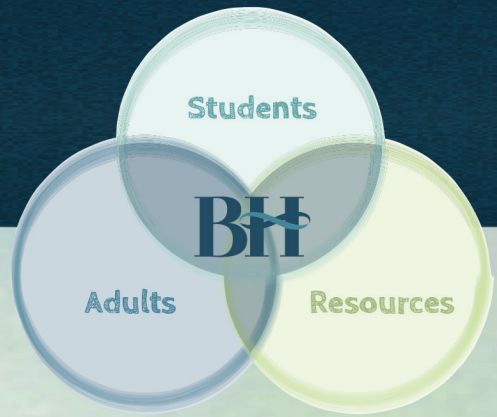
Agreement between Bloomfield Hills Schools and the Administrative Council

July 1, 2016 through June 30, 2019

Bloomfield Hills Schools



Mission Statement

To enable learners to become architects of their futures, building on a foundation of scholarship, citizenship, service and integrity.

Strategic Goals

- Ignite passion, fuel dreams and provide a personal, world-class experience for every student.
- Nurture constructive partnerships that strengthen our entire community.
- Maximize the community's investment, uphold our tradition of financial stewardship and optimize the use and value of all district facilities and properties.

www.bloomfield.org

Core Values

Students

Safe Learning Environment

We will provide all learners with an environment that is physically, emotionally, and intellectually safe, and that encourages inquiry and self-expression.

Choices

We will offer learning choices that develop each student's intellectual, emotional, social, creative, aesthetic, and physical dimensions.

Purpose and Meaning

We will provoke self-reflection so that students may find meaning and purpose in life.

Adults

Passion for Learning

We embrace an attitude, willingly expressed, that relishes wonder, craves knowledge, seeks meaning, loves challenge, and pursues innovation.

Responsibility

We will engage in continuous growth and improvement, make decisions that enhance student learning, and provide opportunities for the community to learn with us.

Resources

Mission-Centered Use of Financial Resources

We will direct our resources toward our mission in ways that balance our core values and our priority commitment to our students.

Securing the Future

We will secure our financial base by developing partnerships to enhance human and material resources.

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ADMINISTRATIVE COUNCIL AGREEMENT
Employment Conditions & Procedures

ARTICLE 1 - GENERAL PROVISIONS

A. Composition of Administrative Council

The Administrative Council shall be the representative and spokesperson for the following administrative staff: Principals, Associate Principals, Nature Center Manager, Supervisor of Wing Lake Developmental Center, Principal of Model High School, Principal of the Alternative High School, Supervisor of the Deaf and Hard of Hearing Program, Principal and Associate Principal of the International Academy (OKMA campus), IBO Coordinators (International Academy), and teacher leader for Reading Recovery . In this Agreement, employees represented by the Administrative Council shall be referred to as Administrators or Administrative Staff.

B. Education Standards

All administrators, with the exception of managers, shall have a minimum of a master's degree or its equivalent. In the event an administrator updates their academic status, the Human Resources Office shall be provided with an official copy of transcripts. The Superintendent may, subject to the approval of the Board of Education, retain administrators who do not hold the master's degree. Remuneration for such administrators will be separately established.

C. Evaluation

Evaluation in writing will be conducted for each administrator by the immediate supervisor. Administrator evaluation will be scheduled as follows:

1. Regular administrative staff will receive one formal evaluation during the school year.

2. Probationary or administrative staff in the first year of an assignment will receive two formal evaluations during the year.

D. No Administrative Tenure

As defined in Article III, Section 1, of the Teacher Tenure Act, no Administrator assumes tenure in other than classroom position, but, rather, retains classroom tenure. In other words, an Administrator does not receive tenure in an Administrative Council position.

E. Professional Rights

If an Administrative Council position is eliminated through reorganization, the Council will be consulted. If a position is eliminated, the Superintendent will work with the Council and the individual affected in determining transfer options.

F. Due Process

Administrators shall be accorded procedural due process.

G. Length of Service/Probationary Period

The length of service for an administrator shall be as follows:

1. An administrator shall serve a two-year probationary period. (The probationary period is defined in Article 8 (F)). The two-year probationary period shall be served if the administrator is new to the District, has been transferred or promoted from a position not covered by the Administrative

Council Agreement, or any time an Administrator is promoted to an administrative position covered by the Administrative Council Agreement. (Promotion is defined as being transferred to a position that results in an increase in pay.)

2. Upon completion of the two-year administrative probationary period, the administrator shall be credited with all continuous full-time employment in a teaching and/or administrative capacity for purposes of determining total length of service with the District.

3. In the event the administrator is transferred, reassigned, or reduced to a teaching position, the above-stated length of service will be credited to the administrator for employment and placement on the teachers' salary schedule. In such event, salary will be established by granting full years of experience for experience in education to the maximum allowable under the provisions of the applicable master agreement.

4. In addition to the placement on the teachers' salary schedule, as set forth in Paragraph 3, above, such administrator shall be credited with the length of service (as defined above) for other terms and conditions of employment, as specifically set forth in the teachers' collective bargaining agreement.

