially superior to applicants with greater seniority.

3. A person temporarily assigned to fill a vacancy shall not be given preference for permanent assignment over any qualified applicant from within the bargaining unit.

4. The Board shall support a policy of promotion from within its own staff, including promotions to supervisory and executive positions. However, this shall, in no manner, restrict the Board from selecting the most suitable candidate.

5. For the purpose of this Agreement, seniority shall be as defined in Article 9 (Seniority, Reduction and Recall).

D. Bargaining unit members shall not be assigned outside the scope of their teaching certificates.

E. All bargaining unit members shall normally be given written notice of their tentative assignments for the forthcoming year prior to the end of the current school year. In any event, notice of said tentative assignment shall be made no later than July 1.

1. Changes in said tentative assignment may be made until August 15 provided the affected bargaining unit member(s) are properly notified.

2. Changes in tentative assignments which are made less than twenty-one (21) days prior to the first teacher work day and which require substantially different preparation shall entitle a bargaining unit member to either two (2) days of compensatory time or compensation equal to two (2) days at his regular rate of pay for time spent in said preparation, unless said change in tentative assignment was made pursuant to the bargaining unit member's(s') request for same or pursuant to another bargaining unit member severing his employment with the Leslie Public Schools.

3. In the event changes in tentative assignments are made less than twenty-one (21) days prior to the first teacher work day pursuant to another bargaining unit member severing his employment with the District, same shall entitle the affected bargaining unit member(s) to two (2) days of compensatory time or compensation equal to two (2) days at the substitute rate of pay as set forth at Appendix B, Section 6 for preparation in the new assignment.

F. Requests for a change of assignment may be made at any time and shall be submitted in writing to the Superintendent with a copy to the Association.

1. The Employer shall furnish the form for such request.

2. The request shall set forth the unit member's certification, qualifications and the position sought.

3. A request for change of assignment, once submitted, shall remain in force for one (1) year.

4. Such requests shall be reviewed twice in each year to assure active consideration by the Employer.

5. The record of said request shall be made part of the unit member's personnel file.

6. No bargaining unit member shall be discriminated against because of a request for change of assignment.

G. In the event of an involuntary transfer from one building level to another, from one subject area to another in grades 7-12 or from one grade level to another at the elementary level, the principal will meet upon the bargaining unit member's request to discuss the reasons for the transfer. It is understood that the final determination regarding assignments rests with the administration.

ARTICLE 9: SENIORITY, REDUCTION AND RECALL

A. It is hereby specifically recognized that it is within the function of the Board of Education to alter or reduce the educational program and curriculum.

B. Before official action on a layoff or reduction of staff is taken by the Board, it will give notice to the Association of the contemplated reduction and afford the Association an opportunity to discuss it with the Board. As soon as the names of the bargaining unit members to be laid off are known, a list of such names shall be provided to the Association.

C. In the event it becomes necessary to reduce the number of bargaining unit members employed by the Board, such reduction shall be based upon seniority, certification and qualification for the remaining positions.

1. For purposes of this Agreement, seniority shall be defined as the number of continuous years of employment in the bargaining unit.

2. Certification shall be defined as holding a valid teaching certificate as recognized by the State of Michigan.

3. Qualifications shall be defined as follows:

   a. Meeting any statutory requirements that exceed certification requirements.

   b. Having the necessary training and certification for highly specialized programs (i.e. Reading Recovery)

   c. Meeting accreditation requirements (i.e. North Central).

D. The Board shall lay off last those qualified bargaining unit members with a valid teaching certificate having the greatest seniority in the bargaining unit; and shall provide written notice of layoff to the affected bargaining unit members and the Association President at least thirty (30) calendar days prior to the effective date of the layoff.

E. In order to promote an orderly reduction in personnel, the following procedure will be used:

1. Probationary bargaining unit members will be laid off first, unless no tenured bargaining unit member is certified and qualified for the position.

2. In the event it is necessary to further reduce staff, tenured bargaining unit members shall be laid off on the basis of seniority, certification and qualification.

3. No new bargaining unit members shall be employed by the Board while there are laid off bargaining unit members unless there are no laid off bargaining unit members who are certified and qualified to fill the remaining positions.

4. In order for a less senior bargaining unit member to be retained in a position, the bargaining unit member shall have certification and qualifications which the more senior bargaining unit member lacks. Should such an occasion arise, the Employer shall endeavor to advise the Association President in advance of the number and category of such bargaining unit members.

5. Any bargaining unit member who is employed in a position other than as a classroom teacher shall not have tenure in such position, but upon satisfactory completion of the probationary period, all certified personnel holding such positions will be granted continuing tenure as classroom teachers.

6. Those bargaining unit members (i.e. Social Workers, etc.) who are not teacher certified and as such are not subject to the Tenure Act, will serve a two (2) year probationary period.

F. The Employer shall develop a seniority list and make the appropriate revisions each semester. A copy of the seniority list shall be forwarded to the Association during the months of October and May of each year.

1. The bargaining unit member's seniority shall be his last date of hire and shall accrue with the first day of work.

2. Days worked in any extra-curricular activity shall neither accrue seniority nor establish a date of hire.

3. Continuous years of employment in the bargaining unit shall not be interrupted by a leave of absence granted pursuant to the provisions of this Agreement and seniority shall continue to accrue.

4. A bargaining unit member who has been laid off, whether in full or in part, shall accrue seniority as if he were employed full time.

5. Should two (2) or more bargaining unit members share the same seniority, they shall be ranked using the following criteria and in the order stated:

   a. Most advanced degree(s) held. Degrees shall be in the field of education and/or subjects taught in the Leslie Public Schools.

   b. Hours beyond most advanced degree(s) held.

   c. Extra-curricular assignment.

d. Outside teaching experience.

f. Last four digits of social security number (lower more seniored).

6. In the event that a bargaining unit member accepts an administrative position within the district, the bargaining unit member shall retain any seniority accrued while in the unit for a period of three (3) years from the effective date of the transfer. If during the three (3) year period the administrator returns to the unit, the administrator will be assigned to an existing vacancy within the bargaining unit. If no vacancy exists, the administrator may displace an existing bargaining unit member with the least seniority provided the administrator is otherwise qualified as defined in section C-3 above and the administrator has more seniority.

7. Those bargaining unit members (i.e. Social Workers, etc.) who are not teacher certified and as such are not subject to the Tenure Act, will serve a two (2) year probationary period.

G. Laid off bargaining unit members shall be recalled in the inverse order of layoff for new or reactivated positions for which they are certified and qualified as defined above.

1. It shall be the responsibility of each bargaining unit member to notify the Board of any change of address and any change of status as it relates to being considered for recall.

2. Notice of recall shall be by certified, return receipt mail. A bargaining unit member shall indicate acceptance of recall by certified mail to the Superintendent within fifteen (15) calendar days from the postmarked date of the notice of recall. Failure to do so shall cause forfeiture of all of said bargaining unit member's seniority unless an exception is granted in writing by the Superintendent.

3. Bargaining unit members who receive written notice of recall and who have signed a contract to teach during the school year in question in another public school district in Michigan shall:

a. Notify the Board in writing that such a contract has been signed.

b. Furnish a written statement from the Superintendent with whom the contract was signed indicating that a release from said contract cannot be obtained.

H. A bargaining unit member shall lose his right to recall when the District offers him a position equivalent to that occupied prior to the effective date of layoff and he refuses such position provided said bargaining unit member is not under contract with another Michigan public school district. If he is under contract with another said school district at the time of recall, he shall retain his right to recall to a position for which he is certified and qualified for the balance of said school year. The bargaining unit member shall not enter into a second contract with another Michigan public school without the written consent of the administration, a copy of which shall be forwarded to the bargaining unit member and the Association. Should a bargaining unit member enter into a second contract with said school district without the written consent of the administration, he shall forfeit his seniority and recall rights under this Agreement.

I. Laid off teachers will remain eligible for recall for a period of three (3) years from the effective date of layoff.

ARTICLE 10: LEAVES OF ABSENCE

A. Paid Leaves

1. At the beginning of each school year, bargaining unit members shall be credited with twelve (12) days of sick leave to be used for absences caused by illness or physical disability to the bargaining unit member. The unused portion of such sick leave shall accumulate from year to year without limit.

   a. The Board shall furnish a written statement at the beginning of each school year setting forth the total amount of accrued sick leave.

   b. Any bargaining unit member who willfully violates or misuses sick leave or who misrepresents any statement or condition under sick leave may be subject to discipline.

   c. The purpose of sick leave is to cover the period of illness or physical disability. Bargaining unit members utilizing same will be expected to return to work as soon as physically able to do so.

   d. In the event a bargaining unit member is injured in the course of his employment and qualifies for Worker Compensation, the bargaining unit member may elect to have the Worker Compensation supplemented by his accumulated sick leave to the extent necessary to maintain his regular earnings. A pro-rata deduction from sick leave will be made.

   e. Leaves of absence with pay chargeable against the bargaining unit member's sick leave shall be granted for the following reasons, but shall not exceed ten (10) days per year. Except in cases of emergency, whenever circumstances permit, a written request must be submitted in advance and approved by the Superintendent.

      (1) A maximum of five (5) days per school year for each critical illness in the immediate family (spouse, children, parents, parents-in-law, sisters and brothers).

      (2) Two (2) days when emergency illness in the family requires a bargaining unit member to make arrangements for necessary medical or nursing care.

      (3) Exceptions to the maximum allowable days under "I" and "2" above may be made at the discretion of the Superintendent.

      (4) Time necessary for medical and dental appointments when, such appointments cannot be made at any other time.

f. Pay for sick days used in excess of that accumulated at the time of illness, may be recovered in a succeeding year or years as they are credited. Reimbursement will be equal to the per diem rate of pay that was current when the time and pay were originally lost.

2. At the beginning of each school year, each bargaining unit member shall be credited with two (2) days to be used for the bargaining unit member's personal business except for a school day preceding or following a vacation period. Personal business days may be used at the discretion of the bargaining unit member.

   a. A bargaining unit member planning to use a personal business day(s) shall notify his principal in writing at least three (3) days in advance, except in the case of an emergency.

   b. No more than three (3) bargaining unit members in a building will be granted personal leave on any given day except in cases of emergency.

   c. Personal days will be granted or denied upon application to the building principal. The principal shall not deny personal leave except as provided herein.

   d. Any unused personal business days will be credited to the bargaining unit member's sick leave accumulation.

   e. It is expressly understood that recreational pursuits are not an appropriate use of personal leave.

3. Recognizing that professional growth is important, professional leave days may be allowed selectively depending upon the principal's assessment of the need and value of each request. Professional leave days shall be used solely for the following:

   a. Observation of other instructional techniques or programs.

   b. Attendance at conferences, workshops, or seminars conducted by colleges, universities, the Michigan Department of Education and the Michigan Education Association and National Education Association and/or affiliate departments thereof. A bargaining unit member attending such conferences and meetings shall be granted sufficient time to attend without loss of compensation.

4. At the beginning of every school year, the Association shall be credited with eight (8) days to be used by bargaining unit members who are officers or agents of the Association. Such use will be at the discretion of the Association. The Association agrees to notify the Board no less than forty-eight (48) hours in advance of taking such leave. The Association will reimburse the District for the cost of a substitute.

5. A bargaining unit member shall be allowed up to a maximum of five (5) working days as funeral leave days, not to be deducted from sick leave, for a death in the immediate family. Immediate family is defined as follows: mother, father, brother,

sister, wife or husband, son or daughter, mother-in-law, father-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, aunt and uncle, grandparents and grandchildren, or a member of the teacher's household.

6. Should a bargaining unit member exhaust his personal business leave in any year, he may be released once in each year to attend the funeral of a non-family member. Such leave shall not be deducted from sick leave. Funeral leave as described above shall be approved in advance by the building principal.

7. A bargaining unit member called for jury duty or to give testimony before any Court of Law not in their own defense shall be compensated the difference between the regular pay and the pay received for the performance of such obligation.

8. Bargaining unit members who are in a reserve unit of the armed forces of the United States shall be granted up to ten (10) days of leave each year for active duty provided sufficient information is provided reflecting that no other alternatives were available in terms of scheduling the required duty. Such bargaining unit members shall be compensated the difference between their regular rate of pay and the pay received for the performance of such duty and shall retain all other rights and benefits during the leave period.

9. Bargaining unit members accepting substitute work during their planning period shall be credited with an equivalent amount of time to be utilized at the bargaining unit member's discretion, subject to the following limitations:

   a. A bargaining unit member who substitutes on six (6) occasions (five (5) occasions at the high school if trimester scheduling is in place) will be entitled to one (1) day off. A maximum of one (1) compensatory day will be afforded to a teacher each year and will be used in a whole day increment.

   b. Utilization of a day off under these provisions is subject to the bargaining unit member's accumulation of sufficient credit to provide for same and providing at least one (1) week's notice.

   c. Not more than one (1) bargaining unit member may be absent under those provisions on a given day except with administrative authorization.

   d. Any unused credit shall be paid at the end of the school year in the bargaining unit member's last check at the rate established in the extra-duty schedule.

   e. Such days may not be used to extend a vacation period except at the Superintendent's discretion.

B. Unpaid Leaves

1. A bargaining unit member shall be granted up to one (1) year of child care leave immediately following the birth of a child. The application for such leave shall be received by the Superintendent no later than sixty (60) calendar days prior to the effective date of such leave and shall include the date on which the bargaining unit member wishes to commence the leave. A bargaining unit member on leave under these provisions who wishes to return to duty, shall file a written request with the Superintendent at least thirty (30) days prior to the end of the leave. This may be extended by mutual consent provided such request is submitted within the time schedule heretofore stated.

   a. For purposes of seniority, a bargaining unit member will be granted credit and experience on the salary schedule for any complete semester of work during the school year in which such leave is granted.

   b. The provisions of this leave will also apply to a bargaining unit member who wishes a leave for adoption of a child or child care purposes.

2. The Board of Education may grant leaves of absence for reasons of health. Absence due to illness in excess of accumulated sick leave automatically places bargaining unit members on leave without pay for the additional days missed. In cases of prolonged illness (two [2] weeks beyond sick leave accumulation), the bargaining unit member must submit a written request for leave to the Superintendent which states the probable date of return. Such leave shall be granted for the balance of the school year or for a maximum of one (1) school year. Upon exhaustion of said leave as provided herein, the bargaining unit member shall either return or submit a medical statement indicating his current condition and a prognosis as to when the bargaining unit member will be able to return to his regular duties. Upon application from the bargaining unit member, the Board may extend the leave.

   a. Approval for a leave may be dependent upon a physician's statement (either a personal physician or one appointed by the Board or both) certifying the bargaining unit member's disability.

   b. Upon acceptance of his application for return to work, the bargaining unit member shall be returned to a position for which he is certified and qualified provided said returning bargaining unit member possesses the seniority necessary to be placed in said position. Placement in such position shall occur at the beginning of a semester.

3. Military leaves without pay shall be granted to any bargaining unit member who shall be inducted or shall enlist in a branch of the armed forces of the United States. Bargaining unit members on a military leave shall be given the benefit of any increments up to four (4) years which would have been credited to them had they remained in active service to the District provided they receive an honorable discharge and give sufficient notice of departure and return dates.

4. Leave without pay will be granted for up to two (2) years to any bargaining unit member who joins the Peace Corps as a full time participant. Any period so served shall be treated as time taught for purposes of increments on the salary schedule. However, such a leave shall begin at the completion of the school year. Bargaining unit members leaving and/or seeking reassignments in the District shall submit a written request at least six (6) months in advance.

5. Leave without pay may be granted upon application for the following purposes:

   a. Study related to the bargaining unit member's licensed field.

   b. Study to meet eligibility requirements for a related professional license other than that held by the bargaining unit member.

   c. Study, research or special assignment involving probable advantage to the District. The regular salary increment shall be credited during such a period.

6. Bargaining unit members who are eligible for leaves under the Family Medical Leave Act will be afforded leaves in accordance with the following provisions:

   a. In addition to the provisions set forth below, Board Policy and Administrative Procedure will govern leaves authorized under the Family Medical Leave Act of 1993.

      In the event the policy and/or administrative procedures are being amended by the Board, the Association will be provided with written notice and the opportunity to negotiate with respect to the changes.

   b. Eligible staff means an employee who has been employed by the District for at least twelve (12) months and who has worked at least 1250 hours during the previous twelve (12) month period.

   c. The Board shall provide up to twelve (12) work weeks of unpaid leave to all eligible staff during any twelve (12) month period for one (1) or more of the following reasons:

      (1) The birth or care of a child.

      (2) The adoption or foster care of a child.

      (3) The care of a spouse, son, daughter, or parent if such individual has a serious health condition.

      (4) A serious health condition of the staff member which disables him from performing the responsibilities of his position.

      A serious health condition may be an illness, injury, impairment, or physical or mental condition that involves in-patient care in a hospital, hospice, or residential medical facility or which requires continuing treatment by a health-care provider.

d. If a leave is necessitated by the serious health condition of the staff member or his family member, and is foreseeable based on planned medical treatment, the staff member shall, whenever possible, provide the Superintendent with thirty (30) calendar days notice and shall schedule the treatment so as not to disrupt the regular operation of the District.

e. When the Superintendent and the staff member agree, such leave may be taken intermittently or on a reduced-schedule leave in the event of birth or adoption. The staff member may take intermittent or reduced-schedule (half-days) leave when medically necessary to care for a spouse, child, or parent who has a serious health condition, or if the staff member has a serious health condition. In both cases, the taking of such leave will result in reducing the twelve (12) week leave period only by the amount of the leave actually taken. When the duration of the leave is foreseeable based upon planned medical treatment and leave time will exceed twenty percent (20%) of the total number of work days within that period, the staff member may be required to take leave in a block (not intermittently) or to transfer to an available, alternate position which better accommodates an intermittent leave. Said position shall be equivalent in pay and shall be one (1) for which the staff member is certified and qualified.

f. In the case of a serious health condition of a family member, the Superintendent will obtain medical certification from the physician of the family member. Said statement shall include the date the serious health condition began, the probable duration, appropriate medical facts regarding the condition, a statement that the staff member is needed to care for a family member and an estimate of the amount of time needed for such care.

Whenever the leave is necessitated by the staff member's own health condition, a statement from his physician will be required. The statement shall verify that the staff member is unable to perform the responsibilities of his position.

g. Any leave or return from leave during the last five (5) weeks of an academic term shall be reviewed individually by the Superintendent to ensure minimal disruption to the instructional program.

h. Subject to the limitations set forth in Article 10 (i.e. 5 days limit for critical illness in the immediate family under section A-1 – E-1, etc.) the Board does require that all accrued paid medical, sick or personal leave be substituted for the Family Medical Leave described in the policy.

i. During a family medical leave, the Board shall maintain the staff member's current coverage under the District's health insurance program.

j. At the end of any leave, the Board shall restore the staff member to his former position or to one that is equivalent in responsibility and compensation.

C. General Leave Provisions

1. A bargaining unit member on leave for one (1) year or less shall be returned to a comparable position for which he is certified and qualified. When the leave is for ninety (90) work days or less, the bargaining unit member shall be returned to the position from which the leave was taken. In either case, return from leave is subject to the absence of any intervening reduction in staff. If same has occurred, the provisions of Article 9 (Seniority, Reduction and Recall), shall apply.

2. Upon return from a medical or disability leave, a bargaining unit member shall submit a doctor's statement certifying his ability to perform his assigned duties.

3. A bargaining unit member returning to duty after an absence due to a contagious disease or a nervous or mental disorder shall present a statement from a physician affirming his ability to resume a position on a regular basis.

4. The Board may extend any leave of absence upon written application from the bargaining unit member.

5. Except as provided elsewhere, the bargaining unit member shall provide the Board with written notice of his intent to return from an unpaid leave of absence thirty (30) calendar days prior to the expiration of the leave.

6. Upon return from an unpaid leave of absence, a bargaining unit member shall resume all rights and benefits under this Agreement.

7. It is expressly understood that recreational pursuits and defense in court regarding a morals charge (unless found innocent) shall not be considered leave.

8. The general leave provisions set forth herein shall not apply to leaves granted under the Family Medical Leave Act.

ARTICLE 11: EVALUATION

A. It shall be the administration's responsibility to evaluate the performance of all bargaining unit members.

In the event the evaluator is not a certified classroom teacher or has no experience in the area of evaluating classroom teacher performance, the administration will meet with the Association to discuss any concerns relative to the implementation of this Section and, as mutually determined to be appropriate, establish an alternate plan for implementation.

B. Prior to any classroom observation, newly hired bargaining unit members will be apprised of the criteria upon which they will be evaluated. In the event the administration changes evaluation criteria, all bargaining unit members will be notified.

When a bargaining unit member is advised he will be evaluated during a given school year, the bargaining unit member may recommend a time for conducting the formal classroom observations.

C. The following procedures will govern the evaluation of bargaining unit members in addition to those requirements which may be set forth in the Michigan Teacher Tenure Act:

1. Tenured teachers will be evaluated at least once every three (3) years. Such evaluations will be completed by March 30 where the evaluation is less than satisfactory. In the event the evaluation is satisfactory, the evaluation will be completed by May 15.

2. Probationary teachers shall be evaluated in writing at least once a year. Such evaluations will be completed by March 30 or at least 60 calendar days prior to the teacher's anniversary date if beginning employment during the school year.

3. Written evaluations shall be submitted to the bargaining unit member within ten (10) working days of the final observation.

   Upon request and within ten (10) working days following receipt of the principal's evaluation, the principal shall arrange a conference with the bargaining unit member to review the written evaluation.

   Bargaining unit members may attach a written reply to the evaluation within ten (10) working days after receipt of the evaluation.

4. To the extent that the evaluation is unsatisfactory, the bargaining unit member will be placed on an individual development plan to assist him in remedying the deficient areas. The plan will be developed in consultation with the bargaining unit member.

5. To the extent the evaluation is unsatisfactory or areas are identified as needing improvement, the reasons will be identified and written suggestions will be made to assist the bargaining unit member.

   The next written evaluation shall indicate whether any previously noted deficiency has been corrected; that said deficiency still exists; or that same was not observed in which case, observation/evaluation of the deficient area will continue.

6. Tenured bargaining unit members not evaluated as set forth herein shall be considered to have performed satisfactorily.

D. Documents of an evaluative and/or disciplinary nature shall first be signed and dated prior to inserting same into the personnel file. A bargaining unit member's signature shall not be interpreted to mean that he necessarily agrees with the content, but shall be interpreted to mean that he has reviewed said material.

ARTICLE 12: MENTOR TEACHERS

A. Pursuant to Section 1526 of the Michigan School Code of 1976, as amended, teachers who are in their first three (3) years of classroom teaching shall be assigned one (1) or more mentors.

B. The rights of selection of mentors and the assignment of responsibilities are reserved to the District.

C. In the event the mentor is a member of the bargaining unit, the following guidelines will apply:

1. The assignment to a mentor position shall be voluntary and mentors must have achieved tenure status.

2. Bargaining unit members who are assigned as mentors, will be in the same building and will possess the same state teacher certification as the mentee. Should there be a need for a deviation from these requirements due to the lack of an acceptable volunteer within the building, the same shall be resolved between the administration and the Association.

3. Mentor assignments will normally be for the entire period for which the mentor assignment is required by law.

   In the event either the mentor or mentee desires a change in the mentor/mentee assignment, the reasons will be set forth in writing to the building principal who shall determine the appropriate course of action.

4. Mentors will not be involved in the formal evaluation procedures set forth in Article 11.

D. Mentors shall receive an annual honorarium of $200.00 per person which will be prorated in the event the assignment does not cover the entire school year. The honorarium will be evenly split where co-mentors are assigned.

ARTICLE 13: JOB SHARING

A. It is agreed between the parties that this Agreement shall be modified to allow for the employment of bargaining unit members in job sharing positions.

B. For purposes of this Agreement, job sharing shall be considered a partial leave of absence for full time personnel. It is understood that bargaining unit members electing job-sharing positions are not eligible for unemployment compensation.

C. The parties agree that job sharing arrangements shall be restricted to two (2) bargaining unit members sharing one (1) full-time position.

1. Agreement to share a full time position shall commit the bargaining unit member(s) for one (1) year and shall expire with the last workday of each school year.

2. Upon dissolution of the shared assignment, the less senior bargaining unit member shall be considered displaced.

3. The junior bargaining unit member shall have the right to displace the bargaining unit member with the least seniority provided he has the necessary certification and qualifications.

4. Should the junior bargaining unit member not possess the necessary seniority and certification to effect paragraph 3 above, he shall be subject to layoff.

D. Job sharing situations shall be presented to the Superintendent by the Association prior to May 1 annually. The Superintendent shall approve or deny proposed job sharing situations no later than June 1 annually.

E. Proposed job sharing situations shall include the following:

1. Schedule the work time and designate the responsibility of each for the workload, i.e. 2-1/2 days on, 2-1/2 days off; mornings and afternoons; first semester, second semester, class hours, etc.

2. Provide a brief written description of how the assignment responsibilities are to be shared.

3. Provide a brief written description of the process to be used in communicating with the immediate supervisor.

F. Bargaining unit members in a shared job assignment shall substitute in the other's absence whenever possible; and shall be compensated in accordance with Section 6 of Appendix B.

G. Bargaining unit members in a shared assignment shall accrue seniority and salary schedule credit as if employed full time.

H. Bargaining unit members in a shared assignment shall receive the pro-rata share of salary which reflects the fraction of time the position is shared and as provided in Appendix A of the this Agreement.

I. Sick leave, personal leave and fringe benefits shall accrue and be credited on a pro-rata basis.

J. Employment in a job sharing position is subject to the terms and conditions outlined in this Agreement.

ARTICLE 14: PROTECTION OF BARGAINING UNIT MEMBERS

A. The Board recognizes its responsibility to give all reasonable support and assistance to bargaining unit members with respect to the maintenance of control and discipline in the classroom. It is likewise recognized that there may be cases where the service and/or authority of personnel not normally on the school payroll will need to be employed to serve the best interests of students.

B. Any case of assault upon a bargaining unit member shall be promptly reported by the bargaining unit member to the building principal. The Board shall render all reasonable assistance to the bargaining unit member in connection with the handling of the incident by law enforcement and judicial authorities.

C. In the event the bargaining unit member incurs medical expenses or loss of work time as a result of an assault while performing his duties with the District, Worker Compensation Insurance provides protection for these expenses and income considerations. Accumulated sick leave may be utilized at the bargaining unit member's option. Reduction of sick leave shall be pro-rated at the same rate as the District's proportion of salary payment.

D. Bargaining unit members are expected to exercise reasonable care with respect to the safety of pupils and property, but shall not be individually liable except in the case of gross negligence or gross neglect of duty, for any damage or loss to person or property.

E. The Board shall reimburse the bargaining unit member for loss or damage to personal property used for instructional purposes, provided the bargaining unit member receives approval from the building principal prior to bringing such items to school.

F. The Michigan Child Protection Law requires the parties to report child abuse or neglect to the Department of Protective Services where there is reasonable cause to suspect that a student has been abused or neglected as defined by said law. Said law provides that the name of any person who reports child abuse/neglect is confidential and further, that disclosure of same may result in criminal as well as civil liability/penalty.

1. Should an administrator receive a complaint against a bargaining unit member, the nature of which requires that he report same to the Department of Protective Services and which may result in disciplinary action against the bargaining unit member due to a breach of this Agreement, Board policy or other work rules, the bargaining unit member shall be informed that a report has been filed.

2. Notwithstanding any investigation of a complaint or the results of any investigation by the Department of Protective Services and/or any law enforcement agency, an administrator shall conduct his own investigation of a complaint against a bargaining unit member.

3. To the extent permitted by law and upon completion of the investigation, all information forming the basis for disciplinary action will be made available to the bargaining unit member and the Association at the request of the bargaining unit member.

4. Prior to the imposition of any discipline, the administrator shall provide a due process hearing wherein the bargaining unit member shall have an opportunity to be heard on the allegation(s) at issue.

G. In recognition of the concept of progressive discipline, the Employer shall notify the bargaining unit member in writing of any alleged delinquencies. Progressive discipline, both oral and written, shall consist of the following except when the nature of the delinquency warrants immediate disciplinary action:

1. An informal conference between the bargaining unit member and his immediate supervisor to discuss the alleged inadequacy.

2. A clear statement of the type of behavior which is perceived a inadequate.

3. A clear statement of the type of behavior which the supervisor believes would resolve the problem.

4. A clear statement of the time in which the bargaining unit member is to meet the supervisor's requirement(s).

5. A clear statement of the action that may be expected if the problem is not resolved.

H. Copies of documents of an evaluative and/or disciplinary nature which are to be inserted into the personnel file shall be forwarded to the bargaining unit member simultaneous to the inclusion of same in the personnel file. The bargaining unit member may, at his option, submit a written statement and have same attached to the file copy of such materials.

I. When a bargaining unit member is requested to sign materials to be placed in the personnel file, such signature shall be understood to indicate his awareness of the material, but shall not be interpreted to mean agreement with the content of the material.

J. Reasonable complaints directed toward a bargaining unit member shall be called to the bargaining unit member's attention. Complaints which are called to the bargaining unit member's attention shall be reduced to writing with the names of the complainants and the administrative action take, if any.

K. No bargaining unit member shall be disciplined, reprimanded, reduced in rank or compensation without just cause. Any such discipline, including an adverse evaluation of tenured teachers a performance shall be subject to the grievance procedure herein set forth including arbitration. Upon request, the grounds forming the basis for disciplinary action shall be made available to the bargaining unit member and the Association in writing. Discipline may include any of the following: warning, written reprimand, suspension with or without pay and/or dismissal.

The non-renewal of a probationary teacher shall not be subject to the just cause standard, nor does a probationary teacher have access to the grievance procedure in the event of a non-renewable decision by the employer.

L. A bargaining unit member shall be entitled to have a representative of the Association present during any meeting which leads to disciplinary action. When a request for such representation is made, no action shall be taken with respect to the unit member until such representative of the Association is present. Should disciplinary action be likely to occur at a given meeting, the unit member shall be advised of the right to representation under this provision.

M. A bargaining unit member shall have the right to review his personnel file and to have an Association Representative accompany him in such review. Confidential credential materials shall be excluded from such review.

N. In the event a request is made for information in a bargaining unit member's personnel file and said request is in accordance with the Freedom of Information Act, the Association and the bargaining unit member who is named in the FOIA request will receive a copy of any and all information that is released to any such petitioner.

ARTICLE 15: PROFESSIONAL DEVELOPMENT

A. District-wide professional development days will be designated in Appendix C (calendar).

B. The parties support the principle of continuous professional development. Participation by bargaining unit members in professional organizations in their areas of specialization is encouraged. Leaves for work on advanced degrees or special studies may be granted when it is mutually agreed that the benefits of such studies will be directly applicable to instructional responsibilities, whether existing or planned for implementation. A posting of such planned programs will precede any granting or approval of compensation by the Board.

ARTICLE 16: SCHOOL IMPROVEMENT

A. The Board, Administration, teachers and Association recognize the necessity of maintaining ongoing district-wide school improvement plans and the importance of continued recognition of quality educational services as a fundamental priority and shared goal of the parties.

B. The Board recognizes that the terms and conditions of the collective bargaining agreement will govern to the extent required by law with respect to wages, hours and other conditions of employment and that those terms shall not be altered or modified through the school improvement process, absent written mutual agreement and ratification by the parties.

C. To the extent any proposed element of the District's school improvement plan conflicts with the terms of this Agreement, the identified provisions may be subject to negotiation at the request of the Board. Any amendments to this Agreement shall be reduced to writing in a Letter of Agreement and subject to ratification by the parties.

D. All bargaining unit members agree to participate on a voluntary basis in the evaluation and improvement of curriculum. To encourage involvement of all bargaining unit members in curriculum development, no bargaining unit member shall be required to participate more frequently than once in each three (3) year period.

E. The Board and the Association pledge themselves to seek to extend the advantages of public education to every student without regard to race, handicap, creed, religion, sex, color or national origin, and to seek to achieve full equality of educational opportunity for all pupils.

ARTICLE 17: NEGOTIATION PROCEDURES

A. This Agreement replaces all previous agreements between the parties. Prior to and during the negotiation of this Agreement, each party made certain proposals to the other. Each party hereto agrees that it has withdrawn all proposals made to the other that are not incorporated in or covered by this Agreement, in whole or in part. The withdrawal of those proposals, in whole or in part, is as much a consideration for this Agreement as is the incorporation therein of matters agreed on. Each party hereto hereby waives any right to require the other to bargain on the subject matter of those proposals, or on any similar proposals or on any other matter that might have been included in or covered by this Agreement, but was not. It is the intention of the parties that this Agreement during its term shall cover all arrangements between the parties concerning wages, hours, and conditions of employment that are to be in effect during the term and that nothing shall be added to the Agreement or subtracted from it by amendment, supplemental agreement or otherwise, other than by subsequent written agreement between and executed by the Employer and the Association.

B. No later than March 1 of the year in which the contract expires, the parties will begin negotiations for a successor Agreement. Through August 31 of that year, the parties agree to use interested-based strategies without external representatives to negotiate a successor agreement, with small numbers of district employees on their respective bargaining teams.

C. Thereafter, in any negotiations described in this Article, neither party shall have any control over the selection of the bargaining representatives of the other party and each party may select its representatives from within or outside the District. It is recognized that no final agreement between the parties may be executed without ratification by a majority of the Board of Education and by a majority of the membership of the Association, but the parties mutually pledge that representatives selected by each, shall be clothed with all necessary power and authority to make proposals, consider proposals, and make concessions in the course of bargaining, subject only to such ultimate ratification.

D. There shall be no less than four (4) signed copies of this Agreement. Two (2) such copies shall be retained by the Employer and two (2) such copies shall be retained by the Association.

E. Except for those rights which are reserved to the Board, when the Board is considering the adoption or a change in policy or administrative rules which affect a mandatory topic of bargaining under PERA, the Association President will be notified in writing. In the event the Association wants to negotiate relative to the impact of such changes, the Association President will notify the Superintendent in writing within seven (7) calendar days of receipt of such notice.

F. One hundred fifty (150) copies of this Agreement will be prepared with twenty-five (25) copies to the Board. The cost will be shared equally by the parties.

G. If any provision of this Agreement or any application of this Agreement to any bargaining unit member or group of bargaining unit members shall be found contrary to law or to administrative regulations required by the Department of Education of the State of

Michigan, then such provisions or applications shall be deemed null and void except to the extent permitted by law, but all other provisions or applications shall continue in full force and effect.

H. This Agreement shall supersede any contrary or inconsistent terms contained in any individual contracts heretofore in effect. All individual contracts shall be made expressly subject to the terms of the negotiated Agreement that has been entered into covering the same school year as the said individual contracts cover.

I. Normally, individual employment contracts shall be issued within thirty (30) days of the conclusion of negotiations between the parties, or by September 30, whichever is later. Normally, extra-duty contracts shall be issued on or before the first day that the bargaining unit member is scheduled to commence work in such assignment.

ARTICLE 18: GRIEVANCE PROCEDURE

A. A grievance shall be defined as an alleged violation of the expressed terms of this Agreement.

B. The following matters shall not be the basis of any grievance filed under the procedure outlined in this Article.

1. The termination of service of or the failure to re-employ any probationary bargaining unit member.

2. The termination of services or failure to re-employ any bargaining unit member to a position on the extra-curricular schedule.

3. Any matter involving the evaluation of a probationary teacher.

4. It is expressly understood that the arbitration provisions shall not apply to those areas for which state or federal law prescribes a procedure or authorizes a remedy (i.e. Tenure, EEOC, MERC).

   It is expressly understood that should the Legislature modify the Tenure Act in such a fashion as to diminish the due process rights afforded to tenured teachers which were formerly precluded under the arbitration provision, the due process provisions shall be subject to negotiations between the parties.

5. Any grievance previously barred from the scope of the grievance procedure.

C. In the event that a bargaining unit member or the Association believes there is a basis for a grievance, he shall first discuss the alleged grievance with his building principal within five (5) days after the grievance occurs or within five (5) days of when the grievant could have been reasonably expected to have knowledge of its occurrence, either personally or accompanied by an Association Representative(s). Any grievance carried by the Association may be suspended at the request of the individual grievant.

D. Within five (5) days of receipt of the written grievance, the principal shall meet with the grievant/Association in an effort to resolve the grievance. The principal shall indicate his disposition of the grievance in writing within five (5) days of such meeting and shall furnish a copy thereof to the Association and the grievant.

E. If the grievant/Association is not satisfied with the disposition of the grievance or, if no disposition has been made within five (5) days of such meeting, the grievance shall be transmitted to the Superintendent. Transmission to the Superintendent shall be within five (5) days of the principal's response or his failure to respond within the time specified. Within seven (7) days, the Superintendent, or his designee, shall meet with the grievant/Association on the grievance and shall indicate his disposition of the grievance in writing within five (5) days of such meeting and shall furnish a copy thereof to the Association and the grievant.

F. If the grievant/Association is not satisfied with the disposition of the grievance by the Superintendent or his designee, or if no disposition has been made within five (5) days of such meeting, the grievance may be transmitted to arbitration. Transmission to arbitration shall be within five (5) days of the response of the Superintendent or his failure to respond within the time specified. The rules for filing for arbitration shall be governed by the American Arbitration Association which shall likewise govern the arbitration proceeding.

G. The decision of the arbitrator shall be final and conclusive and binding upon bargaining unit members, the Board and the Association. Any lawful decision of the arbitrator shall be forthwith placed into effect. The powers of the arbitrator are subject to the following limitations:

1. He shall have no power to add to, subtract from, disregard, alter or modify any of the terms of this Agreement.

2. He shall have no power to establish salary scales or to change any salary.

3. He shall have no power to change any practice, policy or rule of the Board nor substitute his judgment for that of the Board as to the reasonableness of any such practice, policy, rule or any action taken by the Board.

4. He shall have no power to interpret state or federal law.

5. He shall not hear any grievance previously barred from the scope of the grievance procedure.

H. The fees and expenses of the arbitrator shall be shared equally by the parties.

I. The time limits provided in this Article shall be strictly observed, but may be extended by written agreement of the parties. In the event a grievance is filed after May 15 of any year and strict adherence to the time limits may result in hardship to any party, the Board shall use its best efforts to process such grievance prior to the end of the school term or as soon thereafter as possible.

J. Notwithstanding the expiration of this Agreement, any claim or grievance arising hereunder may be processed through the grievance procedure until resolution.

K. Miscellaneous

1. A grievance may be dropped at any level without prejudice.

2. The grievance discussed and the decision rendered at all levels shall be in writing.

3. No reprisals shall be taken by or against the Board, a bargaining unit member, or the Association merely for submitting a grievance.

4. All documents, communications, and records dealing with a grievance shall be filed separately from the personnel files of the participants.

5. All preparation, filing, presentation or consideration of grievances shall be held at times other than when a bargaining unit member or participating Association Representative is to be at his assigned duty station.

6. If any bargaining unit member's dismissal is reversed by court action, the individual bargaining unit member will be returned to the active payroll and reimbursed for any salary loss resulting from his dismissal. This will only be applicable, however, if the individual initiates such legal proceedings within ninety (90) days of the termination date.

7. The term "day," as used herein, shall mean working days. During the summer months, days shall refer to Monday through Friday, excluding holidays.

ARTICLE 19: CONTINUITY OF OPERATION

A. Nothing in this Article shall require the Board to keep school open in the event of severe inclement weather or when otherwise prevented by an Act of God. When schools are closed to all students due to the above conditions, bargaining unit members shall not be required to report to work.

1. When school is closed for the above reasons, bargaining unit members will be notified by telephone and the closing information will be provided to area television and radio stations.

2. Emergency school closings will be considered as days not worked and therefore, not paid. Said days will be rescheduled to provide the number of student instructional days required to receive full state aid payments. Bargaining unit members will be expected to report for work on said rescheduled days at their regular rate of pay.

3. Should it become necessary to reschedule a student instructional day(s), said day(s) shall be added to the end of the negotiated school calendar.

4. A bargaining unit member who has, in accordance with standard procedures, indicated his intent to use a paid leave day(s) when school is closed for the reasons stated above, shall suffer neither loss of leave time nor loss of salary.

5. Should the State Aid Act be amended during the term of this Agreement to permit "Act of God Days" without the requirement to reschedule same, the parties agree that when school is closed for the above reasons, bargaining unit members shall not

be required to report for work and shall suffer neither loss of leave time nor loss of salary. Any other amendments to the State Aid Act during the term of this Agreement shall be subject to negotiation between the parties.

B. The Board and the Association subscribe to the principle that differences shall be resolved by appropriate and peaceful means, in keeping with the high standards of the profession, without interruption of the school program. Accordingly, the Association agrees that during the term of this Agreement, it will not direct, instigate, participate in, encourage, or support any strike against the Board by any teacher or group of teachers.

ARTICLE 20: INSURANCE BENEFITS

A. Bargaining unit members will be eligible to elect Plan A or Plan B.

1. Plan A

Super Care 1 or Choices II (effective not later than October 1, 2009) with $10 generic, $20 brand prescription card, $20/$25/$50 office visit and a $200/$400 in network, $400/$800 out of network deductible;

Delta Dental Plan E-007 with internal and external COB;
$30,000 Term Life Insurance with AD & D;
Vision Care, VSP-2; and
Long Term Disability
90 calendar day modified fill wait period
66 2/3% of salary to a monthly maximum of $3,500.00
Social Security Freeze
Alcoholism/Substance Addiction/Mental & Nervous with two (2) year limit

Those teachers enrolled in Plan A electing 26 pays, will contribute $40.00 per pay period. Those electing 21 pays, will pay an equivalent annual amount over the 21 pay periods. If the Plan A composite rate increase on July 1, 2010 exceeds 10% of the 2009-2010 composite rate, teachers enrolled in Choices II Plan A will share equally in the increase above 10%. If less than 10%, the difference between 10% and the actual increase will be credited towards the bargaining unit members contributions for Choices II Plan A in 2011-2012.

2. Plan B

Effective July 1, 2009, $230 ($245 effective July 1, 2010) per month which the bargaining unit member may retain in cash or apply toward any of the MESSA non-taxable health options and/or an annuity.

Delta Dental Plan Auto +/004 with internal and external COB;
$35,000 Term Life Insurance with AD & D;
Vision Care, VSP-3; and
Long Term Disability Plan (same as Plan A)

3. The Employer shall provide premium payments within the limitations set forth in Section J for a full twelve (12) month period for up to full family coverage. Sponsored dependents or others not falling within the insurance underwriters and/or insurance administrator's definition for single, two (2) party or full family coverage, will not be eligible however, same will be made available through payroll deduction for the bargaining unit member to purchase at his expense.

B. Bargaining unit members working half time or more but less than full-time, will receive a prorated premium contribution toward Plan A or B above.

The Employer shall provide to the bargaining unit member, who works less than half time but more than one quarter time, said bargaining unit member's designation of one (1) of the following MESSA health options for a full twelve (12) month period.

1. Plan A

Single subscriber premium rate toward Choices II.

2. Plan B

a. $15,000 Life Insurance with AD & D;
Delta Dental Plan E-007 with internal and external COB; and
Vision Care, VSP-2

b. The balance of the single subscriber premium may be applied toward any of the MESSA non-taxable health options and/or an annuity.

c. Should a bargaining unit member receive dental and/or vision insurance through a spouse, he may waive his right to receive same in which case the appropriate portion of the single subscriber premium will be applied to the cost of the life insurance policy and the balance may be applied toward any of the MESSA non-taxable health options and/or an annuity.

C. A bargaining unit member who is eligible for the insurance benefits including annuities set forth herein shall be responsible for the completion of all necessary documents and for fulfilling any other requirements set forth by the insurance underwriters/administrators.

D. A bargaining unit member shall report changes in family status to the Personnel Office within thirty (30) days of such change. The bargaining unit member shall be responsible for any overpayment of premiums made by the Board on his behalf for failure to comply with this provision.

E. A bargaining unit member eligible for Medicare may enroll for Medicare benefits (Parts A & B) within thirty (30) days of his first eligibility date. The bargaining unit member shall be responsible for any overpayment of insurance premiums made by the Board for failure to comply with this provision.

1. Bargaining unit members eligible for Medicare benefits on and after January 1, 1983, must notify the Board of Education, in writing, of their primary program

election. Bargaining unit members can either elect Medicare or the Board-provided plan as their primary program as required by TEFRA.

2. To the extent permitted by law, premiums for Medicare supplement and Medicare Part B premiums shall be paid on behalf of the bargaining unit member's spouse and/or his qualified dependent(s) who is eligible for Medicare.

3. The Board of Education will not be liable for any penalties assessed against the bargaining unit member by the insurance carrier as a result of his election.

F. Health care protection shall be provided for a full twelve (12) month period for each bargaining unit member who completes a full academic year of employment and shall otherwise be pro-rated.

G. The health care protection is to be provided to the bargaining unit member's immediate family and other single eligible dependents as defined by the carrier.

H. The Board agrees to provide the above-mentioned benefit programs within the underwriting rules and regulations as set forth by the carrier(s) in the Master Contract held by the policyholder.

I. An open enrollment period shall be provided annually during the month of September.

J. The Employer's contribution toward Plan A health care coverage shall not exceed the full rates for the single, two-party, and full family Choices II Plan. The district's premium contribution for teachers electing Super Care 1 will not exceed the amount paid for Choices II. Only those teachers enrolled in Super Care 1 on July 1, 2009 may continue enrollment in Super Care 1. Any amounts in excess of the district's contributions will be payroll deducted as a condition of the master agreement pursuant to the authority set forth in MCLA 408.477.

In the absence of a successor contract by August 31 of the year this agreement expires, the teachers during successor negotiations will assume the premiums in excess of the Choices II rates in effect during the final year of this agreement in addition to their contractual obligations set forth in section A-1 above.

K. To the extent permitted under Internal Revenue Service Rules and Regulations, the Section 125 plan referenced under Section L below will contain a salary reduction agreement to facilitate the payment of out-of-pocket deductions for premiums above the Board's monthly contribution with pre-tax dollars.

L. The Employer will maintain a qualified plan document which complies with Section 125 of the Internal Revenue Code. The cost associated with fulfilling future reporting requirements will be assumed by the Employer.

ARTICLE 21: DURATION OF AGREEMENT

A. This Agreement shall be effective upon ratification by the parties and shall remain in effect until June 30, 2011.

B. This Agreement shall not be extended orally and it is expressly understood that it shall expire on the date indicated unless the parties mutually agree to the terms of an extension in writing.