5. Upon completion of the administrative probationary period, such administrator shall be deemed to have tenure as a classroom teacher only, as per Article III, Section 1, of the Teacher Tenure Act, provided the administrator has the necessary certification, as defined by the State Board of Education and the Teachers' Tenure Act.

H. Additional Assignments

Contract periods for employment have been made based on the need of the specific position. Administrators who serve other special functions with the school district beyond their contract term will be reimbursed based on the schedule for such special functions.

ARTICLE 2 - WORK YEAR AND VACATION PROVISIONS

A. Non-Scheduled Days

Non-scheduled days are to be mutually agreed upon by the administrator and the immediate supervisor. Necessary administrative support will be provided as approved by the appropriate immediate supervisor.

B. Work Year for School Building Administrators

The work year for building administrators is based on the years of service in the position as follows:

		Years of Service					
		0	1	2	3	4	5
Position				Days Scheduled			
High School Principal		230	229	228	227	226	225
Middle School Principal		225	224	223	222	221	220
Associate HS Principal		226	225	224	223	222	221
Associate MS Principal		217	216	215	214	213	212
Elementary Principal		213	212	211	210	209	208
International Academy Principal		230	229	228	227	226	225
Associate International Academy Principal		226	225	224	223	222	221
Supervisor of Deaf & Hard of Hearing Program		211	211	211	211	211	211
Supervisor of Wing Lake Developmental Center		235	234	233	232	231	230
Principal of Model High School		217	216	215	214	213	212
Principal of Alternative High School		217	216	215	214	213	212
IBO Coordinator/Supervisor		200	200	200	200	200	200
Teacher Leader for Reading Recovery	200	200	200	200	200	200	

C. Holiday Work Schedules

Administrative staff holiday work schedules will be established by the Superintendent. The holiday schedule will be commensurate with the actual schedule developed for other employee groups, when possible.

D. Work Year/Vacation Schedule/Holiday Schedule for Nature Center Manager

The following applies to the Nature Center Manager only:

1. Work Year - 12 months

2. Vacation - The administrator will receive 15 days paid vacation annually during first full year in position, plus 1 additional day each subsequent year to a total of 20 annual vacation days.

3. Paid Holidays - The administrator will receive 10 paid holidays each year as follows:

New Year's Eve	New Year's Day	Good Friday
Memorial Day	Independence Day	Labor Day
Thanksgiving Day	Day after Thanksgiving	Christmas Eve
		Christmas Day

ARTICLE 3 - COMPENSABLE LEAVE DAYS

A. Use of Leave Days

Administrators shall earn one leave day each month during the school year. The twelve leave days for the current school year will be available on July 1 of each school year. The leave days may be used as follows:

1. Personal or Family Illness:
   a. Personal illness of the administrator.

b. Absence for critical illness in the family and/or to make arrangements for medical care (spouse, children, parents, brother, sister, grandparents, parents-in-law, or members of the same household).

2. Personal Days: The administrator may use up to 3 days per year from current leave days as personal days. A reason may be required.

3. Religious Holidays: Absence for observance of religious holidays, not to exceed three (3) days per year.

4. Special Leave: Special leave for important and urgent matters that cannot be handled outside school hours or scheduled at any other time. Special leave days, however, will be at the discretion of the Assistant Superintendent for Human Resources and Labor Relations.

5. Bereavement: Up to three (3) days will be approved for a funeral in the immediate or secondary family.

Additional paid days will be approved dependent on family relations, circumstances and/or travel involved, as determined by the immediate supervisor, provided such additional leave days are available in the current leave allocation. For the purpose of this section, the immediate family shall be defined as spouse, child, parent, brother or sister, grandparents, parents-in-law, or a person living in the administrator's home. Consideration may be given for other special circumstances at the sole discretion of the administration (i.e. grandchild's funeral).

One day shall be granted for the purpose of attending the funeral of a personal friend.

B. Leave Day Provisions

Whenever possible, leave days for personal business, personal, religious holidays, and special leave, as well as any other leave, must be requested in advance. This request shall include a statement that the leave request is for a purpose authorized within this section, as set forth above. The administrator may be requested to set forth a specific reason for such leave.

If the service of an administrator is interrupted by reason of discharge, termination, suspension, or leave, and the administrator has utilized more leave days than have been accumulated on the monthly basis, then the value of the excess paid-for leave days shall be deducted from the last pay check due the administrator at the time of interruption.

C. Inclement Weather Days

Administrative attendance on snow days or other inclement weather days is expected. However, when such days occur and travel to and from the site may not be possible, the administrator may be excused from attendance. In such absence, the Administrator is expected to compensate for the absence by either rescheduling another day of work or by charging the date against current leave, or having it charged as a non-compensable day with a reduction in salary.

D. Leave Bank

For each successive July 1, unused current leave days will be added to the administrator's bank. All days accumulated in this bank shall be for the sole purpose of the Administrator's personal illness, funeral leave and family illness.

The leave bank shall be used in any school year only after the current leave days of that school year have been depleted, in accordance with the above current leave provisions.

E. Salary Continuation (Short-Term Disability)

Salary continuation for short-term disability (STD) purposes shall be paid to an administrator at 100% of current daily rate for a period of one year, after a waiting period of five (5) consecutive work days, during which the administrator's current leave and leave bank will be used, if available, However, the administrator will be allowed to maintain a minimum balance of twenty (20) earned days in the leave bank. The salary continuation benefit shall not be applicable to cover disabilities (illness or injuries) incurred prior to commencing employment with Bloomfield Hills Schools.

After an administrator has received pay for one full year under the provisions of this section, the administrator shall be entitled to apply for disability coverage under the terms of the long-term disability policy provided by the District (see Long-Term Disability, under Insurance Benefits **-** Article 6(N).

F. Jury Duty

1. Notify Human Resources Office: Administrators who are summoned for jury duty must notify the human resources office within twenty-four (24) hours of receipt of such notice. If the administrator then reports for jury duty, that administrator shall continue to receive the regular daily wage (i.e. jury duty pay differential) for each day on which the administrator reports for or performs jury duty and on which the administrator would otherwise have been scheduled to work. Time spent on jury duty shall not be charged against leave days.

2. Jury Duty Pay Differential: To be eligible for jury duty pay differential, the administrator must furnish the human resources office with a written statement from the appropriate public official listing amounts of pay received, the days on jury duty, and a check for the full amount of the jury fee paid, excluding any travel allowance paid to the administrator by the court. This payment by the administrator shall be made to the human resources office no later than two (2) weeks after the return from jury duty. Any administrator found abusing this privilege shall not be entitled to the pay differential.

G. Workers' Disability Compensation

1. Notification: In the event of any on-the-job injury, the administrator must notify the human resources office and complete an accident report as soon as possible, but in no event later than three (3) calendar days after the occurrence.

2. Doctor Visits: An administrator required to go to the doctor as a result of an on-the-job accident will be paid for such work day without such time being charged against leave days, unless such injury was caused by horseplay or negligence of the involved administrator. It is understood that visits other than the initial one at the time of the accident will be scheduled at times other than when the administrator is scheduled to work unless approved by the immediate supervisor.

3. No Leave Days Charged: It is understood that no leave days shall be charged for absences related to a compensable job-related accident.

4. Workers' Compensation Pay Differential: In the event an administrator is absent from work due to a job-related accident, the administrator will be paid, for a period not to exceed twelve months from the date of the accident, the difference between the full salary and such monies as may be received as Workers' Disability benefits (loss-of-time benefits).

   Should the administrator continue to be off work beyond a period of twelve months, short-term disability benefits, provided in the Salary Continuation section of the agreement will not be paid.

5. Benefits Beyond One Year: Benefits beyond one year shall be payable only under the terms of the Workers' Disability Compensation Act and LTD insurance coverage of the District. No District supplement will be made after twelve months.

6. Administrators Who Do Not Return to Work within One Year of Commencement of Leave: If an administrator on Workers' Disability Compensation leave does not return to work upon the conclusion of one calendar year from the date of the commencement of the leave, the administrator's position will not be held open for the administrator. However, if the administrator is medically able to return to work within two calendar years of the date of the commencement of the leave, the administrator will be given consideration or placement in a vacant administrative or instructional position for which the administrator is certified and qualified, as determined by the Superintendent. (If the placement is in the teachers' bargaining group, the placement is subject to the layoff and recall policies applicable to the Bloomfield Hills Education Association.) The administrator must supply a physician's authorization permitting the administrator to return to work and may be required to have a return-to-work examination by a physician or medical facility designated by the District. If the administrator's physician and the district's physician do not agree that the administrator is medically able to return to work, an independent physical or medical facility, paid by the District, may examine the administrator, and this decision will be final. If the administrator retires during the two year time period, this paragraph does not apply.

   If the administrator does not return to work within two years of the date of the commencement of the leave, the administrator will be separated from employment with Bloomfield Hills Schools.

ARTICLE 4 - UNPAID LEAVES OF ABSENCE

A. Leaves of Absence - Without Pay and Without Salary Credit

1. Protracted Illness: Any administrator shall be entitled to a leave of absence in cases of protracted or extended illness. Such administrator must notify and apply for the leave within the first three (3) days of absence, whenever possible. Upon application to the Board, such leave shall be granted for up to one year, except the Board may grant approval for an additional year upon written request.

2. Maternal or Paternal Care Leave: Maternal or paternal care leave shall be considered a non-paid leave. Maternal or paternal care leave of absence will be granted for a maximum of one year (12 months) from the date the leave was effective in accordance with the Family and Medical Leave Act (FMLA). (See Appendix C for the regulations applicable to the FMLA.) Family and Medical Leave Act leave for the birth of a child or for placement of a child for adoption or foster care must conclude within twelve months of the birth or placement. A maternal care leave is non-renewable.