Although the parties may mutually agree to extend the agreement if no successor contract is ratified by June 30, neither party is under any legal or contractual obligation to do so.

BOARD OF EDUCATION

Tim Carroll
President

Adrienne D. Bigg
Secretary

Lorinne Netzley
Superintendent

3-9-10
Date

INGHAM CLINTON EDUCATION ASSOCIATION

President

Chief Negotiator

Chairperson - ICEA

2/1/10
Date

APPENDIX A: SALARY SCHEDULE

Salary Schedule 2007-2008

STEP	BA	BA+20 Sem 30 Term	MA	MA+ 30 Sem 45 Term
1	$34,625	$35,664	$36,701	$37,509
2	$35,894	$37,267	$38,631	$39,879
3	$37,177	$38,869	$40,563	$42,248
4	$39,207	$40,984	$42,923	$44,700
5	$41,401	$43,180	$45,544	$47,231
6	$43,601	$45,456	$47,910	$49,853
7	$45,880	$47,829	$50,530	$52,552
8	$48,246	$50,279	$53,232	$55,342
9	$50,700	$52,812	$56,022	$58,219
10	$53,233	$55,089	$58,768	$60,708
11	$55,854	$58,134	$61,516	$63,199

1. The Board will pay the Employer portion of retirement for bargaining unit members to the Michigan Public School Employee Retirement System (MPSERS).

2. In addition to the salary schedule, experience in the Leslie Public Schools will be recognized by a supplement to salary

Levels

12-14 years $580
15-17 years $1160
18-20 years $1739
21-23 years $2,240
24+ years $2,809

The bargaining unit member's employment anniversary date shall serve as the basis for calculating the respective supplement(s) to salary. Accordingly, when the anniversary date falls after the first but before the last work day in any school year, said supplement shall be a pro-rata portion of the full amount.

3. Horizontal Salary Schedule Advancement

   A. Credit must be earned in an education program from a college or university with an accredited educational program.

   B. Placement on the BA+ column requires the credits be earned after the attainment of a Bachelor's degree and an initial teaching certificate. The credits may be either graduate or Bachelor's level classes.

      Any teacher in the bargaining unit as of June 1, 200 may count credits earned after attainment of their Bachelor's Degree but prior to earning their teaching certificate towards the BA+20 salary schedule.

   C. Placement on the MA+ column requires the credits be graduate level and earned after the attainment of the Master's degree.

D. Horizontal advancement on the salary schedule, as a result of additional hours or degrees, shall be allowed effective the beginning of the school year or second semester provided documentation demonstrating proof of hours and/or degrees has been submitted to the Business Office by the 15th of September or January. Adjusted salaries shall begin as soon as possible retroactive to the beginning of the school year or second semester.

Salary Schedule 2008-2009

STEP	BA	BA+20 Sem 30 Term	MA	MA+ 30 Sem 45 Term
1	$34,625	$35,664	$36,701	$37,509
2	$35,894	$37,267	$38,631	$39,879
3	$37,177	$38,869	$40,563	$42,248
4	$39,207	$40,984	$42,923	$44,700
5	$41,401	$43,180	$45,544	$47,231
6	$43,601	$45,456	$47,910	$49,853
7	$45,880	$47,829	$50,530	$52,552
8	$48,246	$50,279	$53,232	$55,342
9	$50,700	$52,812	$56,022	$58,219
10	$53,233	$55,089	$58,768	$60,708
11	$55,854	$58,134	$61,516	$63,199

1. The Board will pay the Employer portion of retirement for bargaining unit members to the Michigan Public School Employee Retirement System (MPSERS).

4. In addition to the salary schedule, experience in the Leslie Public Schools will be recognized by a supplement to salary

Levels

12-14 years $597
15-17 years $1,195
18-20 years $1,791
21-23 years $2,307
24+ years $2,893

The bargaining unit member's employment anniversary date shall serve as the basis for calculating the respective supplement(s) to salary. Accordingly, when the anniversary date falls after the first but before the last work day in any school year, said supplement shall be a pro-rata portion of the full amount.

5. Horizontal Salary Schedule Advancement

A. Credit must be earned in an education program from a college or university with an accredited educational program.

B. Placement on the BA+ column requires the credits be earned after the attainment of a Bachelor's degree and an initial teaching certificate. The credits may be either graduate or Bachelor's level classes.

Any teachers in the bargaining unit as of June 1, 2000 may count credits earned after attainment of their Bachelor's Degree but prior to earning their teaching certificate towards the BA+20 salary schedule.

C. Placement on the MA+ column requires the credits be graduate level and earned after the attainment of the Master's degree.

D. Horizontal advancement on the salary schedule, as a result of additional hours or degrees, shall be allowed effective the beginning of the school year or February 1 provided documentation demonstrating proof of hours and/or degrees has been submitted to the Business Office by the 15th of September or January. Adjusted salaries shall begin as soon as possible retroactive to the beginning of the school year or February 1.

Salary Schedule 2009-2010

STEP	BA	BA+20 Sem 30 Term	MA	MA+ 30 Sem 45 Term
1	$34,625	$35,664	$36,701	$37,509
1.5	$35,260	$36,466	$37,666	$38,694
2	$35,894	$37,267	$38,631	$39,879
2.5	$36,536	$38,068	$39,597	$41,064
3	$37,177	$38,869	$40,563	$42,248
3.5	$38,192	$39,927	$41,743	$43,474
4	$39,207	$40,984	$42,923	$44,700
4.5	$40,304	$42,082	$44,234	$45,966
5	$41,401	$43,180	$45,544	$47,231
5.5	$42,501	$44,318	$46,727	$48,542
6	$43,601	$45,456	$47,910	$49,853
6.5	$44,741	$46,643	$49,220	$51,203
7	$45,880	$47,829	$50,530	$52,552
7.5	$47,063	$49,054	$51,881	$53,947
8	$48,246	$50,279	$53,232	$55,342
8.5	$49,473	$51,546	$54,627	$56,781
9	$50,700	$52,812	$56,022	$58,219
9.5	$51,967	$53,951	$57,395	$59,464
10	$53,233	$55,089	$58,768	$60,708
10.5	$54,544	$56,612	$60,142	$61,954
11	$55,854	$58,134	$61,516	$63,199

The salary schedule for 2009-2010 reflects the payment of one half of the step increment from 2008-2009 to 2009-2010. (*e.g.*, a teacher on step 5 for 2008-2009, will be placed on step 5.5 for 2009-2010).

1. The Board will pay the Employer portion of retirement for bargaining unit members to the Michigan Public School Employee Retirement System (MPSERS).

2. In addition to the salary schedule, experience in the Leslie Public Schools will be recognized by a supplement to salary

Levels	
12-14 years	$597
15-17 years	$1,195
18-20 years	$1,791
21-23 years	$2,307
24+ years	$2,893

The bargaining unit member's employment anniversary date shall serve as the basis for calculating the respective supplement(s) to salary. Accordingly, when the anniversary date falls after the first but before the last work day in any school year, said supplement shall be a pro-rata portion of the full amount.

3. Horizontal Salary Schedule Advancement

   A. Credit must be earned in an education program from a college or university with an accredited educational program.

   B. Placement on the BA+ column requires the credits be earned after the attainment of a Bachelor's degree and an initial teaching certificate. The credits may be either graduate or Bachelor's level classes.

      Any teachers in the bargaining unit as of June 1, 2000 may count credits earned after attainment of their Bachelor's Degree but prior to earning their teaching certificate towards the BA+20 salary schedule.

   C. Placement on the MA+ column requires the credits be graduate level and earned after the attainment of the Master's degree.

   D. Horizontal advancement on the salary schedule, as a result of additional hours or degrees, shall be allowed effective the beginning of the school year or February 1 provided documentation demonstrating proof of hours and/or degrees has been submitted to the Business Office by the 15th of September or January. Adjusted salaries shall begin as soon as possible retroactive to the beginning of the school year or February 1.

Salary Schedule 2010-2011

STEP	BA	BA+20 Sem 30 Term	MA	MA+ 30 Sem 45 Term
1	$34,625	$35,664	$36,701	$37,509
2	$35,894	$37,267	$38,631	$39,879
3	$37,177	$38,869	$40,563	$42,248
4	$39,207	$40,984	$42,923	$44,700
5	$41,401	$43,180	$45,544	$47,231
6	$43,601	$45,456	$47,910	$49,853
7	$45,880	$47,829	$50,530	$52,552
8	$48,246	$50,279	$53,232	$55,342
9	$50,700	$52,812	$56,022	$58,219
10	$53,233	$55,089	$58,768	$60,708
11	$55,854	$58,134	$61,516	$63,199

The salary schedule for 2010-2011 reflects the payment of one half of the step increment from 2009-2010 to 2010-2011. (e.g., a teacher on step 5 for 2009-2010, will be placed on step 6 for 2010-2011. The half step schedule will end June 30, 2011.

1. The Board will pay the Employer portion of retirement for bargaining unit members to the Michigan Public School Employee Retirement System (MPSERS).

2. In addition to the salary schedule, experience in the Leslie Public Schools will be recognized by a supplement to salary

Levels

12-14 years $597
15-17 years $1,195
18-20 years $1,791
21-23 years $2,307
24+ years $2,893

The bargaining unit member's employment anniversary date shall serve as the basis for calculating the respective supplement(s) to salary. Accordingly, when the anniversary date falls after the first but before the last work day in any school year, said supplement shall be a pro-rata portion of the full amount.

3. Horizontal Salary Schedule Advancement

   A. Credit must be earned in an education program from a college or university with an accredited educational program.

   B. Placement on the BA+ column requires the credits be earned after the attainment of a Bachelor's degree and an initial teaching certificate. The credits may be either graduate or Bachelor's level classes.

Any teachers in the bargaining unit as of June 1, 2000 may count credits earned after attainment of their Bachelor's Degree but prior to earning their teaching certificate towards the BA+20 salary schedule.

C. Placement on the MA+ column requires the credits be graduate level and earned after the attainment of the Master's degree.

APPENDIX B: EXTRA DUTY COMPENSATION

A. Extra Duty Compensation

1. Athletic Compensation

Football

Head Varsity	11%
Assistant Varsity	9%
Junior Varsity Head	9%
Junior Varsity Assistant	7%
Ninth Grade Head	7%
Ninth Grade Assistant	6%
Seventh Grade Head	3%
Seventh Grade Assistant	2.5%
Eighth Grade Head	3%
Eighth Grade Assistant	2.5%

Cross Country

Head Coach	7%
Assistant	$1,242 for 2007-2008 and 2008-2009 $1,267 for 2009-2010 and 2010-2011
Middle School	4%

Boy's Basketball

Head Varsity	11%
Head Junior Varsity	9%
Ninth Grade	7%
Eighth Grade	5%
Eighth Grade Assistant	3%
Seventh Grade	5%
Seventh Grade Assistant	3%

Girl's Basketball

Head Varsity	11%
Head Junior Varsity	9%
Eighth Grade	5%
Eighth Grade Assistant	3%
Seventh Grade	5%
Seventh Grade Assistant	3%

Wrestling

Head Varsity	11%
Head Junior Varsity	9%
Eighth Grade	5%

Baseball
- Head Varsity 9%
- Head Junior Varsity 7%
- Ninth Grade 5%

Track
- Head Varsity 9%
- Assistant Varsity 7%
- Second Assistant 3%
- Middle School - Head coach 7%
- Middle School - Assistant coach 6%
- Middle School - Second Assistant 3%

Golf
- Head Varsity 7%

Softball
- Head Varsity 9%
- Head Junior Varsity 7%

Cheerleading
- Head Varsity ..... 3.5% per season
  ..... [6% if combined with competitive cheer]
- Head Junior Varsity ..... 3.0% per season
- Middle School ..... 2.5% per season

Tennis
- Head Varsity 7%

Volleyball
- Head Varsity 9%
- Head Junior Varsity 7%
- Freshman 7%
- Eighth Grade 5%
- Eighth Grade Assistant 3%
- Seventh Grade 5%
- Seventh Grade Assistant 3%

Director of Intramurals, Grades 5-8 .. $2,429 for 2007-2008 and 2008-2009
$2,478 for 2009-2010 and 2010-2011

Director of Games ..... $2,429 for 2007-2008 and 2008-2009
$2,478 for 2009-2010 and 2010-2011

2. Non-Athletic

Band
- Director of Marching Bands 11%
- Assistant Director of Marching Bands 6%

Vocal Music
- Director High School Vocal Music 11%
- Musical Assistants (3) 3%

Middle School Vocal Director 5%

High School Newspaper 2%
High School Yearbook 4%
High School Forensics 7.5%
Assistant Forensics ..... $1,243 for 2007-2008 and 2008-2009
$1,268 for 2009-2010 and 2010-2011
High School Debate 3%
High School Dramatics 7.5%

Senior Class Sponsors (2) 3%
Junior Class Sponsors (2) 3%
Sophomore Class Sponsors (2) 2%
Ninth Grade Class Sponsors (2) 2%
National Honor Society 3%
High School Student Council 8%
Middle School Student Council ..... $390 for 2007-2008 and 2008-2009
$398 for 2009-2010 and 2010-2011
School Improvement Chair
High School ..... $446 for 2007-2008 and 2008-2009
$455 for 2009-2010 and 2010-2011
Middle School ..... $446 for 2007-2008 and 2008-2009
$455 for 2009-2010 and 2010-2011
Elementary School ..... $446 for 2007-2008 and 2008-2009
$455 for 2009-2010 and 2010-2011
Department Chair ..... $381 for 2007-2008 and 2008-2009
$389 for 2009-2010 and 2010-2011
Quiz Bowl ..... $622 for 2007-2008 and 2008-2009
$634 for 2009-2010 and 2010-2011
SAAD
High School ..... $335 for 2007-2008 and 2008-2009
$342 for 2009-2010 and 2010-2011
Middle School ..... $200 for 2007-2008 and 2008-2009
$204 for 2009-2010 and 2010-2011
PAL ..... $622 for 2007-2008 and 2008-2009
$634 for 2009-2010 and 2010-2011

3. The above percentages will be applied to the following schedule equal to the person's experience in that area, unless otherwise stipulated. Experience in other schools will be recognized for transfer in the same manner as regular teaching experience credit may be transferred.

Step	2007-08	2008-09
1	31,257	31,257
2	32,507	32,507
3	34,380	34,380
4	36,259	36,259
5	38,289	38,289
6	40,323	40,323
7	42,430	42,430

8	44,620	44,620
9	47,327	47,327
10	49,229	49,229
11	51,654	51,654

Step	2009-2010	2010-11
1	31,882	31,882
2	33,157	33,157
3	35,068	35,068
4	36,984	36,984
5	39,055	39,055
6	41,129	41,129
7	43,279	43,279
8	45,512	45,512
9	48,274	48,274
10	50,214	50,214
11	52,687	52,687

4. Five percent (5%) of BA base will be paid to each bargaining unit member whose daily assignment involves duties in more than one (1) building.

   a. Effective with the 1985-1986 school year, new employees shall be entitled to three percent (3%) of the BA base when their daily assignment involves duties in more than one (1) building.

   b. Bargaining unit members shall be entitled to $467.00 when their daily assignment involves duties in more than one (1) building. This stipend will not apply to those bargaining unit members who received a stipend as provided above during the 1987-88 school year provided they remain assigned on an ongoing basis in more than one (1) building in subsequent years.

5. Attendance/Discipline Coordinators will receive their salary as per master agreement salary schedule Appendix A plus $34 times the number of student days.

6. Teachers of Driver Education will be reimbursed at the rate of $19.65 per hour for both classroom and behind-the-wheel instruction.

7. Bargaining unit members will not be expected to substitute in the absence of another bargaining unit member except in cases of emergency.

   a. When regular education classroom teachers are relieved of their normal teaching duties, e.g., a class field trip, senior graduation, said teachers may be asked and will be expected to substitute in the absence of another bargaining unit member with no additional compensation.

b. Should a bargaining unit member substitute in the absence of another bargaining unit member during his conference/preparation period, he will be compensated at the rate of $25.59 per clock hour ($26.10 effective 2009-2010) unless compensatory time is elected under the provisions of Article 10, Section A.9.

c. It is agreed that bargaining unit members who have the responsibility of supervising an intern or a student teacher, shall not be used to substitute in the absence of another bargaining unit member merely by virtue of the fact that he supervises an intern or student teacher.

8. The parties recognize that the Board is not under any obligation to fill any position set forth in the schedule of extra duty compensation at Appendix B of the Master Agreement. If during a period of financial difficulty the Board determines to offer any program on such schedule on a modified or reduced form, the parties will negotiate the rate for that program.

9. The Board reserves the right to pay non-bargaining unit staff assigned to Appendix B positions at a rate which is less than that specified in Appendix B provided that said position(s) are posted within the bargaining unit each year and provided, further, that no qualified bargaining unit member applies for such position(s).

10. Bargaining unit members who are required to work prior to the start of the regular work year or following the last work day of the year in conjunction with their regular assignment, i.e. counselors, will either be authorized for compensatory time or will be paid at their per diem rate of pay.

11. Bargaining unit members who coach and are subject to the provisions of Appendix B, will be evaluated at least once per year during the first and second year of their assignment and at least once every two years thereafter. Evaluations are to be completed and submitted to the coach in writing by the last teacher work day in the school year. The evaluation of coaches is not subject to the grievance procedure.

APPENDIX C: CALENDAR

Unless the State of Michigan requires a day of longer duration, full professional development days will be six (6) actual contact hours in duration excluding lunch time. If a longer day is required by the State of Michigan, the days will be extended accordingly.

It is recognized that MCL 380.1284(A) has set forth a new obligation that the Christmas and Spring Breaks correspond to the Intermediate School District's (ISD) calendar. In any year Leslie has negotiated a calendar that does not comply with the new Christmas and Spring Break requirements, the calendar will be changed to comply by the Association President and Superintendent. Any change will not add to or subtract from the number of days of student attendance or staff work days.

2007-2008 Calendar

	M	T	W	TH	F	# Student Days	# Teacher Days	
August	13	14	15	16	17	0	0	
	20	21	22	23	24	0	0	
	27	**28**	**29**	30	31	0	2	**28 Teachers return 29 PD**
September	**3**	**4**	5	6	7	4	4	**3 Labor Day 4 Half day students**
	10	11	12	13	14	5	5	
	17	18	19	20	21	5	5	
	24	25	26	27	28	4	5	**24 PD Day**
October	1	2	3	4	5	5	5	
	8	9	10	11	12	5	5	
	15	16	17	18	19	5	5	
	22	23	24	25	26	5	5	
	29	30	31	1	**2**	4	5	**2 PD**
November	5	6	7	8	9	5	5	
	12	13	14	15	16	5	5	
	19	20	21	**22**	**23**	3	3	**22 &23 Thanksgiving**
	26	27	28	29	30	5	5	**29 & 30 Half day First trimester ends**
December	3	4	5	6	7	5	5	
	10	11	12	13	14	5	5	
	17	18	19	20	21	5	5	
	24	**25**	**26**	**27**	**28**	0	0	**Christmas Break**
	31	**1**	**2**	**3**	**4**	0	0	**Christmas Break**
January	7	8	9	10	11	5	5	
	14	15	16	17	18	5	5	
	21	22	23	24	25	4	5	**21 MLK Day & PD Day**
	28	29	30	31	1	5	5	
February	4	5	6	7	8	5	5	
	11	12	13	14	**15**	4	5	**15 PD Day**
	18	19	20	21	22	4	4	**18 President's Day**
	25	26	27	28	29	5	5	
March	3	4	5	**6**	**7**	5	5	**6 & 7 Half day Second Trimester ends**
	10	11	12	13	14	5	5	
	17	18	19	20	**21**	4	4	**21 Good Friday**
	24	25	26	27	28	5	5	
	31	1	2	3	4	5	5	
April	**7**	**8**	**9**	**10**	**11**	0	0	**Spring Break**
	14	15	16	17	18	5	5	
	21	22	23	24	25	5	5	
	28	29	30	1	2	5	5	

May	5	6	7	8	9	5	5	
	12	13	14	15	16	5	5	
	19	20	21	22	23	5	5	
	26	27	28	29	30	4	4	**26 Memorial Day**
June	2	3	4	5	6	5	5	
	9	10	11	**12**	**13**	5	5	**12 & 13 Half day staff & students**
	16	17	18	19	20			
						180	**186**	**Total Days**

2008-2009 Calendar

	M	T	W	TH	F	# Student Days	# Teacher Days	Comment
August	18	19	20	21	22			
	25	**26**	27	28	29	0	2	**26 First Day staff, 27 PD Day**
September	**1**	2	3	4	5	4	4	**1st Labor Day, 2nd - 1/2 day for Students**
	8	9	10	11	12	5	5	
	15	16	17	18	19	4	5	**September 15 - PD Day**
	22	23	24	25	26	5	5	
	29	30	1	2	3	5	5	
October	**6**	7	8	9	10	4	5	**October 6 - PD Day**
	13	14	15	16	17	5	5	
	20	21	22	23	24	5	5	
	27	28	29	30	31	5	5	
November	3	4	5	6	7	5	5	
	10	11	12	13	14	5	5	
	17	18	19	20	21	5	5	**25,26 half day trimester exams for students**
	24	25	26	**27**	**28**	3	3	**27 & 28 Thanksgiving Break**
December	1	2	3	4	5	5	5	
	8	9	10	11	12	5	5	
	15	16	17	18	19	5	5	
	22	**23**	**24**	**25**	**26**	0	0	**Christmas Break**
	29	**30**	**31**	**1**	**2**	0	0	**Christmas Break**
January	5	6	7	8	9	5	5	
	12	13	14	15	16	5	5	
	19	20	21	22	23	4	5	**19th MLK & PD Day (on your own)**
	26	27	28	29	30	5	5	
February	2	3	4	5	6	5	5	
	9	10	11	12	**13**	4	5	**February 13 - PD Day**
	16	17	18	19	20	4	4	**February 16 Presidents Day - no staff/students**
	23	24	25	26	27	5	5	
March	2	3	4	5	6	5	5	
	9	10	11	**12**	**13**	5	5	**March 12 -13 Trimester Ends**
	16	17	18	19	20	5	5	**(1/2 days for students)**
	23	24	25	26	27	5	5	
	30	31	1	2	3	5	5	**Spring Break - includes**
April	**6**	**7**	**8**	**9**	**10**	0	0	**Good Friday on April 10**
	13	14	15	16	17	5	5	

	20	21	22	23	24	5	5	
	27	28	29	30	1	5	5	
May	4	5	6	7	8	5	5	
	11	12	13	14	15	5	5	
	18	19	20	21	22	5	5	
	25	26	27	28	29	4	4	**May 25 - Memorial Day**
June	1	2	3	4	5	5	5	
	8	9	**10**	**11**	12	4	4	**10 & 11 Half-day for staff/students**
	15	16	17	18	19	0	0	
						180	**186**	**Total Days**

2009-2010 Calendar

	M	T	W	TH	F	# Student Days	# Teacher Days	Comment
September	31	**1**	2	3	4	0	2	**Sept. 1 - Staff, Sept. 2 - PD**
	7	**8**	9	10	11	4	4	**Sept. 7 - Labor Day, 8 - 1/2 day students**
	14	15	16	17	18	5	5	
	21	22	23	24	25	4	5	**September 21 - PD Day**
	28	29	30	1	2	5	5	
October	5	6	7	8	9	5	5	
	12	13	14	15	16	4	5	**October 12 - PD Day**
	19	20	21	22	23	5	5	
	26	27	28	29	30	5	5	
November	2	3	4	5	6	5	5	
	9	10	11	12	13	5	5	
	16	17	18	19	20	5	5	
	23	24	25	**26**	**27**	3	3	**26 & 27 Thanksgiving Break**
December	30	1	2	**3**	**4**	5	5	**December 3 & 4, Exams - 1/2 day students**
	7	8	9	10	11	5	5	
	14	15	16	17	18	5	5	
	21	**22**	**23**	**24**	**25**	0	0	**Christmas Break**
	28	**29**	**30**	**31**	**1**	0	0	**Christmas Break**
January	4	5	6	7	8	5	5	
	11	12	13	14	15	5	5	
	18	19	20	21	22	4	5	**18th MLK and PD Day (on your own)**
	25	26	27	28	29	5	5	
February	1	2	3	4	5	5	5	
	8	9	10	11	**12**	4	5	**February 12 - PD Day**
	15	16	17	18	19	4	4	**February 15 - Presidents' Day**
	22	23	24	25	26	5	5	
March	1	2	3	4	5	5	5	
	8	9	10	11	12	5	5	
	15	16	17	18	19	5	5	
	22	23	24	**25**	**26**	5	5	**March 25 & 26 Exams - 1/2 day students**
	29	30	31	1	**2**	4	4	**April 2 - Good Friday - no students/staff**
April	**5**	**6**	**7**	**8**	**9**	0	0	**Spring Break**
	12	13	14	15	16	5	5	
	19	20	21	22	23	5	5	
	26	27	28	29	30	5	5	
May	3	4	5	6	7	5	5	

	10	11	12	13	14	5	5	
	17	18	19	20	21	5	5	
	24	25	26	27	28	5	5	
June	31	1	2	3	4	4	4	**May 31 - Memorial Day**
	7	8	9	10	11	5	5	
	14	15	16	**17**	**18**	5	5	**June 17 & 18 - 1/2 days staff/students**
	21	22	23	24	25	0	0	
						0	0	
						180	**186**	**Total Days**

2010-2011 Calendar

	M	T	W	TH	F	# Student Days	# Teacher Days	Comment
September	30	31	1	2	3	0	2	**Aug. 31 - Staff, Sept. 1 - PD**
	6	7	8	9	10	4	4	**Sept. 6 - Labor Day, 7 1/2 day student**
	13	14	15	16	17	5	5	
	20	21	22	23	24	4	5	**September 20 - PD Day**
	27	28	29	30	1	5	5	
October	4	5	6	7	8	5	5	
	11	12	13	14	15	4	5	**October 11 - PD Day**
	18	19	20	21	22	5	5	
	25	26	27	28	29	5	5	
November	1	2	3	4	5	5	5	
	8	9	10	11	12	5	5	
	15	16	17	18	19	5	5	
	22	23	24	**25**	**26**	3	3	**25 & 26 Thanksgiving Break**
December	29	30	1	**2**	**3**	5	5	**December 2 & 3, Exams - 1/2 day stude**
	6	7	8	9	10	5	5	
	13	14	15	16	17	5	5	
	20	**21**	**22**	**23**	**24**	0	0	**Christmas Break**
	27	**28**	**29**	**30**	**31**	0	0	**Christmas Break**
January	3	4	5	6	7	5	5	
	10	11	12	13	14	5	5	
	17	18	19	20	21	4	5	**17th MLK and PD Day (on your own)**
	24	25	26	27	28	5	5	
February	31	1	2	3	4	5	5	
	7	8	9	10	**11**	4	5	**February 11 - PD Day**
	14	15	16	17	18	4	4	**February 14 - Presidents' Day**
	21	22	23	24	25	5	5	
March	28	1	2	3	4	5	5	
	7	8	9	10	11	5	5	
	14	15	16	17	18	5	5	
	21	22	23	**24**	**25**	5	5	**March 24 & 25 Exams - 1/2 day student**
	28	29	30	31	1	5	5	
April	**4**	**5**	**6**	**7**	**8**	0	0	**Spring Break**
	11	12	13	14	15	5	5	
	18	19	20	21	**22**	4	4	**April 22 - Good Friday, no staff/studen**
	25	26	27	28	29	5	5	
May	2	3	4	5	6	5	5	

	9	10	11	12	13	5	5	
	16	17	18	19	20	5	5	
	23	24	25	26	27	5	5	
June	**30**	31	1	2	3	4	4	**May 30 - Memorial Day**
	6	7	8	9	10	5	5	
	13	14	15	**16**	**17**	5	5	**June 16 & 17 - 1/2 days staff/students**
	20	21	22	23	24	0	0	
						0	0	
						180	**186**	**Total Days**

APPENDIX D: GRIEVANCE REPORT FORM

Grievance #_____ **Leslie Public Schools**

GRIEVANCE REPORT

Distribution of Form: (1) Superintendent (2) Principal [Submit to Principal in Duplicate]
(3) Association (4) Teacher

Building	Assignment	Name of Grievant	Date Filed
_____/	_____/	_____/	_____

STEP I

A. Date Cause of Grievance Occurred: _____

B. (1) Statement of Grievance

_____

_____

_____

(2) Relief Sought

_____

_____

_____

_____ _____
Signature *Date*

C. Disposition of Principal

_____

_____

_____

_____ _____
Signature *Date*

If additional space is needed in reporting Section B-1 & 2 of Step I, attach an additional sheet.
(**Note**: Continued)

D. Position of Grievant and/or Association

_____

_____

_____

_____ _____

Signature *Date*

STEP II

A. Date Received by Superintendent or Designee: _____

B. Disposition of Superintendent or Designee

_____

_____

_____

_____ _____

Signature *Date*

C. Position of Grievant and/or Association

_____

_____

_____

_____ _____

Signature *Date*

STEP III

A. Date Submitted to Arbitration: _____

B. Disposition and Award of Arbitrator

_____

_____

_____ _____

Signature *Date*

APPENDIX E: SALARY ELECTION FORM

I, _____, hereby elect to receive my annual salary set forth at
(print name)

Appendix A of the Master Agreement in ☐ twenty-one (21) or ☐ twenty-six (26) installments.
(choose one)

_____ _____
Member's Signature *Date*

Letter of Agreement

between the

Leslie Board of Education

and the

Ingham Clinton Education Association, MEA/NEA

Re: Appendix B: Percentage Adjustments (Cross Country)

Based upon the reduction in the percentage paid to the above referenced sports beginning with the 1997-98 contract year, the parties agree as follows:

1. Jim Hanson will continue to receive the dollar amount paid during the 1997-98 contract year for as long as the individual remains continuously employed in the position.

2. At the point in time the regular Appendix B schedule (See Section A-3) and newly established percentage (See Section A-1) yields a rate in excess of the protected rate established above, the individual will be placed back on the schedule.

3. In the event any individual separates from the position, the protected pay rate will no longer apply.

_____ _____

For the Board Date

_____ _____

For the Association Date

Letter of Agreement

between the

Leslie Board of Education

and the

Ingham Clinton Education Association, MEA/NEA

Re: Article 7(A)(4)(b) Elementary Conference/Planning Time

It is recognized as follows:

1. The district's adopted budget for contains funds sufficient to continue at an average of 275 minutes per week.

2. In the event the district elects to reduce the 275 minutes due to financial reasons (i.e. Executive Order cuts, declining enrollment, etc.) the decision to reduce rests with the district and may not be grieved.

3. Prior to implementing any reduction under section 2 above, the district will advise the Association's President and upon request, will meet to discuss other budget reduction options that are controlled under the teacher master agreement.

4. The schedule of collaborative planning will be made in consultation between the principal and elementary team.

5. This agreement does not set a precedent and specifically expires on June 30, 2011.

_____ _____

For the Board Date

_____ _____

For the Association Date

Letter of Agreement

between the

Leslie Board of Education

and the

Ingham Clinton Education Association, MEA/NEA

Re: Professional Development Days for 2007-2008, 2008-2009, 2009-2010, and 2010-2011 under Section 1527 of the Michigan School Code.

It is hereby agreed as follows:

1. The calendars for 2007-2008, 2008-2009, 2009-2010, and 2010-2011 contain the equivalence of 5 full professional development days.

   The full days of professional development time in the calendar will be 6.0 contact hours plus a 30 minute lunch period unless at the building level it is agreed to forego lunch.

   Professional development time will be considered as teacher work time on site except as provided in Section 2 below.

2. There will be 6.0 total contact hours of professional development time required in lieu of the February 15, 2008, February 13, 2009, February 12, 2010, and February 11, 2011. The following conditions will apply to this time:

   a. The time must have prior administrative approval and meet the requirements of Section 1527 of the Michigan School Code. The basis for review will be the standards established by the Michigan Department of Education. A denial will not be subject to the grievance procedure where the Department of Education does not approve of the time.

   b. The time must be fulfilled outside of existing work time.

   c. A request to have time considered must be submitted in writing to and approved by the building principal in advance. The request must contain sufficient documentation of the activity (i.e. workshop flier, meeting content, location, etc.) and an estimate of time involved.

   d. Evidence of completion must be submitted in writing on forms provided by the district by the last teacher work day in June.

e. A failure to complete the professional development hours or under this section any portion thereof, will result in the loss of pay (at $30 per clock hour) for each hour or portion thereof of professional development time not completed. The loss of the pay is not subject to review through the grievance procedure.

3. In the event the legislature no longer permits the professional development time on your own as described in Section 2, this letter of agreement shall terminate and the aforementioned full days of professional development will be reinstituted in order to achieve compliance.

4. This agreement shall expire on June 30, 2011.

For purposes of establishing the "status quo" under PERA, the successor contract calendar will once again contain 5 full days of professional development as identified in the 2002-2003 school year.

The Association does reserve the right to make proposals to amend the "status quo" on professional development days in successor negotiations.

For the Board	Date
For the Association	Date

Letter of Agreement

between the

Leslie Board of Education

and the

Ingham Clinton Education Association, MEA/NEA

RE: ARTICLE 20(B)—CHANGE IN INSURANCE BENEFITS FOR PART-TIME TEACHERS.

IT IS HEREBY AGREED AS FOLLOWS:

1. Shelley Fassezke and Myrna Coxson will continue to receive premium payments toward Plan A or B at their election as if each was employed full time as long as each remains employed at least half time.

2. If either party moves to a full-time position this letter expires for that particular bargaining unit member.

3. This agreement applies only to Shelley Fassezke and Myrna Coxson and shall not be deemed precedent setting.

FOR THE BOARD DATE **FOR THE ICEA DATE**

Letter of Agreement

between the

Leslie Board of Education

and the

Ingham Clinton Education Association, MEA/NEA

In conjunction with the settlement of the 2007-2011 Master Agreement, the parties agree that not later than the payroll preceding the December 2009 break, full-time bargaining unit members at step 11 or higher of the salary schedule during the 2008-2009 school year who actively employed or on a paid leave of absence in December 2009, shall receive a one-time off schedule payment of $615 (including Ed Schmidt and Connie Smith). Such bargaining unit members working less than full-time shall receive an off schedule payment proportionate to the amount of time worked.

FOR THE BOARD **DATE**

FOR THE ASSOCIATION **DATE**

Leslie Public Schools

Benefits Summaries

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable insurance provider's certificate and riders. Payment amounts are based on the insurance provider's approved amount, less any applicable deductible and/or copay amounts required by the plan.

	Flexible Blue PPO (Plan 2)		Flexible Blue PPO (Plan 3)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Preventive Care Services				
Health Maintenance Exam	Covered – 100% (no deductible or copay)	Not Covered	Covered – 100% (no deductible or copay)	Not covered
Gynecological Exam	Covered – 100% (no deductible or copay)	Not Covered	Covered – 100% (no deductible or copay)	Not covered
Pap Smear Screening – laboratory services	Covered – 100% (no deductible or copay)	Not Covered	Covered – 100% (no deductible or copay)	Not covered
Well-Baby and Child Care	Covered – 100% (no deductible or copay)	Not Covered	Covered – 100% (no deductible or copay)	Not covered
Immunizations	Covered – 100% (no deductible or copay)	Not Covered	Covered – 100% (no deductible or copay)	Not covered
Proctoscopic Exam	Covered – 100% (no deductible or copay)	Not Covered	Covered – 100% (no deductible or copay)	Not covered
Prostate Specific Antigen (PSA) Screening	Covered – 100% (no deductible or copay)	Not Covered	Covered – 100% (no deductible or copay)	Not covered
	Preventive Care Services – Payment for preventive care services is limited to a combined maximum of $500 per member per calendar year		Preventive Care Services – Payment for preventive care services is limited to a combined maximum of $500 per member per calendar year	
Mammography				
Mammography Screening	Covered – 100% (no deductible or copay)	Covered – 80% after out-of-network deductible	Covered – 100% (no deductible or copay)	Covered – 80% after out-of-network deductible
Physician Office Services				
Office Visits	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Outpatient and Home Visits	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Office Consultations	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Urgent Care Visits	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Emergency Medical Care				
Hospital Emergency Room	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible
Ambulance Services – medically necessary	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible
Diagnostic Services				
Laboratory and Pathology Services	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Diagnostic Tests and X-rays	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Prenatal and Postnatal Care	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Delivery and Nursery Care	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible

Leslie Public Schools

Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Inpatient Consultations	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Chemotherapy	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100% after deductible, in participating skilled nursing facilities only. Limited to 90-days per member per calendar year.	Covered – 100% after deductible, in participating skilled nursing facilities only. Limited to 90-days per member per calendar year.
Hospice Care	Covered – 100% after in-network deductible, through a participating hospice program only. Limited to dollar maximum that is reviewed and adjusted periodically.	Covered – 100% after in-network deductible, through a participating hospice program only. Limited to dollar maximum that is reviewed and adjusted periodically.
Home Health Care	Covered – 100% after in-network deductible, by a participating home health care agency only.	Covered – 100% after in-network deductible, by a participating home health care agency only.

Surgical Services

Surgery – includes related surgical services	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Voluntary Sterilization	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible

Human Organ Transplants

Specified Organ Transplants – in designated facilities only	Covered – 100% after in-network deductible, in designated facilities only. Limited to $1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services		Covered – 100% after in-network deductible, in designated facilities only. Limited to $1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone Marrow – specific criteria applies	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Kidney, Cornea and Skin	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Treatment	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
	Limited to a combined maximum of 60 days per calendar year with 120 days lifetime per member.		Limited to a combined maximum of 60 days per calendar year with 120 days lifetime per member.	
Outpatient Mental Health Care	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
	Limited to a combined maximum of 120 visits per member per calendar year.		Limited to a combined maximum of 120 visits per member per calendar year.	
Outpatient Substance Abuse Treatment	Covered – 100% after deductible, in approved facilities only.		Covered – 100% after deductible, in approved facilities only.	
	Limited to annual state-dollar amount		Limited to annual state-dollar amount	

Leslie Public Schools

Other Services

Outpatient Diabetes Management Program	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Allergy Testing	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
Chiropractic Spinal Manipulation	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
	Up to 24 visits per calendar year			
Outpatient Physical, Speech and Occupational Therapy	Covered – 100% after deductible	Covered – 80% after out-of-network deductible	Covered – 100% after deductible	Covered – 80% after out-of-network deductible
	Limited to a combined maximum of 60 visits per member per calendar year.		Limited to a combined maximum of 60 visits per member per calendar year.	
Durable Medical Equipment	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible
Prosthetic and Orthotic Appliances	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible
Private Duty Nursing	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible

Plan Definitions

Eligible participants include Non-Instructional Employees of Leslie Public Schools.

Eligible dependents include (1) an employee's spouse while not divorced or legally separated from the employee; (2) each of the employee's unmarried children who is a dependent within the meaning of the Internal Revenue Code of the United States, to age 25. Coverage is provided through December 31 of the year in which the dependent becomes age 25.

Eligible dental care charges are the actual costs charged for the listed treatments or services to the extent that such charges are reasonable and customary for the services performed or the materials furnished. Reasonable and customary is determined from a compilation of reported usual dental fees charged by doctors in specific geographic areas.

Eligible charges are reimbursed on a year defined as the 12-month period of January 1 through December 31.

Your plan:

a) covers bridge and/or denture work for new or existing insured if the missing teeth were extracted prior to the effective date of the service contract. Only exception is congenitally missing teeth;
b) waives the five-year replacement limitation of bridge, crown or denture work;
c) allows 30 days after termination date for completion of work started before termination.

The preceding material is a generalization of the plan's provisions; the policy is the controlling document.

Ultra-Dent Group Insurance Program

Basic Services — 50% of R&C*°

Basic Services Include Services Such As:

Examinations	Diagnostic X-Rays
Cleaning (Prophylaxis)	Oral Surgery and Anesthetics
Fillings	Root Canals (Endodontics)
Fluoride Treatment (to age 18)	Periodontics

Lifetime Deductible $50

Major Services — 50% of R&C*

Major Services Include Such Services As:

Inlays	Dentures (Full and Partial)
Crowns and/or Bridges	Crown and/or Bridge Repair

Annual Deductible $0

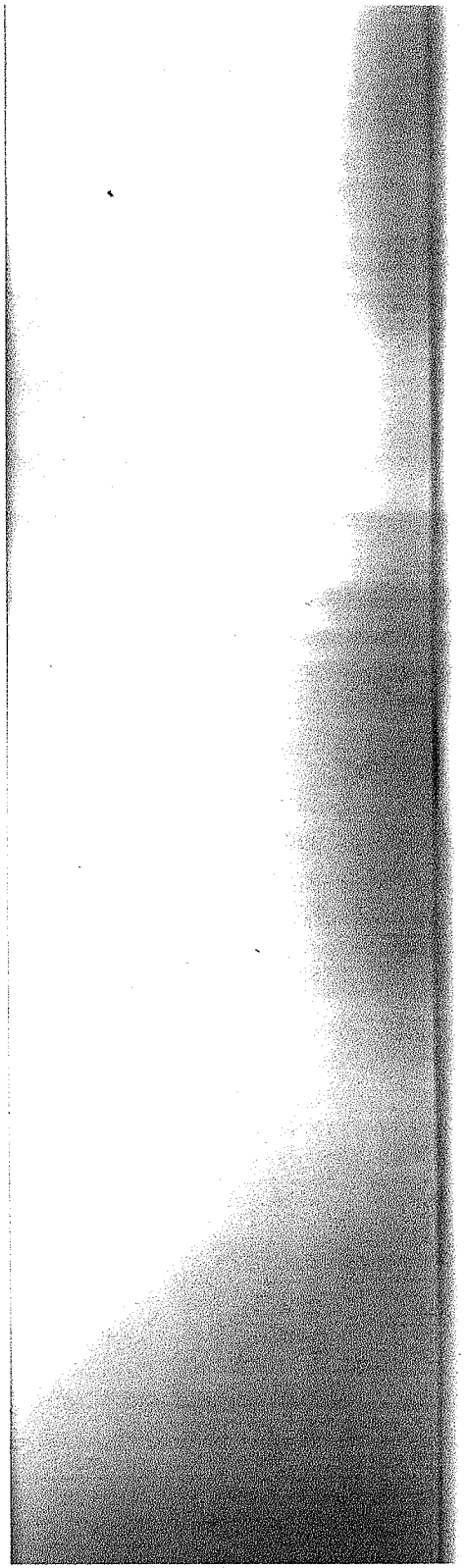
Combined Annual Maximum **$1,000 per year/per person total benefit**

*R&C means reasonable and customary (see eligible dental care charges, previous page).

°**An Incentive Plan is incorporated in this benefit.** The Benefit Level will begin at 50% on selected basic services for the first year, then increase 10% each succeeding benefit year, to a maximum of 100%, provided you visit the dentist at least once during the calendar year for a regular exam and/or cleaning.

Sunlife Life Insurance Policy

Eligible bargaining unit members who are regularly scheduled to work ten hours or more per week will receive premium payments toward $15,000 in group term life insurance coverage with AD&D.



SUPER CARE 1 GROUP LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT, AND HEALTH CARE PLAN

REVISED PLAN EFFECTIVE DATE
JULY 1, 1994

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HEALTH CARE BENEFITS

MEDICARE

ADDITIONAL PLAN INFORMATION

GENERAL INFORMATION

WHO IS ELIGIBLE FOR COVERAGE

The following individuals are eligible to become members of the Michigan Education Special Services Association (MESSA) and may apply for coverage:

- any active, associate, service associate, retiree, or student member of the Michigan Education Association (MEA) as defined in the MEA bylaws;
- any member of a bargaining unit in an educational agency in which a local association of MEA is the recognized bargaining agent and has negotiated MESSA benefits for its members;
- any administrator employed by an educational agency in which a local association of the MEA is a recognized bargaining agent and has negotiated MESSA benefits for its members;
- any retiree eligible for benefits under Section 91 of The Public School Employees Retirement Act of 1979, being MCLA 38.1391, as amended;
- any other eligible individual as defined in the Michigan Education Special Services Association (MESSA) bylaws as constituted on May 20, 1988, as amended.

An application is required if you are:

- enrolling for the first time;
- changing coverages for yourself or your dependents;
- changing school districts; or
- covering dependent children age 19 or older.

Eligible Dependents

If you are covered, your eligible dependents include:

- your spouse;
- your unmarried children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until the end of the calendar year of their 19th birthday;
- your unmarried children beyond the end of the calendar year of their 19th birthday to the end of the calendar year of their 25th birthday who are dependent on you for a majority of their support (dependency for tax purposes, as defined by the IRS, is not required);

- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this plan at the end of the calendar year of their 25th birthday and continuously thereafter) who are mentally retarded or physically handicapped, dependent upon you for a majority of their support, and who are incapable of self-sustaining employment by reason of their mental retardation or physical handicap. (Under no circumstances will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA Group Services to obtain the appropriate form to continue coverage;
- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this plan at the end of the calendar year of their 25th birthday and continuously thereafter), who are full-time students and dependent on you for a majority of their support;
- your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year, and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

It is your responsibility to notify MESSA and your employer:

- **of any change in your employment status;**
- **when you wish to add a spouse and/or dependent(s);**
- **of any change to a dependent's eligibility for coverage;**
- **when a spouse and/or dependent is no longer eligible as defined above.**

Special health care coverage guidelines apply to you and your spouse at age 65 during your active school employment. You should contact your school business office or MESSA for complete details. The Social Security Administration should be contacted regarding Medicare enrollment 120 days prior to attaining age 65.

NOTE: Life and Accidental Death and Dismemberment insurance applies to covered members only. It does not apply to dependents.

WHEN COVERAGE IS EFFECTIVE

The following information details the guidelines for your effective date of coverage.

- If you are a new employee and enroll for coverage within 31 days following the date you became eligible (your date of employment or the day following completion of the eligibility waiting period, whichever is later), your coverage will be effective on the date you became eligible. This date is verified by your employer.
- During open enrollment, the effective date of coverage for all new applications and coverage changes will be that date approved by MESSA and verified by your employer.
- If your application is submitted at any other time, your coverage will be effective on the first day of the month following approval of your application by MESSA.
- If you are absent from work because of bodily injury or sickness on the date your coverage would otherwise become effective, your coverage will not become effective until the day you return to active work. To be considered actively at work for coverage purposes, you must be physically and mentally able to perform your normal duties for a regularly scheduled workday when you report to work.
- Each dependent will be eligible for coverage on the later of the date on which your coverage begins or the date he/she becomes an eligible dependent if enrolled within 31 days. If your application for dependent coverage is submitted at any other time, coverage will be effective on the first day of the month following approval of your application by MESSA.
- If an eligible dependent is confined to a hospital or other medical facility (by reason other than his/her birth therein and if the member is a covered member at the time of the birth) on the date the dependent would normally become eligible for coverage, the dependent's coverage will not become effective until his/her discharge from the hospital or other medical facility, provided your coverage is in effect at that time.
- Each sponsored dependent will be eligible for coverage on the later of the date on which your coverage begins or the first day of January following the date he/she becomes an eligible dependent.