3. Adoption or Paternity Leave: In cases of adoption or paternity, the provisions of Section A(2) above shall apply in accordance with the Family and Medical Leave Act. (See Appendix C)

4. Public Office: Any administrator who has completed the probationary period who files proper application to campaign, or serve, in an elected public office, may be granted leave of absence for one year, except the Board may grant approval for an additional year upon written request.

5. Other Experiences: A leave of absence may be granted for other experiences beneficial to the administrator's effectiveness, as approved by the Board.

B. Family and Medical Leave Act

Basic Leave Entitlement: Bloomfield Hills Schools Family and Medical Leave Regulation allows eligible Employees to take up to twelve (12) work weeks of unpaid leave per year for their own serious health condition, childbirth, or to provide care for the employee's newborn child, newly adopted child, newly placed foster child, or a child, parent or spouse with a serious health condition. Further, certain eligible employees may receive up to twelve (12) work weeks of unpaid leave for military exigencies, and up to a total of

twenty-six (26) work weeks of unpaid leave to care for a covered military service member. Appendix C to this contract contains the regulation applicable to FMLA leave. Compensable absences and use of leave days are included in the calculation of the twelve (12) work weeks for FMLA.

Additional information and forms relating to Family and Medical leaves are available from the Human Resources Department.

C. Military Leaves

Administrators who have been inducted or enlist for military duty in any of the armed forces of the United States shall be granted leaves of absence for a period not to exceed three (3) months beyond their honorable discharge date. Full credit toward advancement on the salary schedule shall be granted.

ARTICLE 5 - PAID LEAVES OF ABSENCE

A. Administrative Growth Leave

The administrative growth leave is designed to provide short-term, paid leaves to enhance administrators' personal and professional knowledge. Eligibility requirements include three years of district administrative service and final program approval by the Superintendent.

ARTICLE 6 - INSURANCE BENEFITS

A. Commencement and Duration of Benefits

Benefits shall commence on the first day of hire. Coverage shall remain in effect as long as the Administrator is actively employed by the school district. If the Administrator terminates during the school year or retires, benefits shall terminate at the end of the month in which the Administrator last works or exhausts Family and Medical Leave Act leave. Benefits will continue through August for Administrators who terminate (not retire) and who have completed the school year and are not scheduled to work in the month of July. Benefits also terminate when an employee commences long term disability leave or has been on workers' disability compensation leave exceeding one year.

B. Benefits

The Board will pay the premiums for the following coverages and benefits as defined in this article and in accordance with contract provisions for eligible members. The Administrator must fully comply with insurance company or self-insurance regulations as a condition of receiving such benefits.

The benefits in this Article are provided for all bargaining unit members and include no provision for reimbursement for those members who do not qualify or do not select such benefits except as provided for in the administrator's cafeteria benefit plan.

C. Life Insurance

The Board shall select the insurance carrier who will provide each administrator with a group term life insurance policy. Such policy shall pay to the administrator's beneficiary the sum of $200,000 upon the death of the insured.

D. Life Option

There will be an optional administrative life insurance group for those administrators who wish to have a reduced life insurance amount. This optional coverage will provide $50,000 group life and $50,000 accidental death and dismemberment. The election of this option, available to all administrative staff at the beginning of each election period, requires a written authorization and may require a physical examination in the event the policy with a greater face value is again desired.

E. **Additional Life Insurance**

The Administrator will have the option to purchase additional term life insurance with pre-tax dollars, to a maximum of $300,000 (if permitted by the insurance company) at the beginning of each Flex Election period. Any amount in excess of $50,000 will be considered as additional imputed income in compliance with current IRS regulations. Evidence of insurability will be required after the initial enrollment period.

F. **Dependent Life Insurance**

The Administrator will have the option to purchase term life insurance for his/her spouse and/or dependents with after-tax dollars at the beginning of each Flex Election period. The coverage shall be offered in the amount of $5,000 and $10,000. Evidence of insurability will be required after the initial enrollment period.

G. **Accidental Death and Dismemberment**

The Board will select the insurance carrier and pay the premium for an accidental death and dismemberment insurance policy in the amount of $50,000. The policy shall pay to the administrator, or the administrator's designated beneficiary, an appropriate amount in accordance with the policy.

H. **Hospital-Medical Insurance – Subject to Compliance with the Publicly Funded Health Contribution Act 2011 PA 152**

The Publicly Funded Health Contribution Act (Public Act 152 of 2011) provides that the District shall pay no more than the annual cost or illustrative rate for a medical benefit plan for employees (including any payments for reimbursement of co-pays, deductibles, or payments into health savings accounts, flexible spending accounts, or similar accounts used for health care costs ("the Additional Payments") than the "hard cap amounts" which are adjusted annually by the State treasurer by October 1 of each year for the following plan year which begins January 1**.** If the District payment for the annual cost or illustrative rates for medical benefit plans offered by the District to employees (including any additional payments) exceed the "hard cap" maximums established by the State treasurer, employees will be required to pay the amount over the hard cap by payroll deduction. The District will discuss such deduction with the Association prior to implementation. If the District payment for the annual cost or illustrative rates for medical benefit plans offered by the District to employees (including any Additional Payments) are less than the "hard cap" maximums, the District will contribute to the employees' Health Savings Account (HSA) or Flexible Savings Account (FSA) according to the formula in H(4) of this article. In no event shall this Section be interpreted to require the District to make a payment which would cause it to violate the Publicly Funded Health Insurance Contribution Act.