WHEN COVERAGE TERMINATES

Super Care 1 benefits end on the first day of the calendar month in which a covered individual becomes age 65. On that date, you will be enrolled in the MESSA Limited Medicare Supplement plan. If, however, you continue active school employment and remain a MESSA member, your Super Care 1 coverage and that of your covered dependents will not end until the first of the following circumstances occurs:

Termination of Employment - Coverage will end on the last day of the month in which you terminate employment.

Non-Payment of Contributions - Coverage will end on the last day of the month preceding the month for which the required contribution has not been remitted to MESSA.

Termination of Employer's Participation - Coverage will end on the last day of any month in which your employer ceases to participate under the Group Policy with Connecticut General, the MESSA/BCBSM Group Agreement, and the MESSA/BCS Group Policy.

Member No Longer Eligible - Coverage will end on the last day of the month in which a member no longer meets the eligibility criteria described on page 2.

Dependent No Longer Eligible - Coverage will end on the date a dependent no longer meets the eligibility criteria described on pages 2-3.

NOTE: An ex-spouse may be continued beyond the date of the divorce if the divorce decree stipulates that the member must provide health coverage for his/her ex-spouse. The member will be required to pay the sponsored dependent contribution in addition to his/her normal contribution. Coverage will terminate on either the date the ex-spouse remarries or the date which is 12 months following the date of the divorce, whichever is earlier.

Termination of Group Policy with Connecticut General and/or MESSA/BCBSM Group Agreement and/or MESSA/BCS Group Policy - Coverage will end on the date the Connecticut General Group Policy and/or the MESSA/BCBSM Group Agreement and/or MESSA/BCS Group Policy terminates.

Medicare Elected as Primary - If you continue active school employment beyond age 65 and elect Medicare as your primary coverage, your coverage under the Super Care 1 plan will end on the first day of the month following the date of your election. A spouse age 65 or older who obtains coverage through an active employee may also elect Medicare as his/her primary coverage; however, the spouse's coverage under the Super Care 1 plan will end on the first day of the month following such an election. See pages 45-46 for additional information.

NOTE: If you cease active work or leave school employment, inquire as to what arrangements, if any, may be made to continue coverage. Also, see "CONTINUATION OF HEALTH COVERAGE" below and the special continuation provisions for life insurance on pages 18-21. Contact MESSA Group Services for additional information.

CONTINUATION OF HEALTH COVERAGE

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Beginning on the date COBRA applies to this group health plan maintained by your employer, continued health coverage will be available for a limited period of time to certain members and their dependents. For COBRA purposes, health coverage includes the benefits described in this booklet except for the Life and Accidental Death and Dismemberment (AD&D) insurance. The continued health coverage is available to covered employees, their spouses, and dependent children (all of whom are referred to as "qualified beneficiaries") whose coverage would otherwise end upon the occurrence of any of the following "qualifying events":

- the death of the covered employee;
- the termination (other than by reason of gross misconduct) or reduction of hours of the covered employee's employment;
- the divorce or legal separation of the covered employee;
- a dependent child ceasing to be a dependent child under the generally applicable provisions of the plan;
- the covered employee becoming entitled to Medicare benefits;
- your employer files for Chapter 11 reorganization under federal bankruptcy laws.

You and your dependent(s) must pay the required contribution, if any, for the continued coverage. Your employer will inform you of the monthly contribution to be paid.

In the event of your divorce or legal separation or in the event your dependent child ceases to be eligible as a dependent under the plan, you or your dependent must notify the Plan Administrator (your employer) of the occurrence of the qualifying event within 60 days after the date of the qualifying event or the date coverage is terminated, whichever is later.

Continued coverage must be elected within an election period that cannot end before the date which is 60 days after the later of (1) the date coverage is terminated and (2) the date you receive notice of the right to continue coverage.

The continued coverage will begin on the date of the qualifying event and end when the first of the following events occurs:

- the date which is 36 months (18 months in the case of the termination or reduction in hours of the covered employee's employment) after the qualifying event;

NOTE: You, or a covered dependent, may be able to extend continuation of coverage from 18 months to 29 months if the Social Security Administration has determined (or determines) that you, or a covered dependent, has been totally disabled since the date of eligibility or within 60 days from the date of eligibility for continuation coverage.

- the first day for which timely payment is not made to the plan with respect to the qualified beneficiary;
- the date upon which your employer terminates participation under the MESSA/BCBSM/BCS Group Agreement/Policy(ies) providing the health benefits described in this booklet;
- the date the qualified beneficiary becomes covered under any other group health plan that is not maintained by your employer (other than a plan containing limitations or exclusions with respect to a pre-existing condition of a qualified beneficiary);
- the date the qualified beneficiary becomes entitled to benefits under Medicare.

If during an established COBRA period of continuance, another qualifying event occurs that also entitles you or your dependent(s) to COBRA continuation, coverage may be extended, but not beyond

the date which is 36 months from the date of the initial qualifying event.

If a qualified beneficiary's continued coverage ends due to the expiration of the 36-month or 18-month maximum continuation period, the qualified beneficiary may enroll in any conversion health plan available. (See "Conversion Privilege.")

Your employer can provide you with more information concerning how these COBRA health plan continuation rights apply to you and your family members and how to elect continued coverage under the plan in the event of a qualifying event.

Conversion Privilege

When you are no longer eligible for the Super Care 1 plan through your employer, an individual health care plan is available to you through BCBSM/BCS. Your benefits will change and coverage will be limited to your immediate family. There will be no interruption of coverage, provided you pay the premiums when due.

To ensure continuous coverage, you must make application within 31 days from the date your coverage terminates with your employer. Contact MESSA Group Services for additional information on how to apply for this coverage.

Surviving Family

Your dependents who are covered under the Super Care 1 plan on the date of your death should contact MESSA Group Services for information regarding continuation of coverage.

HOW TO FILE A CLAIM

Health Care Benefits

Most health care benefits provided by this plan are underwritten by BCBSM. This means you can take advantage of the participating provider network and eliminate the need for any paperwork on your part. Please ask your doctor if he/she participates with BCBSM. The following information explains how providers are paid.

Participating Provider - Is a hospital, doctor, pharmacy, or other provider who signs an agreement with BCBSM to accept its payment as payment-in-full for covered services less any required deductibles and/or co-payments. It allows the provider to bill BCBSM

and to receive payment directly from BCBSM. Reimbursement for services provided by a participating provider is based on BCBSM's determination of the approved amount for the service.

Advantages of Using Participating Providers:

- all paperwork is filled out by the provider;
- no out-of-pocket expenses beyond the plan's deductibles and/or co-payments;
- reduced out-of-pocket expenses in many cases;
- no requirement to pay the participating provider at the time you receive services, other than deductibles and/or co-payments.

Help Yourself - If your doctor does not participate with BCBSM, ask your doctor to participate on your claim. Per-claim participation by your doctor may eliminate the surprise of non-covered out-of-pocket expenses that may be your responsibility.

Showing Your Card - To receive services from a participating provider, just show your MESSA/BCBSM identification card. Your provider must have your contract and group numbers for billing purposes.

Non-Participating Provider - Is a hospital, doctor, pharmacy, or other provider that does not have an agreement with BCBSM. A provider may participate on a per-claim basis by agreeing to accept BCBSM's approved amount as payment-in-full less any required deductibles and/or co-payments. If your provider does not agree to participate, covered services will be paid up to the reasonable amount as determined by MESSA. You will be responsible for any required deductible, co-payment, and any amount exceeding MESSA's payment determination.

If a hospital or physician does not complete a claim form, you will need to request an itemized statement/receipt and send these bills to MESSA. If written authorization is attached to the bill, MESSA will pay the provider; otherwise, payment will be sent to you.

Your itemized statement/receipt should contain the following information:

- member's name and contract number;
- full name of patient and date of birth;
- date of service;
- type of service (type of procedure performed);

- individual charge(s);
- diagnosis;
- provider's name, address, telephone number, and tax payor identification number.

NOTE: If you or your dependent(s) have coverage through another carrier who is primary (see "Coordination of Benefits" on pages 46-47), please send your bill to MESSA along with a copy of the other carrier's explanation of benefits.

MESSA will send you a benefit worksheet (explanation of benefits) when a claim is processed. Please keep these worksheets for future reference.

Care Outside of Michigan

If you or a covered dependent receives treatment in a licensed non-Michigan hospital, just show your MESSA/BCBSM identification card. The hospital billing office will send the bill directly to MESSA or the local Blue Cross plan.

If you or a covered dependent receives any other type of service performed by a physician practicing outside of Michigan, you should ask if the provider participates in the local Blue Cross/Blue Shield plan. If the provider participates in the local plan, the provider should submit the bills to that plan. If the provider does not participate, you should ask for an itemized statement or receipt. Be sure your statement/receipt is itemized with the same information identified under "Non-Participating Provider."

Send these bills to MESSA. If written authorization is attached to the bill, MESSA will pay the provider; otherwise, payment will be sent to you.

Filing Deadlines

All claims must be submitted to MESSA/BCBSM/BCS within two years of the date of service.

If you have any questions regarding your medical claims, please call MESSA Benefits Administration.

LIFE AND/OR ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Life Claims

Contact MESSA Group Services for the forms necessary to file a life insurance claim.

AD&D Claims

Contact MESSA Group Services for the forms necessary to file an AD&D claim. AD&D claims are subject to the following:

Filing Deadline - Written notice of the event upon which the claim is based must be given:

- within 20 days after the loss covered by the policy occurs or begins, or as soon after that time as is reasonably possible.

Notice - Notice must be given by, or on behalf of, the claimant to:

- Connecticut General; or
- MESSA; or
- any other authorized representative of Connecticut General.

The notice must include sufficient information to identify you.

Claim Forms - On receipt of a notice of a claim, Connecticut General or MESSA will give the claimant forms for filing proof of loss. If such forms have not been furnished within 15 days after the giving of the notice, the claimant can fulfill the terms of the policy as to proof of loss by giving written proof of:

- the occurrence of the loss;
- the nature of the loss;
- the extent of the loss.

The proof of loss must be given within the time stated in "Proof of Loss" below.

Proof of Loss - Written proof of the loss must be given to Connecticut General within 90 days after:

- the date of the loss; or
- the end of the period for which Connecticut General is liable.

Late proof will be accepted only if it is furnished as soon as is reasonably possible. In no event, except in the absence of your

legal capacity, will proof be accepted later than one year from the time proof would otherwise have been required. Itemized bills may be required as proof of loss.

Time of Payment of Claims - Benefits are payable upon receipt of due proof of loss.

Payment of Claims - Benefits for loss of life will be paid in accordance with the beneficiary named by you, if any, and the terms of the policy in effect at the time payment is made.

Any part of the benefit for which there is no such beneficiary or terms in effect will be paid to your estate. Any other accrued benefits not paid at your death may, at the option of Connecticut General, be paid either to such beneficiary or your estate. Accidental dismemberment benefits will be payable to you.

If any benefit of the policy is payable to your estate, to you or your beneficiary while a minor, or to you or your beneficiary while not competent to give a valid release, Connecticut General may pay such benefit, up to $1,000, to anyone related by blood or by marriage to you or the beneficiary, and deemed by Connecticut General to be justly entitled. Any such payment made in good faith will discharge Connecticut General to the extent of such payment.

Physical Examination and Autopsy - At its own expense, Connecticut General has the right to have a doctor examine any person when it deems it reasonably necessary and there is a claim pending under the policy. Connecticut General also has the right to make an autopsy in the case of death unless the law forbids it.

Legal Actions - No one may sue for payment of a claim less than 60 days after proof of loss is furnished in accord with the terms of the policy. No one may bring suit more than three years after the date proof of loss is required by the policy.

Time Limit on Certain Defenses - A claim will not be denied nor will the validity of coverage be contested because of any statement with respect to insurability made by you while eligible for coverage under the policy, if:

- the insurance has been in force for at least two years before any such contest; and
- the person with respect to whom any such statement was made was alive during those two years.

Change of Beneficiary - You may change your beneficiary at any time; you do not need the consent of the beneficiary to make such change.

Contact MESSA Group Services with any life and/or AD&D claim questions you may have.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

Underwritten By
CONNECTICUT GENERAL LIFE INSURANCE COMPANY

CONNECTICUT GENERAL LIFE INSURANCE COMPANY hereby certifies that members of MICHIGAN EDUCATION SPECIAL SERVICES ASSOCIATION (called the Policyholder)

who are insured under Group Policy No. 57200 are subject to the terms and conditions of this policy and are insured for the benefits described in the pages of this booklet.

Connecticut General Life Insurance Company, called Connecticut General, insures the life and accidental death and dismemberment benefits. Connecticut General will determine all benefit payments according to the provisions described in the booklet and the group policy.

The insurance is effective only if the person concerned is eligible, becomes covered and remains covered, in accordance with the terms and conditions of the policy. Coverage applies to members only, as defined on page 2. Dependents are not eligible for either the life insurance or accidental death and dismemberment insurance benefits.

This certificate replaces any other certificate issued to you describing these benefits.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

PF75134 amended by PF33333

GENERAL PROVISIONS

The following will explain the life and AD&D benefits available to you under the Super Care 1 plan.

Beneficiary

The beneficiary for your life and AD&D insurance for loss of life will be the person you name as shown in the records kept on the group insurance policy. If there is no named beneficiary living at your death, a lump sum will be paid to the first surviving class that follows:

- spouse;
- children;
- parents;
- brothers and sisters.

If none survives, the benefit will be paid to your estate in a lump sum.

If the beneficiary is a minor with no legal guardian, the minor's share may be paid to the adult (or adults) who, in Connecticut General's opinion, has assumed custody and support of the minor. Payment may be made at a rate of up to $50 a month.

If you die after having applied to convert your group life insurance to an individual insurance policy, the beneficiary named in the individual policy (or in the application for it) will receive any benefits payable under the group insurance policy.

Assignment of Life Insurance

There is only one assignment of your life insurance that is valid. The assignment which:

- states that it is without consideration;
- is made to a named beneficiary;
- is in writing; and
- is accepted by Connecticut General.

The assignment may be made without the consent of the beneficiary.

Once an assignment is accepted and while it remains in force, the assignee can exercise any of the rights and privileges under the

group policy granted to you (including but not limited to, the conversion privilege), and becomes entitled to receive all claim payments under the insurance assigned with respect to which no beneficiary is designated by the assignee, unless the group policy states differently.

Acceptance of an assignment by Connecticut General shall be without further liability as to any action or any payment or other settlement made by Connecticut General before such acceptance. No assignment by you of your accidental death and dismemberment (AD&D) insurance is valid.

Connecticut General

This means Connecticut General Life Insurance Company, one of its affiliated companies, or their designee.

LIFE INSURANCE BENEFITS

The following information will explain your life insurance benefits under the Super Care 1 plan.

How Payment is Made

If you die while covered under the Super Care 1 plan, Connecticut General will pay your beneficiary $5,000. You may choose to have the benefit paid in a lump sum or in installments. You may also change your beneficiary or the method of payment at any time. Contact MESSA Group Services for the appropriate forms.

After your death, your beneficiary may choose the method of payment (if you have not already done so) and name a person to receive the benefit amount which would be paid to the beneficiary's estate in the event your beneficiary died before payment was made.

CONTINUATION OF LIFE INSURANCE COVERAGE

While Disabled

If you become totally disabled by injury or disease and you are not able to perform any work for which you are reasonably qualified by learning or experience, your group life insurance coverage will continue for one year from the date the total disability is approved

by Connecticut General. You will continue to be covered for a benefit of $5,000.

To be eligible for this **extended coverage**, you must be under 65 years old when you become disabled, and you must remain totally disabled during the year-long period.

NOTE: IF YOU REMAIN DISABLED, YOUR CONTRIBUTIONS WILL BE WAIVED AND YOUR COVERAGE WILL CONTINUE.

To minimize the financial burden during your disability, your contributions towards life insurance will be waived.

Your contributions will be waived on the date that Connecticut General receives satisfactory proof of your disability - but no earlier than six months after the onset of the disability. If you remain disabled after the first year of continued benefits, your coverage will continue without any contributions from you as long as you provide Connecticut General with proof of the disability annually, within the three-month period prior to the anniversary of the date the total disability was approved.

If you do any work for pay or gain, you are no longer considered totally disabled.

If you converted to an individual life insurance policy while you were disabled, you must return the individual policy to Connecticut General with your first proof of total disability. Connecticut General will refund any contributions you made for the individual policy.

Connecticut General maintains the right to have its medical representative examine you to verify the disability, but will not do so more than once a year after your extended coverage has continued for more than two years. There is no cost to you for medical exams requested by Connecticut General.

If You Die While Disabled

If you die while you are still disabled, your beneficiary will receive the life insurance benefit as soon as proof of your continued disability is received by Connecticut General.

If you die after you have converted your policy, any amount paid under the individual policy will be deducted from the amount due under the group life insurance policy and any contributions to the individual policy will be refunded to your beneficiary when the policy is returned.

When Your Extended Coverage Ends

Your extended coverage will end if you:

- cease to be totally disabled;
- fail to give required proof of your disability;
- fail to submit to a medical exam.

When your extended coverage ends, you can convert to an individual policy under the same conditions that would apply if you left school employment. See "After Employment Ends" below.

After Employment Ends

You have 31 days to convert to an individual policy and pay your first contribution. You won't need to take a health exam, but you will be limited in your choice of policy. The individual policy amount must be no greater than $5,000, and you cannot convert to a policy that provides term insurance, universal or variable life insurance, benefits for disabilities, or extra benefits for accidental death.

If you have merely changed job classification, and are eligible for coverage under another group policy, the amount of your converted individual policy will be reduced by the amount of that group policy.

The individual policy will take effect 31 days after coverage under the group policy ends. Should you die in that period without converting, Connecticut General will pay your beneficiary the amount you could have converted.

As an option to converting, you may continue your group life insurance on a direct payment basis by paying the required contribution for the cost of this insurance. MESSA will mail you a continuation notice for electing this option upon termination of your employment.

Contact MESSA Group Services for additional information.

After Your Employer Terminates Participation in the Group Policy, or Coverage for Your Job Classification Ends

Again, you have 31 days to convert to an individual policy. The same conditions apply as if your employment ended. In addition, you must have been insured by the group policy for at least five years in a row.

The maximum amount of life insurance you may convert is $2,000,

less any amount you became eligible for under any other group policy during the 31-day conversion period.

Should you die in the 31-day period after your participation ends, or after the group policy itself terminates, and you were insured by the group policy for the preceding five years, you are still covered. Connecticut General will pay your beneficiary the group life insurance policy amount, less the amount of any other group policy under which you became insured during that 31-day period, up to a maximum of $2,000.

Even if you should die within the 31-day conversion period without converting, Connecticut General will still pay your beneficiary the amount you could have converted.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The following information will explain your AD&D benefits under the Super Care 1 plan.

What is Covered

As a MESSA member you have $5,000 of AD&D insurance. If, while you are covered, you receive a bodily injury and experience a loss, Connecticut General will pay you according to the schedule listed under "How AD&D Benefits are Paid."

In order to receive an AD&D benefit, the loss must:

- be caused exclusively by external and accidental means;
- be the direct result of the injury, independent of all other causes;
- occur within 180 days from the date of the injury.

All benefits other than loss of life will be paid to you. If you die, the benefits will be paid to your beneficiary. See "GENERAL PROVISIONS" on page 17 for details about your beneficiary.

You may change your beneficiary at any time. Contact MESSA Group Services for the appropriate forms.

How AD&D Benefits Are Paid

For the Loss Of:	You Receive:
• Life • Both hands or both feet • Sight in both eyes • Any two or more: one foot one hand sight in one eye	100% OF AD&D BENEFIT ($5,000)

For the Loss Of:	You Receive:
• One hand, or • One foot, or • Sight in one eye, or • Speech, or • Hearing	50% OF AD&D BENEFIT ($2,500)

For the Loss Of:	You Receive:
• Thumb and index finger of the same hand	25% OF AD&D BENEFIT ($1,250)

The following defines what is considered a loss:

Definition	
Loss of hand or foot	Loss by cutting off at or above the wrist or ankle joint
Loss of sight, speech, or hearing	Total loss that cannot be recovered
Loss of thumb and index finger	Loss by cutting off at the proximal phalangeal joint

When You Suffer More Than One Loss

If you have more than one loss due to one accident, you will receive payment only for the loss with the largest benefit payout. You will only be paid for the loss resulting from the accident in question, regardless of any previous loss.

Losses Not Covered

No benefits will be paid for losses resulting from, or caused directly or indirectly by:

- bodily or mental infirmity;
- disease or illness of any kind;
- self-destruction or intentionally self-inflicted injury;
- taking part in an insurrection or riot; war or act of war; service in any military or naval organization, unless the injuries are sustained while off-duty;
- taking part in, or as a result of taking part in, a felony.

When Coverage Ends

AD&D coverage ends when your school employment ends or when you reach 65 years of age, whichever happens last. If your school employment ends before you reach age 65, you must pay the required contribution for the cost of this insurance to continue this coverage until you reach age 65.

HEALTH CARE BENEFITS

Underwritten By
BLUE CROSS BLUE SHIELD OF MICHIGAN
(BCBSM)
and
BCS LIFE INSURANCE COMPANY
(BCS)

HEALTH CARE BENEFITS

The following information will explain the health care benefits available to you and your covered dependents and your financial responsibilities under the Super Care 1 plan. When used in this section of the booklet, the words "you" and "your" mean a covered member and his/her covered dependents.

GENERAL PROVISIONS

Lifetime Maximum

Your lifetime maximum benefit amount is $2,000,000 for all services covered under this plan. However, services incurred after the date your coverage terminates are not covered.

Benefit Periods

All benefit periods, except where noted, are based on a calendar year, beginning on January 1st of each year and ending on December 31st of that year.

Deductible

During each benefit period you are required to meet an individual deductible or a family deductible before payment will begin for covered services subject to the deductible. Only services covered under this plan may be applied toward the deductible. The deductible amounts are listed on the "Schedule of Benefits" at the front of this booklet.

- **Carry-Over Provision -** Eligible expenses incurred and applied toward your deductible during the last three months of any calendar year, will be applied toward the following year's deductible.
- **Common Accident Provision -** If a common accident causes injury to two or more covered individuals in your family, a single deductible will be applied, in both the calendar year the accident occurs and the next following calendar year, to the combined covered charges incurred as a result of the common accident.
- **Common Communicable Disease Provisions -** If two or more covered individuals in your family contract the same communicable disease while residing in the same household and

within three months of the date the first person contracted the disease, a single deductible will be applied, in both the calendar year in which the disease was contracted and the next following calendar year, to the combined covered charges incurred as a result of the common disease.

Co-Payment Requirements

After you have met your deductible where required, the plan will pay 90% (except where noted) of the reasonable amount, for all covered services. The remaining 10% is your co-payment.

- **Family Stop-Loss -** This plan has a special feature which limits your out-of-pocket co-payment expenses for each benefit period. Once you have paid $1,000 in co-payment expenses, the plan will pay 100% of the reasonable amount for covered services for the rest of that calendar year. The amount of co-payment liability does not include the cash deductible, charges which exceed specified benefit maximum amounts, charges which exceed a reasonable amount, prescription co-payments, or any charges which are not covered under this plan.

Physician

A "physician" is a doctor of medicine (MD) or osteopathy (DO) legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. An optometrist, dentist, podiatrist, or a doctor of chiropractic who is legally qualified and licensed to practice at the time and place services are performed is deemed to be a physician to the extent that the doctor renders services which he/she is legally qualified to perform.

A "physician" is also a person who is licensed under Act 368 Public Acts of Michigan 1978, as a fully licensed psychologist at the time services are performed. In a state where there are no certification or licensure requirements, a psychologist is one who is recognized as such by the appropriate professional society at the time and place services are performed.

Approved Amounts and Reasonable Amounts

Blue Cross and Blue Shield covered charges, fees, and expenses will not include any amount in excess of what is determined as BCBSM's approved amount. BCS covered charges, fees, and expenses will not include any amount in excess of what BCS

determines to be reasonable.

Medically Necessary

Benefits under this plan are available for services which are determined by MESSA/BCBSM/BCS to be medically necessary. This includes services, supplies, or care provided by a hospital, doctor, or other covered health care provider to diagnose or treat the patient's medical condition, illness, or injury. Services must be consistent with accepted standards for good medical practice and must not be primarily for the convenience of the member, physician, or family.

Pre-Admission Review (PAR)

This is a provision of the plan which authorizes medically necessary admissions to the hospital. You or your doctor must request prior approval from MESSA for admissions to a hospital or other medical facility. If PAR guidelines are not followed you may have additional financial responsibilities in excess of the deductible and co-payment requirements. For additional information about PAR, please refer to the "Pre-Admission Review (PAR)" section on page 29.

Second Surgical Opinion

This is a provision of the plan which pays up to 100% of the reasonable amount towards the cost of a second surgical opinion when required by MESSA. For additional information, please refer to the "Second Surgical Opinion" section on page 33.

Medical Case Management (MCM)

This provision of the plan is designed to assist you if you are diagnosed with a catastrophic illness or injury. The program is tailored to meet your individual needs, based on your unique medical condition. Prior approval must be obtained from MESSA before benefits can begin. Eligibility for and termination of MCM benefits is made on a case-by-case basis in accordance with BCBSM/BCS's criteria.

For additional information, please refer to the "MEDICAL CASE MANAGEMENT (MCM)" section on page 43.

HOSPITAL BENEFITS

The following information explains your inpatient hospital benefits and applicable limitations.

Inpatient Hospital Benefits

After you have followed the Pre-Admission Review (PAR) requirements explained below and your admission has been determined by MESSA to be medically necessary, inpatient semi-private room and board and covered ancillary services are paid at 100% of the reasonable amount.

Private room rates, when not medically necessary, are paid at the hospital's average charge for semi-private accommodations plus $5 per day. However, if you are admitted into a non-participating hospital that doesn't have semi-private accommodations, reimbursement is made at 80% of the hospital's minimum charge for a private room plus $5 per day.

Pre-Admission Review (PAR)

If you satisfy the following PAR requirements, benefits will be paid as indicated under "Inpatient Hospital Benefits." If you do not satisfy the following requirements, you will be responsible for 20% of the covered doctor and hospital charges.

PAR Requirements - You or your doctor must request prior approval for all elective (non-emergency) admissions to a hospital. To comply with PAR, the following requirements must be satisfied.

A completed PAR form must be sent to MESSA at least two weeks before the scheduled admission. You must complete your section of the PAR form (included in your Super Care Claim Kit) and your doctor must complete the remaining portion of the form and mail it to the following address:

Michigan Education Special Services Association
PRE-ADMISSION REVIEW
P.O. Box 2570
East Lansing, MI 48826-2570

If a two-week notice is not possible, you or your doctor can call MESSA for an immediate review of the admission request. The toll-free telephone number is: 1-800-336-0022

MESSA will review your doctor's request and determine whether or not your admission will be authorized under BCBSM's medically

necessary criteria. MESSA will determine the number of days initially approved and will send written notice of the decision to you, your doctor, and the hospital.

Emergency Hospital Admissions - Advance approval is not required for emergency admissions. However, your doctor or hospital must notify MESSA within 48 hours of the start of your admission, or within 72 hours of the start of the admission if it begins on a weekend (5 p.m. Friday through 9 a.m. Monday) or a holiday. MESSA will then determine the number of days to be authorized under BCBSM's medically necessary criteria, and will provide written notice to you, your doctor, and the hospital.

Requesting Additional Days - The hospital or your doctor can request additional days beyond the days initially approved. Whenever possible, such requests should be made up to 48 hours before the end of the days initially approved. MESSA will let you, your doctor, and the hospital know if the request for additional days has been approved.

If the extension is not approved and your hospital admission exceeds the number of days determined by MESSA to be medically necessary, you will be responsible for the following:

- charges for inpatient hospital room and board;
- other charges for medical services and supplies furnished by the hospital;
- physician charges for inpatient hospital visits;
- any other charges related to the days not approved.

Requesting Approval After Admission - If your doctor fails to get approval before you're admitted, MESSA will still review a request, either while you are in the hospital or after your dismissal. The disadvantage is that you won't know before the admission whether the care is covered and you may be responsible for 20% of all covered charges.

Appealing a Non-Approved Admission or Extension - Your doctor may appeal all decisions by requesting a review by MESSA. **[See section "How to Appeal a Claim Denial."]**

Receiving Services Without Prior Approval - If the required Pre-Admission Review is not obtained, those covered charges stated above which are determined to be medically necessary for inpatient hospital confinement and physician in-hospital visits will be

reimbursed at 80% of the amount that would otherwise have been paid in accordance with the Super Care 1 plan and Pre-Admission Review. You will be responsible for the remaining 20%. If you were given prior notice of MESSA's denial of benefits before the admission began, or if you accepted such liability by entering into a prior agreement with your doctor, you will be responsible for all charges (both hospital and doctor) resulting from the admission.

OUTPATIENT HOSPITAL BENEFITS

When performed in the outpatient department of a hospital, benefits include:

First Aid Emergency Care

Outpatient treatment due to an accidental injury is paid at 100% of the reasonable amount for hospital and/or doctor services. Benefits include the initial examination and treatment and follow-up treatment of accidental injuries within 90 days of the injury. Beyond 90 days, follow-up care is paid at 90% of the reasonable amount subject to the deductible.

Life-Threatening Medical Emergency Care

When provided in an outpatient department of a hospital, the initial examination and treatment of conditions determined to be medical emergencies are paid at 90% of the reasonable amount.

A medical emergency is an illness that is a life-threatening condition which requires immediate attention and treatment. The condition must have severe symptoms that occur suddenly and unexpectedly, and be such that failure to render immediate treatment could result in significant impairment of bodily functions, cause permanent damage to your health, or place your life in jeopardy.

Other Medical Emergency Care

Services for medical emergency care, determined not to be life-threatening, provided in the outpatient department of a hospital, are paid at 90% of the reasonable amount after your deductible has been met.

Scheduled Outpatient Surgery

Hospital charges for covered scheduled outpatient surgery are paid at 100% of the reasonable amount. Surgical fees are covered under

the "SURGICAL BENEFITS" section. Please refer to page 33.

SKILLED NURSING FACILITY BENEFITS

A skilled nursing facility provides comprehensive inpatient care of either a short or extended duration and is operated under the general direction of a licensed physician. Benefits include:

Skilled Nursing Care Admissions

If care is received in a **participating** facility, room and board charges and covered miscellaneous charges are paid at 90% of the approved amount after your deductible has been met. A skilled nursing admission must occur within 14 days of a hospital confinement for the same condition, or your doctor must certify that admission into a skilled nursing facility is medically necessary or an alternative to hospital confinement. **This benefit does not include custodial or domiciliary care.**

If care is received in a **non-participating** facility, room and board charges are paid at 90% of the reasonable amount up to a maximum of $45 per day after you have met your deductible. Covered miscellaneous charges are paid according to plan provisions.

INPATIENT MEDICAL BENEFITS

Inpatient Medical Care

After you have followed the PAR requirements (MESSA's Pre-Admission Review) and your hospital admission has been determined to be medically necessary, inpatient medical care billed by your licensed physician is paid at 100% of the reasonable amount. This includes care for general medical conditions as well as nervous and mental conditions. Benefits include inpatient care received in special care units (e.g., intensive, burn, and cardiac care) and inpatient consultation when the services of a consulting physician are required in the diagnosis and treatment of a condition.

Inpatient Routine Newborn Medical Care

Visits by a **participating** provider are paid at 100% of the approved amount.

Visits by a **non-participating** provider for a newborn are paid at 100% up to $30 for the first visit and $10 for each subsequent visit.

SURGICAL BENEFITS

Surgery

Surgical procedures determined to be medically necessary and performed by a licensed physician are paid at 100% of the reasonable amount. Inpatient surgical procedures are subject to the PAR requirements as outlined on page 29. Certain surgical procedures require a second opinion.

- **Multiple Surgeries -** Performed on the same day and through the same incision are considered related. This plan will pay for the surgery having the greatest benefit reimbursement. However, when surgeries are made through separate incisions, the greater surgery is paid at 100% of the reasonable amount and the lesser surgery at 50% of the reasonable amount.
- **Bilateral Surgical Procedures -** If performed in separate incisions, both procedures are considered as one procedure and reimbursement will be made at 150% of the reasonable amount for the respective unilateral procedure.
- **Voluntary Sterilization -** Services are covered for voluntary sterilization, regardless of the medical necessity, for both males and females. However, a reversal of a sterilization is not covered.
- **Contraceptive Devices -** Services for the insertion and removal of an intrauterine device by a licensed physician are covered.

Second Surgical Opinion

Benefits are payable for a required second surgical opinion provided by a board certified specialist for any non-emergency surgical procedures listed below.

- **Coronary Bypass -** Open heart surgery
- **Hysterectomy -** Surgical removal of uterus
- **Laminectomy -** Removal of intervertebral disc
- **Pacemaker Implants -** Surgical implant of cardiac regulator
- **Total Joint Replacement (Hip or Knee) -** Replacement of a joint with artificial prosthesis

Definition of Second Surgical Opinion - This means an opinion on the need for surgery recommended by another surgeon. This opinion is to be given:

- no later than six months after the first opinion by another surgeon on the need for the same operation;
- by a board certified specialist in the field of surgery related to the condition;
- in writing.

Definition of Board Certified Specialist - "Board Certified Specialist" means a physician who, by the nature of the physician's specialty, is qualified to consider the surgical procedure being proposed.

What is Covered - For the listed procedures, the plan will pay 100% of the reasonable amount for the cost of the required second surgical opinion. If, after obtaining the required second opinion, you proceed with the surgery, covered charges made by the physician for performing the surgical procedure are paid as indicated under "Surgery."

If you do not obtain a required second surgical opinion for a listed surgical procedure and proceed with the surgery, covered charges incurred in connection with the surgery, including the surgeon's, assistant surgeon's, and anesthesiologist's covered charges are paid at 80% of the reasonable amount for charges that would otherwise have been paid if the required second surgical opinion had been obtained. This does not apply to hospital charges.

Technical Surgical Assistance

Services are paid at 100% of the reasonable amount for surgical assistance provided by a licensed physician for surgical procedures which require Technical Surgical Assistance as determined by MESSA/BCBSM.

Anesthesia

Services for the administration of drugs or gases, either on an inpatient or outpatient basis are paid at 100% of the reasonable amount when performed with other covered services. Anesthesia must be administered and billed by a certified registered nurse anesthetist or a licensed physician other than the operating surgeon or the surgeon's assistant.

HUMAN ORGAN TRANSPLANT BENEFITS

Services for human organ transplants performed during the transplant benefit period are paid at 100% of the reasonable amount when prior approval has been obtained from MESSA/BCBSM/BCS and services are received at an approved facility. The human organ transplants covered are:

- Heart
- Heart-lung
- Lung
- Pancreas
- Liver

Services for kidney, cornea, skin, and certain bone marrow transplants are covered as standard benefits, as outlined elsewhere in this booklet, unless they are determined to be research and/or experimental in nature. They are not subject to the guidelines outlined in this section. **Contact MESSA Health Care Relations regarding benefits for bone marrow transplants.**

A benefit period begins five days before the transplant surgery and ends one year later. During this period, services are covered up to a separate lifetime transplant maximum of $1,000,000 per each type of transplant. For each re-transplant, a new benefit period begins, however, the same $1,000,000 maximum applies.

Covered services include:

- hospital and medical expenses;
- transplant-related medical services, such as office visits, visiting nurse, home health care, cardiac rehabilitation, and durable medical equipment;
- surgical storage and transportation costs of donated organs up to $10,000 subject to the lifetime transplant maximum (all other donor-related expenses are not covered);
- anti-rejection drugs (after the first year, drugs are covered up to a maximum of $10,000 per year subject to the lifetime transplant maximum);
- transportation, meals, and lodging up to $10,000 (subject to the lifetime transplant maximum) for the patient and one companion (two if the patient is age 18 or under).

Your physician must request authorization from MESSA/BCBSM/BCS prior to the surgery. This is to ensure your surgery is performed in a facility that meets established standards. Authorization for the transplant will be sent to you, your physician, and the transplant facility.

DIAGNOSTIC BENEFITS

The following diagnostic services, when medically necessary and ordered by a physician, are paid at 100% of the reasonable amount.

Diagnostic Radiology

Benefits are payable for diagnostic x-rays, isotopes, and ultrasounds required in the diagnosis of an illness or injury. CAT scans and magnetic resonance imaging (MRI) are also payable when medically necessary.

Laboratory and Pathology Services

Benefits are payable for laboratory and pathology tests that are required in the diagnosis of an illness or injury.

Diagnostic Services

Benefits are payable for EKGs, EMGs, EEGs, thyroid function tests, and nerve conduction studies required in the diagnosis of an illness or injury.

THERAPY BENEFITS

The following therapy services are paid as indicated below if obtained in the outpatient department of a hospital, a doctor's office, or a freestanding facility. Therapies must be medically necessary and ordered by and performed under the supervision or direction of a legally qualified physician except where noted. Benefits include the following:

Physical Therapy

Services are paid at 90% of the reasonable amount after you have met your deductible. Services must be performed by a licensed physical therapist. Therapy must be designed to improve or restore the patient's functional level when there has been a loss in

musculoskeletal functioning due to an illness or injury.

NOTE: In order to be sure that you receive your full benefits, we recommend that you ask your doctor to send MESSA/BCBSM/BCS a course of treatment plan before your treatments begin.

Speech Therapy

Services are paid at 90% of the reasonable amount after you have met your deductible if provided by a registered speech therapist. For non-developmental conditions, treatment is available for both adults and children. For congenital and severe developmental conditions, treatment is available only for children.

NOTE: In order to be sure that you receive your full benefits, we recommend that you ask your doctor to send MESSA/BCBSM/BCS a course of treatment plan before your treatments begin.

Chemotherapy

Services for a malignancy are paid at 100% of the reasonable amount. Benefits include the cost of administration, physician services, and drugs except when the treatment or drug is considered experimental or research in nature.

Radiation Therapy

Services for a malignancy are paid at 100% of the reasonable amount. Benefits include x-rays, radium, external radiation, or radioactive isotopes, except when the treatment is considered experimental or research in nature.

Hemodialysis

Services are paid at 90% of the reasonable amount after your deductible has been met.

Outpatient Psychotherapy

Services are paid at 90% of the reasonable amount after your deductible has been met. Services must be provided by a licensed physician or a fully licensed psychologist or obtained at a BCBSM participating outpatient psychiatric care center. Benefits are limited to a maximum of 50 visits per person per calendar year. A visit shall

be counted for each period of treatment which lasts one hour or less. Treatment periods extending beyond one hour will be counted as multiple visits with each additional hour (or portion of an hour) counting as one visit. Convulsive therapy treatments are not subject to the 50-visit maximum.

Outpatient Substance Abuse Therapy

Services provided in a licensed substance abuse facility are paid at 90% of the reasonable amount after your deductible has been met.

Vision Therapy

Services for vision therapy performed by a qualified orthoptist to correct defective visual habits are paid at 90% of the reasonable amount after your deductible has been met. Benefits are not provided for the following:

- learning disabilities;
- reading problems including dyslexia;
- reading or educational enhancement;
- non-accommodative strabismus, such as muscle paralysis.

OTHER BENEFITS

Allergy Services

Diagnostic laboratory tests are paid at 100% of the reasonable amount. Allergy therapy is paid at 90% of the reasonable amount after your deductible has been met. Covered therapy includes scratch and/or puncture tests, therapeutic treatments (i.e., injections), and supplies. All allergy therapy services and related diagnostic laboratory tests are limited to a combined benefit maximum of $625 per calendar year.

Medical Weight Loss Treatment

Services performed by a qualified physician for the treatment of morbid obesity are paid at 90% of the reasonable amount after your deductible has been met. Covered laboratory services ordered for your weight loss treatment are paid at 100% of the reasonable amount. Benefits are covered up to $625 (this includes all services relating to this diagnosis) per special benefit period. To qualify for this benefit you must be one and one-half times the recommended

normal weight. For this condition, a special benefit period begins with the date of the first service and ends three years following that date.

Home Health Care

Services are paid at 100% of the reasonable amount for medically necessary services when provided by a home health care agency. To qualify for this benefit, a covered person must have physician certification assuring home health care is a medically necessary alternative to hospital confinement. The services are available based on a 30-day benefit period. The benefit period may be renewed with certification from your physician. Covered services include:

- part-time skilled nursing care (full-time care is not included) rendered by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN);
- medical care rendered by a home health aide or nurse's assistant under the direct supervision of a Registered Nurse;
- medical supplies other than drugs and medicines requiring a written prescription from a physician;
- rental of medical equipment (not to exceed purchase price);
- physical therapy, occupational therapy, speech therapy, social service guidance, and nutritional guidance provided by a home health care agency;
- hospital services and supplies related to the injury or illness which required or would have required the hospital confinement and would normally be provided by the hospital.

NOTE: Meals and general housekeeping services are not covered.

HOSPICE CARE BENEFITS

Hospice benefits allow covered terminally ill patients to spend their final days at home, or in a special hospice facility as approved by MESSA. You may apply for hospice benefits after discussion with, and a referral by, your attending physician. Benefits become available when:

- the covered patient is terminally ill with a life expectancy of six months or less as certified in writing by the attending physician; or
- you are a covered dependent of the terminally ill patient meeting

the requirements described above.

The following services for the patient will be paid at 100% of the reasonable amount up to a limit of $5,000:

- inpatient care provided by a hospice inpatient unit, hospital, or skilled nursing facility contracting with the hospice program:
- occasional respite care of up to five days duration, within a 30 calendar day period, to relieve family members or other persons caring for the member at home;
- part-time skilled nursing care (full-time not included) by a Registered Nurse or Licensed Practical Nurse;
- medical supplies;
- rental of medical equipment (not to exceed purchase price);
- physical therapy, emotional support services, homemaker, or home health aide services (provided by or on behalf of the hospice program);
- charges for physician services.

For the patient and other covered individuals of the patient's family, counseling services provided by or on behalf of the hospice facility are covered also. Family counseling sessions are paid up to $25 per session, up to a maximum of 12 sessions. This benefit ends:

- 12 months after the date of the first family unit counseling session;
- 18 months after the date the hospice benefit began; or
- upon payment of the maximum hospice benefit payment ($5,000), whichever occurs first.

CANCER SCREENING BENEFITS

Preventive screening for cancer is covered at 100% of the reasonable amount. This includes screening of the prostate, breast, uterus, colon, and rectum in individuals without symptoms or who are not considered to be at risk. This benefit is subject to the following limitations:

Prostate

One prostate examination in any three-year period if you are between the ages of 20 and 39. One prostate examination per calendar year if you are age 40 and older. This examination is done

by a physician during an office visit.

Breast

One breast examination per calendar year. One baseline mammogram if you are between the ages of 35 and 39. One mammogram in any two-year period if you are between the ages of 40 and 49. One mammogram per calendar year if you are age 50 or older.

Uterus

One pelvic examination and one pap smear per calendar year.

Colon and Rectum

One digital rectal examination is allowed every year if you are age 40 or older. One stool slide test every year if you are age 50 or older. One proctosigmoidoscopy examination every three to five years after age 50 following two negative examinations, one year apart.

NOTE: This benefit will apply only when ordered by a physician and billed as cancer screening.

MISCELLANEOUS BENEFITS

The following services and supplies, when medically necessary, are paid at 90% of the reasonable amount after your deductible has been met.

Physician Office Call

Includes diagnosis or treatment, but not routine physician care.

Private Duty Nursing

Medical services performed by either a Registered Nurse or Licensed Practical Nurse when prescribed by a physician.

Durable Medical Equipment

The rental cost, not to exceed the purchase price, of durable medical equipment when prescribed by a physician. Benefits include items such as hospital beds and/or wheelchairs. Items such as air purifiers, whirlpools, air conditioners, and exercise equipment are not covered.

Medical Supplies

Certain medical supplies when prescribed by a physician. Covered items include, but are not limited to:

- ostomy supplies;
- needles and syringes;
- compression or anti-embolism stockings, when prescribed for vascular conditions (limited to two pairs per calendar year);
- surgical brassieres following a mastectomy (limited to three per calendar year).

Ambulance Service

Transportation services by professional ambulance to and/or from the nearest hospital equipped to furnish treatment. Within the United States and Canada, benefits are payable for emergency transportation by air ambulance to the nearest hospital equipped to furnish treatment. In all cases, only the patient's transportation is covered.

NOTE: Ambulance transportation is not covered for patient or family convenience, or for physician preference.

Braces, Prosthetic and Orthotic Appliances

External appliances when they replace an absent part of the body or are intended to correct a defect of form or a function of the body. Appliances must be prescribed by a physician. Repairs or replacements are covered due to wear and tear or natural growth, unless otherwise specified. Benefits include, but are not limited to:

- artificial eyes, ears, nose, larynx, limbs;
- eyeglasses and hearing aids when required because of an accidental injury sustained while covered by this plan;
- orthopedic shoes meeting guidelines established by MESSA/ BCBSM/BCS;
- one pair of prescription eyeglasses or contact lenses when required because of: a) cataract surgery performed while covered by this plan; or b) the absence of an organic lens;
- external breast prosthesis following a mastectomy;
- prefabricated custom-made orthotic appliances;
- one wig for each episode of hair loss due to chemotherapy, up to a maximum of $400 per wig.

Dental Services

Dental treatment by a licensed dentist or dental surgeon required because of an accidental injury to sound natural teeth sustained while covered by this plan and only if coverage has been continuous since the date of the accidental injury. Charges by a dental surgeon for the removal of cysts and tumors of the mouth and jaw, and the extraction of impacted teeth are covered.

An initial mandibular orthopedic repositioning appliance is covered at 90% of the reasonable amount, up to a maximum of $450. Benefits include molding, fitting of, and office visits for adjustments to the appliance. Repair or replacement of appliance is not covered.