The health insurance coverage provided the July 1, 2012-June 30, 2015 (extended to June 30, 2016) contract will remain in effect through December 31, 2016.

Effective January 1, 2017, the District will offer, either by self-insurance or a policy of insurance, the following group medical coverage options to each full-time employee who makes proper application to participate in such coverage and to participate in the Bloomfield Hills Schools Flexible Benefits Plan:

1) Medical Coverage

a. Preferred provider organization (PPO) High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) - $1300/0% *(See Appendix A for a Summary of the Benefits)

b. Preferred Provider Organization (PPO) High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) - $2000/0% *(See Appendix A for a Summary of the Benefits)

c. Health Maintenance Organization (HMO) High Deductible Plan (HDHP) with a Health Savings Account (HSA) - $1350/0% (except as noted in the plan document.) *(See Appendix A for a Summary of the Benefits and the prescription drug coverage)

*Please refer to the Coverage summary in Appendix A for additional information.
Appendix A is provided for information purposes only and not part of the contract.

2) *PPO HSA Prescription Drug Coverage – Triple Tier Copayment.
The HSA prescription drug benefit, including mail order drugs, is subject to the same deductible and same annual co-insurance/co-pay dollar maximums as the PPO HSA medical coverage. Benefits are not payable until the annual deductible has been met. After the deductible has been satisfied, the applicable co-pays apply.

Copayments are based on the type of drug obtained. The copayment is $5 generic/$25 formulary (preferred) brand/$50 non-formulary (non-preferred) brand:

*(See Appendix A for a Summary of the Prescription Drug Coverage for the PPO)

3) Health Savings Accounts
Employees who are enrolled in the group medical coverage described above and who are otherwise eligible to make and receive Health Savings Account (HSA) contributions may make contributions to a Health Savings Account (HSA) through the Bloomfield Hills Schools Flexible Benefits Plan. Such employees may also receive a District Contribution to his/her Health Savings Account (HSA) through the Bloomfield Hills Schools Flexible Benefits Plan. Such contributions are based upon the formula described below. However, no contribution will be made by the school district if the contribution would make the District out of compliance with Public Act 152 of 2011.

4) Formula for District Contribution to Employee Health Savings Accounts (HSA)

i. Determine the number of staff members enrolled in the PPO HSA 1250/0% insurance plan**s** for the applicable plan year. (Open enrollment counts will be used for this purpose).
ii. Use the annual or illustrative rates for the applicable plan year and determine the cost of the plans.
iii. Determine the "hard cap" amount for single, two persons and full family for the applicable plan year. .
iv. Subtract the total annual cost or illustrative rates amount from the "hard cap" for the applicable plan year for single, two person and full family. These amounts represent the differential between the "hard cap" and the illustrative rates that are available to be used for the percentage contribution to employee's individual HSAs. (NOTE: If no amount is available, there will be no contribution to the individual HSAs.)

v. The percentage contribution to the individual HSAs will be determined as follows:
    a) Calculate total sum of HSA funding
        1. Take the number of single subscribers x the respective differential (calculated in #IV above).
        2. Take the number of two person subscribers x the respective differential (calculated in #IV above).
        3. Take the number of full family subscribers x the respective differential (calculated in #IV above).
        4. Take the sum of 1, 2, and 3.
    b) Calculate total employee deductible expense
        1. Take the number of single subscribers x the deductible.
        2. Take the number of two person and full family subscribers x the Deductible. .
        3. Take the sum of 1 and 2.

c) Divide (a) by (b) to calculate percent of deductible contributed to the HSA per employee.

vi. See Appendix B for an example of the application of the formula.

Other Factors

Annual Calendar Year Limits: The combined employee and District HSA contributions shall not exceed the annual calendar year limits established by the IRS for such contributions. See IRS Publication 969 for eligibility.

Mid-Plan Year Status Changes: Employees who have mid-plan year life status changes will have their HSA employer paid contribution prorated by 12 months, provided they are eligible to participate in the HSA plan.

HSA/FSA: Those employees who are not eligible to participate in an HSA because they are enrolled in Medicare, or employees who do not elect to participate in HSA will receive the employer contribution into a Flexible Spending Account.

5) Proration of District Contribution to Health Savings Account (HSA)

An election by an Employee to receive medical/hospitalization coverage under the District's High Deductible Health Plan (HDHP) and to receive the District contribution to a Health Savings Account (HSA) associated with that coverage is irrevocable for the Plan Year for which the election is made. In the event that the employment of an Employee who has elected to receive a District HSA contribution ceases before the end of the Plan Year and he/she does not continue coverage under the District's HDHP for the remainder of the Plan Year, the District may deduct from any pay or other amounts owed to the employee, including the Employee's final paycheck, an amount equal to the District HSA contribution associated with any period in which the Employee was not covered by the District's HDHP. Similarly, if an Employee otherwise ceases coverage under the District's HDHP before the end of the Plan Year, the District may deduct from the Employee's pay following the election to cease coverage, in one or more installments, an amount equal to the District HSA contribution associated with any period in which the Employee was not covered by the District's HDHP.

If an Employee, after the start of the Plan Year, modifies his/her election to receive medical/hospitalization coverage from two person or full family to single coverage, the District may deduct from the Employee's pay, following the coverage modification election, in one or more installments, an amount equal to the difference between District HSA contribution for single coverage associated with any period in which the Employee was covered by single coverage.

Employees who elect, after the start of the Plan Year, to receive medical/hospitalization coverage under the District's High Deductible Health Plan, and to receive the District Health Savings Account contribution, due to a mid-plan year change in family status, a mid-plan year court order, or a mid-plan year change in eligibility for Medicaid or CHIP, will receive a prorated District HSA contribution based on the ratio of the number of months of the Plan Year in which they participate in the District's HDHP, divided by 12 months, provided that they are otherwise eligible to receive HSA contributions.

6) The following terms and features also apply to the group medical coverage provided by the District:

a) Cash Payment in Lieu of Medical/Hospitalization Insurance
The District will provide a Cash in Lieu of Health coverage option under the Bloomfield Hills Schools Flexible Benefits Plan for each full plan year beginning on or after January 1, 2013 for those individuals who do not elect the employer-provided medical/hospitalization coverage. Staff who do not have medical/hospitalization coverage from another source are not eligible for this benefit.

Single Opt Out	$1250
Two-Person Opt Out	$1900
Full Family Opt Out	$2550

b) Family Continuation Coverage
Medical insurance will include family continuation coverage for each eligible employee who makes proper application to participate.

c) Employee Contribution
Each employee electing health insurance coverage shall make the following pro-rated pre-tax contribution:

Single	$500
Two-Person	$1000
Full Family	$1000

d) Health Risk Assessment/Rebate

Health Risk Assessment: Employees (and their spouses, if applicable) are expected to participate in an annual health risk assessment with his/her health care provider. The health risk assessment includes height, weight, pulse and tests for the following outlined on the Health Risk Assessment form:

Fasting Glucose
Hemogram
Lipid Panel

The Health Risk Assessment form will be available in the Human Resources Department (and on the Human Resources web page).

Rebate of Pre-tax Contribution: Employees and their spouses (if applicable) who participate in the annual health risk assessment (HRA) are eligible to receive a rebate of the full amount of the employee pre-tax contribution provided in subparagraph H(6)(c) of this article. Eligibility for the rebate is based upon receipt by the Human Resources Department of the completed health risk assessment (HRA) form by September 15. If September 15 falls on a weekend, the following Monday will be the due date. The same Health Risk Assessment form may not be used for two consecutive plan years.

Forms received after the due date will not qualify the employee for the rebate. *There will be no exceptions*. In the event of two-person or full-family coverage, where only one adult participates in the annual health risk assessment, the rebate will be reduced by 50%. Single member households with dependent children will be rebated at 100%.

e) Flexible Benefits Plan

The District will provide a cafeteria plan or flexible benefits plan which will permit pre-tax premium copayments for all fringe benefits which constitute "qualified benefits" permitted by the IRS to be offered on a pre-tax basis through a cafeteria plan. The plan will also permit eligible employees to choose between group medical coverage and the Cash Payment in Lieu of Medical/Hospitalization Insurance described in Section H(6)(a)&(b) of this article and permit employee and employer Health Savings Account contributions, subject to applicable tax requirements.

I. Duplication of Hospital/Medical Coverage Permitted While District is Self-Insured

Duplication of hospitalization insurance is permitted as long as the District is self-insured. The employee must notify the Human Resources Department of any personal hospitalization coverage or coverage from spouse's hospitalization insurance plan. Any employee or dependent who is covered by any medical coverage which is not a high deductible health plan (HDHP) shall not be eligible to make contributions to a health savings account (HSA) in connection with participation in the HDHP sponsored by the District or to receive District contributions to an HSA.

J. Dental

The Board shall pay the premiums that will provide each administrative staff member with a dental plan that will include basic care, prosthetics and orthodontic benefits. Coverage shall include: Class I (100%); Class II (100%); Class III (70%) and Class IV (60%). A $1,000 orthodontic lifetime maximum per family member up to age 19 is included in Class IV. Calendar maximum amount is $1,500.