MEDICAL CASE MANAGEMENT (MCM)

This is a benefit designed to assist you if you are diagnosed with a catastrophic illness or injury. It is tailored to meet your unique medical needs. Prior approval must be obtained from MESSA before benefits under MCM can begin. The payment of benefits will be based on an objective review of your medical status, current treatment plan, projected treatment plan, long-term cost implications, and the effectiveness of care.

Eligibility for MCM benefits and termination of such benefits is made on a case-by-case basis in accordance with BCBSM/BCS criteria. The following medical conditions may be considered for MCM:

- pancreatitis;
- major head trauma;
- spinal cord injury;
- amputations;
- multiple fractures;
- severe burns;
- neonatal high-risk infants;
- severe stroke;
- multiple sclerosis;
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease);
- Acquired Immune Deficiency Syndrome (AIDS);
- Crohn's disease;
- cancer.

Medical Case Management is designed to give you and your family members flexibility and direct involvement in the management of your health care.

NOTE: Prior approval must be obtained from MESSA before benefits can begin.

If you have any questions regarding MCM, please contact the MESSA Health Care Resources department at 1-800-441-4626.

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to the Super Care 1 plan (these are in addition to limitations appearing elsewhere in this booklet):

- artificial insemination (including in vitro fertilization) and related services;
- care for conditions connected with employment with any employer;
- charges incurred because of war, declared or undeclared, or any act thereof, or for injury or sickness sustained or contracted in the armed forces of any country, or for services provided in a Veterans' Administration Hospital for a covered person with military service connected disability, or for services, supplies, or treatments provided or covered under any governmental plan or law, or which would have been furnished without cost in the absence of this coverage, or for which the covered person has no legal obligation to pay;
- clerical fees including fees for patient records;
- custodial care or basic care, that care which can be provided by someone other than an RN or LPN, and which is care provided primarily to assist the person in the activities of daily living;
- dental care (except as previously specified) including repairs of supporting structures for partial or complete dentures, dental implants, extractions, extraction repairs, bite splints, braces and appliances, and other dental work or treatment;
- educational care and cognitive therapy;
- eye examinations and eyeglasses or other corrective visual appliances except as specified under miscellaneous benefits;
- hearing aids (except as previously specified);
- inpatient hospital confinement for the sole purpose of testing for,

or detoxification of, allergy or allergy-related conditions;

- items for the personal comfort or convenience of the patient;
- radial keratotomy and related services;
- reversal of sterilization procedures and related services;
- routine health examinations and related services or routine screening procedures including pre-marital or pre-employment examinations (except as previously specified under cancer screening benefits);
- services, supplies, or treatment provided by an immediate relative or by anyone who customarily lives in the member's household;
- services and supplies that are not medically necessary according to accepted standards of medical practice including any services which are experimental or research in nature;
- services, treatments, or care provided after the coverage termination date;
- surgery for cosmetic or beautifying purposes, except for the correction of conditions resulting from an accidental injury or from an illness if the accidental injury occurred or the illness was contracted while covered under this plan and only if coverage has been continuous since the date of the accidental injury or the date the illness was contracted;
- transplants (other than previously specified) and all charges arising out of or associated with these transplants whether incurred prior to the transplant, at the time of the transplant, or subsequently;
- transportation expenses (except as previously specified) including meals and lodging.

MEDICARE

General Information

The Medicare health care program is designed to provide health care benefits to persons age 65 and older, and to certain disabled persons. The Social Security Administration is the sole authority for determining eligibility, called "entitlement," for Medicare coverage. If you are eligible for care under this program, you are called a

"beneficiary."

Generally, except for certain disability situations, you cannot become eligible for Medicare until age 65. You are eligible to enroll during the seven-month period beginning three months before and ending three months after the month in which you reach age 65. You must apply for Medicare coverage through your local Social Security office.

When you reach 65, and are eligible for Medicare, but continue working, you have two options.

- You may continue Super Care 1 as your primary health insurance plan. To do so requires no action on your behalf. You can/should also enroll in Medicare. If you choose this option, your health insurance benefits will be the same as those provided to your associates under the age of 65. In addition, you may have additional hospital and medical benefits under Medicare.

or

- You may elect Medicare as your primary health insurance plan. To make this election, you must reject coverage under the Super Care 1 plan in writing. If you choose this option, your spouse will also no longer be eligible for the Super Care 1 plan. In addition, your employer is prohibited by federal regulations from providing you with a Medicare supplement plan.

If you cover a dependent spouse age 65 or older, your employer must provide your spouse the same benefits you select until you retire. This rule also applies if your spouse is the working employee, and you are age 65 or older.

ADDITIONAL PLAN INFORMATION

Coordination of Benefits

This plan requires coordination of benefits (COB). COB is used when you are eligible for payment under more than one group health, dental, vision, or automobile no-fault insurance plan. This provision is to assure you that your covered expenses will be paid, but that the combined payments of all programs will neither exceed the amount of the actual cost, nor the amount that would have been paid in the absence of other coverage. Under COB, the plan that has the first obligation to pay is called the primary plan.

The guidelines used to determine the primary plan are:

- A group plan or automobile no-fault insurance plan with no provision for the coordination of benefits is always primary; otherwise,
- The plan sponsored by the employer of the person receiving the treatment is primary; or
- If the claim is for a dependent child covered under two or more plans, the primary plan is that of the parent whose birthday anniversary falls earlier in the year. If the birthdates are identical, the plan which has covered the dependent the longest is primary. However, benefits for children of divorced or separated spouses are determined in the following order:
  1. Plan of parent having financial responsibility as designated by court decree.
  2. Custodial parent's plan.
  3. Plan of the custodial parent's new spouse (if remarried).
  4. Plan of non-custodial parent.
- If the primary plan cannot be determined using the above guidelines, then the plan covering the person longest is primary. The only exception to this rule is that if the coverage is through a member who is retired or laid off and there is also coverage through a plan not involving a retired or a laid-off employee, the plan through the person who is not a retired or laid-off employee will be primary.

These COB provisions shall apply to any government or tax-supported program and Medicare*. These provisions shall also apply to any benefits or services provided by group student health programs. Except for automobile no-fault insurance coverage, these COB provisions shall not apply to any non-group policy.

*The term "Medicare" means the benefits available under Medicare Part A and Part B whether or not you are entitled to or have subscribed for Medicare Part A and Part B.

Release of Information

Each person covered under this plan hereby authorizes physicians, hospitals, and other providers of service to furnish to MESSA/BCBSM/BCS, upon their request, information relating to services which the covered person is or may be entitled to under this plan. Physicians, hospitals, and other providers of services are

hereby authorized to permit MESSA/BCBSM/BCS to examine their records with respect to the services and to submit to MESSA/BCBSM/BCS reports of the services in the detail MESSA/BCBSM/BCS requests. All information related to treatment of the covered person will remain confidential except for the purpose of determining rights and liabilities arising under this plan.

How To Appeal a Claim Denial

Written Complaint

If you do not agree with a claim denial, you may request a review. Your request must be in writing and may include additional facts or comments that support your position. In gathering information to submit with your request, you may obtain copies of pertinent documents if you pay a reasonable copying charge. In some cases, authorization may be needed for the release of confidential information, such as medical records.

Your request for review must be submitted within 90 days after receiving a notice of denial. Please send your request to MESSA Benefits Administration.

A decision will be made by MESSA/BCBSM normally within 30 days of MESSA's receipt of request for review or the date all information required of you is furnished, whichever date is later. The decision will be in writing and will specify the reasons for MESSA's/BCBSM's decision.

Managerial-Level Conference

If you are dissatisfied with this decision, you may request a Managerial-Level Conference. The decision resulting from this conference will be rendered not later than 90 days after we receive your initial written request for a review.

If you are dissatisfied with the result of your Managerial-Level Conference, you may request an Informal Review and Determination by the Insurance Commissioner within 120 days of our decision.

Expedited Appeals

If a physician substantiates either orally or in writing that handling your complaint under the above time frames will acutely jeopardize your life, you are eligible for an expedited grievance procedure.

Under this procedure, you will receive an initial determination within 72 hours after your complaint is received. If you want further review

by MESSA/BCBSM, you must request it within three business days after our initial determination. We will give you a final decision within 30 days of the receipt of your request. If either our initial or final determination is made orally, we will provide a written confirmation to you not later than two business days after our oral determination.

If you are dissatisfied with the final determination of your expedited grievance, you may request an Informal Review and Determination by the Insurance Commissioner within 10 days of MESSA's/BCBSM's final decision.

Contest

A person seeking payment from MESSA/BCBSM/BCS, directly or indirectly, will be furnished with the specific reason(s) for denial of a claim and an explanation of any additional information required from or on behalf of the member or dependent for reconsideration of the claim in accordance with MESSA/BCBSM/BCS's claim review procedure. No action or suit at law may be commenced upon or under this plan until 30 days after notice has been given by the member and/or covered dependent to MESSA/BCBSM/BCS that the reconsidered decision of MESSA/BCBSM/BCS under its claim review procedure is unacceptable, nor may such action be brought at all later than two years after such claim has arisen.

Subrogation/Right of Recovery

From time to time, MESSA/BCBSM/BCS may pay claims for which another person or persons, insurance company, or other organization (including the covered member's employer or any Workers' Disability or Occupational Act insurer) is responsible for paying ("Responsible Party"). In these cases, the covered member:

1. Grants to MESSA/BCBSM/BCS the covered member's right to recover from the Responsible Party to the extent of MESSA/BCBSM/BCS's payment. MESSA, BCBSM, and BCS have entered into an agreement assigning this right to recovery to MESSA.
2. Grants to MESSA/BCBSM/BCS a first priority security interest (meaning the right to be paid before any other person, including the covered member) from money recovered on all money that a covered member or a covered member's estate or beneficiaries recover in a verdict, judgment, settlement (regardless of whether the settlement is part of a legal action), or otherwise. Any part of the recovery that is used to pay attorneys' fees and costs will not be subject to MESSA/BCBSM/BCS's lien.
3. Agrees to inform MESSA/BCBSM/BCS when the covered member (or a beneficiary) hires an attorney to represent the covered member or beneficiary with respect to a claim for recovery against a Responsible Party whether that claim is made through litigation or is asserted prior to litigation.
4. Agrees to inform any attorney retained of MESSA/BCBSM/BCS's rights under this booklet.
5. Agrees to take whatever steps are necessary to assist MESSA/BCBSM/BCS in enforcing its right of recovery, including but not limited to cooperating in trial preparation, discovery, and by testifying in any civil action.

If an overpayment is made by MESSA/BCBSM/BCS for any reason, including but not limited to a payment under any Workers' Disability or Occupational Disease Act or law, clerical error, or misstatement of fact, MESSA/BCBSM/BCS shall have the right to recover such overpayments from the covered member (or a beneficiary of the covered member's estate), or to deduct such amount of overpayment from future benefit payments.

Medical Examination

MESSA, at its own expense, shall have the right and opportunity to have an individual examined by a physician of its choice as often as it may reasonably require while a claim is pending under this plan.

Additional Information About Your Coverage

The benefits described in this booklet are issued by one of three insurance companies.

Connecticut General Life Insurance Company underwrites the life and AD&D benefits.

BCS Life Insurance Company underwrites the following medical benefits described in this booklet:

- Manipulations (above the BCBSM approved amounts), modalities, and orthotics charged by a chiropractor;
- Outpatient physical therapy billed by a skilled nursing facility;
- Outpatient diabetic education programs approved by MESSA;
- Prescription medication (given in a doctor's office or hospital clinic, out-of-state charges, and member paid charges);

- Vision service;
- TMJ, excluding surgery, anesthesia, and x-ray, but including MORA and follow-up treatment;
- $5 per day toward a non-medically necessary private room rate;
- Take home drugs, equipment, and supplies from hospitals billed along with emergency room treatment, or inpatient stay, or outpatient scheduled surgery charges;
- Supplier's charges for rental of equipment used to do pneumogram at home;
- Wigs prescribed due to hair loss from chemotherapy;
- Consultations with Christian Science Practitioners;
- 10% co-payment for physical therapy due to accidental injury;
- 10% co-payment on 24-hour observation stay in a participating facility;
- Amounts paid to non-participating providers in excess of BCBSM's approved amounts;
- Out-of-state inpatient bills more than 1 year old;
- MESSA covered charges that are exclusions in out-of-state Blue Cross plans;
- BCBSM advance payment plan co-payments and deductibles; and
- COB balances on inpatient out-of-state facilities.

All other medical benefits included in this booklet are underwritten by Blue Cross Blue Shield of Michigan.

This booklet is intended to be an easy-to-read guide. An official description of benefits is contained in the applicable coverage documents. These documents are available for examination at MESSA's headquarters, without charge, during regular business hours.

Blue Cross Blue Shield of Michigan (BCBSM) and BCS Life Insurance Company (BCS) share the administration of this program with the Michigan Education Special Services Association (MESSA). Information concerning enrollees may be reviewed by MESSA, BCBSM, and BCS.

This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed according to the laws of the State of Michigan.

MESSA reserves the right to modify or discontinue the group program at any time. All provisions of the group program are set forth in the Group Policy insured by Connecticut General Life Insurance Company and in the Group Agreement between MESSA and Blue Cross Blue Shield of Michigan (BCBSM) and the Group Policy insured by BCS Life Insurance Company (BCS). The Group Policies and Group Agreement are the controlling documents.

MESSA
ChoicesII
Group Insurance for School Employees

MESSA®

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Section 1: The Language of Health Care

This section explains the terms used in your coverage booklet.

Accidental Injury
Any physical damage caused by an action, object, or substance outside the body, such as:

- strains, sprains, cuts, and bruises
- allergic reactions caused by an outside force such as bee stings or other insect bites
- extreme frostbite, sunburn, or sunstroke
- swallowing poisons
- drug overdosing
- inhaling smoke, carbon monoxide, or fumes

Accredited Hospital
A facility that has been endorsed by one of the following organizations: Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on Accreditation of Rehabilitation Facilities (see the definition of "Hospital").

Acquisition Cost
The actual cost of the hearing aid to the audiologist, hearing aid specialist, or dealer.

Acute Care
Medical care that requires a wide range of medical, surgical, obstetrical, or pediatric treatment. It generally requires a hospital stay of less than 30 days.

Acute Care Facility
A facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions which require a hospital stay of less than 30 days. The facility is not used primarily for:

- custodial, convalescent, tuberculosis, or rest care
- care of the aged or substance abusers
- skilled nursing or other nursing care

Allogeneic (Allogenic) Bone Marrow Transplant
A procedure using another person's bone marrow or peripheral blood stem cells to transplant into the patient. This includes syngeneic transplants (when the donor is the identical twin of the patient).

Ambulatory Surgery
Elective surgery that does not require use of extensive hospital facilities and support systems, but is not usually performed in a doctor's office.

Ambulatory Surgery Facility
A freestanding outpatient surgical facility offering surgery and related care that can be safely

performed without the need for overnight inpatient hospital care. It does not include an office of a physician or other private practice office.

Ancillary Services
Services other than room, board and nursing such as drugs, dressings, laboratory services and physical therapy.

Approved Amount
The lower of the billed charge or our maximum payment level for the covered service. Co-payments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Approved Hospice
A hospice provider that meets all state licensing and MESSA/BCBSM approval requirements.

Attending Physician
The physician in charge of a case and the one exercising overall responsibility for the patient's care.

Audiologist
A person who is qualified in the state in which services are provided and certified by the American Speech and Hearing Association to conduct audiometric examinations and hearing aid evaluation tests on individuals with impaired hearing.

Audiometric Examination
A procedure to evaluate the patient's hearing and measure hearing loss.

Autologous Bone Marrow Transplant
A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.

BCBSM
Blue Cross Blue Shield of Michigan.

BCS
BCS Life Insurance Company.

Blue Cross Plan
Any nonprofit hospital service plan approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.

Blue Shield Plan
Any nonprofit medical service plan approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.

BlueCard Participating PPO Provider
A provider who participates with the host plan's PPO.

BlueCard Program PPO
A national program that allows Blue Cross Blue Shield of Michigan PPO members to receive health care services in other states.

Chronic
A disease or ailment that lasts a long time or recurs frequently. Heart disease and arthritis are examples of chronic diseases.

Conformity Test
A follow-up visit to the physician-specialist or audiologist who prescribed the hearing aid to verify that the patient received the prescribed hearing aid and to evaluate its effectiveness.

Connecticut General
Connecticut General Life Insurance Company, one of its affiliated companies, or their designee.

Copayment
The portion of the approved amount that you must pay for a covered service after your deductible has been met.

Covered Services
The services, treatments or supplies identified as payable in your Certificate.

Note: Covered services must be medically necessary to be payable (see definition of "Medically Necessary").

Custodial Care
Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, bathing, dressing, and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

Deductible
The amount that you must pay for covered services before benefits are paid by us.

Dental Care
Care given to diagnose, treat, restore, fill, remove or replace teeth, or the structures supporting the teeth, including changing the bite or position of the teeth.

Dialysis
Removal of toxic substance(s) from the blood.

Direct Supervision
The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.

Dispensing Fee
The amount we pay the provider for supplying a hearing aid, including the cost of an ear mold.

Durable Medical Equipment
Equipment that can withstand repeated use and is used for a medical purpose by a patient who is ill or injured. It may be used in the home.

Ear Mold
A device made of soft rubber, plastic, or nonallergenic materials, vented or nonvented, that is fitted to the outer ear canal and pinna of the patient.

Effective Date
The date your coverage begins under this contract. This date is established by MESSA and BCBSM.

End Stage Renal Disease
Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Exclusions
Situations, conditions, or services that are not covered by the subscriber's contract.

Experimental or Investigational
A service that has not been scientifically demonstrated to be as safe and effective for treatment of the patient's condition as conventional or standard treatment.

Facility
A hospital or clinic that offers acute care or specialized treatment, such as substance abuse, rehabilitation treatment, skilled nursing care or physical therapy.

Fecal Occult Blood Screening
A laboratory test to detect blood in feces or stool.

First Aid
Treatment given for an accidental injury.

First Degree Relative
An immediate family member; that is, a mother, father, sister or brother.

Flexible Sigmoidoscopy
A visual examination of the lower portion of the colon through the rectum, using a flexible instrument called a sigmoidoscope.

Freestanding Outpatient Physical Therapy Facility
An independently owned and operated facility, separate from a hospital, that provides outpatient physical therapy services and functional occupational therapy or speech and language pathology services.

Genetic Markers
Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens (HLA), these six chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. A complete HLA match occurs when all six of the clinically important markers of the donor are identical to those of the patient.

Gynecological Examination
A history and physical examination of the female genital tract.

Health Maintenance Examination
A comprehensive history and physical examination including blood pressure measurement, ocular tonometry (measurement of pressure in the eye), skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling potential risk factors.

Hearing Aid
An electronic device worn by the patient to amplify sound and improve the patient's hearing. A hearing aid may include an ear mold.

Hearing Aid Evaluation Test
A series of subjective and objective tests used by an audiologist or physician-specialist to determine what model and make of hearing aid should be prescribed to improve the patient's hearing.

Hearing Aid Specialist/Dealer
Any person or organization licensed to sell hearing aids prescribed by a physician-specialist or audiologist.

High-dose Chemotherapy
A procedure that involves giving patients cell destroying drugs in doses higher than approved by the FDA for therapy. This treatment is often life threatening and requires that bone marrow and/or peripheral blood stem cell transplants, transfusions, drugs or potent antibiotics be given to the patient in order to treat adverse side effects of high dose chemotherapy.

Hospice
A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

Hospital
A facility that provides inpatient diagnostic and therapeutic services 24 hours every day for patients who are injured or acutely ill. The facility provides a professional staff of licensed physicians and nurses to supervise the care of the patients.

Independent Physical Therapist
A licensed physical therapist who is not employed by a hospital, physician or freestanding outpatient physical therapy facility and who maintains an office, separate from a hospital or freestanding outpatient physical therapy facility, with the equipment necessary to adequately provide physician-prescribed physical therapy.

Lobar Lung
Transplantation of a portion of a lung from a brain dead or living donor to a recipient.

Maternity Care
Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.

Maxillofacial Prosthesis
A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

Medical Emergency
A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury.

Medically Necessary
A service must be medically necessary in order to be covered. There are two definitions: one applies to physician services and one applies to hospital services.

- **Medical necessity for payment of physician services:**
  Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type and/or medical specialty, that:

  - the covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician.

  - in the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

Note: In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.

- **Medical necessity for payment of hospital services:**
  A determination that allows for the payment of hospital services when all of the following conditions are met:

  - the covered service is for the treatment, diagnosis of symptoms of an injury, condition or disease.

  - the service, treatment, or supply is **appropriate** for the symptoms and is consistent with the diagnosis.

  - **Appropriate** means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

  For inpatient hospital stays, acute care as an inpatient must by necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

  - The services are not mainly for the convenience of the member or health care provider.

  - The treatment is not generally regarded as experimental or investigational by BCBSM.

  - The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

Member
An individual who is a member of MESSA.

MESSA
The Michigan Education Special Services Association.

Nonpanel Provider
Hospitals, physicians, and other licensed facilities or health care professionals who have not agreed to provide services to members enrolled in MESSA Choices II or do not participate with BCBSM.

Nonparticipating Hospital
A hospital that has not signed a participation agreement with BCBSM or another Blue Cross plan to accept the approved amount as payment in full.

Nonparticipating Provider
Physicians or other health care professionals who have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

Occupational Therapy
A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

- develop, improve, or restore the performance of necessary neuro-muculoskeletal functions affected by an illness or injury or following surgery
- help the patient learn to apply the newly restored or improved function to meet the demands of daily living
- design and use splints, ortheses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raised toilet seats)

Orthotic Device
An appliance worn outside the body to correct a body defect of form or function.

Outpatient Psychiatric Facility
A licensed facility providing outpatient mental health services. It includes centers for mental health care such as hospitals, clinics, day treatment centers and Community Mental Health Centers as defined in the Federal Community Mental Health Centers Act of 1963, as amended.

Outpatient Substance Abuse Treatment Program
A program that provides medical and other services specifically for drug and alcohol abuse on an outpatient basis.

Panel Providers
Hospitals, physicians and other licensed facility or health care professionals who provide services to members enrolled in MESSA Choices II, participate with BCBSM or participate on a per claim basis. Panel providers have agreed to accept our approved amount as payment in full for covered services provided through the MESSA Choices II program.

Pap Smear
A method used to detect abnormal conditions, including cancer of the female genital tract.

Partial Liver
A portion of the liver taken from a brain dead or living donor.

Participating Ambulatory Surgery Facility
A freestanding ambulatory surgery facility that has a signed participation agreement with BCBSM to accept the approved amount for covered services as full payment.

Participating Hospital
A hospital that **has** signed a participation agreement with BCBSM to accept the approved amount as payment in full. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Participating Provider
Physicians or other health care professionals who **have** signed a participation agreement with BCBSM to accept the approved amount as payment in full. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Patient
The member or eligible dependent who is awaiting or receiving medical care and treatment.

Per Claim Participation
Available to nonparticipating providers when they elect to accept the approved amount for specific covered services as payment in full.

Peripheral Stem Cell Transplant
A procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.

Pheresis
Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets, stem cells) after which the remaining components are reinfused into the patient or donor.

Physical Therapy
The use of specific activities or methods to treat disability when there is a loss of neuro-musculoskeletal function due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient's specific muscles or joints to restore or improve:

- muscle strength
- joint motion
- coordination
- general mobility

Physician
A physician is a doctor of medicine (MD) or osteopathy (DO) legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. An optometrist, dentist, podiatrist, or a doctor of chiropractic who is legally qualified and licensed to practice at the time and place services are performed is deemed to be a physician to the extent that the doctor renders services which he/she is legally qualified to perform.

Physician is also a person who is licensed under Act 368 Public Acts of Michigan 1978, as a fully licensed psychologist at the time services are performed. In a state where there are no certification or licensure requirements, a psychologist is one who is recognized as such by the appropriate professional society at the time and place services are performed.

Preferred Provider Organization
A limited group of health care providers who have agreed to provide services to MESSA members enrolled in this PPO program. These providers accept the approved amount as payment in full for covered services.

Primary Payer
The health care coverage plan that pays first when you are provided benefits by more than one carrier.

Prosthetic Device
An artificial appliance that:

- replaces all or part of a body part or
- replaces all or part of the functions of a permanently disabled or poorly functioning body organ

Provider
A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

Psychologist
A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.

Purging
A process in which all abnormal cells in a sample are separated to obtain a clean sample with only normal blood producing cells.

Radiology Services
These include x-ray exams, radium, radon, cobalt therapy, ultrasound testing, radioisotopes, computerized axial tomography scans and magnetic resonance imaging scans.

Referral
The process by which the member's PPO physician directs a patient to a specialist for a specific service or treatment plan.

Residential Substance Abuse Treatment Program
A program that provides medical and other services specifically for substance abusers in a facility that operates 24 hours a day, seven days a week. Treatment in a program is sometimes called "intermediate care".

Respite Care
Relief to family members or other persons caring for terminally ill persons at home.

Screening Services
Procedures or tests ordered for a patient (or for almost all patients of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a routine physical are considered screening.

Semi-Private Room
A hospital room with two beds.

Services
Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat disease, injury, condition or pregnancy.

Skilled Care
A level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be:

- ordered by the attending physician
- medically necessary
- provided by a registered nurse or a licensed practical nurse
- supervised by a registered nurse or physician

Skilled Nursing Facilities
Facilities that provide continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

Specialty Hospitals
Hospitals that treat specific diseases, such as mental illness.

Speech and Language Pathology Services
Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

Stem Cells
Primitive blood cells originating in the marrow, but also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells, and platelets.

Substance Abuse
Taking alcohol or other drugs in amounts that can:

- harm a person's physical, mental, social and economic well-being
- cause a person to lose self-control
- endanger the safety or welfare of others because of the substance's habitual influence on the person

Technical Surgical Assistance
Aid given in a hospital to the operating physician during surgery by another physician not in charge of the case.

Note: Professional active assistance requires direct physical contact with the patient.

Total Body Radiation
A process that uses intensive x-ray treatment to attempt to suppress all existing cancer cells. This treatment also affects normal cells.

We, Us, Our
Used when referring to MESSA, BCBSM and/or BCS.

You and Your
Used when referring to any person covered under the member's coverage.

Section 2: Information About Your Coverage

Who is Eligible for Coverage

The following individuals are eligible to become members of the Michigan Education Special Services Association and may apply for coverage:

- any active associate, service associate, retiree or student member of the Michigan Education Association as defined in the MEA bylaws
- any member of a bargaining unit in an educational agency in which a local association of MEA is the recognized bargaining agent and has negotiated MESSA benefits for its members
- any administrator employed by an educational agency in which a local association of the MEA is the recognized bargaining agent and has negotiated MESSA benefits for its members
- any retiree eligible for benefits under Section 91 of The Public School Employee Retirement Act of 1979, being MCLA 38.1391, as amended
- any other eligible individual as defined in the Michigan Education Special Services Association bylaws as constituted on May 20, 1988, as amended

An application is required if you are:

- enrolling for the first time
- changing coverage for yourself or your dependents
- changing school districts
- covering dependent children age 19 or older

Eligible Dependents

If you are covered, your eligible dependents include:

- your spouse
- your unmarried children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until the end of the calendar year of their 19th birthday
- your unmarried children beyond the end of the calendar year of their 19th birthday to the end of the calendar year of their 25th birthday who are dependent on you for a majority of their support (Dependency for tax purposes, as defined by the IRS, is not required.)

- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this program at the end of the calendar year of their 25th birthday and continuously thereafter) who are mentally retarded or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their mental retardation or physical handicap. (Under no circumstances will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.

- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this program at the end of the calendar year of their 25th birthday and continuously thereafter) who are full time students and dependent on you for a majority of their support.

- your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year, and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

It is your responsibility to notify MESSA and your employer:

- of any change in your employment status

- when you wish to add a spouse and/or dependent(s)

- of any change to a dependent's eligibility for coverage

- when a spouse and/or dependent is no longer eligible as defined above.

Special health care coverage guidelines apply to you and your spouse at age 65 during your active school employment. You should contact your school business office or MESSA for complete details. The Social Security Administration should be contacted regarding Medicare enrollment 120 days prior to attaining age 65.

Note: Life and Accidental Death & Dismemberment Insurance applies to covered members only. It does not apply to dependents.

When Coverage is Effective

The following information details the guidelines for your effective date of coverage:

- If you are a new employee and enroll for coverage within 31 days following the date you became eligible (your date of employment or the day following completion of the eligibility waiting period, whichever is later), your coverage will be effective on the date you became eligible. This date is verified by your employer.

- During open enrollment, the effective date of coverage for all new applications and coverage changes will be that date approved by MESSA and verified by your employer.

- If your application is submitted at any other time, your coverage will be effective on the first day of the month following approval of your application by MESSA.

- If you are absent from work because of bodily injury or sickness on the date your coverage would otherwise become effective, your coverage will not become effective until the day you return to active work. To be considered actively at work for coverage purposes, you must be physically and mentally able to perform your normal duties for a regularly scheduled workday when you report to work.

- Each dependent will be eligible for coverage on the later of the date on which your coverage begins or the date he/she becomes an eligible dependent if enrolled within 31 days. If your application for dependent coverage is submitted at any other time, coverage will be effective on the first day of the month following approval of your application by MESSA.

- If an eligible dependent is confined to a hospital or other medical facility (by reason other than his/her birth therein and the member has active coverage with MESSA at the time of birth) on the date the dependent would normally become eligible for coverage, the dependent's coverage will not become effective until his/her discharge from the hospital or other medical facility, provided your coverage is in effect at that time.

- Each sponsored dependent will be eligible for coverage on the later of the date on which your coverage begins or the first day of January following the date he/she becomes an eligible dependent.

When Coverage Terminates

MESSA Choices II benefits end on the first day of the calendar month in which a covered individual becomes age 65. On that date, you will be enrolled in the MESSA Limited Medicare Supplemental Plan. If, however, you continue active school employment and remain a MESSA member, your MESSA Choices II coverage and that of your covered dependents will not end until the first of the following circumstances occurs:

Termination of Employment - Coverage will end on the last day of the month in which you terminate employment.

Nonpayment of Contributions - Coverage will end on the last day of the month preceding the month for which the required contribution has not been remitted to MESSA.

Termination of Employer's Participation - Coverage will end on the last day of any month in which your employer ceases to participate under the MESSA/BCBSM/BCS Group Agreement.

Member No Longer Eligible - Coverage will end on the last day of the month in which a member no longer meets the eligibility criteria described in this section.

Dependent No Longer Eligible - Coverage will end on the date a dependent no longer meets the eligibility criteria described in this section.

Note: An ex-spouse may be continued beyond the date of the divorce if the divorce decree stipulates that the member must provide health coverage for his/her ex-spouse. The member will be required to pay the sponsored dependent contribution in addition to his/her normal contribution. Coverage will terminate on either the date the ex-spouse remarries or the date which is 12 months following the date of the divorce, whichever is earlier.

Termination of the MESSA/BCBSM Group Agreement and/or the MESSA/BCS Group Policy and/or the Group Policy with Connecticut General - Coverage will end on the date the MESSA/BCBSM Group Agreement and/or the MESSA/BCS Group Policy and/or the Connecticut General Group Policy terminates.

Medicare Elected as Primary - If you continue active school employment beyond age 65 and elect Medicare as your primary coverage, your coverage under MESSA Choices II will end on the first day of the month following the date of your election. A spouse age 65 or older who obtains coverage through an active employee may also elect Medicare as his/her primary coverage; the spouse's coverage under MESSA Choices II Program will end on the first day of the month following such an election.

Note: If you cease active work or leave school employment, inquire as to what arrangements, if any, may be made to continue coverage. Also see "Continuation of Coverage" below. Contact MESSA for additional information.

Continuation of Coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act)
COBRA is a federal law that extends the opportunity for group coverage to members who no longer qualify as members of a group. For COBRA purposes, coverage includes the benefits described in this coverage booklet. The continued coverage is available to covered employees, their spouses, and dependent children (all of whom are referred to as "qualified beneficiaries") whose coverage would otherwise end upon the occurrence of any of the following "qualifying events":

- the death of the covered employee
- the termination (other than by reason of gross misconduct) or reduction of hours of the covered employee's employment
- the divorce or legal separation of the covered employee
- a dependent child ceasing to be a dependent child under the generally applicable provisions of the program
- the covered employee becoming entitled to Medicare benefits.

We have listed the most common qualifying events.

You and your dependent(s) must pay the required contribution, if any, for the continued coverage. Your employer will inform you of the monthly contribution to be paid. In the event of your divorce or legal separation or if your dependent child ceases to be eligible as a dependent under the program, you or your dependent must notify the plan administrator (your employer) of the occurrence of the qualifying event within 60 days after it occurs or the date coverage is terminated, whichever is later.

Continued coverage must be elected within an election period that cannot end before the date which is 60 days after the later of (1) the date coverage is terminated and (2) the date you receive notice of the right to continue coverage.

The continued coverage will begin on the date of the qualifying event and end when the first of the following events occurs:

- the date which is 36 months (18 months in the case of the termination or reduction in hours of the covered employee's employment) after the qualifying event

Note: You, or a covered dependent, may be able to extend continuation of coverage from 18 months to 29 months if the Social Security Administration has determined (or determines) that you, or a covered dependent, has been totally disabled since the date of eligibility for continuation coverage or within 60 days following that date. Continuation coverage may be extended only if the Social Security Administration makes its determination within 18 months of the qualifying event.

- the first day for which timely payment for the qualifying beneficiary is not made to the plan
- the date upon which your employer terminates participation under the MESSA/BCBSM/BCS Group Agreement/Policy that provides the benefits described in this coverage booklet.
- the date the qualified beneficiary becomes covered under any other group health plan that is not maintained by your employer (other than a plan containing limitations or exclusions with respect to a pre-existing condition of the qualified beneficiary)
- the date the qualified beneficiary becomes entitled to benefits under Medicare.

If during an established COBRA period of continuance, another qualifying event occurs that also entitles you or your dependent(s) to COBRA continuation, coverage may be extended, but not beyond the date which is 36 months from the date of the initial qualifying event.

If a qualified beneficiary's continued coverage ends due to the expiration of the 36-month, 29-month, or 18-month maximum continuation period, the qualified beneficiary may enroll in any conversion health plan available. (See "Conversion Privilege" below.)

Your employer can provide you with more information concerning how these COBRA health plan continuation rights apply to you and your family members and how to elect continued coverage under the plan in the event of a qualifying event.

Conversion Privilege

When you are no longer eligible for the MESSA Choices II program through your employer, an individual health care plan is available to you through BCBSM/BCS. Your benefits will change and coverage will be limited to your immediate family. There will be no interruption of coverage, provided you pay the premiums when due. To ensure continuous coverage, you must make application within 31 days from the date your coverage terminates with your employer. Contact MESSA for additional information on how to apply for this coverage.

Surviving Family

Your dependents who are covered under the MESSA Choices II program on the date of your death, should contact MESSA for information regarding continuation of coverage.

Life and Accidental Death and Dismemberment (AD&D) Benefits

Connecticut General Life Insurance Company

hereby certifies that members of

Michigan Education Special Services Association

(called the Policyholder)

who are insured under Group Policy No. 57200 are subject to the terms and conditions of this policy and are insured for the benefits described in the pages of this booklet.

Connecticut General Life Insurance Company, called Connecticut General, insures the life and accidental death and dismemberment benefits. Connecticut General will determine all benefit payments according to the provisions described in the booklet and the group policy.

The insurance is effective only if the person concerned is eligible, becomes covered and remains covered, in accordance with the terms and conditions of the policy. Coverage applies to members only, as defined on page 11. Dependents are not eligible for either the life insurance or accidental death and dismemberment insurance benefits.

This certificate replaces any other certificate issued to you describing these benefits.

Connecticut General Life Insurance Company

PF75134 amended by PF33333

Section 3: Life and Accidental Death and Dismemberment (AD&D) Benefits

General Provisions

The following will explain the life and AD&D benefits available to you under the MESSA Choices II program.

Beneficiary

The beneficiary for your life and AD&D insurance for loss of life will be the person you name as shown in the records kept on the group insurance policy. If there is no named beneficiary living at your death, a lump sum will be paid to the first surviving class that follows;

- spouse;
- children;

- parents;
- brothers and sisters.

If none survives, the benefit will be paid to your estate in a lump sum.

If the beneficiary is a minor with no legal guardian, the minor's share may be paid to the adult (or adults) who, in Connecticut General's opinion, has assumed custody and support of the minor. Payment may be made at a rate of up to $50 a month.

If you die after having applied to convert your group life insurance to an individual insurance policy, the beneficiary named in the individual policy (or in the application for it) will receive any benefits payable under the group insurance policy.

Assignment of Life Insurance

There is only one assignment of your life insurance that is valid. The assignment which:

- states that it is without consideration;
- is made to a named beneficiary;
- is in writing; and
- is accepted by Connecticut General. The assignment may be made without the consent of the beneficiary.

Once an assignment is accepted and while it remains in force, the assignee can exercise any of the rights and privileges under the group policy granted to you (including but not limited to, the conversion privilege), and becomes entitled to receive all claim payments under the insurance assigned with respect to which no beneficiary is designated by the assignee, unless the group policy states differently.

Acceptance of an assignment by Connecticut General shall be without further liability as to any action or any payment or other settlement made by Connecticut General before such acceptance. No assignment by you of your accidental death and dismemberment (AD&D) insurance is valid.

Life Insurance Benefits

The following information will explain your life insurance benefits under the MESSA Choices II program.

How Payment is Made

If you die while covered under the MESSA Choices II program, Connecticut General will pay your beneficiary $5,000. You may choose to have the benefit paid in a lump sum or in installments. You may also change your beneficiary or the method of payment at any time. Contact MESSA Group Services for the appropriate forms.

After your death, your beneficiary may choose the method of payment (if you have not already done so) and name a person to receive the benefit amount which would be paid to the beneficiary's estate in the event your beneficiary died before payment was made.

Continuation of Life Insurance Coverage

While Disabled

If you become totally disabled by injury or disease and you are not able to perform any work for which you are reasonably qualified by learning or experience, your group life insurance coverage will continue for one year from the date the total disability is approved by Connecticut General. You will continue to be covered for a benefit of $5,000.

To be eligible for this **extended coverage**, you must be under 65 years old when you become disabled, and you must remain totally disabled during the year-long period.

Note: If you remain disabled, your contributions will be waived and your coverage will continue.

To minimize the financial burden during your disability, your contributions towards life insurance will be waived.

Your contributions will be waived on the date that Connecticut General receives satisfactory proof of your disability—but no earlier than six months after the onset of the disability. If you remain disabled after the first year of continued benefits, your coverage will continue without any contributions from you as long as you provide Connecticut General with proof of the disability annually, within the three-month period prior to the anniversary of the date the total disability was approved.

If you do any work for pay or gain, you are no longer considered totally disabled.

If you converted to an individual life insurance policy while you were disabled, you must return the individual policy to Connecticut General with your first proof of total disability. Connecticut General will refund any contributions you made for the individual policy.

Connecticut General maintains the right to have its medical representative examine you to verify the disability, but will not do so more than once a year after your extended coverage has continued for more than two years. There is no cost to you for medical exams requested by Connecticut General.

If You Die While Disabled

If you die while you are still disabled, your beneficiary will receive the life insurance benefit as soon as proof of your continued disability is received by Connecticut General.

If you die after you have converted your policy, any amount paid under the individual policy will be deducted from the amount due under the group life insurance policy and any contributions to the individual policy will be refunded to your beneficiary when the policy is returned.

When Your Extended Coverage Ends

Your extended coverage will end if you:

- cease to be totally disabled;
- fail to give required proof of your disability;
- fail to submit to a medical exam.

When your extended coverage ends, you can convert to an individual policy under the same conditions that would apply if you left school employment. See "After Employment Ends" below.

After Employment Ends

You have 31 days to convert to an individual policy and pay your first contribution. You won't need to take a health exam, but you will be limited in your choice of policy. The individual policy amount must be no greater than $5,000, and you cannot convert to a policy that provides term insurance, universal or variable life insurance, benefits for disabilities, or extra benefits for accidental death.

If you have merely changed job classification, and are eligible for coverage under another group policy, the amount of your converted individual policy will be reduced by the amount of that group policy.

The individual policy will take effect 31 days after coverage under the group policy ends. Should you die in that period without converting, Connecticut General will pay your beneficiary the amount you could have converted.

As an option to converting, you may continue your group life insurance on a direct payment basis by paying the required contribution for the cost of this insurance. MESSA will mail you a continuation notice for electing this option upon termination of your employment.

Contact MESSA Group Services for additional information.

After your Employer Terminates Participation in the Group Policy, or Coverage for Your Job Classification Ends

Again, you have 31 days to convert to an individual policy. The same conditions apply as if your employment ended. In addition, you must have been insured by the group policy for at least five years in a row.

The maximum amount of life insurance you may convert is $2,000, less any amount you became eligible for under any other group policy during the 31-day conversion period.

Should you die in the 31-day period after your participation ends, or after the group policy itself terminates, and you were insured by the group policy for the preceding five years, you are still covered. Connecticut General will pay your beneficiary the group life insurance policy amount, less the amount of any other group policy under which you became insured during that 31-day period, up to a maximum of $2,000.

Even if you should die within the 31-day conversion period without converting, Connecticut General will still pay your beneficiary the amount you could have converted.

Accidental Death and Dismemberment (AD&D) Benefits

The following information will explain your AD&D benefits under the MESSA Choices II program.

What is Covered

As a MESSA member you have $5,000 of AD&D insurance. If, while you are covered, you receive a bodily injury and experience a loss, Connecticut General will pay you according to the

schedule listed under "How AD&D Benefits are Paid."

In order to receive an AD&D benefit, the loss must:

- be caused exclusively by external and accidental means;
- be the direct result of the injury, independent of all other causes;
- occur within 180 days from the date of the injury.

All benefits other than loss of life will be paid to you. If you die, the benefits will be paid to your beneficiary. See "General Provisions" in this section for details about your beneficiary.

You may change your beneficiary at any time. Contact MESSA Group Services for the appropriate forms.

How AD&D Benefits are Paid

For the Loss of:	**You Receive:**
Life Both hands or both feet Sight in both eyes Any two or more: one foot one hand sight in one eye	100% of AD&D Benefit ($5,000)

For the Loss of:	**You Receive:**
One hand, or One foot, or Sight in one eye, or Speech, or Hearing	50% of AD&D Benefit ($2,500)

For the Loss of:	**You Receive:**
Thumb and index finger of the same hand	25% of AD&D Benefit ($1,250)

The following defines what is considered a loss:

Definition	
Loss of one hand or foot	Loss by cutting off at or above the wrist or ankle joint
Loss of sight, speech, or hearing	Total loss that cannot be recovered
Loss of thumb and index finger	Loss by cutting off at the proximal phalangeal joint

When You Suffer More Than One Loss

If you have more than one loss due to one accident, you will receive payment only for the loss with the largest benefit payout. You will only be paid for the loss resulting from the accident in

question, regardless of any previous loss.

Losses Not Covered

No benefits will be paid for losses resulting from, or caused directly or indirectly by:

- bodily or mental infirmity;
- disease or illness of any kind;
- self-destruction or intentionally self-inflicted injury;
- taking part in an insurrection or riot, war or act of war, service in any military or naval organization, unless the injuries are sustained while off-duty;
- taking part in, or as a result of taking part in, a felony.

When Coverage Ends

AD&D coverage ends when your school employment ends or when you reach 65 years of age, whichever happens last. If your school employment ends before your reach 65, you must pay the required contribution for the cost of this insurance to continue this coverage until you reach age 65.

Health Care Benefits

Underwritten By
Blue Cross Blue Shield of Michigan
(BCBSM)
and
BCS Life Insurance Company
(BCS)

Section 4: What You Must Pay

This section explains the deductibles and copayments you must pay each calendar year. It also explains the annual and lifetime maximums we will pay.

Panel Providers

Deductible Requirements
You pay no deductible for covered services provided by panel providers.

Copayment Requirements
You are required to pay the following flat dollar copayments or percentage copayment for each covered service provided by panel providers:

- $25 copayment per visit for facility services in a hospital emergency room. This copayment is waived if the patient is admitted or if the services are required to treat an accidental injury.
- $5 copayment per office, outpatient, home medical care visit or office consultation. This copayment requirement is **not** imposed for:
  - first aid and medical emergency treatment in a physician's office
  - pre and post natal care
  - allergy testing and therapy
  - immunizations and therapeutic injections
- $10 copayment for urgent care visits. This copayment is waived if services are required to treat a medical emergency or accidental injury.
- 10 percent copayment of the approved amount for private duty nursing care, outpatient substance abuse treatment and outpatient mental health care (including psychiatric testing).

When you receive covered services from a panel provider, we will pay the approved amount directly to the provider. You are responsible only for the flat dollar copayments and percentage copayments described in this coverage booklet.

Nonpanel Providers

Deductible Requirements

You are required to pay the following deductible each calendar year for covered services provided by nonpanel providers:

- $250 for one member
- $500 for the family (when two or more members are covered under your contract)
  - two or more members must meet the family deductible
  - if the one member deductible has been met, but not the family deductible, we will pay covered services only for that member who has met the deductible
  - covered services for the remaining family members will be paid when the full family deductible has been met.

Note: Deductibles paid in one calendar year are not applied to the deductible you must pay the following year.

When you receive covered services from a nonpanel provider, you will be required to pay a deductible for most covered services. However, you will not be required to pay a deductible if:

- a panel provider refers you to a nonpanel provider
- you receive services for the initial exam to treat a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- you receive services from:
  - home health care agencies
  - hospice programs
  - ambulance providers
  - durable medical equipment suppliers
  - prosthetic and orthotic suppliers
  - freestanding physical therapy facilities
  - ambulatory surgery facilities
  - skilled nursing facilities

Copayment Requirements

You are required to pay the following flat dollar copayment or percentage copayments for each covered service provided by a nonpanel provider:

- $25 copayment for facility services in a hospital emergency room. This copayment requirement is waived if the patient is admitted or if the services are required to treat an accidental injury.

- 10 percent copayment of the approved amount for private duty nursing services.
- 20 percent of the approved amount for most other services, including inpatient and outpatient mental health care (including psychiatric testing) and substance abuse treatment, which contributes toward your annual copayment maximum for nonpanel services.

Note: Mental health care and substance abuse treatment have special payment limitations. See Section 6 of your certificate for details.

Your annual copayment maximum for nonpanel services is:

- $2,000 for one member
- $4,000 for two or more members

Once the annual copayment maximum is met, no more copayments will be required for the remainder of the year, except that copayments continue to be required for private duty nursing.