K. Vision

The Board will select and pay the premium for a vision care program for those administrators who are full-time and other eligible employees. (Eligibility for this benefit for less than full-time employees is defined in Section L below.)

The vision care program will provide a percentage of reimbursement for services in the areas of vision care in accordance with the coverage schedules provided by the carrier. The plan shall provide for an annual evaluation, lenses and $35 for frames.

L. Benefits - Less than Full Time

Each less-than-full-time or shared-time administrative staff member will have the premiums paid for the following coverages as elected by the administrator:

1. Each administrator working a schedule of at least 75% but less than 100% will be eligible for up to full family hospital/medical, dental and vision insurance. In the event that health insurance is not elected, the defined cash in lieu of health insurance option may be elected.

2. Each administrator assigned a schedule of less than 75% may elect single-subscriber health, dental and vision. In the event that no health plan is elected, the defined cash in lieu of health insurance option may be elected.

3. Each administrator will be provided with short-term disability, long-term disability and life insurance, as defined in the collective bargaining agreement.

M. Flexible Spending Accounts

1. Health Care Reimbursement Account: The administrator will have the option to participate in a pre-tax Health Care Reimbursement Account as defined by the Internal Revenue Service and as outlined in the *Educated Choices* Workbook.

2. Dependent Care Reimbursement Account: The administrator will have the option to participate in a pre-tax Dependent Care Reimbursement Account as defined by the Internal Revenue Service and as outlined in the *Educated Choices* Workbook.

N. Long-Term Disability

1. Benefits: The Board of Education shall select and pay the premium for a Long-Term Disability Insurance plan. Such disability insurance shall provide benefits of 66 2/3% of the monthly earnings to the administrator who is unable to work due to extended sickness or injury. The benefits of this plan shall commence after twelve (12) months of such sickness or injury, or upon the termination of salary continuation provided under compensable leave days, whichever is longer. Benefits shall be payable until the administrator reaches age sixty-five (65)**,** provided the administrator continues to be disabled under the provisions of the insurance policy.

2. Computation of Monthly Earnings: For the purposes of Long-Term Disability coverage, monthly earnings shall be the administrator's regular salary at the time of the disability divided by twelve (12) months.

3. Benefits Reduced by Other Remuneration: The amount received from the insurance company will be reduced by any primary remuneration for which the administrator is eligible during the benefit period from the employer, the Michigan Public School Employees' Retirement System, the Federal Social Security Act (both primary and dependent), the Railroad Retirement Act, Veterans' benefits or other such pensions.

4. Position Held Open for One Year: On the date an administrator commences a long-term disability leave, the administrator's position will no longer be held open for the administrator. However, if the administrator is medically able to return to work within one calendar years of the date of the commencement of the leave, the administrator will be given consideration for placement in a vacant administrative or instructional position for which the administrator is certified and qualified, as determined by the Superintendent. (If the placement is in the teachers' bargaining group, the placement is subject to the layoff and recall policies applicable to the Bloomfield Hills Education Association). The administrator must supply a physician's authorization permitting the administrator to return to work and may be required to have a return-to-work examination by a physician or medical facility designated by the District. If the administrator's physician and the district's physician or medical facility do not agree that the administrator is medically able to return to work, an independent physician or medical facility, paid by the District, may examine the administrator, and this decision will be final. This paragraph does not apply to an administrator who retires.

   If the administrator does not return to work within one year from the commencement of the leave, the administrator will be separated from employment with Bloomfield Hills Schools.

ARTICLE 7 - PAYROLL PROCEDURES AND DEDUCTIONS

A. Payroll Procedures

1. Administrators shall be paid over twenty-six (26) paydays at their building, or elsewhere as provided, from the time they begin service on their new contract year. Pay dates are every other Friday.

B. Payroll Deductions

The Board will make voluntary payroll deductions from the salaries of administrators according to the following list, and any other voluntary deductions, as approved by the Board. All authorizations for payroll deductions will be made on one form, include the following:

1. United Fund
2. Direct Deposit
3. Credit Union
4. 403B and 457 Tax Sheltered Accounts (those approved by the Board)
5. Tax Deferred Retirement Purchase (TDP)
6. Municipal Income Taxes of Pontiac and Detroit for those administrators who have submitted written authorization for said deduction
7. Flexible Spending Account/Cafeteria Plan
8. Long-Term Care
9. Insurance Contributions and Health Savings Accounts

C. Tax Sheltered Accounts - Advance Purchase

All administrators are entitled to a tax sheltered account (403(b) qualified) salary deduction on the first pay of their salary year up to 10% of their contract amount if they elect such deduction on a timely basis. This amount will be allowed in addition to any amount otherwise authorized by the administrator for bi-weekly deduction during the pay year.

The administrator must arrange for the deduction with their TSA carrier, and the one-time deduction authorization must be received in the payroll office at least ten days prior to the first pay date of the new salary year.

ARTICLE 8 - TERMS OF EMPLOYMENT

The Board of Education recognizes that the administrators of the District hold the same high aspirations of conduct and performance that the Board holds for them and the two parties will work cooperatively in their mutual efforts to attain and maintain educational excellence for students.