Note: Copayments for private duty nursing are not applied to your annual copayment maximum.

You will not be required to pay a percentage copayment if:

- a panel provider refers you to a nonpanel provider
- you receive services for the initial exam to treat a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- you receive services from:
  - home health care agencies
  - hospice programs
  - ambulance providers
  - durable medical equipment suppliers
  - prosthetic and orthotic suppliers
  - freestanding physical therapy facilities
  - ambulatory surgery facilities
  - skilled nursing facilities

We will not apply charges toward your deductible or copayment requirements for panel and nonpanel providers that:

- exceed our approved amount
- are for noncovered services and limited covered services (i.e., accidental injuries and medical emergencies), or
- apply to deductibles or copayments paid under other health care coverages.

Care Outside of Michigan

If you or a covered dependent receives treatment in an accredited non-Michigan hospital, just show your MESSA/BCBSM identification card. The hospital billing office will send the bill directly to MESSA or the local Blue Cross plan.

If you or a covered dependent receives any other type of service performed by a physician practicing outside of Michigan, the physician's billing office will either bill the local Blue Cross plan directly or provide you with an itemized statement or receipt. Send the itemized statement to MESSA. If written authorization is attached to the statement, MESSA will pay the provider, otherwise, payment will be sent to you.

Section 5: Coverage for Hospital and Facility Services

Coverage is available for:

- Inpatient Hospital Services
- Outpatient Hospital Facility Services
- Human Organ Transplants
- Bone Marrow Transplants
- Freestanding Ambulatory Surgery Facility Services
- Home Health Care Services
- Hospice Services
- Skilled Nursing Facility Services

All services must be prescribed by your physician and determined to be medically necessary. See Section 1 for definitions.

See Section 4 for further details about "What You Must Pay."

Inpatient Hospital Benefits

After you have followed the Pre-Admission Review (PAR) requirements explained below and your admission has been determined by MESSA to be medically necessary, benefits will be paid as indicated under "Inpatient Hospital Benefits." If you do not satisfy the following requirements, you may have additional financial responsibilities in excess of the deductible and copayments.

Pre-Admission Review (PAR)

Panel and Participating Hospitals
The hospital will take care of this requirement for you.

Nonparticipating Hospitals
If you are using a nonparticipating hospital, then you, your doctor or hospital must request prior approval for all elective (non-emergency) admissions to a hospital.

- A completed Pre-Admission Review form must be sent to MESSA at least two weeks before the scheduled admission. Mail it to MESSA at:

  Michigan Education Special Services Association
  Pre-Admission Review
  P.O. Box 2560
  East Lansing, MI 48826-2560

  OR

- You, your doctor or hospital must call MESSA for a review of the admission request. The toll-free telephone number is 1.800.336.0022. MESSA will review your doctor's request and determine whether your admission will be authorized under BCBSM's medically necessary criteria. MESSA will determine the number of days initially approved and will send written notice of the decision to you, your doctor and the hospital.

Emergency Hospital Admissions
Advance approval is not required for emergency admissions. However, your doctor or hospital must notify MESSA within 48 hours of the start of your admission, or within 72 hours of the start of the admission if it begins on a weekend (5 p.m. Friday through 9 a.m. Monday) or a holiday. MESSA will then determine the number of days to be authorized under BCBSM's medically necessary criteria, and will provide written notice to you, your doctor and the hospital.

Requesting Additional Days
The hospital or your doctor can request additional days beyond the days initially approved. Whenever possible, such requests should be made up to 48 hours before the end of the days initially approved. MESSA will let you, your doctor and the hospital know if the request for additional days has been approved.

If the extension is **not** approved and your hospital admission exceeds the number of days determined by MESSA to be medically necessary, you will be responsible for the following:

- charges for inpatient hospital room and board
- other charges for medical services and supplies furnished by the hospital
- physician charges for inpatient hospital visits
- any other charges related to the days not approved

Requesting Approval After Admission
If the hospital or your physician fails to get approval before you are admitted, MESSA will still review a request, either while you are in the hospital or after your discharge. The disadvantage is that you will not know before the admission whether the care is covered.

Appealing a Non-Approved Admission or Extension
Your doctor may appeal all decisions by requesting a review by MESSA.

Receiving Services Without Prior Approval
If the required Pre-Admission Review is not obtained, those covered charges stated above which are determined to be medically necessary for inpatient hospital confinement and physician in-hospital visits will be reimbursed at 80 percent of the amount, after deductible, that would otherwise have been paid in accordance with the MESSA Choices II plan and Pre-Admission Review. You will be responsible for the remaining 20 percent. The disadvantage to receiving services without prior approval is that you will not know before the admission whether care is covered.

If you were given prior notice of MESSA's denial of benefits before the admission began, or if you accepted such liability by entering into a prior agreement with your doctor, you will be responsible for all charges (both hospital and doctor) resulting from the admission.

Outpatient Hospital Facility Services

When performed in the outpatient department of a hospital, benefits include:

First Aid Emergency Care
Outpatient treatment due to an accidental injury is paid at 100 percent of the approved amount for hospital and/or doctor services. Benefits include the initial examination and treatment.

Medical Emergency Care
The initial examination and treatment of conditions determined to be medical emergencies are payable when provided in an outpatient department of a hospital, subject to a flat dollar copayment of $25 per visit.

Note: This $25 copayment is not applied if:
- *the patient is admitted*
- *services were required to treat an accidental injury*

Scheduled Outpatient Surgery
Hospital charges for covered scheduled outpatient surgery are paid according to the provisions in Section 7.

Human Organ Transplants

Services for kidney, cornea and skin transplants are covered as standard benefits provided by this certificate. They are not subject to guidelines outlined in this section.

Human organ transplant services must be preapproved. The preapproval process allows a provider to know if we will cover the proposed human organ transplant surgery, related services, hospital admission and length of stay at the hospital before treating you. If preapproval is not obtained before you receive the human organ transplant services described below, they will not be covered.

A decision to preapprove services will be based on the information your provider submits for review. BCBSM/MESSA reserves the right to request other information to determine if preapproval is approriate.

When performed in a BCBSM-designated facility, we pay the approved amount, minus required deductible and copayments for transplantation of the following human organs:

- heart
- heart-lung(s)
- liver
- lung(s)
- pancreas
- partial liver
- lobar lung
- simultaneous pancreas-kidney
- small intestine (small bowel), pediatric only
- combined small intestine-liver, pediatric only

Note: A small bowel transplant is considered medically necessary in pediatric patients with short bowel syndrome who have established long-term dependency on total parenteral nutrition and have developed severe complications due to parenteral nutrition.

A small bowel transplant is considered experimental for adults. See the "General Conditions" section of this coverage booklet for guidelines related to experimental procedures.

Because of ongoing medical research and technological advances, procedures that have been considered experimental may become generally accepted, standard treatments. To be covered under this plan, these procedures must be recognized as a standard of care and be medically necessary for the illness or injury being treated.

All payable human organ transplant services, except anti-rejection drugs, must be provided during the benefit period that begins five days before, and ends one year after, the organ transplant.

When directly related to the transplant, we pay for:

- facility and professional services
- anti-rejection drugs and other transplant-related prescription drugs, as needed. Our payment will be based on the amount we determine to be reasonable and necessary and is subject to the **$1,000,000** lifetime maximum for the human organ transplant benefit under this coverage booklet
- medically necessary services needed to treat a condition arising out of the organ transplant surgery **if** the condition:
  - occurs during the benefit period and
  - is a direct result of the organ transplant surgery

Note: We will pay for any medically necessary service needed to treat a condition as a result of the organ transplant surgery, if it is a benefit under any of our certificates.

We also pay for the following:

- up to $10,000 for travel, meals and lodging. This includes:
  - cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living related donor)
  - reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient
  - reasonable and necessary costs of meals up to $30 per day for the patient and person(s) eligible to accompany the patient
- cost of acquiring the organ. This includes:
  - surgery to obtain the organ
  - storage of the organ
  - transportation of the organ
  - payment for covered services for donors if the donor does not have transplant services under any health care plan

Note: We will pay what we determine to be reasonable and necessary for the cost of acquiring the organ. The total payment for all services combined for each organ transplant will not be more than the $1,000,000 lifetime maximum for the specified human organ transplant benefit under this coverage booklet.

Bone Marrow Transplants

We pay for:

- autologous bone marrow and peripheral blood stem cell transplants (including harvesting and storing the marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year)
- allogeneic bone marrow and peripheral blood stem cell transplants (including harvesting the marrow and/or peripheral blood stem cells) if the donor is:
  - a first degree relative and matches at least four of the six important HLA genetic markers with the patient or
  - not a first degree relative and matches five of the six important HLA genetic markers with the patient
- high-dose chemotherapy
- total body radiation

- blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)
- a search of the National Bone Marrow Donor Program Registry for a donor

Note: A search will begin only when the need for a donor is established.

- infusion of colony stimulating growth factors
- hospitalization in an intensive care unit, special care unit or private room
- services you receive as a donor of bone marrow and/or peripheral blood stem cells (e.g., infusion of growth stimulating factors, hospitalization, blood tests and harvesting as detailed above)

Allogeneic bone marrow and peripheral blood stem cell transplants are covered to treat:

- acute lymphocytic leukemia
- acute non-lymphocytic leukemia
- aplastic anemia
- beta thalassemia, major
- chronic myeloid leukemia
- Hodgkin's disease (relapsed and stage III or IV)
- Hurler's syndrome
- myelodysplastic syndromes
- neuroblastoma (stage III or IV)
- non-Hodgkin's lymphoma (intermediate or high grade)
- osteopetrosis
- severe combined immune deficiency disease
- Wiskott-Aldrich syndrome
- sickle cell disease (when complicated by stroke)
- myelofibrosis

Autologous bone marrow and peripheral blood stem cell transplants are covered to treat:

- acute lymphocytic leukemia
- acute non-lymphocytic leukemia
- germ cell tumors of the ovary, testis, mediastinum,retroperitoneum

- Hodgkin's disease (state III or IV)
- neuroblastoma (stage III or IV)
- non-Hodgkin's lymphoma (intermediate or high grade)
- metastatic breast cancer (stage IV)
- multiple myeloma
- primitive neuroectodermal tumors
- Ewing's sarcoma
- medulloblastoma
- Wilms' Tumor

Note: We also pay for any services related to or for high-dose chemotherapy, total body radiation, allogeneic or autologous bone marrow and/or peripheral blood stem cell transplants to treat conditions other than those listed above if the services are not otherwise excluded from coverage as experimental or investigational.

We also pay for antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Because of ongoing medical research and technological advances, procedures that have been considered experimental may become generally accepted, standard treatments. To be covered under this plan, these procedures must be recognized as a standard of care and be medically necessary for the illness or injury being treated.

We do not pay for:

- any services related to or for allogeneic bone marrow transplants and/or peripheral blood stem cell transplants when the donor does not meet the HLA genetic marker matching requirements
- purging of and/or positive stem cell selection of:
  - bone marrow stem cells or
  - peripheral blood stem cells
- harvesting and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplant within one year
- health care services provided by persons who are not legally qualified or licensed to provide such services
- services that are not medically necessary ("Medically Necessary" is defined in Section 1)
- any facility, physician or associated services related to any of the above named exclusions

Ambulatory Surgery Facility Services

We pay for medically necessary facility services provided by an ambulatory surgery facility. The services must be directly related to performing ambulatory surgery.

Home Health Care Services

This program provides an alternative to long-term hospital care by offering coverage for care and services in the patient's home. Services must be prescribed by the patient's attending physician, be medically necessary and be provided by a home health care agency.

To qualify for this benefit, a covered person must have physician certification assuring home health care is a medically necessary alternative to hospital confinement. The services are available based on a 30-day benefit period. The benefit period may be renewed with certification from your physician. Covered services include:

- part-time skilled nursing care (full-time care is not covered) rendered by a registered nurse or a licensed practical nurse
- medical care rendered by a home health aide or nurse's assistant under the direct supervision of a registered nurse
- medical supplies other than drugs and medicines requiring a written prescription from a physician
- rental of medical equipment (not to exceed purchase price)
- physical therapy, occupational therapy, speech therapy, social service guidance and nutritional guidance provided by a home health care agency
- hospital services and supplies related to the injury or illness which required or would have required the hospital confinement and would normally be provided by the hospital

Note: Meals, general housekeeping services and custodial care are not covered.

Hospice Services

Hospice benefits allow covered terminally ill patients to spend their final days at home or in a special hospice facility as approved by MESSA/BCBSM. You may apply for hospice benefits after discussion with, and with a referral by your attending physician.

Benefits become available when:

- the covered patient is terminally ill with a life expectancy of six months or less as certified in writing by the attending physician or
- you are a covered dependent of the terminally ill patient meeting the requirements described above.

The following services for the patient will be paid up to a maximum which is reviewed and adjusted periodically (call MESSA for information about the current maximum amount). All of the following services are covered:

- inpatient care provided by a hospice inpatient unit, hospital or skilled nursing facility contracting with the hospice program
- occasional respite care of up to five days duration, within a 30 calendar day period, to relieve family members or other persons caring for the member at home
- part-time skilled nursing care (full-time not included) by a registered nurse or licensed practical nurse
- medical supplies
- rental of medical equipment (not to exceed purchase price)
- physical therapy, emotional support services, homemaker or home health aide services (provided by or on behalf of the hospice program)
- charges for physician services
- bereavement counseling for the family after the patient's death.

  This bereavement counseling benefit ends:

  - 12 months after the date of the first family unit counseling session
  - 18 months after the date the hospice benefit began or
  - upon payment of the maximum hospice benefit payment, whichever occurs first

See Section 4 for details about your copayment responsibilities.

Skilled Nursing Facility Services

A skilled nursing facility provides comprehensive inpatient care of either a short or extended duration and is operated under the general direction of a licensed physician. This program provides benefits for skilled care in a skilled nursing facility only for the period that is necessary for the proper care and treatment of the patient, up to a maximum of 120 days per member, per calendar year. *This benefit does not include custodial or domiciliary care.*

Section 6: Mental Health and Substance Abuse Services

All services must be medically necessary and provided by an eligible provider.

Eligible Providers

The network contains the following mental health and substance abuse treatment provider types who have agreed to provide services to MESSA members enrolled in MESSA Choices II:

- Licensed physicians
- Psychiatrists
- Fully licensed psychologists
- Certified clinical social workers*
- Certified nurse specialists in mental health*
- Hospital-based mental health facilities
- Outpatient psychiatric care facilities
- Hospital-based and freestanding residential substance abuse facilities
- Outpatient substance abuse treatment programs

**Services from these providers are covered only if performed in a panel outpatient psychiatric care facility or under the direct supervision of an MD or DO.*

What You Must Pay

Panel Provider

Inpatient Care
All care must be medically necessary and your panel provider must preapprove all services. Care is payable as follows for a panel hospital, residential substance abuse treatment facility or panel halfway house:

- no deductible
- 100 percent of the approved amount
- no limit on hospital days as long as days are authorized

Outpatient Care
All care must be medically necessary. Care is payable as follows for a licensed mental health facility, substance abuse facility or outpatient treatment facility by an eligible provider:

- no deductible
- 10 percent copayment of the approved amount for each visit

- A combined limit of 50 panel and nonpanel visits per member, per calendar year for outpatient mental health care (psychiatric testing does not count toward this visit maximum)

Nonpanel Provider

Inpatient Care
Inpatient care must always be medically necessary. Care is payable as follows for services provided in a nonpanel hospital or residential substance abuse treatment facility:

- 20 percent of the approved amount for each visit, which contributes toward your annual copayment maximum for nonpanel services
- Services are subject to the nonpanel deductible

Outpatient Care
Medically necessary outpatient care in a licensed mental health facility, substance abuse facility or outpatient treatment facility by an eligible provider is payable as follows:

- 20 percent copayment of the approved amount (for each visit), which contributes toward your annual copayment maximum for nonpanel services
- Services are subject to the nonpanel deductible
- A combined limit of 50 panel and nonpanel visits per member, per calendar year for outpatient mental health care (psychiatric testing does not count toward this visit maximum)
- Unlimited visits for outpatient substance abuse treatment when provided in a licensed substance abuse facility

Section 7: Coverage for Physician and Other Professional Provider Services

This section describes physician and other professional provider services covered by your coverage booklet.

All services must be medically necessary to be covered.

See Section 4 for details about your copayment responsibility.

Physician Services That are Payable

Other than voluntary sterilization, screening mammography and preventive care services, covered services must be medially necessary to be paid. (Medically Necessary" is defined in Section 1.)

We pay our approved amount for the physician services described in this section (deductible and copayment information is in Section 4.)

Surgery

Payment includes:

- physician's surgical fee
- pre- and post-surgery medical care provided by the surgeon while the patient is in the hospital
- visits to the attending physician for the usual pre- and post-surgery care

Multiple Surgeries

When multiple surgeries are performed on the same day by the same physician, payment is as follows:

- multiple surgeries through the same incision by the same physician are considered related; therefore, we will pay our approved amount of the more difficult procedure
- multiple surgeries through different incisions by the same physician are paid as follows:
  - our approved amount for the more costly procedure and
  - 50 percent of our approved amount for the less costly procedure(s)

Note: Determination of the more or less difficult procedure is based on the BCBSM approved amount.

Panel and participating providers follow these guidelines and agree to accept our payment as payment in full. However, nonpanel and nonparticipating providers may bill you for the difference between the approved amount, less any required deductible and copayments, and billed charges.

Dental Surgery

Dental surgery is payable **only** for:

- multiple extractions or removal or unerupted teeth, alveoloplasty or gingivectomy performed in a hospital when the patient has an existing concurrent hazardous medical condition
- surgery on the jaw joint
- arthrocentesis performed for the reversible or irreversible treatment of jaw joint disorders

Anesthesia

Services for giving anesthesia to patients undergoing covered services are payable to either:

- a physician, other than the physician performing the service
- a physician who orders and supervises anesthetist services

If the operating physician gives the anesthesia, the services are included in our payment for the surgery.

We do not pay for local anesthetics.

Cosmetic Surgery

Cosmetic surgery is payable for the following conditions:

- the correction of conditions resulting from an accidental injury
- an illness (or accidental injury) if the injury occurred or the illness was contracted while covered under this plan; and only if coverage has been continuous since the date of the accidental injury or the date the illness was contracted

Note: Cosmetic surgery for beautifying purposes primarily performed to improve appearance is not covered.

Technical Surgical Assistance (TSA)

In some cases, an additional physician provides technical assistance to the surgeon. Certain procedures, when performed in a hospital inpatient or outpatient setting or in an ambulatory surgery facility, are identified as requiring TSA. A list of covered and approved TSA surgeries and additional information is available from MESSA.

We do not pay for TSA:

- when services of interns, residents or other physicians employed by the hospital are available at the time of surgery or
- when services are provided in a location other than a hospital or ambulatory surgery facility

Obstetrics

Prenatal and postnatal services are payable, as are services provided by the physician attending a birth.

Newborn Examination

A newborn's first routine physical exam is payable when provided during the inpatient hospital stay. The exam must be provided by a doctor other than the anesthesiologist or the attending physician.

Note: You must notify us within 30 days of the newborn's birth so we can add the newborn to your contract. You should contact MESSA for additional information.

Medical Care

We pay medical care by your attending physician while you are in the hospital or in a skilled nursing facility.

Inpatient and Outpatient Consultations

We pay for inpatient and outpatient consultations when your physician requires assistance in diagnosing or treating your condition. The assistance is required because of the special skill and knowledge of the consulting physician or professional provider.

We do not pay for staff consultations required by a facility's or program's rules.

Note: Consultations in a panel physician's office are subject to a flat $5 copayment requirement.

Emergency Treatment

We pay for services of one or more physicians for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office.

Note: Deductible and copayments are not required for these emergency panel or nonpanel physician services.

Chemotherapy

We pay for chemotherapeutic drugs that are:

- ordered by a physician for the treatment of a specific type of malignant disease
- provided as part of a chemotherapy program
- approved by the Food and Drug Administration for use in chemotherapy

Note: If the FDA has not approved the drug for the specific disease being treated, BCBSM's Medical Policy Department determines the appropriateness of the drug for that disease by using the following criteria:

  - current medical literature must confirm that the drug is effective for the disease being treated
  - recognized oncology organizations must generally accept the drug as treatment for the specific disease
  - the physician must obtain informed consent from the patient for the treatment

We also pay for:

- physician services for the administration of the chemotherapy drug, **except** those taken orally
- the chemotherapy drug administered in a medically approved manner
- other FDA-approved drugs classified as:
  - anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
  - drugs used to enhance chemotherapeutic drugs

- drugs to prevent or treat the side effects of chemotherapy treatment

- administration sets, refills and maintenance of implantable or portable pumps and ports

End Stage Renal Disease

Physician services are payable for the treatment of ESRD. Services may be provided in the hospital, a freestanding facility (designated by BCBSM to provide such services) or in the home.

Note: Physician services for the treatment of ESRD are covered in coordination with Medicare. It is important that individuals with ESRD apply for Medicare coverage through the Social Security Administration. BCBSM is the primary payer to Medicare for up to 33 months (this includes the three-month waiting period from the time the member is diagnosed with ESRD), if the member is under age 65 and eligible for Medicare because of ESRD.

Therapeutic Radiology

We pay for physician services to treat medical conditions by x-ray, radon, radium, external radiation or radioactive isotopes. The services must be provided by the attending physician or by another physician if prescribed by the attending physician.

Diagnostic Radiology

We pay for physician services to diagnose disease, illness, pregnancy or injury through:

- X-ray
- ultrasound
- radioactive isotopes
- Computerized Axial Tomography
- Magnetic Resonance Imaging for specific diagnoses (you may call MESSA for more information about any restrictions)

The services must be provided by the attending physician or by another physician if prescribed by the attending physician.

Diagnostic Services

We pay for physician services to diagnose disease, illness, pregnancy or injury through tests such as:

- thyroid function
- electrocardiogram
- electroencephalogram
- electromyogram
- nerve conduction
- pulmonary function studies

The services must be provided by the attending physician or by another physician if prescribed by the attending physician.

Diagnostic Laboratory and Pathology Services

We pay for laboratory and pathology exams needed to diagnose a disease, illness, pregnancy or injury. The services must be provided by the patient's attending physician.

Note: If the physician has a laboratory perform these services, it must be a panel laboratory. You will be required to pay the nonpanel copayment when services are provided by a nonpanel laboratory unless:

- standard office laboratory tests approved by BCBSM are to be performed in a panel physician's office in connection with medical care
- the laboratory and pathology services are performed at a hospital on an inpatient or outpatient basis
- the services are performed by any participating substance abuse facility in connection with treatment of substance abuse
- your physician refers you to a nonpanel laboratory for tests (the physician must complete a referral form)
- services are received when you are enrolled for Medicare complementary coverage

Allergy Services

We pay for the following allergy testing and therapy services performed by, or under the supervision of, a physician:

- survey, including history, physical exam and diagnostic laboratory studies
- intradermal, scratch and puncture tests
- patch, photo, insufflate and provocative antigen tests
- procedures to desensitize patients to antigens or haptens
- ultrasound, radiotherapy and radiothermy treatments
- injections of antiallergen, antihistamine, bronchodilator or antispasmodic agents

We do not pay for:

- fungal or bacterial skin tests (such as those given for tuberculosis or diptheria)
- environmental studies, evaluation or control

Chiropractic Services

We pay for spinal manipulation to treat misaligned or displaced vertebrae of the spine. Benefits are provided for a maximum of 38 visits per member, per calendar year. We also pay for x-rays when the diagnosis is an incomplete or partial dislocation in the spinal area.

Note: Services provided by nonpanel providers are combined with services provided by panel providers to meet the 38-visit maximum per year. Copayments are not required when services are provided in a panel physician's office.

Therapy Services

The following therapy services are paid as indicated below if obtained in the outpatient department of a hospital, doctor's office, freestanding facility or by an independent physical therapist. Any therapy must be medically necessary and ordered by, and performed under, the supervision or direction of a legally qualified physician except where noted.

Services are covered up to a **combined** benefit maximum of 60 visits per member, per calendar year, whether obtained from a panel or nonpanel provider. All services provided in any outpatient location (hospital-based, freestanding facility or physician's office) are combined to meet the 60 visit maximum. This benefit maximum renews each calendar year. We recommend that a course of treatment plan be submitted to MESSA before treatment begins.

Benefits include the following:

- Physical Therapy
  Services must be performed by a licensed physical therapist. Therapy must be designed to improve or restore the patient's functional level when there has been a loss in musculoskeletal functioning due to an illness or injury.

- Speech Therapy
  Services must be performed by a registered speech therapist. For non-developmental conditions, treatment is available for both adults and children. For congenital and severe developmental conditions, treatment is available only for children.

The following therapy services are also covered when medically necessary if obtained in an outpatient department of a hospital, doctor's office, or a freestanding facility (unless otherwise stated). See Section 4 for your copayment and/or deductible responsibilities.

- Chemotherapy
  Services for malignancy include the cost of administration, physician services and drugs, except when the treatment or drug is considered experimental or investigational

- Radiation Therapy
  Services for malignancy include x-rays, radium, external radiation or radioactive isotopes, except when the treatment is considered experimental or investigational.

- Vision Therapy
  Services must be performed by a qualified orthoptist to correct defective visual habits. Benefits are not provided for the following:

  · learning disabilities

  · reading problems, including dyslexia

  · reading or educational enhancement

  · non-accommodative strabismus, such as muscle paralysis

- Hemodialysis
  Services are payable when provided in the hospital outpatient department, freestanding facility or in a home hemodialysis program.

Office, Outpatient, and Home Medial Care Visits

We pay for office, outpatient and home medical care visits and consultations.

Note: Only medically necessary services are payable, less applicable deductible and copayments.

The following services will not require any copayments when provided in a panel **or** nonpanel physician's office:

- first aid and medical emergency treatment

The following services will not require any copayments when provided in a panel physician's office:

- prenatal and postnatal care
- allergy services
- immunizations and therapeutic injections

We do not pay for routine eye refractions and audiometric tests, **except** in connection with a medical diagnosis, pregnancy or injury.

Voluntary Sterilization

We pay for voluntary sterilization.

Screening Mammography

Routine mammography screening is available per the following schedule:

- for members between the ages of 35 and 40:
  - one initial routine baseline mammography
- for members age 40 and over:
  - one routine mammography screening per calendar year

Preventive Care Services

We pay for the preventive care services listed below **only** when rendered by panel providers. Preventive care services do not have a dollar maximum per year, but are limited to visit maximums listed below. Copayments are **not** required for these services.

Note: These preventive care services are currently recognized as standard screening procedures as related to health maintenance examinations:

Health Maintenance Examination

One examination per member, per calendar year. This comprehensive history and physical examination includes blood pressure measurement, ocular tonometry (measurement of pressure in the eye), skin exam for malignancy, breast exam, testicular exam, rectal exam and health counseling regarding potential risk factors.

Flexible Sigmoidoscopy Examination

One routine flexible sigmoidoscopy examination per member, per calendar year.

Gynecological Examination

One routine gynecological examination per member, per calendar year.

Routine Pap Smear

Laboratory and pathology services for one routine Pap smear per member, per calendar year when prescribed and performed by a physician.

Fecal Occult Blood Screening

One fecal occult blood screening per member, per calendar year to detect blood in the feces or stool.

Well Baby and Child Care Visits and Immunizations

We pay for well baby and child care visits through age 15 as follows:

- six visits per year for children up to and including age 1
- two visits per year for children up to and including ages 2 through age 3
- one visit per year for children up to and including ages 4 through age 15

Note: We also pay for childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics.

Prostate Specific Antigen Screening

We pay for one routine prostate specific antigen screening per member, per calendar year.

Routine Laboratory and Radiology Services

We pay for the following services once per member, per calendar year, when performed as routine screening:

- chemical profile
- complete blood count or any of its components
- urinalysis
- chest x-ray
- EKG

Section 8: Other Covered Health Care Services

This section describes coverage for other health care services in addition to your facility and physician services.

Dental Services

Dental treatment by a licensed dentist or dental surgeon required because of an accidental injury to sound natural teeth sustained while covered by this plan and only if coverage has been continuous since the date of the accidental injury. Charges by a dental surgeon for the removal of cysts and tumors of the mouth and jaw, and the extraction of impacted teeth are covered.

Durable Medical Equipment

Covered services include the rental cost, not to exceed the purchase price, of durable medical equipment when prescribed by a physician. Benefits include items such as hospital beds and/or wheelchairs. Items such as air purifiers, whirlpools, air conditioners and exercise equipment are not covered.

Medical Supplies

We pay for medical supplies and dressings to be used in your home for the treatment of a specific medical condition.

Medical Weight Loss Treatment

Services performed by a qualified physician for the treatment of morbid obesity are covered. Laboratory services, otherwise covered under the BCBSM plan, ordered for weight loss treatment are also covered. Services are covered up to $625 (this includes all services relating to this diagnosis) per special benefit period. To qualify for this benefit you must be one and one-half times the recommended normal weight. For this condition, a special benefit period begins with the date of the first service and ends three years following that date.

Prescription Drug Benefits

Prescription drug benefits are provided by the MESSA Preferred Rx Program enclosed with this coverage booklet.

Private Duty Nursing Services

We pay for private nursing services in your home or in a hospital if it is:

- skilled care given by a professional registered nurse or licensed practical nurse (requiring, for example: administration of I.V. drugs, ventilator care, etc.)
- medically necessary and required on a 24-hour basis
- given in a hospital, because the hospital lacks intensive or cardiac care units or has no space in such units
- provided by a nurse who is not related to or living with the patient

All progress notes must be submitted with the claim form.

Professional Ambulance Services

Covered services include transportation by professional ambulance to, or from, the nearest hospital equipped to furnish treatment. Within the United States and Canada, benefits are also available for emergency transportation by air ambulance to the nearest hospital equipped to furnish treatment. In all cases, only the patient's transportation is covered. Ambulance transportation is not covered for patient or family convenience or for physician preference.

Prosthetic and Orthotic Devices

Covered services include:

External appliances when they replace an absent part of the body or are intended to correct a defect of form or a function of the body. Appliances must be prescribed by a physician. Repairs or replacements are covered due to wear and tear or natural growth, unless otherwise specified. Benefits include, but are not limited to:

- external breast prostheses following a mastectomy. These include three post-surgical brassieres each calendar year. Additional brassieres are covered if they are required because of:
  - a significant change in body weight or
  - hygienic reason
- artificial eyes, ears, nose, larynx, limbs
- eyeglasses and hearing aids when required because of an accidental injury sustained while covered by this plan
- orthopedic shoes meeting guidelines established by MESSA and BCBSM
- one pair of prescription eyeglasses or contact lenses when required because of:
  - cataract surgery performed while covered by this plan
  - the absence of an organic lens
- prefabricated custom-made orthotic appliances
- external cardiac pacemakers
- maxillofacial prosthesis when BCBSM approved; these devices may be provided by dentists

Medical Case Management (MCM)

This is a benefit designed to assist you if you are diagnosed with a catastrophic illness or injury. It is tailored to meet your unique medical needs. Approval of benefits will be based on an objective review of your medical status, current treatment plan, projected treatment plan, long-term cost implications and the effectiveness of care.

Eligibility for MCM benefits and termination of such benefits is made on a case-by-case basis in accordance with medically necessary criteria. The following medical conditions are examples of what may be considered for MCM:

- pancreatitis
- major head trauma
- spinal cord injury
- amputations
- multiple fractures
- severe burns
- neonatal high-risk infants
- severe stroke
- multiple sclerosis
- amyotrophic lateral sclerosis (Lou Gehrig's disease)
- acquired immune deficiency syndrome (AIDS)
- Crohn's disease
- cancer

Medical Case Management is designed to give you and your family members flexibility and direct involvement in the management of your health care.

Note: Prior approval must be obtained from MESSA before benefits can begin.

If you have any questions regarding MCM, please contact MESSA at 1.800.441.4626.

Section 9: Hearing Care

This section describes coverage for hearing care services. These services require authorization from a physician. No coverage is available for these services without authorization.

Your physician must refer you to a physician-specialist who is board certified as an otologist, otolaryngologist, or otorhinolaryngologist. This physician-specialist determines whether the hearing loss can be offset by a hearing aid. The medical hearing loss examination is covered under the standard medical care benefits of this program and is not included in the maximum benefit limitation of this section.

Covered expenses are:

- An audiometric examination for either ear, or both ears, that

- is prescribed by a physician-specialist;
- is performed by a physician-specialist or audiologist or hearing aid specialist/dealer;
- is performed within six months of a medical hearing loss examination by a physician-specialist;
- includes tests for measuring hearing perception relating to air conduction, bone conduction, speech reception threshold and speech discrimination; and
- includes a summary of findings.

- A hearing aid evaluation test and a conformity test for either ear, or both ears, that:
  - is prescribed by a physician-specialist;
  - is performed following a medical hearing loss examination and an audiometric examination; and
  - is performed by a physician-specialist or audiologist or hearing aid specialist/dealer.
- The actual cost and dispensing fee for a hearing aid for either ear, or both ears. The hearing aid must be:
  - designed to be worn in the ear, behind the ear, or on the body;
  - prescribed by a physician-specialist, audiologist or hearing aid specialist/dealer based on the most recent audiometric examination and hearing aid evaluation test;
  - the make and model prescribed by the physician-specialist, audiologist, or hearing aid specialist/dealer; and
  - provided by a hearing aid specialist or dealer.

There is a plan maximum benefit, adjusted annually based on the Consumer Price Index (CPI), for a hearing aid for each ear during a thirty-six (36) month period. Contact MESSA for information about the contract limit.

Expenses not covered for hearing care include:

- an audiometric examination by an audiologist or hearing aid specialist/dealer that is not prescribed by a physician-specialist;
- hearing aids delivered more than sixty (60) days after coverage ended;
- the trial and testing of different makes and models of hearing aids when such testing is **not** supported by the results of the most recent audiometric examination;
- charges for "spare" hearing aids;
- replacement of hearing aids that are lost or broken, unless this benefit was not used for at least thirty-six (36) months;

- hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements.

Section 10: Exclusions and Limitations

The following exclusions and limitations apply to the MESSA Choices II program. These are in addition to limitations appearing elsewhere in this coverage booklet.

- artificial insemination (including in vitro fertilization) and related services
- treatment of work-related injuries covered by workers' compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by an employer
- charges incurred because of war, declared or undeclared, or any act thereof; or for injury or sickness sustained or contracted in the armed forces of any country; or for services provided in a Veterans Administration Hospital for a covered person with military service-connected disability; or for services, supplies or treatments provided or covered under any governmental plan or law or which would have been furnished without cost in the absence of this coverage or for which the covered person has no legal obligation to pay. However, care and services are payable if federal laws require the government sponsored program to be secondary.
- clerical fees including fees for patient records
- custodial care or basic care that can be provided by someone other than a registered nurse or licensed practical nurse, and which is care provided primarily to assist the person in the activities of daily living
- dental care (except as previously specified) including repairs of supporting structures for partial or complete dentures, dental implants, extractions, extraction repairs, bite splints, braces and appliances and other dental work or treatment
- educational care and cognitive therapy
- eye examinations and eyeglasses or other corrective visual appliances except as specified elsewhere in this Certificate;
- inpatient hospital confinement for the sole testing for, or detoxification of, allergy or allergy-related conditions
- items for the personal comfort or convenience of the patient
- reversal of sterilization procedures and related services
- routine health examinations and related services or routine screening procedures (except as previously specified in Section 7)

- services, supplies, or treatment provided by an immediate relative or by anyone who customarily lives in the member's household

- services and supplies that are not medically necessary according to accepted standards of medical practice including any services which are experimental or investigational

  However, because of ongoing medical research and technological advances, procedures that have been considered experimental may become generally accepted standard treatments. To be covered under this plan, these procedures must be recognized as a standard of care and be medically necessary for the illness or injury being treated.

- surgery for cosmetic or beautifying purposes, except for the correction of conditions resulting from an accidental injury or from an illness

- transplants (other than those previously specified) and all charges arising out of, or associated with, these transplants whether incurred prior to the transplant, at the time of the transplant or subsequent to the transplant

- transportation expenses (except as previously specified) including meals and lodging

- unless otherwise stated in this coverage booklet, any services, treatment, care or supplies provided before the effective date of this coverage, or after the date on which coverage ends, except hospital, skilled nursing facility or residential substance abuse facility services for inpatient admissions that began before, and extended beyond, the date coverage ends

- health care services provided by persons who are not legally qualified or licensed to provide such services

- anti-rejection drugs that do not have Food and Drug Administration approval

- items that are not considered directly related to travel, meals and lodging in conjunction with the initial surgery and hospitalization for a human organ transplant (examples include, but are not limited to, the following: clothing, personal hygiene and related services, car maintenance, babysitters or daycare services and entertainment)

- radiology procedures not directly related and necessary to diagnose the disease, illness, pregnancy or injury (such as an ultrasound solely to determine the gender of the fetus)

- self-administered, over-the-counter drugs

- services, care, supplies or devices not prescribed by a physician

- care and services for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under this coverage booklet

- speech and language pathology services to treat chronic conditions, congenital or inherited speech abnormalities, developmental conditions or learning disabilities except for children

- medical or dental services performed for irreversible treatment of jaw joint disorders, **except** for:

  - surgery on the jaw joint

- diagnostic x-rays
- arthrocentesis

Note: The above restriction applies to any condition causing the jaw joint disorder.

Section 11: General Conditions of Your Coverage

This section lists and explains certain general conditions that apply to your coverage. These conditions may make a difference in how, where and when benefits are available to you.

Contest

A person seeking payment from MESSA/BCBSM/BCS, directly or indirectly, will be furnished with the specific reason(s) for denial of a claim and an explanation of any additional information required from, or on behalf of, the member or dependent for reconsideration of the claim in accordance with MESSA/BCBSM/BCS's claim review procedure.

No action or suit at law may be commenced upon or under this plan until 30 days after notice has been given by the member and/or covered dependent to MESSA/BCBSM/BCS that the reconsidered decision of MESSA/BCBSM/BCS is unacceptable, nor may such action be brought at all later than two years after such claim has arisen.

Coordination of Benefits

This plan requires Coordination of Benefits (COB). COB is used when you are eligible for payment under more than one group health, dental, vision or automobile no-fault insurance plan. This provision is to assure you that your covered expenses will be paid, but that the combined payments of all programs will neither exceed the amount of the actual cost, nor the amount that would have been paid in the absence of other coverage. Under COB, the plan that has the first obligation to pay is called the primary plan.

The guidelines used to determine the primary plan are:

- a group plan or automobile no-fault insurance plan with no provision for the coordination of benefits is always primary; otherwise,
- the plan sponsored by the employer of the person receiving the treatment is primary
- If the claim is for a dependent child covered under two or more plans, the primary plan is that of the parent whose birthday anniversary falls earlier in the year. If the birthdates are identical, the plan that has covered the dependent the longest is primary. However, benefits for a child of divorced or separated spouses are determined in the following order:
  - plan of parent having financial responsibility as designated by court decree;
  - custodial parent's plan;
  - plan of the custodial parent's new spouse (if remarried)
  - plan of noncustodial parent.

- If the primary plan cannot be determined using the above guidelines, then the plan covering the person the longest is primary. The only exception to this rule is that if the coverage is through a member who is retired or laid off, and there is also coverage through a plan not involving a retired or laid off employee, the plan covering the person who is not a retired or laid off employee will be primary.

These COB provisions shall apply to any government or tax-supported program, unless other procedures are required by law. These provisions shall also apply to any benefits or services provided by group student health programs. Except for automobile no-fault insurance coverage, these COB provisions shall not apply to any non-group policy.

Determination of Medical Necessity

There may be instances when benefit restrictions may be waived for in-network services. When medically appropriate, personal care physicians and/or network managers may obtain authorization for covered services beyond our normal payment rules.

Experimental or Investigational Services

We do not pay for experimental or investigational drugs or services. Facility services and physician services, including diagnostic tests, which are related to experimental or investigational procedures, are also not payable.

The BCBSM medical director is responsible for determining whether the use of any service is experimental or investigational. The service may by determined to be experimental or investigational when there is:

- a written experimental or investigational plan by the attending provider or another provider studying the same service, or
- a written informed consent used by the treating provider in which the service is referred to as experimental, investigational or other than conventional or standard therapy, or
- an on-going clinical trial

The BCBSM medical director uses the following information in the evaluation process:

- scientific data such as controlled studies in peer review journals or medical literature
- information from the Blue Cross and Blue Shield Association or other local or national bodies
- information from local and national medical societies, other appropriate professional societies, organizations, committees or governmental bodies
- approval, when applicable, by the Food and Drug Administration, the Office of Health Technology Association and other governmental agencies
- accepted national standards of practice in the medical profession
- approval by the Institutional Review Board of the hospital or medical center

How to Appeal a Claim Denial

Written Complaint

If you do not agree with a claim denial, you may request a review. Your request must be in writing and may include additional facts or comments that support your position. In gathering information to submit with your request, you may obtain copies of pertinent documents if you pay a reasonable copying charge. In some cases, authorization may be needed for the release of confidential information, such as medical records.

Your request for review must be submitted within 90 days after receiving a notice of denial. Please send your request to MESSA Benefits Administration.

A decision will be made by MESSA/BCBSM normally within 30 days of MESSA's receipt of request for review or the date all information required of you is furnished, whichever date is later. The decision will be in writing and will specify the reason for MESSA's/BCBSM's decision.

Managerial-Level Conference

If you are dissatisfied with this decision, you may request a Managerial-Level Conference. The decision resulting from this conference will be rendered not later than 90 days after we receive your initial written request for a review.

If you are dissatisfied with the result of your Managerial-Level Conference, you may request an Informal Review and Determination by the Insurance Commissioner within 120 days of our decision.

Expedited Appeals

If a physician substantiates either orally or in writing that handling your complaint under the above time frames will acutely jeopardize your life, you are eligible for an expedited grievance procedure.

Under this procedure, you will receive an initial determination within 72 hours after your complaint is received. If you want a further review by MESSA/BCBSM, you must request it within three business days after our initial determination. We will give you a final decision within 30 days of the receipt of your request. If either our initial or final determination is made orally, we will provide a written confirmation to you not later than two business days after our oral determination.

If you are dissatisfied with the final determination of your expedited grievance, you may request an Informal Review and Determination by the Insurance Commissioner within 10 days of MESSA's/BCBSM's final decision.

Release of Information

Each person covered under this plan hereby authorizes physicians, hospitals and other providers of service to furnish to MESSA/BCBSM/BCS, upon their request, information relating to services which the covered person is or may be entitled to under this plan. Physicians, hospitals, and other providers of services are authorized to permit MESSA/BCBSM/BCS to examine their records and to submit to MESSA/BCBSM/BCS reports in the detail MESSA/BCBSM/BCS requests.

All information related to treatment of the covered person will remain confidential except for the purpose of determining rights and liabilities arising under this plan or when release is required by law.

Subrogation/Right of Recovery

From time to time, MESSA/BCBSM/BCS may pay claims for which another person or persons, insurance company or other organization (including the covered member's employer or any workers' disability or occupational disease act insurer) is responsible. In these cases, the covered member:

- Grants MESSA/BCBSM/BCS the covered member's right to recover from the responsible party to the extent of MESSA/BCBSM/BCS's payment. MESSA, BCBSM, and BCS have entered into an agreement assigning this right to recovery to MESSA.

- Grants MESSA/BCBSM/BCS a first priority security interest (meaning the right to be paid before any other person, including the covered member) from money recovered on all money that a covered member or a covered member's estate or beneficiaries recover in a verdict, judgment, settlement (regardless of whether the settlement is part of a legal action) or otherwise. Any part of the recovery that is used to pay attorneys' fees and costs will not be subject to MESSA/BCBSM/BCS's lien.

- Agrees to inform MESSA/BCBSM/BCS when the covered member (or a beneficiary) hires an attorney to represent the covered member or beneficiary with respect to a claim for recovery against a responsible party whether that claim is made through litigation or is asserted prior to litigation.

- Agrees to inform any attorney retained of MESSA/BCBSM/BCS's rights under this coverage booklet.

- Agrees to take whatever steps are necessary to assist MESSA/BCBSM/BCS in enforcing its right of recovery, including but not limited to, cooperating in trial preparation, discovery and by testifying in any civil action.

If an overpayment is made by MESSA/BCBSM/BCS for any reason, including but not limited to a payment under any workers' disability or occupational disease act or law, clerical error, or misstatement of fact, MESSA/BCBSM/BCS shall have the right to recover such overpayments from the covered member (or a beneficiary of the covered member's estate) or to deduct such amount of overpayment from future benefit payments.

Time Limit for Legal Action

Legal action against us may not begin later than two years after we have received a complete claim for services. No action or lawsuit may be started until 30 days after you notify us that our decision under the claim review procedure is unacceptable.

What Laws Apply

This contract is subject to and interpreted under the laws of the state of Michigan.

Section 12: How to File a Health Claim

Health care benefits provided by this plan are underwritten by BCBSM and BCS.

- **BCBSM Panel and Participating Provider**
  A hospital, doctor, pharmacy or other provider who contracts with BCBSM or who participates per claim to accept its payments as payment-in-full for covered services less any required copayments or deductibles. It allows the provider to bill BCBSM and to receive payment directly from BCBSM. Reimbursement for services provided by a participating provider is based on BCBSM's approved amount. All paperwork is completed by the provider.

Note: Some nonpanel providers may be BCBSM participating providers.

- **Nonparticipating Provider**
  A hospital, doctor, pharmacy or other provider that does not have a contract with BCBSM. However, a nonparticipating provider may participate on a per claim basis by agreeing to accept BCBSM's approved amount as payment-in-full, less any required deductibles and/or copayments.

If your provider does not agree to participate, covered services will be paid up to the approved amount as determined by MESSA. You will be responsible for any required deductible or copayment and any amount exceeding MESSA's payment determination.

If a hospital or physician does not complete a claim form, you will need to request an itemized statement/receipt and send these bills to MESSA. If written authorization is attached to the bill, MESSA will pay the provider; otherwise, payment will be sent to you.

Your itemized statement/receipt should contain the following information:

- member's name and contract number
- full name of patient and date of birth
- date of service
- type of service (type of procedure performed)
- individual charge(s)
- diagnosis
- provider's name, address, telephone number and tax-payer identification number

Note: If you or your dependent(s) have coverage through another carrier who is primary (see "Coordination of Benefits" in section 11), please send your bill to MESSA along with a copy of the other carrier's explanation of benefits. MESSA will send you a benefit worksheet (explanation of benefits) when a claim is processed. Please keep these worksheets for future reference.

Care Outside of Michigan

If you or a covered dependent receive treatment in an accredited non-Michigan hospital, just show your MESSA/BCBSM identification card. The hospital billing office will send the bill directly to MESSA or the local Blue Cross plan.

If you or a covered dependent receives any other type of service performed by a physician practicing outside of Michigan, the physician's billing office will either bill the local Blue Cross plan directly or provide you with an itemized statement or receipt. Send these itemized statements to MESSA. If written authorization is attached to the statement, MESSA will pay the provider; otherwise, payment will be sent to you.

Additional Information

Certain eligible expenses for services, supplies or care not otherwise covered under the BCBSM coverage are covered under the group policy underwritten by BCS Life Insurance Company. These covered expenses include:

- Manipulations (above BCBSM approved amounts), modalities, and orthotics charged by a chiropractor;
- Outpatient physical therapy billed by a skilled nursing facility;
- Outpatient diabetic education programs approved by MESSA;
- Prescription medication (given in a doctor's office or hospital clinic, out-of-state charges, and member paid charges);
- Vision service;
- TMJ, excluding surgery, anesthesia and x-ray, but including MORA and follow-up treatment;
- Take home drugs, equipment and supplies from hospitals billed along with emergency room treatment, inpatient stay or outpatient scheduled surgery charges;
- Supplier's or supplier's charges for rental of equipment used to do pneumogram at home;
- Consultations with Christian Science Practitioners;
- Copay for physical therapy due to accidental injury;
- Copay on 24-hour observation stay in a participating facility;
- Amounts paid to non-participating providers in excess of BCBSM's approved amounts;
- Out-of-state inpatient bills more than one year old;
- MESSA covered charges that are exclusions in out-of-state Blue Cross plans;
- BCBSM advance payment plan copayments and deductibles;
- COB balances in inpatient out-of-state facilities;
- Hearing care services;
- Michigan MSW who is a member of the Academy of Certified Social Workers; and
- Services of nonpanel outpatient psychiatric care facilities and nonpanel substance abuse treatment programs.

Section 13: How to File a Life and/or Accidental Death and Dismemberment Claim

Life Claims

Contact MESSA Group Services for the forms necessary to file a life insurance claim.

AD&D Claims

Contact MESSA Group Services for the forms necessary to file an AD&D claim. AD&D claims are subject to the following:

Filing Deadline - Written notice of the event upon which the claim is based must be given:

- within 20 days after the loss covered by the policy occurs or begins, or as soon after that time as is reasonably possible.

Notice - Notice must be given by, or on behalf of, the claimant to:

- Connecticut General; or
- MESSA; or
- any other authorized representative of Connecticut General.

The notice must include sufficient information to identify you.

Claim Forms - On receipt of a notice of a claim, Connecticut General or MESSA will give the claimant forms for filing proof of loss. If such forms have not been furnished within 15 days after the giving of the notice, the claimant can fulfill the terms of the policy as to proof of loss by giving written proof of:

- the occurrence of the loss;
- the nature of the loss;
- the extent of the loss.

The proof of loss must be given within the time stated in "Proof of Loss" below.

Proof of Loss - Written proof of the loss must be given to Connecticut General within 90 days after:

- the date of the loss; or
- the end of the period for which Connecticut General is liable.

Late proof will be accepted only if it is furnished as soon as is reasonably possible. In no event, except in the absence of your legal capacity, will proof be accepted later than one year from the time proof would otherwise have been required. Itemized bills may be required as proof of loss.

Time of Payment of Claims - Benefits are payable upon receipt of due proof of loss.

Payment of Claims - Benefits for loss of life will be paid in accordance with the beneficiary named by you, if any, and the terms of the policy in effect at the time payment is made.

Any part of the benefit for which there is no such beneficiary or terms in effect will be paid to your estate. Any other accrued benefits not paid at your death may, at the option of Connecticut General, be paid either to such beneficiary or your estate. Accidental dismemberment benefits will be payable to you.

If any benefit of the policy is payable to your estate, to you or your beneficiary while a minor, or to you or your beneficiary while not competent to give a valid release, Connecticut General may pay such benefit, up to $1,000, to anyone related by blood or by marriage to you or the beneficiary, and deemed by Connecticut General to be justly entitled. Any such payment made in good faith will discharge Connecticut General to the extent of such payment.

Physical Examination and Autopsy - At its own expense, Connecticut General has the right to have a doctor examine any person when it deems it reasonably necessary and there is a claim pending under the policy. Connecticut General also has the right to make an autopsy in the case of death unless the law forbids it.

Legal Actions - No one may sue for payment of a claim less than 60 days after proof of loss is furnished in accord with the terms of the policy. No one may bring suit more than three years after the date proof of loss is required by the policy.

Time Limit on Certain Defenses - A claim will not be denied nor will the validity of coverage be contested because of any statement with respect to insurability made by you while eligible for coverage under the policy, if:

- the insurance has been in force for at least two years before any such contest; and
- the person with respect to whom any such statement was made was alive during those two years.

Change of Beneficiary - You may change your beneficiary at any time; you do not need the consent of the beneficiary to make such change.

Contact MESSA Group Services with any life and/or AD&D claim questions you may have.

MESSA
www.messa.org
1475 Kendale Boulevard, PO Box 2560
East Lansing, MI 48826-2560
800.292.4910

2010 Rate Renewal Exclusively for Leslie Public Schools

Renewal Effective 07/01/2010

Quote #: 307549
MESSA Field Rep: Larry Asher
Date Created: 04/06/2010

PAK C - 139A Teachers

Medical:	MESSA Choices II
OV/UC/ER Copay:	$20/$25/$50
RX Drug Copay:	$10/$20
Deductible:	In-$200/$400, Out-$400/$800
Riders Included:	Adult Immunizations
Composite:	
Dental:	
Class I:	80%
Class II:	80%
Class III:	80%
Annual Max:	$1,000
Class IV:	80%
Lifetime Max:	$1,300
Riders:	2 Cleanings
Composite:	
Vision:	VSP 2
Composite:	
Life Insurance:	$30,000
Rate/$1000	
Volume	
Composite:	
AD&D Coverage:	$30,000
Rate/$1000	
Volume	
Composite:	
LTD Benefit	66 2/3% Max $3,500
Max Monthly Salary:	$5,250
Waiting Period:	90 CDMF
Alcohol/Drug:	2 Year Limitation
Mental/Nervous:	2 Year Limitation
Soc. Sec. Offset:	Family
Pre-Exist Cond.:	Waived
COLA:	No
Rate/$100	
Covered Salary	
Composite:	
Total Composite Rate per Member	
Total Monthly Rate per Member - Single	
Total Monthly Rate per Member - 2-Person	
Total Monthly Rate per Member - Family	

VSP2

Schedule of Benefits

PLAN EFFECTIVE DATE: September 1, 2002

EMPLOYEES ELIGIBLE: All employees of a participating Employer.

DEPENDENTS ELIGIBLE: All dependents as defined.

VISION CARE BENEFITS FOR YOU AND YOUR DEPENDENTS:

VSP PANEL PROVIDER

Benefits for examinations, lenses or frames which are Covered Charges and obtained from a VSP Panel Provider are provided in accordance with an agreement between Vision Service Plan (VSP) and the panel provider. Under this agreement a provider accepts the VSP payment as payment in full for incurred Covered Charges, after satisfaction of the applicable deductibles. See the "Note" below for reimbursement for frames and cosmetic contact lenses.

Covered Charges for vision care services and materials, other than cosmetic contact lenses, obtained from a VSP Panel Provider are subject to a deductible of $6.50 for each examination and an additional deductible of $18.00 for the combined charges for lenses and frames.

Note: The total maximum benefit payable for each insured person in each plan year for frames is $65.00.

The total maximum benefit payable for each insured person in each plan year for all cosmetic contact lenses and examinations is $90.00. Deductibles do not apply to cosmetic contact lenses and examinations for them.

NON-PANEL PROVIDER

Benefits for examinations, lenses or frames which are Covered Charges and obtained from a Non-Panel Provider are subject to the following maximum amount of reimbursement.

Vision Examination	**Maximum Amount Performed by an:**	
	Optometrist	**Ophthalmologist**
	$28.50	$38.50

Spectacle Lenses (Pair):	**Clear**	**Color Tints/Color Coats**	**Polarized**
Single Vision	$29.00	$33.00	$ 47.00
Bifocal	51.00	61.00	81.00
Trifocal	63.00	75.00	101.00
Lenticular	75.00	89.00	119.00

Frames	$44.00
Contact Lenses (Pair - including the exam)	
Necessary	$175.00
Cosmetic (Elective)	90.00

When Your Insurance Begins

BECOMING ELIGIBLE

If you were insured on the day before the Plan Effective Date, you will be eligible on the Plan Effective Date. Otherwise, you will be eligible on the date of your employment or on the day following completion of the eligibility waiting period as determined by your Employer, whichever is later. The Plan Effective Date is shown in the Schedule of Benefits.

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

BECOMING INSURED

If you are not required to contribute toward the cost of your insurance, you will become insured on the day you become eligible.
If you are required to pay any portion of the cost of your insurance, you will become insured on the latest of:

a. the day you become eligible, if you enroll for your insurance on or before the day you become eligible.
b. the day you enroll for your insurance, if you enroll on or before the thirty-first (31st) day following the day you become eligible.
c. the first day of the month following the date your application is approved by the Company, if you enroll for your insurance more than thirty-one (31) days following the day you become eligible.

If you were eligible, but were not insured under the replaced plan for a coverage, you will be treated as if you had enrolled for that coverage under this plan more than thirty-one days after the date you became eligible.

When Your Dependents' Insurance Begins

DEPENDENT

This term means:

- your spouse. Your spouse must not be legally separated from you.
- your unmarried children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until the end of the calendar year of their 19th birthday;
- your unmarried children beyond the end of the calendar year of their 19th birthday to the end of the calendar year of their 25th birthday who are dependent on you for a majority of their support (dependency for tax purposes, as defined by the IRS, is not required);
- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this plan at the end of the calendar year of their 25th birthday and continuously thereafter) who are mentally retarded or physically handicapped, dependent upon you for a majority of their support, and who are incapable of self-sustaining employment by reason of their mental retardation or physical handicap. (Under no circumstances will mental illness be considered a cause of incapacity nor will it be

considered as a basis for continued coverage.) Please contact MESSA Group Services to obtain the appropriate form to continue coverage;

- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this plan at the end of the calendar year of their 25th birthday and continuously thereafter), who are full-time students and dependent on you for a majority of their support;
- your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year, and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

BECOMING ELIGIBLE

Each person who is your dependent on the day you become eligible for insurance is eligible on that day. Each other person is eligible on the day that person becomes your dependent.

BECOMING INSURED

If any one of your dependents is eligible under this plan for a coverage as an employee, that person is not eligible for that coverage as a dependent. If both you and your spouse are insured under this plan as employees, your children may only be enrolled as dependents of you or your spouse.

If you are not required to contribute toward the cost of Dependents' Insurance, each eligible dependent will be insured beginning with the later of these dates:

a. the day on which your insurance begins,
b. the date he/she becomes an eligible dependent.

If you are required to contribute toward the cost of Dependents' Insurance, and your dependents are enrolled:

a before their date of eligibility, they will be insured on the date they become eligible.
b. within thirty-one days of their date of eligibility, they will be insured on the day of enrollment.
c. more than thirty-one days following the day they become eligible, they will not be insured until the first day of the month following the day MESSA approves the application. Each dependent may be asked to have a physical exam at your expense.

If you have eligible dependents, but they were not insured under the replaced plan for a coverage, they will be treated as if they had been enrolled for that coverage under this plan more than thirty-one days after the date they became eligible.

Your dependents will not be insured before the day your insurance begins.

Vision Care Benefits

WHAT IS COVERED

Benefits are payable for Covered Expenses incurred while the person is insured for these benefits. These charges must be made by a doctor, optometrist or optician.

WHAT ARE COVERED EXPENSES

1. Charges for a vision examination but not for more than one performed on an insured person during a plan year.
2. Charges for corrective spectacle lenses and frames but not more than one pair of such lenses and one frame per insured person during a plan year.
3. Charges for corrective contact lenses but not more than one pair of such lenses per insured person during a plan year.

Note: For each plan year, charges for contact lenses and the examination are in lieu of all other Covered Charges during the plan year for each insured person.

HOW MUCH

VSP Panel Provider

By obtaining examinations, lenses or frames from a VSP Panel Provider, an insured person will pay no more than the deductible, if any, specified in the Schedule of Benefits for each service or material that is a Covered Charge, except, if an insured person selects a service or material which exceeds the plan allowance for any Covered Charge, the insured person will have to pay the provider the excess costs directly. The insured person must also pay the provider for services and materials that are not Covered Charges.

Non-Panel Provider

If an insured person receives an examination by, or purchases lenses or frames from a Non-Panel Provider, the insured person must pay the provider the full cost of the service or material. You will then be reimbursed for Covered Charges up to the maximum amount for the service or material as shown in the Schedule of Benefits.

NOT COVERED

No payment shall be made for:

1. Non-corrective 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 plan 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 extra cost of progressive lenses.
8. The cost of frames that exceeds the plan allowance.
9. Charges by a VSP Panel Provider for cosmetic (elective) contact lenses, including the examination, that exceed the plan allowance.

10. Charges by a Non-Panel Provider for vision examinations, lenses and frames to the extent that such charges exceed the maximum amount shown in the Schedule of Benefits.

IMPORTANT: See "General Information" for other conditions that may affect this coverage.

General Information

DEFINITIONS

The Company. This term means Connecticut General Life Insurance Company, one of its affiliated companies, or their designee.

Doctor. This term means:

a. a physician legally licensed to practice medicine and surgery.
b. any other legally licensed practitioner of the healing arts who renders services within the scope of his or her license. For health insurance expenses, such services will include those covered under the Group Policy for which benefits must be provided by law when rendered by that practitioner.

This term does not include a resident doctor, an intern, or a person in training.

VSP Panel Providers. This term means ophthalmologists and optometrists who have entered into an agreement with Vision Service Plan, a non-profit corporation, to provide vision examinations, corrective lenses and frames.

Non-Panel Providers. This term means ophthalmologists and optometrists who have entered into an agreement with Vision Service Plan, and opticians.

Vision Examination. This term means a complete analysis of the eyes and related structures to determine the presence of visual problems or other abnormalities and includes the prescribing of corrective lenses, when needed.

Necessary Contact Lenses. This term means contact lenses furnished because visual acuity is not correctable to 20/70 in the better eye with spectacle lenses, but can be corrected to 20/70 or better by the use of contact lenses.

Cosmetic (Elective) Contact Lenses. This term means contact lenses not included in the definition of Necessary Contact Lenses.

HOW TO USE THE PLAN

You may choose one of the three following options to obtain vision care.

OPTION I - If You Choose To See A VSP Panel Doctor

1. Select a doctor from the list of VSP Panel Doctors in your geographic area and make an appointment for an examination.
2. The Panel Doctor will contact VSP to confirm your eligibility for benefits prior to your appointment date.
3. The VSP Panel Doctor will collect any applicable deductible and take care of all paperwork for payment. VSP will pay the doctor for the services you received according to VSP's agreement with the doctor.

OPTION II - If You Choose To See An Optometrist, Ophthalmologist, or Dispensing Optician Who Is Not A VSP Panel Provider

1. Make an appointment and receive the necessary services from the provider. Pay the provider the full fee and obtain an itemized receipt which must contain the following information:
    a. Patient's name
    b. Date services began
    c. The services and materials you received
    d. The type of lenses you received (single vision, bifocal, trifocal, etc.)
2. Enter the member's social security number and employer name on the receipt. If the patient is a dependent, write the patient's birth date, relationship to the member, and the member's name. Mail the receipt to:

    VISION SERVICE PLAN
    P.O. Box 997105
    Sacramento, CA 95899-7105
3. You will then be reimbursed directly for the expense of services and materials received subject to the maximum amounts shown in the Schedule of Benefits.

OPTION III - If You Choose To See A Non-Panel Doctor For An Examination And Have A VSP Panel Doctor Fill Your Prescription

1. After receiving an examination from the doctor, pay the doctor the exam fee. Obtain a receipt for the exam and the prescription for your lenses. The receipt must contain all the information described in Option II, except for the references to materials and lenses.
2. The Panel Doctor will contact VSP to confirm your eligibility for benefits prior to your appointment date.
3. Take your prescription from your examination to the VSP Panel Doctor on your first visit.
4. The VSP Panel Doctor will fit you with your new glasses or contacts, collect any applicable deductible and take care of any paperwork for payment for materials and lenses.
5. Submit your receipt for your examination as you would under Option II.
6. You will be reimbursed for your exam up to the maximum amount shown in the Schedule of Benefits and VSP Panel Doctor will be paid by the VSP for dispensing your glasses or contacts.

YOUR RIGHT TO FILE AN INTERNAL GRIEVANCE AND TO REQUEST AN INDEPENDENT EXTERNAL REVIEW

Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, provides an internal grievance procedure, including a managerial-level conference, if you believe that we have violated Sections 402 and 403 of Public Act 350.

Public Act 251 of 2000 provides you with the right to request an external review from the Commissioner of Financial and Insurance Services if we have denied, reduced or terminated an admission, availability of care, continued stay or other health care service. Normally, you must exhaust our standard internal grievance procedure before you can request an external review.

INTERNAL GRIEVANCES

Standard Internal Grievance Procedure

Under the standard internal grievance procedure, we must provide you with our final written determination within 35 calendar days of our receipt of your written grievance. However, that timeframe may be suspended for any amount of time that you are permitted to take to file your grievance, and for a period of up to 10 days if we have not received information we have requested from a health care provider, for example, your doctor or hospital. The standard internal grievance procedure is as follows:

- You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payments.
- Mail your written grievance to the address found in the top right hand corner of the first page of your Explanation of Benefits statement or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting.
- We will respond to your grievance in writing. If you agree with our response, it becomes our final determination and the grievance ends.

If you disagree with our response to your grievance, you may then request a managerial-level conference. You must request the conference in writing.

Mail your request to:

Manager, Legal and Compliance
MESSA
P.O. Box 2560
East Lansing, MI 48826-2560

Our written proposed resolution will be our final determination regarding your grievance.

- If you disagree with our final determination, or if we fail to provide it to you within 35 days of the date we received your original written grievance, you may request an external review from the Michigan Commissioner of Financial and Insurance Services.

In addition to the information found above, you should also know:

- You may authorize in writing another person, including, but not limited to a physician, to act on your behalf at any stage in the standard grievance procedure.
- Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish.
- You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service for a reasonable copying charge.

Expedited Internal Grievance Procedure

If a physician substantiates verbally or in writing that adhering to the timeframe for the standard internal grievance would jeopardize your life or health, or would seriously jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance. You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service *prior* to you having

received that health care service or if you believe we have failed to respond timely to a request for benefits or payment. The procedure is a follows:

- You may submit your expedited internal grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone. Call 800.742.2328.
- We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.
- If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Commissioner.

In addition to the information on the preceding page, you should also know:

- You may authorize, in writing, another person, including, but not limited to, a physician, to act on your behalf at any stage in the expedited internal grievance procedure.
- If our decision is communicated to you verbally, we must provide you with written confirmation within two (2) business days.

EXTERNAL REVIEWS

Standard External Review Procedure

Once you have exhausted our standard internal grievance procedure, you or your authorized representative have the right to request an external review from the Commissioner. The standard external review process is as follows:

- Within 60 days of the date you either received our final determination or should have received it, you must send a written request for an external review to the Commissioner.

  Mail your request, including the required forms that we will supply you, to:

  Appeals Section
  Office of Financial & Insurance Services
  P.O. Box 30220
  Lansing, MI 48909

- If your request for external review concerns a medical issue, and is otherwise found to be appropriate for external review, the Commissioner will assign an Independent Review Organization, consisting of independent clinical peer reviewers, to conduct the external review. You will have an opportunity to provide additional information to the Commissioner within seven (7) days after you submit your request for an external review. We must provide documents and information considered in making our final determination to the Independent Review Organization within seven (7) business days after we receive notice of your request from the Commissioner.
- The assigned Independent Review Organization will recommend, within 14 days, whether the commissioner should uphold or reverse our determination. The Commissioner must decide within seven (7) business days whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.
- If your request for external review is related to non-medical issues, and is otherwise found to be appropriate for external review, the Commissioner's staff will conduct the external review. The Commissioner's staff will recommend whether the Commissioner

should uphold or reverse our determination. The Commissioner will notify you of the decision. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

Expedited External Review Procedure

If a physician substantiates verbally or in writing that you have a medical condition for which the timeframe for completion of an expedited internal grievance seriously jeopardizes your life or health, or would jeopardize your ability to regain maximum function, and, you have filed a request for an expedited internal grievance, you may request an expedited external review, from the Commissioner. You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service *prior* to your having received that health care service. The expedited external review process is as follows:

- Within 10 days of your receipt of our denial, termination, or reduction in coverage for health care service, you or your authorized representative may request an expedited external review from the Commissioner.

To do so in writing, mail your request, including the required forms that we will supply to you, to:

Appeals Section
Office of Financial & Insurance Services
P.O. Box 30220
Lansing, MI 48909

To do so by telephone, call the following toll free number: 877.999.6442.

- Immediately after receiving your request, the Commissioner will decide if it is appropriate for external review and assign an Independent Review Organization to conduct the expedited external review. If the Independent Review Organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Commissioner should uphold or reverse our determination.

The Commissioner must decide within 24 hours whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

NON-DUPLICATION OF BENEFITS

If an insured person is entitled to benefits for vision care under this plan and at least one other plan, the amount of benefits provided by this plan for that care may be reduced to the extent that the total payment provided for a calendar year by all plans by which the person is covered will not be more than the total of the allowable expenses that the person incurs in the same year. This will be done as set forth in Order of Payment.

Plan. This term means any plan that provides medical or vision care coverage:

a. by any group insurance, or by any other method of coverage for persons in a group.
b. by any governmental plan, except Medicaid (Title XIX of the Federal Social Security Act as it now is or as it may be changed).

c. required by law.

d. by a "no-fault" motor vehicle plan.

This term does not mean school accident insurance or group hospital indemnity benefits.

Allowable Expenses. This term means any necessary, reasonable and customary item of expense, a part of the cost of which is covered by this Plan, or one of the other plans, except Medicare or a "no-fault" motor vehicle plan.

Medicare. This term means Title XVIII of the Federal Social Security Act, as it now is, or as it may be changed. A person who is eligible for Medicare will be deemed to have all the coverages for which he or she is so eligible.

No-fault Motor Vehicle Plan. This term means a motor vehicle plan which is required by law and provides medical care payments which are made, in whole or in part, without regard to fault.

A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.

Order of Payment. When a person is covered under two or more plans, the rules that follow will decide the order in which the plans will pay benefits:

1. A plan which does not have a provision like this Non-Duplication of Benefits will pay before this Plan.
2. A plan which covers a person other than as a dependent will pay before a plan which covers a person as a dependent.
3. A plan which covers a person as a dependent of a person whose date of birth occurs earlier in a calendar year will pay before a plan which covers the person as a dependent of a person whose date of birth occurs later in a calendar year; provided that:
   a. if said dates of birth are the same, the plan which has covered a person for the longest time will pay first.
   b. if any other plan does not have a provision for dates of birth, as set forth above, that plan will determine the order of payment with respect to dependents.

   In this clause, date of birth means day and month of birth. It does not mean year of birth. However, if the person is a dependent child of divorced or separated parents, the order will be as follows:

   a. if the parent with custody has not remarried, his or her plan will pay before the plan of the parent without custody.

   b. if the parent with custody has remarried, his or her plan will pay before the plan of the step-parent or the parent without custody; and the plan of the step-parent will pay before the plan of the parent without custody.

   However, if there is a court decree which sets forth a financial duty for the health care expenses of the child, the plan of the parent with such financial duty will pay first.
4. If these three rules do not decide which plan will pay its benefits first, the plan which has covered the person for the longest time will pay first.

   Exception:

   a. Subject to (b) below:

      If a plan covers a person for whom claim is made as a laid-off employee, or as his or her dependent, the benefits of that plan will be determined after those of a plan that covers such person as an employee who is not laid-off or as his or her dependent.

b. If any other plan does not have a provision like that in (a), this Exception will not apply to that plan.

To administer claims, the Company, without the consent of any person, will have the right:

a. to give or to get any data needed to determine benefits under this provision.
b. to recover any sum paid above that is required by this provision.
c. to pay an organization the sum it paid, but which should have been paid by the Company. Amounts so paid will be deemed benefits paid under this Plan; and to the extent so paid there will be no more liability under this Plan.

RIGHT OF RECOVERY

If an overpayment is made due to any reason, including but not limited to a payment under any Workers' Disability Compensation or Occupational Disease Act or law, clerical error or misstatement of age, the Company shall have the right to recover such overpayment from the insured person, or to deduct such amount of over-payment from future benefits.

If you or your dependents incur expenses on account of bodily injury or sickness caused by negligence or wrong of a third party, and benefits are payable under the Group Policy, you will receive the benefits, provided that, if there is recovery by you or your dependents or a personal representative from the third party or his or her personal representative, whether by judgment, settlement or otherwise, on account of such bodily injury or sickness, you shall reimburse the Company to the extent of the total amount of such benefits paid under the Group Policy, but not in an amount in excess of the proceeds of any such recovery after the deduction of reasonable and necessary expenditures, including attorney fees, incurred in effecting such recovery.

WHEN INSURANCE ENDS

Your insurance ends when any of the following events occurs:

a. you leave school employment.
b. you are no longer eligible.
c. contributions are no longer made for the cost of insurance.
d. your Employer's participation under the Group Policy is terminated.
e. the Group Policy ceases.

A dependent's insurance ends when any of the following events occurs:

a. your insurance ends.
b. that dependent is no longer an eligible dependent.

If you cease active work, ask your Employer if arrangements may be made to continue insurance.

CESSATION OF VISION CARE BENEFITS

No vision care benefits will be paid for any vision examinations performed and lenses and frames ordered on or after the date insurance terminates.

COBRA OPTIONAL CONTINUANCE

If your insurance or that of a dependent ends, you and your dependent may each have the right to continue health insurance under the COBRA Optional Continuance. A notice of each person's

rights under this option will be provided by your Employer. Any person who has questions regarding COBRA Optional Continuance should contact their Employer.

This booklet may also describe Optional Continuance rights which may apply to you or your dependents when coverage ends. Although the requirements under the Optional Continuance and the COBRA Optional Continuance may not be the same, a person may be entitled to continue coverage under both. You can ask your Employer if the other option applies to you or your dependents.

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

Any provisions of the Group Policy that provide for continuation of insurance during a leave of absence and reinstatement of insurance following a return to active service are modified by the following provisions of the federal Family and Medical Leave Act of 1993 where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

1. that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
2. you are an eligible employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Cancelled Insurance Following Leave

Upon your return to active service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any cancelled insurance will be reinstated as of the date of your return.

You will not be required to satisfy any Service or Benefit Waiting Period or the requirements of any pre-existing condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

Notice

Your Employer reserves the right to:

a. modify, amend or change the provisions of the Group Policy(ies) subject to the Company's approval;
b. terminate the Group Policy(ies) on any date on which your Employer must pay premiums to the Company;
c. require, change or discontinue at any time, contributions toward the cost of coverage under this plan; and
d. modify, amend, change or discontinue this plan at any time.

Connecticut General
Life Insurance Company
(Herein called The Company)

hereby certifies that employees of the Participating Employer indicated in the Schedule who are insured under Group Policy Number 57227 issued by The Company to:

MICHIGAN EDUCATION SPECIAL SERVICES ASSOCIATION

(Herein called the Policyholder)

are, subject to the terms and conditions of said policy, insured for the benefits described in the pages of the booklet.

The Company insures the vision care coverage. The Company will determine all benefit payments according to the provisions described in the booklet and the Group Policy.

The insurance is effective only if the person concerned is eligible, becomes insured and remains insured, in accordance with the terms and conditions of the policy. This certificate replaces any other certificate issued to you describing this coverage.

GENERAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES. No statement relating to insurability made by any member eligible for coverage under the policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the lifetime of the person with respect to whom any such statement was made.

Note: For the purposes of the following provisions, information submitted to MESSA shall be considered to have been furnished to The Company as herein specified.

NOTICE OF CLAIM. Written notice of claim must be given to The Company no later than twenty (20) days after the date of the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of you or the beneficiary to The Company at its Home Office in Hartford, Connecticut or to any authorized agent of The Company, with information sufficient to identify you, shall be deemed notice to The Company.

CLAIM FORMS. The Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS. Written proof of loss must be furnished to The Company within ninety (90) days after the date of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as possible and in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required. The Company may require, as part of proof of claim, itemized bills of the physician or other source of services or supplies. The Company also has the right to arrange for audits of bills from any provider of services and supplies.

PAYMENT OF CLAIMS. All benefits will be payable to you. If any benefits of the policy shall be payable to your estate, or to you if you are not competent to give valid release, The Company may pay such benefit up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of you who is deemed by The Company to be equitably entitled thereto. Any payment made by The Company in good faith pursuant to this provision shall fully discharge The Company to the extent of such payments.

PHYSICAL EXAMINATIONS. The Company at its own expense shall have the right and opportunity to examine any person when and as often as it may reasonably require during the pendency of a claim under the policy.

LEGAL ACTIONS. No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Connecticut General
Life Insurance Company

The Group Policy provides that MESSA and The Company shall share the responsibility for administering the payment of the vision care benefits described in this booklet.

VSP3

Schedule of Benefits

PLAN EFFECTIVE DATE: September 1, 2002

EMPLOYEES ELIGIBLE: All employees of a participating Employer.

DEPENDENTS ELIGIBLE: All dependents as defined.

VISION CARE BENEFITS FOR YOU AND YOUR DEPENDENTS:

VSP PANEL PROVIDER

Benefits for examinations, lenses or frames which are Covered Charges and obtained from a VSP Panel Provider are provided in accordance with an agreement between Vision Service Plan (VSP) and the panel provider. Under this agreement a provider accepts the VSP payment as payment in full for incurred Covered Charges, after satisfaction of the applicable deductibles. See the "Note" below for reimbursement for frames and cosmetic contact lenses.

Note: The total maximum benefit payable for each insured person in each plan year for frames is $65.00.

The total maximum benefit payable for each insured person in each plan year for all cosmetic contact lenses and examinations is $115.00.

NON-PANEL PROVIDER

Benefits for examinations, lenses or frames which are Covered Charges and obtained from a Non-Panel Provider are subject to the following maximum amount of reimbursement.

Vision Examination	**Maximum Amount Performed by an:**	
	Optometrist	**Ophthalmologist**
	$35.00	$45.00

Spectacle Lenses (Pair):	**Clear**	**Color Tints/Color Coats**	**Polarized**
Single Vision	$38.00	$42.00	$56.00
Bifocal	60.00	70.00	90.00
Trifocal	72.00	84.00	110.00
Lenticular	108.00	118.00	138.00

Frames	$55.00
Contact Lenses (Pair - including the exam)	
Necessary	$200.00
Cosmetic (Elective)	115.00

When Your Insurance Begins

BECOMING ELIGIBLE

If you were insured on the day before the Plan Effective Date, you will be eligible on the Plan Effective Date. Otherwise, you will be eligible on the date of your employment or on the day following completion of the eligibility waiting period as determined by your Employer, whichever is later. The Plan Effective Date is shown in the Schedule of Benefits.

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

BECOMING INSURED

If you are not required to contribute toward the cost of your insurance, you will become insured on the day you become eligible.
If you are required to pay any portion of the cost of your insurance, you will become insured on the latest of:

a. the day you become eligible, if you enroll for your insurance on or before the day you become eligible.
b. the day you enroll for your insurance, if you enroll on or before the thirty-first (31st) day following the day you become eligible.
c. the first day of the month following the date your application is approved by the Company, if you enroll for your insurance more than thirty-one (31) days following the day you become eligible.

If you were eligible, but were not insured under the replaced plan for a coverage, you will be treated as if you had enrolled for that coverage under this plan more than thirty-one days after the date you became eligible.

When Your Dependents' Insurance Begins

DEPENDENT

This term means:

- your spouse. Your spouse must not be legally separated from you.
- your unmarried children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until the end of the calendar year of their 19th birthday;
- your unmarried children beyond the end of the calendar year of their 19th birthday to the end of the calendar year of their 25th birthday who are dependent on you for a majority of their support (dependency for tax purposes, as defined by the IRS, is not required);
- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this plan at the end of the calendar year of their 25th birthday and continuously thereafter) who are mentally retarded or physically handicapped, dependent upon you for a majority of their support, and who are incapable of self-sustaining employment by reason of their mental retardation or physical handicap. (Under no circumstances will mental illness be considered a cause of incapacity nor will it be

considered as a basis for continued coverage.) Please contact MESSA Group Services to obtain the appropriate form to continue coverage;

- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this plan at the end of the calendar year of their 25th birthday and continuously thereafter), who are full-time students and dependent on you for a majority of their support;
- your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year, and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

BECOMING ELIGIBLE

Each person who is your dependent on the day you become eligible for insurance is eligible on that day. Each other person is eligible on the day that person becomes your dependent.

BECOMING INSURED

If any one of your dependents is eligible under this plan for a coverage as an employee, that person is not eligible for that coverage as a dependent. If both you and your spouse are insured under this plan as employees, your children may only be enrolled as dependents of you or your spouse.

If you are not required to contribute toward the cost of Dependents' Insurance, each eligible dependent will be insured beginning with the later of these dates:

a. the day on which your insurance begins,
b. the date he/she becomes an eligible dependent.

If you are required to contribute toward the cost of Dependents' Insurance, and your dependents are enrolled:

a before their date of eligibility, they will be insured on the date they become eligible.
b. within thirty-one days of their date of eligibility, they will be insured on the day of enrollment.
c. more than thirty-one days following the day they become eligible, they will not be insured until the first day of the month following the day MESSA approves the application. Each dependent may be asked to have a physical exam at your expense.

If you have eligible dependents, but they were not insured under the replaced plan for a coverage, they will be treated as if they had been enrolled for that coverage under this plan more than thirty-one days after the date they became eligible.

Your dependents will not be insured before the day your insurance begins.

Vision Care Benefits

WHAT IS COVERED

Benefits are payable for Covered Expenses incurred while the person is insured for these benefits. These charges must be made by a doctor, optometrist or optician.

WHAT ARE COVERED EXPENSES

1. Charges for a vision examination but not for more than one performed on an insured person during a plan year.
2. Charges for corrective spectacle lenses and frames but not more than one pair of such lenses and one frame per insured person during a plan year.
3. Charges for corrective contact lenses but not more than one pair of such lenses per insured person during a plan year.

Note: For each plan year, charges for contact lenses and the examination are in lieu of all other Covered Charges during the plan year for each insured person.

HOW MUCH

VSP Panel Provider

By obtaining examinations, lenses or frames from a VSP Panel Provider, an insured person will pay no more than the deductible, if any, specified in the Schedule of Benefits for each service or material that is a Covered Charge, except, if an insured person selects a service or material which exceeds the plan allowance for any Covered Charge, the insured person will have to pay the provider the excess costs directly. The insured person must also pay the provider for services and materials that are not Covered Charges.

Non-Panel Provider

If an insured person receives an examination by, or purchases lenses or frames from a Non-Panel Provider, the insured person must pay the provider the full cost of the service or material. You will then be reimbursed for Covered Charges up to the maximum amount for the service or material as shown in the Schedule of Benefits.

NOT COVERED

No payment shall be made for:

1. Non-corrective 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 plan 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 extra cost of progressive lenses.
8. The cost of frames that exceeds the plan allowance.
9. Charges by a VSP Panel Provider for cosmetic (elective) contact lenses, including the examination, that exceed the plan allowance.

10. Charges by a Non-Panel Provider for vision examinations, lenses and frames to the extent that such charges exceed the maximum amount shown in the Schedule of Benefits.

IMPORTANT: See "General Information" for other conditions that may affect this coverage.

General Information

DEFINITIONS

The Company. This term means Connecticut General Life Insurance Company, one of its affiliated companies, or their designee.

Doctor. This term means:

a. a physician legally licensed to practice medicine and surgery.
b. any other legally licensed practitioner of the healing arts who renders services within the scope of his or her license. For health insurance expenses, such services will include those covered under the Group Policy for which benefits must be provided by law when rendered by that practitioner.

This term does not include a resident doctor, an intern, or a person in training.

VSP Panel Providers. This term means ophthalmologists and optometrists who have entered into an agreement with Vision Service Plan, a non-profit corporation, to provide vision examinations, corrective lenses and frames.

Non-Panel Providers. This term means ophthalmologists and optometrists who have entered into an agreement with Vision Service Plan, and opticians.

Vision Examination. This term means a complete analysis of the eyes and related structures to determine the presence of visual problems or other abnormalities and includes the prescribing of corrective lenses, when needed.

Necessary Contact Lenses. This term means contact lenses furnished because visual acuity is not correctable to 20/70 in the better eye with spectacle lenses, but can be corrected to 20/70 or better by the use of contact lenses.

Cosmetic (Elective) Contact Lenses. This term means contact lenses not included in the definition of Necessary Contact Lenses.

HOW TO USE THE PLAN

You may choose one of the three following options to obtain vision care.

OPTION I - If You Choose To See A VSP Panel Doctor

1. Select a doctor from the list of VSP Panel Doctors in your geographic area and make an appointment for an examination.
2. The Panel Doctor will contact VSP to confirm your eligibility for benefits prior to your appointment date.
3. The VSP Panel Doctor will collect any applicable deductible and take care of all paperwork for payment. VSP will pay the doctor for the services you received according to VSP's agreement with the doctor.

OPTION II - If You Choose To See An Optometrist, Ophthalmologist, or Dispensing Optician Who Is Not A VSP Panel Provider

1. Make an appointment and receive the necessary services from the provider. Pay the provider the full fee and obtain an itemized receipt which must contain the following information:
    a. Patient's name
    b. Date services began
    c. The services and materials you received
    d. The type of lenses you received (single vision, bifocal, trifocal, etc.)
2. Enter the member's social security number and employer name on the receipt. If the patient is a dependent, write the patient's birth date, relationship to the member, and the member's name. Mail the receipt to:

    VISION SERVICE PLAN
    P.O. Box 997105
    Sacramento, CA 95899-7105
3. You will then be reimbursed directly for the expense of services and materials received subject to the maximum amounts shown in the Schedule of Benefits.

OPTION III - If You Choose To See A Non-Panel Doctor For An Examination And Have A VSP Panel Doctor Fill Your Prescription

1. After receiving an examination from the doctor, pay the doctor the exam fee. Obtain a receipt for the exam and the prescription for your lenses. The receipt must contain all the information described in Option II, except for the references to materials and lenses.
2. The Panel Doctor will contact VSP to confirm your eligibility for benefits prior to your appointment date.
3. Take your prescription from your examination to the VSP Panel Doctor on your first visit.
4. The VSP Panel Doctor will fit you with your new glasses or contacts, collect any applicable deductible and take care of any paperwork for payment for materials and lenses.
5. Submit your receipt for your examination as you would under Option II.
6. You will be reimbursed for your exam up to the maximum amount shown in the Schedule of Benefits and VSP Panel Doctor will be paid by the VSP for dispensing your glasses or contacts.

YOUR RIGHT TO FILE AN INTERNAL GRIEVANCE AND TO REQUEST AN INDEPENDENT EXTERNAL REVIEW

Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, provides an internal grievance procedure, including a managerial-level conference, if you believe that we have violated Sections 402 and 403 of Public Act 350.

Public Act 251 of 2000 provides you with the right to request an external review from the Commissioner of Financial and Insurance Services if we have denied, reduced or terminated an admission, availability of care, continued stay or other health care service. Normally, you must exhaust our standard internal grievance procedure before you can request an external review.

INTERNAL GRIEVANCES

Standard Internal Grievance Procedure

Under the standard internal grievance procedure, we must provide you with our final written determination within 35 calendar days of our receipt of your written grievance. However, that timeframe may be suspended for any amount of time that you are permitted to take to file your grievance, and for a period of up to 10 days if we have not received information we have requested from a health care provider, for example, your doctor or hospital. The standard internal grievance procedure is as follows:

- You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payments.
- Mail your written grievance to the address found in the top right hand corner of the first page of your Explanation of Benefits statement or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting.
- We will respond to your grievance in writing. If you agree with our response, it becomes our final determination and the grievance ends.

If you disagree with our response to your grievance, you may then request a managerial-level conference. You must request the conference in writing.

Mail your request to:

Manager, Legal and Compliance
MESSA
P.O. Box 2560
East Lansing, MI 48826-2560

Our written proposed resolution will be our final determination regarding your grievance.

- If you disagree with our final determination, or if we fail to provide it to you within 35 days of the date we received your original written grievance, you may request an external review from the Michigan Commissioner of Financial and Insurance Services.

In addition to the information found above, you should also know:

- You may authorize in writing another person, including, but not limited to a physician, to act on your behalf at any stage in the standard grievance procedure.
- Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish.
- You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service for a reasonable copying charge.

Expedited Internal Grievance Procedure

If a physician substantiates verbally or in writing that adhering to the timeframe for the standard internal grievance would jeopardize your life or health, or would seriously jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance. You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to you having

received that health care service or if you believe we have failed to respond timely to a request for benefits or payment. The procedure is a follows:

- You may submit your expedited internal grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone. Call 800.742.2328.
- We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.
- If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Commissioner.

In addition to the information on the preceding page, you should also know:

- You may authorize, in writing, another person, including, but not limited to, a physician, to act on your behalf at any stage in the expedited internal grievance procedure.
- If our decision is communicated to you verbally, we must provide you with written confirmation within two (2) business days.

EXTERNAL REVIEWS

Standard External Review Procedure

Once you have exhausted our standard internal grievance procedure, you or your authorized representative have the right to request an external review from the Commissioner. The standard external review process is as follows:

- Within 60 days of the date you either received our final determination or should have received it, you must send a written request for an external review to the Commissioner.

  Mail your request, including the required forms that we will supply you, to:

  Appeals Section
  Office of Financial & Insurance Services
  P.O. Box 30220
  Lansing, MI 48909

- If your request for external review concerns a medical issue, and is otherwise found to be appropriate for external review, the Commissioner will assign an Independent Review Organization, consisting of independent clinical peer reviewers, to conduct the external review. You will have an opportunity to provide additional information to the Commissioner within seven (7) days after you submit your request for an external review. We must provide documents and information considered in making our final determination to the Independent Review Organization within seven (7) business days after we receive notice of your request from the Commissioner.
- The assigned Independent Review Organization will recommend, within 14 days, whether the commissioner should uphold or reverse our determination. The Commissioner must decide within seven (7) business days whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.
- If your request for external review is related to non-medical issues, and is otherwise found to be appropriate for external review, the Commissioner's staff will conduct the external review. The Commissioner's staff will recommend whether the Commissioner

should uphold or reverse our determination. The Commissioner will notify you of the decision. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

Expedited External Review Procedure

If a physician substantiates verbally or in writing that you have a medical condition for which the timeframe for completion of an expedited internal grievance seriously jeopardizes your life or health, or would jeopardize your ability to regain maximum function, and, you have filed a request for an expedited internal grievance, you may request an expedited external review, from the Commissioner. You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to your having received that health care service. The expedited external review process is as follows:

- Within 10 days of your receipt of our denial, termination, or reduction in coverage for health care service, you or your authorized representative may request an expedited external review from the Commissioner.

To do so in writing, mail your request, including the required forms that we will supply to you, to:

Appeals Section
Office of Financial & Insurance Services
P.O. Box 30220
Lansing, MI 48909

To do so by telephone, call the following toll free number: 877.999.6442.

- Immediately after receiving your request, the Commissioner will decide if it is appropriate for external review and assign an Independent Review Organization to conduct the expedited external review. If the Independent Review Organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Commissioner should uphold or reverse our determination.

The Commissioner must decide within 24 hours whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

NON-DUPLICATION OF BENEFITS

If an insured person is entitled to benefits for vision care under this plan and at least one other plan, the amount of benefits provided by this plan for that care may be reduced to the extent that the total payment provided for a calendar year by all plans by which the person is covered will not be more than the total of the allowable expenses that the person incurs in the same year. This will be done as set forth in Order of Payment.

Plan. This term means any plan that provides medical or vision care coverage:

a. by any group insurance, or by any other method of coverage for persons in a group.
b. by any governmental plan, except Medicaid (Title XIX of the Federal Social Security Act as it now is or as it may be changed).

c. required by law.

d. by a "no-fault" motor vehicle plan.

This term does not mean school accident insurance or group hospital indemnity benefits.

Allowable Expenses. This term means any necessary, reasonable and customary item of expense, a part of the cost of which is covered by this Plan, or one of the other plans, except Medicare or a "no-fault" motor vehicle plan.

Medicare. This term means Title XVIII of the Federal Social Security Act, as it now is, or as it may be changed. A person who is eligible for Medicare will be deemed to have all the coverages for which he or she is so eligible.

No-fault Motor Vehicle Plan. This term means a motor vehicle plan which is required by law and provides medical care payments which are made, in whole or in part, without regard to fault.

A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.

Order of Payment. When a person is covered under two or more plans, the rules that follow will decide the order in which the plans will pay benefits:

1. A plan which does not have a provision like this Non-Duplication of Benefits will pay before this Plan.
2. A plan which covers a person other than as a dependent will pay before a plan which covers a person as a dependent.
3. A plan which covers a person as a dependent of a person whose date of birth occurs earlier in a calendar year will pay before a plan which covers the person as a dependent of a person whose date of birth occurs later in a calendar year; provided that:
   a. if said dates of birth are the same, the plan which has covered a person for the longest time will pay first.
   b. if any other plan does not have a provision for dates of birth, as set forth above, that plan will determine the order of payment with respect to dependents.

   In this clause, date of birth means day and month of birth. It does not mean year of birth. However, if the person is a dependent child of divorced or separated parents, the order will be as follows:

   a. if the parent with custody has not remarried, his or her plan will pay before the plan of the parent without custody.

   b. if the parent with custody has remarried, his or her plan will pay before the plan of the step-parent or the parent without custody; and the plan of the step-parent will pay before the plan of the parent without custody.

   However, if there is a court decree which sets forth a financial duty for the health care expenses of the child, the plan of the parent with such financial duty will pay first.
4. If these three rules do not decide which plan will pay its benefits first, the plan which has covered the person for the longest time will pay first.

   Exception:

   a. Subject to (b) below:

      If a plan covers a person for whom claim is made as a laid-off employee, or as his or her dependent, the benefits of that plan will be determined after those of a plan that covers such person as an employee who is not laid-off or as his or her dependent.

b. If any other plan does not have a provision like that in (a), this Exception will not apply to that plan.

To administer claims, the Company, without the consent of any person, will have the right:

a. to give or to get any data needed to determine benefits under this provision.
b. to recover any sum paid above that is required by this provision.
c. to pay an organization the sum it paid, but which should have been paid by the Company. Amounts so paid will be deemed benefits paid under this Plan; and to the extent so paid there will be no more liability under this Plan.

RIGHT OF RECOVERY

If an overpayment is made due to any reason, including but not limited to a payment under any Workers' Disability Compensation or Occupational Disease Act or law, clerical error or misstatement of age, the Company shall have the right to recover such overpayment from the insured person, or to deduct such amount of over-payment from future benefits.

If you or your dependents incur expenses on account of bodily injury or sickness caused by negligence or wrong of a third party, and benefits are payable under the Group Policy, you will receive the benefits, provided that, if there is recovery by you or your dependents or a personal representative from the third party or his or her personal representative, whether by judgment, settlement or otherwise, on account of such bodily injury or sickness, you shall reimburse the Company to the extent of the total amount of such benefits paid under the Group Policy, but not in an amount in excess of the proceeds of any such recovery after the deduction of reasonable and necessary expenditures, including attorney fees, incurred in effecting such recovery.

WHEN INSURANCE ENDS

Your insurance ends when any of the following events occurs:

a. you leave school employment.
b. you are no longer eligible.
c. contributions are no longer made for the cost of insurance.
d. your Employer's participation under the Group Policy is terminated.
e. the Group Policy ceases.

A dependent's insurance ends when any of the following events occurs:

a. your insurance ends.
b. that dependent is no longer an eligible dependent.

If you cease active work, ask your Employer if arrangements may be made to continue insurance.

CESSATION OF VISION CARE BENEFITS

No vision care benefits will be paid for any vision examinations performed and lenses and frames ordered on or after the date insurance terminates.

COBRA OPTIONAL CONTINUANCE

If your insurance or that of a dependent ends, you and your dependent may each have the right to continue health insurance under the COBRA Optional Continuance. A notice of each person's

rights under this option will be provided by your Employer. Any person who has questions regarding COBRA Optional Continuance should contact their Employer.

This booklet may also describe Optional Continuance rights which may apply to you or your dependents when coverage ends. Although the requirements under the Optional Continuance and the COBRA Optional Continuance may not be the same, a person may be entitled to continue coverage under both. You can ask your Employer if the other option applies to you or your dependents.

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

Any provisions of the Group Policy that provide for continuation of insurance during a leave of absence and reinstatement of insurance following a return to active service are modified by the following provisions of the federal Family and Medical Leave Act of 1993 where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

1. that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
2. you are an eligible employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Cancelled Insurance Following Leave

Upon your return to active service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any cancelled insurance will be reinstated as of the date of your return.

You will not be required to satisfy any Service or Benefit Waiting Period or the requirements of any pre-existing condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

Notice

Your Employer reserves the right to:

a. modify, amend or change the provisions of the Group Policy(ies) subject to the Company's approval;

b. terminate the Group Policy(ies) on any date on which your Employer must pay premiums to the Company;

c. require, change or discontinue at any time, contributions toward the cost of coverage under this plan; and

d. modify, amend, change or discontinue this plan at any time.

Connecticut General
Life Insurance Company
(Herein called The Company)

hereby certifies that employees of the Participating Employer indicated in the Schedule who are insured under Group Policy Number 57227 issued by The Company to:

MICHIGAN EDUCATION SPECIAL SERVICES ASSOCIATION

(Herein called the Policyholder)

are, subject to the terms and conditions of said policy, insured for the benefits described in the pages of the booklet.

The Company insures the vision care coverage. The Company will determine all benefit payments according to the provisions described in the booklet and the Group Policy.

The insurance is effective only if the person concerned is eligible, becomes insured and remains insured, in accordance with the terms and conditions of the policy. This certificate replaces any other certificate issued to you describing this coverage.

GENERAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES. No statement relating to insurability made by any member eligible for coverage under the policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the lifetime of the person with respect to whom any such statement was made.

Note: For the purposes of the following provisions, information submitted to MESSA shall be considered to have been furnished to The Company as herein specified.

NOTICE OF CLAIM. Written notice of claim must be given to The Company no later than twenty (20) days after the date of the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of you or the beneficiary to The Company at its Home Office in Hartford, Connecticut or to any authorized agent of The Company, with information sufficient to identify you, shall be deemed notice to The Company.

CLAIM FORMS. The Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS. Written proof of loss must be furnished to The Company within ninety (90) days after the date of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as possible and in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required. The Company may require, as part of proof of claim, itemized bills of the physician or other source of services or supplies. The Company also has the right to arrange for audits of bills from any provider of services and supplies.

PAYMENT OF CLAIMS. All benefits will be payable to you. If any benefits of the policy shall be payable to your estate, or to you if you are not competent to give valid release, The Company may pay such benefit up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of you who is deemed by The Company to be equitably entitled thereto. Any payment made by The Company in good faith pursuant to this provision shall fully discharge The Company to the extent of such payments.

PHYSICAL EXAMINATIONS. The Company at its own expense shall have the right and opportunity to examine any person when and as often as it may reasonably require during the pendency of a claim under the policy.

LEGAL ACTIONS. No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Connecticut General
Life Insurance Company

The Group Policy provides that MESSA and The Company shall share the responsibility for administering the payment of the vision care benefits described in this booklet.

DELTA DENTAL®

DeltaPremier
Summary of Dental Plan Benefits
For Group#0000666-0006
LESLIE PUBLIC SCHOOLS

Control Plan - Delta Dental Plan of Michigan

Benefit Year - January 1 through June 30

Covered Services -	Delta Dental Pays	You Pay
Class I Benefits		
Diagnostic and Preventive Services - Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings and fluoride treatments)	100%	0%
Emergency Palliative Treatment - Used to temporarily relieve pain	100%	0%
Class II Benefits		
Radiographs - X-rays	90%	10%
Oral Surgery Services - Extractions and dental surgery, including preoperative and postoperative care	90%	10%
Endodontic Services - Used to treat teeth with diseased or damaged nerves (for example, root canals)	90%	10%
Periodontic Services - Used to treat diseases of the gums and supporting structures of the teeth	90%	10%
Relines and Repairs - Relines and repairs to bridges and dentures	90%	10%
Minor Restorative Services - Used to repair teeth damaged by disease or injury (for example, amalgam [silver] and resin [white] fillings)	90%	10%
Major Restorative Services - Used when teeth can't be restored with another filling material (for example, crowns)	90%	10%
Class III Benefits		
Prosthodontic Services - Used to replace missing natural teeth (for example, bridges and dentures)	90%	10%
Class IV Benefits		
Orthodontic Services (to age 19) - Used to correct malposed teeth and/or facial bones (for example, braces)	75%	25%

Waiting Period - Employees hired after January 1, 2000 who are eligible for dental benefits are covered on the first day of employment.

Eligible People - All building administrators who do not choose the contractor-sponsored medical health program as certified to Delta by the contractor as subscribers eligible for full family coverage.

Also eligible are your legal spouse and your dependent children.

Where two subscribers are eligible under the same group and are legally married to each other, they will be enrolled under two application cards and will receive benefits under the separate Delta Dental contracts. The contractor pays the full cost of this plan.

Maximum Payment - $1,000 per person total per benefit year on Class I, Class II and Class III Benefits. Delta Dental's payment for Class IV Benefits will not exceed a lifetime maximum of $1,200 per eligible person.

Deductible - None.

MESSA
www.messa.org
1475 Kendale Boulevard, PO Box 2560
East Lansing, MI 48826-2560
800.292.4910

2010 Rate Renewal Exclusively for
Leslie Public Schools
Renewal Effective 07/01/2010

Quote #: 307549
MESSA Field Rep: Larry Asher
Date Created: 04/06/2010

Bundle 1 - 139C Building Administrators

Vision:	VSP 2
Life Insurance:	$40,000
Rate/$1000	
Volume	
AD&D Coverage:	$40,000
Rate/$1000	
Volume	
LTD Benefit	66 2/3% Max $5,000
Max Monthly Salary:	$7,500
Waiting Period:	90 CDMF
Alcohol/Drug:	2 Year Limitation
Mental/Nervous:	2 Year Limitation
Soc. Sec. Offset:	Family
Pre-Exist Cond.:	Waived
COLA:	No
Rate/$100	
Covered Salary	

Bundle 1 COBRA RATE

LESLIE PUBLIC SCHOOLS

REPORT ON FINANCIAL STATEMENTS
(with additional information)

FOR THE YEAR ENDED JUNE 30, 2009

CONTENTS

CONTENTS - continued

HARRIS GROUP
Certified Public Accountants

INDEPENDENT AUDITORS' REPORT

October 19, 2009

Board of Education
Leslie Public Schools
Leslie, Michigan

We have audited the accompanying financial statements of the governmental activities, each major fund and the aggregate remaining fund information of Leslie Public Schools as of and for the year ended June 30, 2009, which collectively comprise the District's basic financial statements as listed in the table of contents. These basic financial statements are the responsibility of the District's management. Our responsibility is to express an opinion on these basic financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities, each major fund and the aggregate remaining fund information of Leslie Public Schools as of June 30, 2009, and the respective changes in financial position for the year then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued a report dated October 19, 2009 on our consideration of Leslie Public Schools' internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts and grants and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

The managements discussion and analysis and required budgetary comparison information on pages 2 – 11 and 36 - 37, are not a required part of the basic financial statements but are supplementary information required by accounting principles generally accepted in the United States of America. We have applied certain limited procedures, which consisted principally if inquires of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise Leslie Public School's basic financial statements. The combining and individual nonmajor fund financial statements are presented for purposes of additional analysis and are not a required part of the basic financial statements. The combining and individual nonmajor fund financial statements have been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, are fairly stated in all material respects in relation to the basic financial statements taken as a whole.

This section of Leslie Public School's annual financial report presents its discussion and analysis of the district's financial performance during the fiscal year ending June 30, 2009. Please read it in conjunction with the transmittal letter at the front of this report and the district's financial statements, which immediately follow this section.

Financial Highlights

- The district's assets exceeded its liabilities on June 30, 2009 by $2,586,295.
- Compared to the previous year, the district's total net assets increased by $157,518, or 6 %.
- Fund expenditures were approximately $14 million, which exceeded revenues by approximately $294,000.
- Student enrollment decreased by 27 to 1,372 students based on a blended student count.
- The district's tax base decreased by 5.7% compared with a 5.9% increase in the prior year.

Overview of the Financial Statements

This annual report consists of three parts: 1) management's discussion and analysis (this section), 2) the basic financial statements, and 3) required supplementary information. The basic financial statements include two kinds of statements that present different views of the district.

1) The first two statements are *district-wide financial statements* that provide both *short-term* and *long-term* information about the district's *overall* financial status.
2) The remaining statements are *fund financial statements* that focus on *individual parts* of the district, reporting the district's operations in more detail than the district-wide statements.
   a) The *governmental funds statements* tell how basic services such as regular and special education were financed in the short term as well as what remains for future spending.
   b) *Fiduciary funds* statements provide information about the financial relationships in which the district acts solely as a trustee or agent for the benefit of others.

The financial statements also include notes that explain some of the information in the statements and provide more detailed data. The statements are followed by a section of required supplementary information that further explains and supports the financial statements with a comparison of the district's budget for the year. Figure A-1 shows how the various parts of this annual report are arranged and related to one another.

Figure A-2 summarizes the major features of the district's financial statements, including the portion of the district's activities they cover and the types of information they contain. The remainder of this overview section of management's discussion and analysis highlights the structure and contents of each of the statements.

Figure A-1
Organization of Leslie Public Schools Annual Financial Report

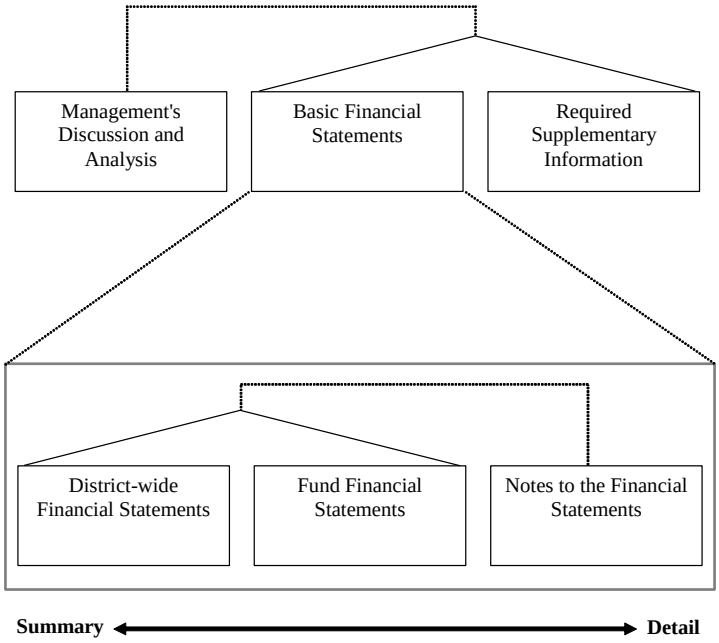


Figure A-2
Major Features of the District-Wide and Fund Financial Statements

		Fund Financial Statements	
	District-Wide Statements	***Governmental Funds***	***Fiduciary Funds***
Scope	Entire district (except fiduciary funds)	The activities of the district that are not proprietary or fiduciary, such as special education and building maintenance	Instances in which the district administers resources on behalf of someone else, such as scholarship programs and student activities monies
Required Financial Statements	1) Statement of net assets 2) Statement of activities	1) Balance Sheet 2) Statement of revenues, expenditures, and changes in fund balances	1) Statement of fiduciary net assets 2) Statement of changes in fiduciary net assets
Accounting Basis and Measurement Focus	Accrual accounting and economic resources focus	Modified accrual accounting and current financial focus	Accrual accounting and economic resources focus
Type of Asset / Liability Information	All assets and liabilities both financial and capital, short-term and long-term	Generally assets expected to be used up and liabilities that come due during the year or soon thereafter; no capital assets or long-term liabilities included	All assets and liabilities, both short-term and long-term; funds do not currently contain capital assets, although they can
Type of Inflow / Outflow Information.	All revenues and expenses during year, regardless of when cash is received or paid	Revenues for which cash is received during or soon after the end of the year; expenditures when goods or services have been received the related liability is due and payable	All additions and deductions during the year, regardless of when cash is received or paid

District-wide Financial Statements

The district-wide statements report information about the district as a whole using accounting methods similar to those used by private-sector companies. The Statement of Net Assets includes all of the district's assets and liabilities. All of the current year's revenues and expenses are accounted for in the Statement of Activities regardless of when cash is received or paid.

The two district-wide statements report the district's *net assets* and how they have changed. Net assets, the difference between the district's assets and liabilities, is one way to measure the district's financial health or *position*.

- Over time, increases or decreases in the district's net assets are an indicator of whether its financial position is improving or deteriorating, respectively.
- To assess the districts overall health, you need to consider additional non-financial factors such as changes in the district's property tax base and the condition of school buildings and other facilities.

Fund Financial Statements

The fund financial statements provide more detailed information about the district's funds, focusing on its most significant or "major" funds: not the district as a whole. Funds are accounting devices the district uses to keep track of specific sources of funding and spending on particular programs:

- Some funds are required by state law and by bond covenants.
- The district establishes other funds to control and manage money for particular purposes (such as repaying its long-term debts) or to show that it is properly using certain revenues.

The district has two kinds of funds:

1. *Governmental funds*: Most of the district's basic services are included in governmental funds, which generally focus on: a) how cash and other financial assets that can readily be converted to cash flow in and out, and b) the balances left at year-end that are available for spending. Consequently, the governmental funds statements provide a detailed short-term view that helps you determine whether there are more or fewer financial resources that can be spent in the near future to finance the district's programs. Because this information does not encompass the additional long-term focus of the district-wide statements, this report includes reconciliation schedules that explain the relationship, or differences, between the District-wide Statements and the Fund Financial Statements.
2. *Fiduciary funds*: The district is the trustee, or fiduciary, for assets that belong to others, such as student activities funds. The district is responsible for ensuring that the assets reported in these funds are used only for their intended purposes and by those to whom the assets belong. The district excludes these activities from the district-wide financial statements because it cannot use these assets to finance its operations.

Financial Analysis of the District as a Whole

As noted earlier, net assets are the difference between assets and liabilities. On June 30, 2009, the district had total assets of approximately $20.5 million, liabilities of approximately $18.0 million, and net assets of approximately $2.6 million. Figure A-3, below, provides a summary of net assets for the years ending on June 30, 2009 and June 30, 2008.

Figure A-3
Condensed Statement of Net Assets

	2009	2008	Change	
Assets				
Current	$ 4,621,520	$ 4,662,335	$ (40,815)	(0.9) %
Non-Current	15,925,282	16,625,523	(700,241)	(4.2)
	$ 20,546,802	**$ 21,287,858**	**$ (741,056)**	**(3.5)**
Liabilities				
Current	$ 4,710,769	$ 4,013,902	$ 696,867	17.4 %
Non-Current	13,249,738	14,845,179	(1,595,441)	(10.8)
	17,960,507	**18,859,081**	**(898,574)**	**(4.8)**
Net Assets				
Invested in capital assets, net of related debt	1,127,290	722,029	405,261	56.13
Restricted	416,121	398,951	17,170	4.3
Unrestricted	1,042,884	1,307,797	(264,913)	(20.3)
	2,586,295	**2,428,777**	**157,518**	**6.5**
Liabilities and Net Assets	**$ 20,546,802**	**$ 21,287,858**	**$ (741,056)**	**(3.5) %**

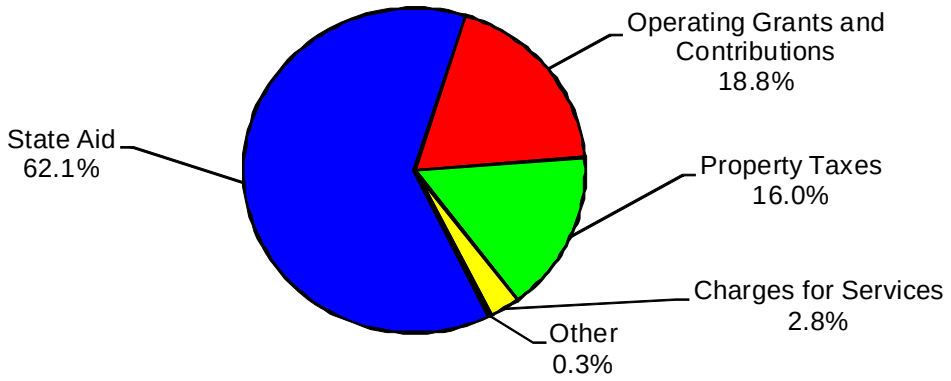
The above table shows the district's net assets on June 30, 2009, when compared to the prior year, increased by $157,518, or 6.5%. The primary reasons for this increase are increased federal operating grants coupled with the accumulation of long–term funds to pay for future debt payments. The reader will note that while revenues increased by $16,124, the district's expenses increased by $86,108.

Figure A-4
Changes in Net Assets from Operating Results

	2009	2008	Change	
Revenues				
Charges for Services	$ 386,555	$ 387,635	$ (1,080)	(0.3) %
Operating Grants and Contributions	2,556,427	2,044,575	511,852	25.0
Capital Grants and Contributions	33,000	27,153	5,847	21.5
Property Taxes	2,199,888	2,296,706	(96,818)	(4.2)
State Aid	8,536,524	8,912,532	(376,008)	(4.2)
Other	37,475	65,144	(27,669)	(42.4)
	13,749,869	13,733,745	16,124	.1
Expenses				
Instruction	6,994,977	6,871,380	123,597	1.8
Pupil & Instructional Services	1,129,325	1,108,634	20,691	1.9
Administration & Business	1,340,495	1,308,446	32,049	2.5
Operations & Maintenance	1,395,956	1,402,175	(6,219)	(0.4)
Transportation	561,107	579,058	(17,951)	(3.1)
Facilities Acquisition	430,848	430,848	-	-
Interest on Long Term Debt	685,180	690,039	(4,859)	(0.7)
Other	1,054,463	1,115,663	(61,200)	(5.5)
	13,592,351	13,506,243	$ 86,108	0.6 %
Increase / (Decrease) in Net Assets	$ 157,518	$ 227,502		

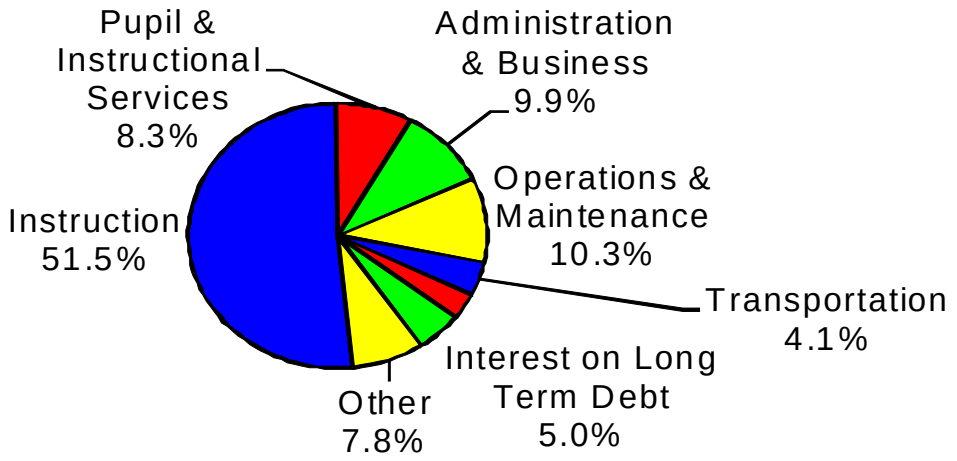
Revenues The district's total revenues of $13.7 million were more than expenses; increasing net assets by $157,518 over last year (see Figure A-4). State formula aid accounted for most of the district's revenue, contributing about 62 cents of every dollar raised. Another 16 percent came from property taxes levied by the district. Operating grants and contributions comprised 19 percent of the revenue (see Figure A-5).

Figure A-5
Sources of Revenues for Fiscal Year Ending June 30, 2009



Expenses Around 60% of the district's $13.6 million of expenses were used for instruction, pupil services, and instructional services; which was a slight increase from the prior year. The school and district administrative and business activities accounted for 9.9% of total costs; which is a slight increase from last year. Operations and Maintenance comprised 10.3% of current year expenses compared to 10.4% of the prior year expenses. (see Figure A-6).

Figure A-6
Expenses for Fiscal Year Ending June 30, 2009



Financial Analysis of the District's Funds
While the district's net assets increased by over $157,000 per the district-wide statements, the district's combined governmental fund balances decreased by over $294,000 per the fund financial statements. As stated earlier, the fund financial statements do not encompass the long-term focus of the district-wide statements. This fact causes the discrepancy between the district-wide statements and fund financial statements. A detail explanation for the discrepancy is provided in the financial statements. The specific report is entitled "Reconciliation of the Statement of Revenues, Expenditures, and Changes in Fund Balance to the Statement of Activities".

The $294,000 decrease in fund balances is attributable mainly to funding the operations of the athletic fund of $185,000.

General Fund Budgetary Highlights

Over the course of the year, the district revised the annual operating budget five times.

Although the district's final budget for the general fund anticipated that expenditures would exceed revenues by $442,741, the actual results for the year showed only a $252,995 deficit. The chart presented in Figure A-7 compares the general fund budgeted and actual revenues and expenditures.

Figure A-7
General Fund Expenditures - Budget versus Actual

	2008-09 Budget	2008-09 Actual	2008-09 Variance		2007-08 Actual
Revenues:					
Local and other sources	$ 815,448	$ 840,070	$ 24,622	3.0 %	$ 1,210,650
Intermediate sources	685,000	684,252	(748)	(0.1)	768,097
State sources	9,230,575	9,179,890	(50,685)	(0.5)	9,605,655
Federal sources	817,362	811,182	(6,180)	(0.8)	276,058
Transfers from Other Funds	12,650	12,650	-		
	11,561,035	11,528,044	(32,991)	(0.3)	11,860,460
Expenditures:					
Salaries and Benefits	9,957,131	9,855,610	101,521	1.0	9,755,619
Utilities, Phones, etc	535,808	512,979	22,829	4.3	451,802
Purchased Services	732,371	684,574	47,797	6.5	617,093
Supplies and Materials	351,964	323,057	28,907	8.2	401,199
Capital Outlay	142,057	127,529	14,528	10.2	356,010
Miscellaneous	98,028	92,397	5,631	5.7	109,299
Transfers to Other Funds	186,417	184,893	1,524	0.8	165,448
	12,003,776	11,781,039	222,737	1.9 %	11,856,470
Net change in fund balances	$ (442,741)	$ (252,995)	$ 189,746		$ 3,990

Capital Asset and Debt Administration

Capital Assets

By the end of 2009, the district had invested $26.4 million in a broad range of capital assets, including school buildings, athletic facilities, computer hardware, and school buses. This amount is virtually unchanged from the prior year. Total depreciation expense for the year was $674,749. Figure A-8 details the historical costs, accumulated depreciation, and book value of the district's capital assets.

Figure A-8
Statement of Capital Assets

	Historical Cost	Accumulated Depreciation	Net Asset Value
Land and Buildings			
Land	$ 300,000	$	$ 300,000
Buildings	22,962,450	8,486,630	14,475,820
Building Improvements	315,156	83,961	231,195
Site Improvements	160,874	61,442	99,432
	23,738,480	8,632,033	15,106,447
Equipment			
Athletic Equipment	16,818	5,558	11,260
Audio Visual Equipment	96,101	69,002	27,099
Business Machines	7,390	4,693	2,697
Communications Equipment	41,470	33,565	7,905
Computer Hardware	415,861	317,909	97,952
Computer Software	67,247	46,780	20,467
Copier Equipment	69,720	59,466	10,254
Custodial Equipment	77,931	49,583	28,348
Electrical/Plumbing	9,019	4,510	4,509
Flooring Replacement	87,109	57,914	29,195
Furniture	197,010	197,010	
Grounds Equipment	90,651	49,783	40,868
HVAC Systems	121,842	14,021	107,821
Instructional Equipment	5,807	4,227	1,580
Kitchen Equipment	61,409	30,836	30,573
Lockers	41,859	41,859	
Maintenance Equipment	7,099	7,027	72
Music/Stage Equipment	168,018	114,106	53,912
Outdoor Equipment	175,079	88,661	86,418
Surveillance/Security Equip.	79,611	61,072	18,539
Transportation Equipment	3,300	2,475	825
	1,840,351	1,260,057	580,294
Vehicles	806,174	567,633	238,541
Totals at Historical Cost	$ 26,385,005	$ 10,459,723	$ 15,925,282

Long Term Debt

At year-end, the district had approximately $14.7 million in outstanding long-term debt. This amount is about $940,000 less than the prior year, as shown in Figure A-9.

Figure A-9
Statement of Long Term Debt

	Beginning Value	Net Increase/ Decrease	Ending Value
Bonded Debt			
1998 Debt	$ 1,920,000	$ (625,000)	$ 1,295,000
2007Non-Voted Debt	245,000	(25,000)	220,000
2008 Debt	7,855,000		7,855,000
Durant Bonds, Limited Obligation	143,851	(13,558)	130,293
Subtotal Bonded Debt	10,163,851	(663,558)	9,500,293
School Bond Loan Fund			
Borrowings from the SBLF	4,181,342		4,181,342
Interest on SBLF borrowings	1,056,049	(254,407)	801,642
Subtotal SBLF	5,237,391	(254,407)	4,982,984
Compensated Absences			
Terminal leave for professional staff	48,052	5,194	53,246
Terminal leave for classified staff	2,637	162	2,799
Unused vacation for classified staff	17,762	(17,762)	
Subtotal compensated absences	68,451	(12,406)	56,045
Deferred amounts on Refunding	166,716	(9,853)	156,863
Total	$ 15,636,409	$ (940,224)	$ 14,696,185

Factors Bearing on the District's Future

State economic circumstances continue to have a significant impact on the district's budget. Despite rising costs, there was no increase in the per pupil foundation allowance in 2008-09. Fortunately, funding from the American Recovery and Reinvestment Act was available to stabilize funding and avoid a mid-year reduction in state funding for schools. While it is expected that additional Recovery Act funds will be used to stabilize school revenues in 2009-10, the district anticipates a decrease in the 2009-10 foundation allowance and is preparing to make additional budget reductions in order to maintain a balance budget.

At the time these financial states were prepared, the district can report favorable matters that will benefit its financial position. They are:

1. An increase in enrollment for the 2009-10 school year
2. Completion of contract negotiations with district teachers with no increase to base salary
3. Availability of additional grant funding under the American Recovery and Reinvestment Act

Contacting the District's Financial Management

This financial report is designed to provide the district's citizens, taxpayers, customers, and investors and creditors with a general overview of the district's finances and to demonstrate the district's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Leslie Public Schools Business Office, 4141 Hull Road, Leslie, MI 49251.

Basic Financial Statements

LESLIE PUBLIC SCHOOLS
STATEMENT OF NET ASSETS
JUNE 30, 2009

	Governmental Activities
ASSETS	
Current assets:	
Cash and cash equivalents	$ 917,648
Investments	1,742,229
Other Receivables	65,158
Due from other governmental units	1,817,329
Inventory and prepaid items	79,156
Total current assets	4,621,520
Noncurrent assets:	
Capital assets, net of accumulated depreciation	15,925,282
Total assets	$ 20,546,802
LIABILITIES AND NET ASSETS	
Current liabilities:	
Accounts payable and other current liabilities	$ 1,319,478
Note payable	2,000,000
Deferred revenue	889
Current portion of long term debt	1,390,402
Total current liabilities	4,710,769
Noncurrent liabilities:	
Noncurrent portion of long-term liabilities	13,249,738
Total liabilities	17,960,507
Net assets:	
Invested in capital assets, net of related debt	1,127,290
Restricted for:	
Prepaid items	79,156
Capital projects	1,471
Debt retirement	335,494
Unrestricted	1,042,884
Total net assets	2,586,295
	$ 20,546,802

See notes to financial statements.

LESLIE PUBLIC SCHOOLS
STATEMENT OF ACTIVITIES
FOR THE YEAR ENDED JUNE 30, 2009

Functions/Programs	Expenses	Program Revenues: Charges for Services	Program Revenues: Operating Grants and Contributions	Program Revenues: Capital Grants and Contributions	Net (expenses) And changes in Net assets: Total
Governmental activities:					
Instruction:					
Basic programs	$ 5,855,583	$	$ 707,748	$ 7,000	$ (5,140,835)
Added needs	1,139,394		1,001,733		(137,661)
	6,994,977		1,709,481	7,000	(5,278,496)
Supporting services:					
Pupil	654,707		235,149		(419,558)
Instructional staff	474,618		133,787		(340,831)
General administration	300,682				(300,682)
School administration	862,496				(862,496)
Business	177,317		23,956		(153,361)
Operation and maintenance	1,395,956	17,195	101,553		(1,277,208)
Pupil transportation services	561,107	1,120	72,733		(487,254)
Central support services	219,354				(219,354)
Other support services	812,986	368,240	279,768		(164,978)
	5,459,223	386,555	846,946		(4,225,722)
Other activities:					
Community Services	20,981				(20,981)
Facilities acquisition	430,848			26,000	(404,848)
Interest on long term debt	685,180				(685,180)
Depreciation, unallocated	1,142				(1,142)
	1,138,151			26,000	(1,112,151)
Total governmental activities	$ 13,592,351	$ 386,555	$ 2,556,427	$ 33,000	(10,616,369)
General revenues:					
Property taxes, levied for general purposes					694,044
Property taxes, levies for debt services					1,505,844
Unrestricted state aid					8,536,524
Interest and investment earnings					28,641
Miscellaneous					8,834
Total General revenues and special items					10,773,887
CHANGES IN NET ASSETS					157,518
Net assets – beginning of year					2,428,777
Net assets – end of year					$ 2,586,295

See notes to financial statements.

LESLIE PUBLIC SCHOOLS
BALANCE SHEETS
GOVERNMENTAL FUNDS
JUNE 30, 2009

	General	1998 Debt Service	Other Governmental Funds	Total Governmental Funds
ASSETS				
Cash and cash equivalents	$ 560,307	$ 134,223	$ 223,118	$ 917,648
Investments	1,742,229			1,742,229
Taxes receivable				
Interest receivable				
Other receivables	2,404			2,404
Due from other funds	12,432		18,500	30,932
Due from other governmental units	1,804,505		12,824	1,817,329
Inventory			11,716	11,716
Prepaid items	67,440			67,440
	$ 4,189,317	$ 134,223	$ 266,158	$ 4,589,698
LIABILITIES AND FUND BALANCES				
Liabilities:				
Note payable	$ 2,000,000	$	$	$ 2,000,000
Accrued interest payable	18,407			18,407
Accounts payable and accrued expenses	92,036	7,622	21,124	120,782
Due to other funds	18,500		12,432	30,932
Payroll Deductions and Withholdings	530,985			530,985
Deferred revenue	889			889
Deposits held for others				
Salaries payable	561,456		237	561,693
Total liabilities	3,222,273	7,622	33,793	3,263,688
Fund balances:				
Reserved for:				
Prepaid items	67,440		11,716	79,156
Capital projects			1,471	1,471
Debt retirement		126,601	208,893	335,494
Unreserved:				
Undesignated	899,604		10,285	909,889
Total fund balances	967,044	126,601	232,365	1,326,010
	$ 4,189,317	$ 134,223	$ 266,158	$ 4,589,698

See notes to financial statements.

LESLIE PUBLIC SCHOOLS
RECONCILIATION OF THE GOVERNMENTAL FUNDS BALANCE SHEET
WITH THE STATEMENT OF NET ASSETS
JUNE 30, 2009

Amounts reported for governmental activities in the statement of net assets are difference because:

Total Fund Balance - Governmental Funds		**$ 1,326,010**
Capital assets used in governmental activities are not financial resources and therefore are not reported as assets in governmental funds.		
The cost of capital assets is	26,385,005	
Accumulated depreciation is	(10,459,723)	
		15,925,282
Amounts due from Intermediate sources (governmental unit) were earned this year but won't be collected soon enough for the current period's expenditures, and therefore are not included in the funds. They are reported in the statement of activities as program revenues, and in the net assets as due from governmental units.		62,754
Long-term liabilities, including bonds payable, are not due and payable in the current period and therefore are not reported as liabilities in the funds. Long-term liabilities at year end consist of:		
Unamortized Bond Premiums, net of net of amortization	314,715	
Deferred charges, net of amortization	(157,852)	
Bonds Payable	9,500,293	
Accrued interest payable	31,566	
School Bond Loan Fund Proceeds Payable	4,181,342	
Accrued interest on the School Bond Loan Funds Proceeds	801,642	
Special Termination Benefits Payable	56,045	(14,727,751)
Total net assets - governmental activities		**$ 2,586,295**

See notes to financial statements.

LESLIE PUBLIC SCHOOLS
STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCE
GOVERNMENTAL FUNDS
FOR THE YEAR ENDED JUNE 30, 2009

	General	1998 Debt Service	Other Governmental Funds	Total Governmental Funds
REVENUES:				
Property taxes	$ 694,044	$ 987,780	$ 518,064	$2,199,888
Other local sources	112,371	3,586	395,642	511,599
Intermediate sources	684,252			684,252
State sources	9,179,890		49,735	9,229,625
Federal sources	811,182		247,140	1,058,322
Other sources	33,655			33,655
Total revenues	11,515,394	991,366	1,210,581	13,717,341
EXPENDITURES:				
Instruction:				
Basic instruction	5,811,271			5,811,271
Added needs	1,135,408			1,135,408
Total Instruction	6,946,679			6,946,679
Support Services:				
Pupil services	650,469			650,469
Instructional staff	501,945			501,945
General Administration	301,959			301,959
School Administration	860,325			860,325
Business	177,317			177,317
Operations and Maintenance	1,388,114			1,388,114
Transportation	509,633			509,633
Central Support services	203,813			203,813
Community services	20,982			20,982
Food service			524,548	524,548
Athletic activities			275,320	275,320
Capital outlay			26,000	26,000
Principal and interest	34,910	1,050,251	539,579	1,624,740
Total support services	4,649,467	1,050,251	1,365,447	7,065,165
Total expenditures	11,596,146	1,050,251	1,365,447	14,011,844
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENDITURES	(80,752)	(58,885)	(154,866)	(294,503)
OTHER FINANCING SOURCES (USES):				
Operating transfers in	12,650		184,893	197,543
Operating transfers out	(184,893)		(12,650)	(197,543)
Total other financing sources (uses)	(172,243)		172,243	
NET CHANGES IN FUND BALANCES	(252,995)	(58,885)	17,377	(294,503)
FUND BALANCES – Beginning	1,220,039	185,486	214,988	1,620,513
FUND BALANCES – End	$ 967,044	$ 126,601	$ 232,365	$ 1,326,010

See notes to financial statements.

LESLIE PUBLIC SCHOOLS
RECONCILIATION OF THE STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCE TO THE STATEMENT OF ACTIVITIES
FOR THE YEAR ENDED JUNE 30, 2009

Total net change in fund balances - governmental funds			**$ (294,503)**
Amounts reported for governmental activities in the statement of activities are different because:			
Capital outlays to purchase or build capital assets are reported in governmental funds as expenditures. However, for governmental activities those costs are shown in the statement of net assets and allocated over their estimated useful lives as annual depreciation expenses in the statement of activities. This is the amount by which capital outlays exceeds depreciation in the period.			
	Depreciation expense	(674,749)	
	Capital outlays	142,276	(532,473)
Some amounts from governmental units were for the prior period, but they were not received soon enough to be recorded in the prior period's governmental funds statements.			32,528
In the statement of activities, certain compensated absences (vacations) and special termination benefits are measured by the net change in amounts from the beginning to the end of the year. In the governmental funds, however, expenditures for these items are measured when paid. The net increase/(decrease) in amounts included in the statement of activities are:			
	Compensated absences (vacations)	17,762	
	Special Termination Benefits Payable	(5,356)	12,406
Repayment of bond principal is an expenditure in the governmental funds, but It reduces long-term liabilities in the statement of net assets and does not affect the statement of activities.			1,156,418
The district issued refunding bonds during the year. Governmental funds report the effect of the difference between the carrying amount of the defeased debt and its reacquisition price when debt if first issued, whereas these amounts are deferred and amortized in the statement of activities.			
	Net effect of amortization of issuance costs, deferred charges, and bond premiums		9,853
The accrued interest on the bonds as of 6/30/2009 was $31,566 compared to $43,308 as reported for 6/30/2008. The decrease of $11,742 is reported on the statement of activities as less interest expense than the amounts Actually disbursed during the period and reported in the governmental funds			11,742
An amount of $238,453 for interest costs were accreted to the district's SBLF liability. This is a long-term debt that is not included as an expenditure in the governmental funds. It is treated as an expense in the statement of activities.			(238,453)
Change in net assets of governmental activities.			**$ 157,518**

See notes to financial statements.

LESLIE PUBLIC SCHOOLS
STATEMENT OF FIDUCIARY NET ASSETS
AGENCY FUNDS
JUNE 30, 2009

	2009	2008
ASSETS		
Cash	$ 93,669	$ 71,818
Due from General Fund		18,946
Total assets	$ 93,669	$ 90,764
LIABILITIES		
Liabilities:		
Due to student groups and others	$ 93,669	$ 90,764

See notes to financial statements.

LESLIE PUBLIC SCHOOLS
AGENCY FUNDS – STUDENT ACTIVITY FUNDS
SCHEDULE OF RECEIPTS, DISBURSEMENTS AND LIABILITIES
YEAR ENDED JUNE 30, 2009

	Balances, beginning of year	Receipts	Disbursements	Balances, End of year
Administrative	$ 816	$ 2,169	$ 2,557	$ 428
High school	42,187	128,647	125,447	45,387
Middle school	23,587	33,701	34,458	22,830
Elementary school	24,174	27,290	26,440	25,024
	$ 90,764	$ 191,807	$ 188,902	$ 93,669

See notes to financial statements.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements of Leslie Public Schools (the District) have been prepared in conformity with U.S. generally accepted accounting principles (GAAP) as applied to government units. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The more significant of the District's accounting policies are described below.

A. Reporting Entity

In evaluating how to define the District, for financial reporting purposes, management has considered all potential component units. The decision to include a potential component unit in the reporting entity was made by applying the criteria set forth in GAAP, currently GASB Statement #14, *The Financial Reporting Entity*.

Based on the application of these criteria, the financial statements of Leslie Public Schools contain all the funds and account group controlled by the District's Board of Education as no other entity meets the criteria to be considered a blended component unit or a discretely presented component unit of the District nor is the District a component unit of another entity.

B. Government-wide and fund financial statements

The government-wide financial statements (i.e., the statement of net assets and the statement of changes in net assets) report information on all of the non-fiduciary activities of the school district. For the most part, the effect of the interfund activity has been removed from these statements. *Governmental activities*, which normally are supported by taxes and intergovernmental revenues, are reported separately from *business-type activities*, which rely to a significant extent on fees and charges for support. The District has no business-type activities.

The statement of activities demonstrates the degree to which the direct expenses of a given function are offset by program revenues. *Direct expenses* are those that are clearly identifiable with a specific function. Program revenues include 1) charges to customers or applicants who purchase, use or directly benefit from the goods, services or privileges provided by a given function and 2) grants and contributions that are restricted to meeting the operational or capital requirements of a particular function. Taxes and other items not properly included among program revenues are reported instead as *general revenues.*

Separate financial statements are provided for governmental funds and fiduciary funds, even though the latter are excluded from the government-wide financial statements. Major individual governmental funds are reported as separate columns in the fund financial statements.

C. Measurement Focus, Basis of Accounting and Basis of Presentation

The government-wide financial statements are reported using the *economic resources measurement focus* and the *accrual basis of accounting*, as are the fiduciary fund financial statements. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of related cash flows. Property taxes are recognized in the year for which they are levied. Grants and similar items are recognized as revenue as soon as all eligibility requirements imposed by the provided have been met.

Governmental fund financial statements are reported using the *current financial resources measurement focus* and the *modified accrual basis of accounting.* Revenues are recognized as soon as they are both measurable and available. Revenues are considered to be *available* when they are collectible within the current period or soon enough thereafter to pay liabilities of the current period. For this purpose, the government considers revenues to be available if they are collected within 60 days of the end of the current fiscal period. Expenditures generally are recorded when a liability is incurred, as under accrual accounting. However, debt service expenditures, as well as expenditures related to compensated absences are recorded only when a payment is due.

The district reports the following major governmental funds:

The *general fund* is the District's primary operating fund. It accounts for all financial resources of the district, except those required to be accounted for in another fund.

The *1998 debt service funds* accounts for the resources accumulated and payments made for principal and interest on long-term general obligation debt of governmental funds.

Additionally, the district reports the following fund types:

The *agency fund* is custodial in nature and does not present the results of operations or have a measurement focus. Agency funds are accounted for using the modified accrual basis of accounting. This fund is used to account for assets that the District holds for others in an agency capacity (primarily student activities).

Private-sector standards of accounting and financial reporting issued prior to December 1, 1989, generally are followed in the government-wide financial statements to the extent that those standards do not conflict with or contradict guidance of the Governmental Accounting Standards Board.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

C. Measurement Focus, Basis of Accounting and Basis of Presentation (continued)

As a general rule the effect of interfund activity has been eliminated from the government-wide financial statements.

Amounts reported as *program revenues* include 1) charges to customers or applicants for goods, services, or privileges provided, 2) operating grants and contributions, and 3) capital grants and contributions. Internally dedicated resources are reported as *general revenues* rather than as program revenues. Likewise, general revenues include all taxes.

Property taxes, state foundation revenue, interest and charges for services are susceptible to accrual. Other receipts and taxes become measurable and available when cash is received by the District and are recognized as revenue at that time. State and federal revenues are recognized as follows:

State Foundation Revenue

The State of Michigan utilizes a foundation grant approach which provides for a specific annual amount of revenue per student based on a state-wide formula. The foundation is funded from state and local sources. Revenues from state sources are primarily governed by the School Aid Act and the School Code of Michigan. The Michigan Department of Education administers the allocation of state funds to school districts based on information supplied by the districts. For the year ended June 30, 2009 the foundation allowance was based on the pupil membership counts taken in February and September 2008.

The State portion of the foundation is provided primarily by a state education property tax millage of 6 mills and an allocated portion of state sales and other taxes. The local portion of the foundation is funded primarily by non-homestead property taxes, which may be levied at a rate of up to 18 mills. The state revenue is recognized during the foundation period and is funded through payments from October 2008 to August 2009. Thus, the unpaid portion at June 30th is reported as due from other governmental units. The local revenue is recognized as outlined in Note 1 – Property Taxes.

Categorical

The District also receives revenue from the State to administer certain categorical education programs. State rules require that revenue earmarked for these programs be expended for its specific purpose. Categorical funds received which are not expended by the close of the fiscal year are recorded as deferred revenue.

Federal Revenue

Expenditure-driven grants are recognized as revenue when the qualifying expenditures have been incurred and all other grant requirements have been met.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

D. Assets, Liabilities and Equity

1. Cash and investments

Cash includes amounts in demand deposits and certificates of deposit.

The District reports its investments in accordance with GASB Statements No. 31, *Accounting and Financial Reporting for* Certain *Investments and for External Investment Pools* and GASB Statement No. 40, *Deposit and Investment Risk Disclosure.* Under these standards, certain investments are valued at fair value as determined by quoted market prices, or by estimated fair values when quoted market prices are not available. The standards also provide that certain investments are valued at cost (or amortized cost) when they are of a short-term duration, the rate of return is fixed, such as certificates of deposit, and the district intends to hold the investment until maturity.

State statutes authorize the District to invest in bonds and other direct and certain indirect obligations of the U.S. Treasury; certificates of deposit, savings accounts, deposit accounts, or depository receipts of a bank or credit union, which is a member of the Federal Deposit Insurance Corporation or Nation Credit Union Administration, respectively; in commercial paper rated at the time of purchase within the three highest classifications established by not less than two standard rating services and which mature not more than 270 days after the date of purchase. The District is also authorized to invest in U.S. Government or federal agency obligation repurchase agreements, bankers' acceptances of U.S. banks, and mutual funds composed of investments as outlined above.

2. Short-term Interfund Receivables/Payables

During the course of operations, numerous transactions occur between individual funds for goods provided or services rendered. These receivables and payables are classified as "due from other funds" or "due to other funds" on the balance sheet in the governmental fund financial statements.

3. Property Taxes

Property taxes levied by the District are collected by various municipalities and periodically remitted to the District. The taxes are levied as of December 1 and are due upon receipt of the billing by the taxpayer and become a lien on the first day of the levy year. The actual due date is February 14, after which time the bills become delinquent and penalties and interest may be assessed by the collecting entity. School District property tax revenues are recognized when levied to the extent that they result in current receivables (collected within sixty days after year end). Amounts received subsequent to August 31 are recognized as revenue when collected.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

D. Assets, Liabilities and Equity (continued)

For the year ended June 30, 2009, the District levied the following amounts per $1,000 of taxable valuation:

Fund	Mills
General Fund:	
Non-Principle Residence Exemption (PRE)	17.0617
Commercial personal property	6.000
Debt service funds :	
PRE, Non-PRE, Commercial Personal Property	7.3900

4. Inventories and Prepaid Items

Inventories are valued at the lower of cost (first-in, first-out) or market. Inventories in the special revenue funds consisting of expendable supplies held for consumption, are recorded as expenditures when consumed rather than when purchased.

Certain payments to vendors reflect costs applicable to future accounting periods and are recorded as prepaid items in both government-wide and fund financial statements.

5. Capital Assets

Capital assets, which include property, plant, and equipment are reported in the government-wide financial statements. Capital assets are defined by the district as assets with an initial individual cost of more than $2,500 and an estimated useful life of more than one year. An exception to this policy is made in the case of computer or information technology purchases, substantially all of which are capitalized regardless of price. Such assets are recorded at historical cost or estimated historical cost if purchased or constructed. Donated capital assets are recorded at estimated fair market value at the date of donations.

The costs of normal maintenance and repairs that do not add to the value of the asset or materially extend asset lives are not capitalized.

Property, plant and equipment of the district are depreciated using the straight line method over the following estimated useful lives:

Buildings	50 yrs
Building and site improvements	20 yrs
General equipment	10-15 yrs
Vehicles	8 yrs
Office furniture and fixtures	7 yrs
Computer equipment	5 yrs

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

D. Assets, Liabilities and Equity (continued)

6. Compensated Absences

It is the district's policy to permit employees to accumulate earned but unused vacation and sick pay benefits. All vacation and sick pay is accrued in the government-wide financial statement. A liability for these amounts is reported in governmental funds only if they are expected to be liquidated with expendable available resources (generally sixty days).

7. Unemployment Insurance

The District reimburses the State of Michigan for the actual amount of unemployment benefits disbursed by the State on behalf of the District. Billings are received for amounts paid by the State through June 30 are accrued.

8. Long-term Obligations

In the government-wide financial statements, long-term debt and other long-term obligations are reported as liabilities in the statement of net assets.

For governmental fund types, bond premiums and discounts, as well as issuance costs, are recognized during the current period. Bond proceeds are reported as other financing sources net of applicable premium or discount. Issuance costs, even if withheld from the actual net proceeds received, are reported as debt service expenditures.

9. Fund Balance

In the fund financial statements, the unreserved fund balances for governmental funds represent the amount available for budgeting future operations. The reserved fund balances for governmental funds represent the amount that has been legally identified for specific purposes or indicates that a component of assets does not constitute "available spendable resources." The designated fund balances for governmental funds represent tentative plans for future use of financial resources.

10. Use of Estimates

The process of preparing general purpose financial statements in conformity with generally accepted accounting principles requires the use of estimates and assumptions regarding certain types of assets, liabilities, revenues, and expenditures. Such estimates primarily relate to unsettled transactions and events as of the date of the financial statements. Accordingly, upon settlement, actual results may differ from estimated amounts.

NOTE 2 – STEWARDSHIP, COMPLIANCE AND ACCOUNTABILITY

A. Budgetary information

Budgets are adopted on a basis consistent with generally accepted accounting principles. Annual appropriations budgets are adopted for the general, special revenue and debt service funds. All annual appropriations lapse at fiscal year end.

The District maintains a formalized encumbrance accounting system.

The District follows these procedures in establishing the budgetary data reflected in the financial statements:

1. The Superintendent submits to the School Board a proposed operating budget for the fiscal year commencing on July 1. The operating budget includes proposed expenditures and the means of financing them. The level of control for the budgets is at the functional level as set forth in the combined statement of revenues, expenditure and changes in fund balances – budget and actual – GAAP basis – general, special revenue and debt service funds.

2. Public hearings are conducted to obtain taxpayer comments.

3. Prior to July 1, the budget is legally adopted by the School Board resolution pursuant to the Uniform Budgeting and Accounting Act (P.A. 621 of 1978). The Act requires that the budget be amended prior to the end of the fiscal year when necessary to adjust appropriations if it appears that revenues and other financing sources will be less than anticipated or so that expenditures will not be in excess of original estimates. Expenditures shall not be made or incurred, unless authorized in the budget, or in excess of the amount appropriated.

4. The Superintendent is authorized to transfer budgeted amounts between major expenditure functions within any fund; however, these transfers and any revisions that alter the total expenditures of any fund must be approved by the School Board.

5. Formal budgetary integration is employed as a management control device during the year for the general fund.

6. The budget as presented, has been amended. Supplemental appropriations were made during the year with the last one approved prior to June 30th.

NOTE 3 – DEPOSITS, INVESTMENTS AND CREDIT RISK

Cash and cash equivalents are held separately in the name of the District by each of the District's funds.

Deposits

At year-end, the carrying amount of the District's deposits were $1,011,317 and the bank balance was $1,131,266 of which $317,181 was covered by federal depository insurance and $814,085 was uninsured and uncollateralized.

Investments

The District had the following investments as of June 30, 2009:

	Fair Value	Weighted Average Maturity(Years)	Standard & Poors Rating	%
MILAF External Investment Pool – MIMAX	$1,742,229	0.0027	AAAm	100

1 day maturity equals 0.0027. One year equals 1.0.

Interest Rate Risk – The district does not have a formal investment policy that limits investment maturities as a means of managing its exposure to fair value losses arising from increasing interest rates.

Credit Risk - State statutes authorize the District to invest in bonds and other direct and certain indirect obligations of the U.S. Treasury; certificates of deposit, savings accounts, deposit accounts, or depository receipts of a bank or a credit union, which is a member of either the Federal Deposit Insurance Corporation or the National Credit Union Administration, respectively; in commercial paper rated at the time of purchase within the three highest classifications established by not less than two standard rating services and which mature not more than 270 days after the date of purchase. The District is also authorized to invest in U.S. Government or federal agency obligation repurchase agreements, bankers' acceptances of U.S. banks, and mutual funds composed of investments as outlined above. The district has no investment policy that would further limit its investment choices. As of June 30, 2009, the district's investment in the Michigan Municipal Bond Revenue Note was rated SP-1+ by Standard and Poor's.

Concentration of Credit Risk – The district places no limit on the amount the district may invest in any one issuer. All of the districts investments are reported in the General fund.

A reconciliation of cash as shown on the combined balance sheet follows:

Carrying amount of deposits	$ 560,153
Investments	451,164
Total	$ 1,011,317
Cash and cash equivalents:	
Governmental activities	$ 917,648
Fiduciary funds	93,669
Total	$ 1,011,317

NOTE 4 – NOTE PAYABLE

At June 30, 2009 the District has outstanding a $2,000,000 revenue note (state aid note) dated August 20, 2009. The note, which has an interest rate of 1.63%, matures August 20, 2009. The note is secured by the full faith and credit of the District, the investment contract, as well as pledged state aid. The short term note is used to facilitate cash flow needs.

The following is a summary of the changes in short-term liabilities for the year ended June 30, 2009:

	Beginning Balance	Additions	Reductions	Ending Balance
Note payable	$ 1,750,000	$ 2,000,000	$ 1,750,000	$ 2,000,000

NOTE 5 – RECEIVABLES

Receivables at June 30 consist of the following:

	General fund	Special Revenue funds
Governmental units	$ 1,804,505	$ 12,824
Interest	2,404	
	$ 1,806,909	$ 12,824

Amounts due from governmental units include amounts due from federal, state and local sources for various projects and programs.

Because of the District’s favorable collection experience, no allowance for doubtful accounts has been recorded.

NOTE 6 – LONG-TERM LIABILITIES

At June 30, 2009, general obligation debts and other long-term obligations currently outstanding are as follows:

$12,265,000 1998 serial bonds payable in annual installments of $65,000 to $655,000 through May 1, 2025; interest at 4.3% to 5.0%	$	1,295,000
$270,000 2008 serial bonds payable in annual installments of $25,000 to $30,000 through May 1, 2017; interest at 3.8% to 4.2%		220,000
$7,855,000 2009 serial bonds payable in annual installments of $470,000 to $665,000 through May 1, 2025; interest at 3.0% to 5.0%		7,855,000
Limited obligation Durant bonds payable in annual installments of $10,742 to $22,000 through May 2013, interest at 4.76%		130,293
Total bonded debt		9,500,293
Borrowings from State of Michigan under the School Bond Loan Fund, including interest		4,982,984
Refunding deferrals, net of charges		156,863
Termination benefits		56,045
	$	14,696,185

NOTE 6 – LONG-TERM LIABILITIES (concluded)

The annual requirements to amortize long-term obligations outstanding as of June 30, 2009 including interest of $3,052,102 are as follows:

Year ending June 30,	Principal	Interest	Total
2010	$ 684,203	$ 381,699	$ 1,065,902
2011	699,880	350,400	1,050,280
2012	695,588	317,713	1,013,301
2013	780,622	324,811	1,105,433
2014	675,000	272,660	947,660
2015-2019	2,945,000	990,819	3,935,819
2020-2024	2,550,000	395,200	2,945,200
2025	470,000	18,800	488,800
	9,500,293	3,052,102	12,552,395
Due to School Bond Loan Fund	4,982,984		4,982,984
Refunding deferrals, net of charges	156,863		156,863
Termination benefits	56,045		56,045
	$ 14,696,185	$ 3,052,102	$ 17,748,287

At June 30, 2009, net assets of $335,494 are available in the debt service funds to service the general obligation debt.

The following is a summary of the changes in long-term liabilities for the year ended June 30, 2009:

	Beginning balance	Additions	Reductions	Ending balance	Due within one year
Governmental Activities:					
Bonds payable:					
General obligation bonds	$ 10,020,000	$	$ 650,000	$ 9,370,000	$ 670,000
Limited obligation bonds	143,851		13,558	130,293	14,203
Refunding deferrals, net of charges	166,716		9,853	156,863	9,853
Total bonds payable	10,330,567		673,411	9,657,156	694,056
Other liabilities:					
School bond loan fund	5,237,391	238,453	492,860	4,982,984	696,346
Termination benefits	68,451	6,298	18,704	56,045	
Total long-term liabilities	$ 15,636,409	$ 244,751	$ 1,184,975	$ 14,696,185	$ 1,390,402

NOTE 7 – GOVERNMENTAL FUND TYPE INTERFUND TRANSACTIONS

Amounts due to and from other funds for the Districts governmental fund types at June 30, 2009 are as follows:

Receivable fund	Payable fund	Amount
General fund	Athletic fund	$ 8,912
General fund	Food Service fund	3,520
Capital projects fund	General fund	18,500
		$ 30,932

The outstanding balances between funds result mainly from a timing difference of accounting transactions between the funds.

Inter-fund transfers for the year ended June 30, 2009 were as follows:

Fund Transferred Out	Fund Transferred In	Amount
General fund	Athletic Activities	$ 184,893
Food service	General fund	12,650
		$ 197,543

Transfers to the Food Service and Athletic Funds were to cover operating deficits.

NOTE 8 – DISCLOSURE OF INFORMATION ABOUT CAPITAL ASSETS

Capital asset balances and activity for the year ended June 30, 2009 were as follows:

	Beginning of year	Additions	Retirements	End of year
Governmental activities:				
Capital assets not being depreciated:				
Land	$ 300,000	$	$	$ 300,000
Capital assets, being depreciated				
Buildings	$ 23,392,980	$ 45,500	$	$ 23,438,480
Equipment and technology	1,878,390	96,776	134,815	1,840,351
Vehicles	806,174			806,174
Total historical cost	$ 26,077,544	$ 142,276	$ 134,815	$ 26,085,005
Less accumulated depreciation:				
Buildings	$ 8,189,305	$ 442,728	$	$ 8,632,033
Equipment and technology	1,218,346	176,526	134,815	1,260,057
Vehicles	512,138	55,495		567,633
Total accumulated depreciation	$ 9,919,789	$ 674,749	$ 134,815	$ 10,459,723
Governmental activities capital assets, net	$ 16,457,755	$ (532,473)	$	$ 15,925,282

Deprecation expense was charged to governmental functions as follows:

Depreciation not allocated	$ 1,142
Basic programs	38,553
Added needs	4,659
Pupil services	4,129
Instructional staff services	40,301
General administration	1,368
School administration	2,171
Operations and maintenance	50,418
Transportation services	61,036
Central services	19,252
Facilities acquisition	430,849
Other	20,871
	$ 674,749

NOTE 9 – EMPLOYEE RETIREMENT SYSTEM – DEFINED BENEFIT PLAN

Plan Description – The District contributes to the statewide Michigan Public School Employees' Retirement System (MPSERS), a cost sharing multiple-employer defined benefit pension plan administered by the nine member board of the MPSERS. The MPSERS provides retirement benefits and postretirement benefits for health, dental and vision. The MPSERS was established by Public Act 136 pf 1945 and operated under the provisions of Public Act 300 of 1980, as amended. The MPSERS issues a publicly available financial report that includes financial statements and required supplementary information for MPSERS. That report may be obtained by writing to Michigan Public School Employees Retirement System, P.O. Box 30026, Lansing, Michigan 48909 or by calling (517) 322-6000.

Funding Policy – Member Investment Plan (MIP) members enrolled in MIP prior to January 1, 1990 contribute a permanently fixed rate of 3.9% of gross wages. The MIP contribution rate was 4.0% from January 1, 1987, the effective date of the MIP, until January 1, 1990 when it was reduced to 3.9%. Members first hired January 1, 1990 or later and returning members who did not work between January1, 1987 through December 31, 1989 contribute at the following graduated permanently fixed contribution rate: 3% of the first $5,000; 3.6% of $5,001 through $15,000; 4.3% of all wages over $15,000.

Basic plan members make no contributions. For a limited period ending December 31, 1992, an active Basic Plan member could enroll in the MIP by paying the contributions that would have been made had enrollment occurred initially on January 1, 1987 or on the date of hire, plus interest. MIP contributions at the rate of 3.9% of gross wages begin at enrollment. Market rate interest is posted to member accounts on July 1st on all MIP monies on deposit for 12 months. If a member leaves MPSERS service and no pension is payable, the member's accumulated contribution plus interest, if any, are refundable.

The District is required to contribute the full actuarial funding contribution amount to the pension benefits, plus an additional amount to fund retiree health care benefit amounts on a cash disbursement basis. The rates for the year ended June 30, 2009 were 16.54%. The contribution requirements of plan members and the District are established and may be amended by the MPSERS Board of Trustees. The District contributions to MPSERS for the year ended June 30, 2009, 2008 and 2007 were $1,175,783, $1,190,320, and $1,255,159, respectively, equal to the required contribution for each year.

The District is not responsible for the payment of retirement benefits which is the responsibility of the State of Michigan.

Other Post-Employment Benefits – Under the MPSERS' Act, all retirees have the option of continuing health, dental and vision coverage.

NOTE 10 – RISK MANAGEMENT

The District is exposed to various risk of loss related to torts; theft of, damage to, and destruction of assets; errors and omissions; injuries to employees' and natural disasters. The District participates in two distinct pools of educational institutions within the State of Michigan for self-insuring property and casualty and workers' disability compensation. The pools are considered Public entity risk pools. The District pays annual premiums to each pool for the respective insurance coverage. In the event a pool's total claims and expenses for one policy year exceed the total normal annual premiums for said years, all members of the specific pool's policy year may be subject to special assessments to make up the deficiency. Each of the pools maintain reinsurance for claims in excess of $500,000 for each occurrence with the overall maximum coverage being unlimited. The District has not been informed of any special assessments being required.

The District continues to carry commercial insurance for other risks of loss, including employee health and accident insurance.

NOTE 11 – COMMITMENTS AND CONTINGENCIES

The District borrows from time to time to facilitate its cash flow needs.

NONMAJOR GOVERNMENTAL FUNDS

Special revenue funds account for revenue sources that are legally restricted to expenditure for specific purposes.

Food Service fund – This fund accounts for the Districts school lunch program.

Athletic Activities fund – This fund accounts for the Athletic activities of the District.

The Durant Debt Service and the 2008 Debt Service funds account for the resources accumulated and payments made for principal and interest on long-term general obligation debt of governmental funds.

Capital Projects funds accounts for the receipt of debt proceeds and the acquisition of fixed assets or construction of major capital projects.

Capital projects fund – This fund is used to account for the general construction of facilities and structures of the district. This fund is funded by transfers from the general fund.

REQUIRED SUPPLEMENTARY INFORMATION

LESLIE PUBLIC SCHOOLS
GENERAL FUND
STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCES – BUDGET AND ACTUAL – GAAP BASIS
YEAR ENDED JUNE 30, 2009

	Budgeted Amounts			Variance with Final Budget-Favorable (unfavorable)
	Original	Final	Actual	
Property taxes	$ 667,306	$ 694,706	$ 694,044	$ (662)
Other local sources	77,742	105,142	112,371	7,229
Intermediate sources	780,000	685,000	684,252	(748)
State sources	9,776,130	9,230,575	9,179,890	(50,685)
Federal sources	287,175	817,362	811,182	(6,180)
Other sources	15,600	15,600	33,655	18,055
Total revenues	11,603,953	11,548,385	11,515,394	(32,991)
EXPENDITURES:				
Instruction:				
Basic instruction	5,797,955	5,913,779	5,811,271	102,508
Added needs	1,102,686	1,137,647	1,135,408	2,239
Total Instruction	6,900,641	7,051,426	6,946,679	104,747
Support Services:				
Pupil services	657,333	657,333	650,469	6,864
Instructional staff	495,010	506,969	501,945	5,024
General Administration	303,740	306,390	301,959	4,431
School Administration	882,395	885,045	860,325	24,720
Business	188,209	188,209	177,317	10,892
Operations and Maintenance	1,311,969	1,373,276	1,388,114	(14,838)
Transportation	615,267	570,267	509,633	60,634
Central Support services	213,022	218,022	203,813	14,209
Community services	25,512	25,512	20,982	4,530
Debt service:				
Principal	25,000	25,000	25,000	-
Interest and other fiscal charges	9,910	9,910	9,910	-
Total support services	4,727,367	4,765,933	4,649,467	116,466
Total expenditures	11,628,008	11,817,359	11,596,146	221,213
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENDITURES	(24,055)	(268,974)	(80,752)	188,222
OTHER FINANCING SOURCES (USES):				
Operating transfers in		12,650	12,650	
Operating transfers out	(188,807)	(186,417)	(184,893)	1,524
Total other financing sources (uses)	(188,807)	(173,767)	(172,243)	1,524
NET CHANGES IN FUND BALANCES	$ (212,862)	$ (442,741)	(252,995)	$ 189,746
FUND BALANCES:				
Beginning of year			1,220,039	
End of year			$ 967,044	

LESLIE PUBLIC SCHOOLS
1998 DEBT SERVICE FUND
SCHEDULE OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCE
- BUDGET AND ACTUAL
YEAR ENDED JUNE 30, 2009

	Budgeted Amounts			Variance with Final Budget- Favorable (unfavorable)
	Original	Final	Actual	
REVENUES:				
Property taxes	$ 1,485,130	$ 1,485,130	$ 987,780	$ (497,350)
Investment income	19,500	19,500	3,586	(15,914)
Total revenues	1,504,630	1,504,630	991,366	(513,264)
EXPENDITURES:				
Debt service:				
Principal	907,639	907,639	625,000	282,639
Interest and other fiscal charges	456,280	456,280	425,251	31,029
Total expenditures	1,363,919	1,363,919	1,050,251	313,668
	140,711	140,711	(58,885)	(199,596)
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENDITURES	$ 140,711	$ 140,711	(58,885)	$ (199,596)
FUND BALANCES:				
Beginning of year			185,486	
End of year			$ 126,601	

OTHER SUPPLEMENTAL INFORMATION

LESLIE PUBLIC SCHOOLS
COMBINING BALANCE SHEET
NONMAJOR GOVERNMENTAL FUNDS
JUNE 30, 2009

	Special Revenue Funds		Debt Service Funds			
	Food Service	Athletic Activities	Durant Debt Service	2008 Debt Service	Capital Project	Total Nonmajor Governmental Funds
ASSETS						
Cash and cash equivalents	$ 1,630	$ 11,068	$	$ 208,949	$ 1,471	$ 223,118
Receivables:						
Other						
Due from other funds					18,500	18,500
Due from other governmental units	12,824					12,824
Inventory	11,716					11,716
	$ 26,170	$ 11,068	$	$ 208,949	$ 19,971	$ 266,158
Liabilities:						
Accounts payable and accrued expenses	$ 1,065	$ 1,503	$	$ 56	$ 18,500	$ 21,124
Due to other funds	3,520	8,912				12,432
Deferred revenue						
Salaries payable	237					237
Total liabilities	4,822	10,415		56	18,500	33,793
Fund balances:						
Reserved for:						
Inventory						
Capital projects					1,471	1,471
Debt retirement				208,893		208,893
Unreserved:						
Undesignated	21,348	653				22,001
Total fund balances	21,348	653		208,893	1,471	232,365
	$ 26,170	$ 11,068	$	$ 208,949	$ 19,971	$ 266,158

LESLIE PUBLIC SCHOOLS
COMBINING STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCES
NONMAJOR GOVERNMENTAL FUNDS
FOR THE YEAR ENDED JUNE 30, 2009

	Special Revenue Funds		Debt Service Funds			
	Food Service	Athletic Activities	Durant Debt Service	2008 Debt Service	Capital Project	Total Nonmajor Governmental Funds
REVENUES:						
Local sources:						
Lunch and milk sales	$ 277,867	$	$	$	$	$ 277,867
Admission and other		90,373				90,373
Property taxes				518,064		518,064
Interest	42	54		1,300	6	1,402
Other					26,000	26,000
State sources	32,627		17,108			49,735
Federal sources	221,649					221,649
USDA donated commodities	25,491					25,491
Total revenues	557,676	90,427	17,108	519,364	26,006	1,210,581
EXPENDITURES:						
Food service	524,548					524,548
Athletic activities		275,320				275,320
Facilities site improvements						
Principal and interest			17,108	522,471		539,579
Capital outlay					26,000	26,000
Other						
Total expenditures	524,548	275,320	17,108	522,471	26,000	1,365,447
EXCESS (DEFICIENCY) OF REVENUES OVER (UNDER) EXPENDITURES	33,128	(184,893)		(3,107)	6	(154,866)
OTHER FINANCING SOURCES (USES):						
Operating transfers in		184,893				184,893
Operating transfers out	(12,650)					(12,650)
Total other financing sources (uses)	(12,650)	184,893				172,243
EXCESS (DEFICIENCY) OF REVENUES AND OTHER FINANCING SOURCES OVER (UNDER) EXPENDITURES AND OTHER FINANCING (USES)	20,478			(3,107)	6	17,377
FUND BALANCES, beginning of year	870	653		212,000	1,465	214,988
FUND BALANCES, end of year	$ 21,348	$ 653	$	$ 208,893	$ 1,471	$ 232,365

LESLIE PUBLIC SCHOOLS
FOOD SERVICE SPECIAL REVENUE FUND
SCHEDULE OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCE
- BUDGET AND ACTUAL
YEAR ENDED JUNE 30, 2009

	Budgeted Amounts			Variance with Final Budget- Favorable
	Original	Final	Actual	(unfavorable)
REVENUES:				
Local sources:				
Lunch, milk sales and other	$ 253,646	$ 275,646	$ 277,867	$ 2,221
Interest	40	40	42	2
State sources	36,467	31,867	32,627	760
Federal sources	204,173	220,173	221,649	1,476
USDA donated commodities	18,950	18,950	25,491	6,541
Total revenues	513,276	546,676	557,676	11,000
EXPENDITURES:				
Salaries	155,926	155,926	154,989	937
Purchased services	1,450	8,450	7,933	517
Supplies and other	268,900	279,900	272,281	7,619
Employee benefits	87,000	89,750	89,345	405
Total expenditures	513,276	534,026	524,548	9,478
EXCESS (DEFICIENCY) OF REVENUES OVER (UNDER) EXPENDITURES		12,650	33,128	20,478
OTHER FINANCING SOURCES (USES):				
Outgoing operating transfers		(12,650)	(12,650)	
Total other financing sources (uses)		(12,650)	(12,650)	
EXCESS (DEFICIENCY) OF REVENUES AND OTHER FINANCING SOURCES OVER (UNDER) EXPENDITURES	$	$	20,478	$ 20,478
FUND BALANCES, beginning of year			870	
FUND BALANCES, end of year			$ 21,348	

LESLIE PUBLIC SCHOOLS
ATHLETIC ACTIVITIES SPECIAL REVENUE FUND
SCHEDULE OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCE - BUDGET AND ACTUAL
YEAR ENDED JUNE 30, 2009

	Budgeted Amounts			Variance with Final Budget- Favorable (unfavorable)
	Original	Final	Actual	
REVENUES:				
Local sources:				
Admission and other	$ 81,549	$ 85,999	$ 90,373	$ 4,374
Interest	70	50	54	4
Total revenues	81,619	86,049	90,427	4,378
EXPENDITURES:				
Salaries	153,317	153,866	153,866	
Purchased services	22,000	25,000	27,230	(2,230)
Supplies and other	56,320	55,320	55,944	(624)
Employee benefits	38,789	38,280	38,280	
Total expenditures	270,426	272,466	275,320	(2,854)
EXCESS (DEFICIENCY) OF REVENUES OVER (UNDER) EXPENDITURES	(188,807)	(186,417)	(184,893)	1,524
OTHER FINANCING SOURCES:				
Incoming operating transfers	188,807	186,417	184,893	(1,524)
Total other financing sources	188,807	186,417	184,893	(1,524)
EXCESS (DEFICIENCY) OF REVENUES AND OTHER FINANCING SOURCES OVER (UNDER) EXPENDITURES	$	$		$
FUND BALANCES, beginning of year			653	
FUND BALANCES, end of year			$ 653	

LESLIE PUBLIC SCHOOLS
SCHEDULE OF BONDED DEBT SERVICE REQUIREMENTS – 2008 REFUNDING BONDS
JUNE 30, 2009

	Interest rate	Principal Amount	Interest amount	Total
Year ending June 30:				
2010	4.60%	$ -	$ 309,625	$ 309,625
2011	4.70%	-	309,625	309,625
2012	3.00%	650,000	309,625	959,625
2013	3.25%	665,000	290,125	955,125
2014	3.25%	650,000	268,512	918,512
2015-2019	Various	2,870,000	984,538	3,854,538
2020-2024	4.00%	2,550,000	395,200	2,945,200
2025	4.00%	470,000	18,800	488,800
		$ 7,855,000	$ 2,886,050	$ 10,741,050

Principal payments due on first day of May

Interest payments due on the first day of May and November

Original issue – February 26, 2008 $7,855,000

Purpose – Partially refund the 1998 bonds

LESLIE PUBLIC SCHOOLS
SCHEDULE OF BONDED DEBT SERVICE REQUIREMENTS – 2007 EQUIPMENT BONDS
JUNE 30, 2009

	Interest rate	Principal Amount	Interest amount	Total
Year ending June 30:				
2010	3.94%	$ 30,000	$ 8,945	$ 38,945
2011	3.98%	30,000	7,762	37,762
2012	4.02%	30,000	6,568	36,568
2013	4.05%	30,000	5,362	35,362
2014	4.08%	25,000	4,148	29,148
2015-2017	Various	75,000	6,281	81,281
		$ 220,000	$ 39,066	$ 259,066

Principal payments due on first day of May

Interest payments due on the first day of May and November

Original issue – July 1, 2007 $270,000

Purpose – These bonds were issued for the purpose of remodeling school facilities; installing and equipping technology; and purchasing a school bus.

LESLIE PUBLIC SCHOOLS
SCHEDULE OF BONDED DEBT SERVICE REQUIREMENTS – 1998 DEBT
JUNE 30, 2009

	Interest rate	Principal Amount	Interest amount	Total
Year ending June 30:				
2010	4.60%	$ 640,000	$ 60,225	$ 700,225
2011	4.70%	655,000	30,785	685,785
		$ 1,295,000	$ 91,010	$ 1,386,010

Principal payments due on first day of May

Interest payments due on the first day of May and November

Original issue – March 1, 1998 $12,265,000

Purpose – Partially refund the 1995 bonds

LESLIE PUBLIC SCHOOLS
SCHEDULE OF BONDED DEBT SERVICE REQUIREMENTS – DURANT DEBT
JUNE 30, 2009

	Interest rate	Principal amount	Interest amount	Total
Year ending June 30:				
2010		$ 14,203	$ 2,904	$ 17,107
2011		14,880	2,228	17,108
2012		15,588	1,520	17,108
2013		85,622	29,324	114,946
		$ 130,293	$ 35,976	$ 166,269

Principal payments due on fifteenth day of	May
Interest payments due on the fifteenth day of	May and November
Original issue – 1999	$243,624

This bond, including the interest hereon, is issued in anticipation of payments appropriated and to be appropriated by the State under Section 11g(3) of Act 94 to the School District (the "State Aid Payments"). The School District hereby pledges and assigns to the Authority all of its rights to and in such State Aid Payments as security for this bond and the State Aid Payments which are hereby pledged shall be subject to a statutory lien in favor of the Authority as authorized by Act 94. This bond is a self-liquidating bond and is not a general obligation of the School District and does not constitute an indebtedness of the School District within any constitutional or statutory limitation, and is payable both as to principal and interest, solely from such State Aid Payments. The School District, as requested by the Authority, hereby irrevocably authorizes the payment of the State Aid Payments directly to the Authority's Depository.

LESLIE PUBLIC SCHOOLS

ADDITIONAL REPORTS REQUIRED BY

OMB CIRCULAR A-133

YEAR ENDED JUNE 30, 2009

CONTENTS

HARRIS GROUP
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REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF THE FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

October 19, 2009

To the Board of Education
Leslie Public Schools
Leslie, Michigan

We have audited the financial statements of the governmental activities, each major fund, and the aggregate remaining fund information of Leslie Public Schools as of and for the year ended June 30, 2009, which collectively comprise the Leslie Public School's basic financial statements and have issued our report thereon dated October 19, 2009. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered Leslie Public Schools' internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Leslie Public Schools' internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of Leslie Public Schools' internal control over financial reporting.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects Leslie Public Schools' ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of Leslie Public Schools' financial statements that is more than inconsequential will not be prevented or detected by Leslie Public Schools' internal control.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements of the financial statements will not be prevented or detected by Leslie Public Schools' internal control. Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

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Compliance and Other Matters

As part of obtaining reasonable assurance about whether Leslie Public Schools' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which would have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

We noted certain matters that we reported to management of Leslie Public Schools in a separate letter dated October 19, 2009.

This report is intended solely for the information and use of the board of education, management and federal awarding agencies and pass-through entities and is not intended to be and should not be used by anyone other than these specific parties.

Certified Public Accountants

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Certified Public Accountants

REPORT ON COMPLIANCE WITH REQUIREMENTS APPLICABLE TO EACH MAJOR PROGRAM AND INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY OMB CIRCULAR A-133

October 19, 2009

To the Board of Education
Leslie Public Schools
Leslie, Michigan

Compliance

We have audited the compliance of Leslie Public Schools with the types of compliance requirements described in the *U.S. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement* that are applicable to each of its major federal programs for the year ended June 30, 2009. Leslie Public Schools' major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs. Compliance with the requirements of laws, regulations, contracts and grants applicable to each of its major federal programs is the responsibility of Leslie Public Schools' management. Our responsibility is to express an opinion on Leslie Public Schools' compliance based on our audit.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about Leslie Public Schools' compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination on Leslie Public Schools' compliance with those requirements.

In our opinion, Leslie Public Schools complied, in all material respects, with the requirements referred to above that are applicable each of its major federal programs for the year ended June 30, 2009.

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Internal Control Over Compliance

The management of Leslie Public Schools is responsible for establishing and maintaining effective internal control over compliance with the requirements of laws, regulations, contracts and grants applicable to federal programs. In planning and performing our audit, we considered Leslie Public Schools' internal control over compliance with the requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of Leslie Public Schools' internal control over compliance.

A *control deficiency* in an entity's internal control over compliance exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect noncompliance with a type of compliance requirement of a federal program on a timely basis. A *significant deficiency* is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to administer a federal program such that there is more than a remote likelihood that noncompliance with a type of compliance requirement of a federal program that is more than inconsequential will not be prevented or detected by the entity's internal control.

A *material weakness* is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material noncompliance with a type of compliance requirement of a federal program will not be prevented or detected by the entity's internal control.

Our consideration of the internal control over compliance was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above.

Schedule of Expenditures of Federal Awards

We have audited the financial statements of the governmental activities, each major fund, and the aggregate remaining fund information of Leslie Public Schools as of and for the year ended June 30, 2009, and have issued our report thereon dated October 19, 2009. Our audit was performed for the purpose of forming our opinions on the financial statements that collectively comprise the Leslie Public School's basic financial statements. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by OMB Circular A-133 and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated, in all material respects, in relation to the basic financial statements taken as a whole.

This report is intended solely for the information and use of the board of education, management and federal awarding agencies and pass-through entities and is not intended to be and should not be used by anyone other than these specific parties

Certified Public Accountants

LESLIE PUBLIC SCHOOLS
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 2009

Federal grantor/pass-through grantor/ program title	Federal CFDA number	Pass-through grantor's number	Award amount	Prior year Expenditures	Accrued (Deferred) revenue 6/30/08	Current year receipts	Current year expenditures	Accrued (Deferred) Revenue 6/30/09
U.S. Department of Agriculture								
Passed through Michigan Department of Education:								
Child Nutrition Cluster:								
National School Lunch Program – Section 4	10.555	81950	$ 26,375	$ 23,086	$ 1,218	$ 4,507	$ 3,289	$
National School Lunch Program – Section 4		91950	24,787			24,787	24,787	
National School Lunch Program – Section 11		81960	125,297	109,468	5,701	21,530	15,829	
National School Lunch Program – Section 11		91960	129,660			122,808	129,660	6,852
USDA Commodity Recall		81965	6			6	6	
			306,125	132,554	6,919	173,638	173,571	6,852
National School Lunch Program – Breakfast	10.553	81970	48,270	43,670	2,006	6,607	4,601	
National School Lunch Program – Breakfast		91970	43,477			40,867	43,477	2,610
			91,747	43,670	2,006	47,474	48,078	2,610
Food Distribution:								
Entitlement commodities	10.550		23,379			23,379	23,379	
Bonus commodities			2,112			2,112	2,112	
			25,491			25,491	25,491	
Total Child Nutrition Cluster			423,363	176,224	8,925	246,603	247,140	9,462
Total Department of Agriculture			423,363	176,224	8,925	246,603	247,140	9,462
Department of Education								
Passed through Michigan Department of Education:								
ECIA Title I	84.010	815300708	198,049	195,218	28,218	31,049	2,831	
		915300809	206,247			179,634	206,247	26,613
			404,296	195,218	28,218	210,683	209,078	26,613

Federal grantor/pass-through grantor/ program title	Federal CFDA number	Pass-through grantor's number	Award Amount	Prior year Expenditures	Accrued (Deferred) revenue 6/30/08	Current year receipts	Current year expenditures	Accrued (Deferred) Revenue 6/30/09
Service Provider Self Review	84.027	0804400708	4,000	4,000	4,000	4,000		
ECIA Title VI	84.298	0802500708	284	284	284	284		
Technology Literature	84.318	0842900708	1,861	1,671	1,671	1,671		
		0942900809	1,780			1,780	1,780	
			3,641	1,671	1,671	3,451	1,780	
Improving teacher quality	84.367	0805200708	67,838	58,710	7,248	16,376	9,128	
		0905200809	69,103			67,210	69,103	1,893
			136,941	58,710	7,248	83,586	78,231	1,893
ARRA Budget Stabilization	84.394A		510,347				510,347	510,347
Total passed through Michigan Department of Education			1,059,509	259,883	41,421	302,004	799,436	538,853
Passed through Ingham Intermediate School District								
Preschool Grant	84.173A	804600708	9,206	9,206	9,206	9,206		
		904600809	7,926				7,926	7,926
			17,132	9,206	9,206	9,206	7,926	7,926
TOTAL DEPARTMENT OF EDUCATION			1,076,641	269,089	50,627	311,210	807,362	546,779
Department of Health and Human Services								
Passed through Ingham Intermediate School District								
Medicaid Outreach	93.778		6,779	6,779	111	3,931	3,820	
TOTAL FEDERAL AWARDS			$ 1,506,783	$ 452,092	$ 59,663	$ 561,744	$ 1,058,322	$ 556,241

LESLIE PUBLIC SCHOOLS
NOTES TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 2009

NOTES:

1. Basis of presentation – The accompanying schedule of expenditures of federal awards includes the grant activity of Leslie Public Schools and is presented on the modified accrual basis of accounting. The information in the schedule is presented in accordance with OMB Circular A-133 and reconciles with the amounts presented in the preparation of the general purpose financial statements.

2. ARRA Budget Stabilization CDFA# 84.394A, and National School Lunch Program CFDA #10.555, 10.553 and 10.550 were audited as a major program, representing 64.6% of expenditures.

3. The threshold for distinguishing Type A and Type B programs was $300,000.

4. Management has utilized the Grant Auditors Report (Form R7120) in preparing the Schedule of Expenditures of Federal Awards.

5. Federal expenditures are reported as revenue in the following funds in the general purpose financial statements:

General fund	$ 811,182
Special revenue funds	247,140
Total Federal Awards	$ 1,058,322

6. Leslie Public Schools was not determined to be a low-risk auditee.

LESLIE PUBLIC SCHOOLS
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
YEAR ENDED JUNE 30, 2009

Section I – Summary of Auditors' Results

Financial statements

Type of auditors' report issued:	*Unqualified*
Internal control over financial reporting:	
• Material weakness(es) identified:	___ Yes __X__ No
• Significant deficiencies identified that are not considered to be material weaknesses?	___ Yes __X__ None reported
Noncompliance material to financial statements noted?	___ Yes __X__ No

Federal Awards

Internal control over major programs:	
• Material weakness(es) identified:	___ Yes __X__ No
• Significant deficiencies identified that are not considered to be material weaknesses?	___ Yes __X__ None reported
Type of auditors' report issued on compliance for major programs:	*Unqualified*
Any audit finding disclosed that are required to be reported with Section 510(a) of Circular A-133?	___ Yes __X__ No

Identification of major programs:

CFDA Number(s)	Name of Federal Program
84.394A	ARRA Budget Stabilization
10.555, 10.553, 10.550	National School Lunch Program

Dollar threshold used to distinguish between type A and type B programs:	$300,000
Auditee qualified as low-risk auditee?	___ Yes __X__ No

Section II – Financial Statement Findings

None.

LESLIE PUBLIC SCHOOLS
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
YEAR ENDED JUNE 30, 2009
(Continued)

Section III – Federal Award Findings and Questioned Costs

None.

LESLIE PUBLIC SCHOOLS
SCHEDULE OF PRIOR AUDIT FINDINGS

Financial Statement Audit

None

HARRIS GROUP
Certified Public Accountants

October 19, 2009

To the Board of Education
Leslie Public Schools
Leslie, MI

In planning and performing our audit of the financial statements of Leslie Public Schools as of and for the year ended June 30, 2009, in accordance with auditing standards generally accepted in the United States of America, we considered Leslie Public Schools' internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. However, during our audit, we noted certain matters involving the internal control and other operational matters that are presented for your consideration. This letter does not affect our report dated October 19, 2009 on the financial statements of Leslie Public Schools. Our comments and recommendations, all of which have been discussed with appropriate members of management, are intended to improve the internal control or result in other operator efficiencies. Our comments are summarized as follows.

Statement No. 54 of the Governmental Accounting Standards Board

The GASB recently released this statement. The objective of this statement is to clear up confusion regarding the relationship between reserved fund balance and restricted net assets. This statement establishes fund balance classifications that comprise a hierarchy based primarily on the extent to which a government is bound to observe constraints imposed upon the use of the resources reported in governmental funds.

The initial distinction that is made in reporting fund balance information is identifying amounts that are considered *nonspendable*, such as fund balance associated with inventories. This Statement also provides for additional classification as restricted, committed, assigned and unassigned based on the relative strength of the constraints that control how specific amounts can be spent.

The *restricted* fund balance category includes amounts that can be spent only for the specific purposes stipulated by constitution, external resource providers, or through enabling legislation.

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The *committed* fund balance classification includes amounts that can be used only for the specific purposes determined by a formal action of the government's highest level of decision-making authority.

Amounts in the *assigned* fund balance classification are intended to be used by the government for specific purposes but do not meet the criteria to be classified as restricted or committed. In governmental funds other than the general fund, assigned fund balance represents the remaining amount that is not restricted or committed.

Unassigned fund balance is the residual classification for the government's general fund and includes all spendable amounts not contained in the other classifications. In other funds, the unassigned classification should be used only to report a deficit balance resulting from overspending for specific purposes for which amounts had been restricted, committed, or assigned. Governments are required to disclose information about the processes through which constraints are imposed on amounts in the committed and assigned classifications.

The requirements of this statement are effective for financial statements for periods beginning after June 15, 2010. Early implementation is encouraged. Fund balance reclassifications made to conform to the provisions of this Statement should be applied retroactively by restating fund balance for all prior periods presented.

We would be happy to discuss these changes and the affect they have on your financial statements for future years.

This report is intended solely for the information and use of Leslie Public Schools, management, and others within the organization, and is not intended to be and should not be used by anyone other than these specified parties.

Certified Public Accountants

HARRIS GROUP
Certified Public Accountants

October 19, 2009

To the Board of Education
Leslie Public Schools
Leslie, MI

We have audited the financial statements of the governmental activities, each major fund, and the aggregate remaining fund information of the Leslie Public Schools for the year ended June 30, 2009. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards and *Government Auditing Standards* and OMB Circular A-133, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated June 19, 2009. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Leslie Public Schools are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the year ended June 30, 2009. We noted no transactions entered into by the governmental unit during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting Leslie Public School's financial statements were:

> Management's estimate of the liability of the payout of employee compensated absences is based on expected payout. Depreciation is based on the estimated useful life of the assets. We evaluated the key factors and assumptions used to develop the amount of depreciation charged in determining that it is reasonable in relation to the financial statements taken as a whole.

The disclosures in the financial statements are neutral, consistent and clear. Certain financial statements disclosures may be particularly sensitive because of their significance to financial statement users. There were no sensitive disclosures affecting the financial statements.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

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Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to each opinion unit's financial statements taken as a whole.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October 19, 2009.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the governmental unit's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the governmental unit's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of Board of Education and management of Leslie Public Schools and is not intended to be and should not be used by anyone other than these specified parties.

Very truly yours,

Certified Public Accountants

Leslie Public Schools
Superintendent Compensation

09-10 Compensation

Amount	Description
91,471	Base Salary, 3% decrease from 09-10
10,700	Tax Deferred Payment or Annuity
3,600	Car allowance for work related trips of 100 round trip miles or less
600	Access to her personal cell phone
106,371	

09-10 Insurances/Other

Amount	Description
9,364	Blue Cross blue Shield Flex 2. Does not include any of the $4,000 deductible which is paid by Board
1,503	Dental
187	Vision
1,594	LTD
284	Life Insurance
12,932	if 0% of the deductible is used
(650)	Contribution to Health Insurance
4,000	Maximum Deductible
16,282	

122,653 Total 09-10 Salary and Benefits

Leslie Public Schools
Dues/Fees 2009-10

Acct #	Amount	Description	Association
111179021	625.00	WW NCA Accreditation Fees	North Central Association
111279036	237.64	MS Membership	Michigan Interscholastic Forensic Assoc
111279036	625.00	MS NCA Accreditation Fees	North Central Association
111279000	375.00	MS Membership	Michigan School Band & Orchestra Membership
111279000	125.00	Event Fee	Michigan School Band & Orchestra Membership
111374098	375.00	HS Membership	Michigan School Band & Orchestra Membership
111374098	135.00	Event Fee	Michigan School Band & Orchestra Membership
111374099	355.00	HS Membership	Michigan School Vocal Music Association
111374099	125.00	Event Fee	Michigan School Vocal Music Association
111374099	110.00	Event Fee	Michigan School Vocal Music Association
111374095	625.00	HS NCA Accreditation Fees	North Central Association
122574100	6,444.00	Instructional Tech Consortium	Ingham ISD
123174000	3,207.00	Membership	Michigan Association of School Boards
123174000	900.00	k-12 Membership Dues	School Equity Caucus
123174000	50.00	Rural District Dues	Michigan Association of School Boards
123274000	200.00	Supt. Membership	Michigan Negotiators Assoc
123274000	805.00	Supt. Membership	Michigan Association of School Administrators
123274000	210.00	Supt. Membership	Michigan Institute for Education Management
123274000	80.00	Supt. Membership	Michigan Association of School Administrators
124174010	39.00	WW Principal Membership	Association for Supervision & Curriculum
124174010	535.00	WW Principal Membership	Michigan Elementary & Middle School Principal's Association
124174030	39.00	MS Principal Membership	Association for Supervision & Curriculum
124174030	365.00	MS Principal Membership	Michigan Association of Secondary School Principals
124174090	95.00	HS Membership	National Honor Society
124174090	81.00	HS Membership	National Honor Society
124174090	39.00	HS Principal Membership	Association for Supervision & Curriculum
124174090	574.00	HS Principal Membership	Michigan Association of Secondary School Principals
125274000	250.00	Annual Flex Spending Fee	Markat Benefit Administrators
128474100	129.00	Tech Director Membership	Michigan School Business Officials
	17,754.64		