A. Two-Year Term of Employment

Subject to the limitations listed below, the Board of Education agrees that each administrator will be employed for an initial term of two years, and continuing from year to year thereafter unless notification is given by either party, to comply with laws as provided in Act 451, PA 1976, as amended by Act 289, PA 1996, and any amendments thereto. (MCL 380.1229) An administrator may terminate his/her employment contract by giving 30 days written notice of resignation to the Superintendent or Assistant Superintendent for Human Resources and Labor Relations.

B. Administrative Staff Layoffs, Reassignments, & Personnel Reductions

Upon written notice and in accordance with the procedures of the above statute, staff changes due to layoffs, reassignments, and/or personnel reductions, the administrator's contract shall be terminated.

C. Unsatisfactory Performance

If an administrator's performance is considered unsatisfactory, a program of assistance shall be instituted as soon as practicable. If after one year of such assistance program, the administrator's performance is not satisfactory, then, upon written notice, and in accord with the procedures of the above statute, and any applicable Board policies, employment may be terminated. The one-year program of assistance is not applicable to probationary administrators.

It is understood that the president and other officers of the Administrators' Association can be helpful in improving a peer's performance and, toward that end, the president will be made aware of unsatisfactory performance on the part of any member of this group.

D. Professional Conduct

The administrator agrees to perform the administrator's contract and the employment duties and functions required of all personnel of the school district in a manner that encourages quality in the educational process and fulfills the standard professional conduct. In the event of acts of misconduct, as opposed to unsatisfactory performance, said administrator may be terminated after written charges, notice, and an opportunity to have the charges reviewed with the Superintendent and/or the Board of Education.

E. Insubordination

Acts such as insubordination will not be tolerated and, depending upon the nature of the offense, can lead to immediate dismissal.

F. Probationary Period

All new administrators shall serve a probationary period of two years. The administrator shall be evaluated during the probationary period and a satisfactory evaluation is necessary for continuation of the administrator's contract and employment as an administrator. The one-year program of assistance is not applicable to probationary administrators.

ARTICLE 9 - PROFESSIONAL REIMBURSEMENT

A. Administrative Council Growth Fund

The Administrative Growth Fund, in the amount of $40,000.00, shall be used for the reimbursement of professional growth items such as conference expenses, tuition reimbursement, membership in professional organizations, and employment related items. An administrator may carry over any of his/her unused growth fund allocation from year to year.

1. Conferences: The Board recognizes the importance of state and national conferences and school visitations and agrees to pay expenses incurred while attending conferences and visitations, subject to prior approval by the administrator's immediate supervisor and Administrative Growth Fund budgetary constraints.

2. Tuition Reimbursement: The Board recognizes the value of advanced graduate courses in a specialized field as beneficial to the administrator and the school district and agrees to pay for books and tuition, subject to prior approval by the administrator's immediate supervisor and Administrative Growth Fund budgetary constraints.

3. Professional Organization Membership: Dues paid to professional educational organizations will be reimbursed subject to the prior approval of the administrator's immediate supervisor and Administrative Growth Fund budgetary restraints.

4. Employment Related Items: The Board will reimburse the administrator for employment related items such as books, supplies, technology and technology related items. The reimbursement is subject to the prior approval of the administrator's immediate supervisor and Administrative Growth Fund budgetary restraints. (Any technology or related items will remain the property of Bloomfield Hills Schools and must be returned upon separation from employment).

5. Reimbursement of Expenses: Requests for reimbursement shall be made to the Administrative Council president using a designated form. Such request must be made on or before June 30 of the school year in which the purchase was made.

6. Technology Related Items: Technology related items purchased through the Administrative Growth Fund must be returned to the district upon resignation or retirement. However, if items are three

years old or more, the items do not need to be returned to the district upon separation from employment.

B. Other Reimbursements

1. Mileage: Administrators required in the course of their work to drive personal automobiles shall receive the approved IRS rate, effective January 1 each year. The allowance shall be given for use of personal cars for business of the District, as approved by the administrator's immediate supervisor. The following rules shall apply:

   a. Administrators will not receive payment for mileage driven within district boundaries. Administrators will receive mileage driven out of school district boundaries. The administrator is not required to take the lessor of the mileage from their home or work site to the activity.

   b. If an administrator is required to attend an out-of-district evening or weekend activity, they can receive payment for mileage from their homes to that activity. The administrator is not required to take the lessor of the mileage from their home or work location to the activity.

ARTICLE 10 - SEVERANCE

A. Severance Program

The District will provide a Board paid tax sheltered contribution as a severance benefit. The severance program is available for those administrative staff members who have a minimum of ten years of administrative service to the Bloomfield Hills Schools. Eligibility will be based upon one of three categories for administrative service of 10, 15 or 18 years. Years between categories will place the administrator in the lower category for eligibility purposes.

1. Severance Benefit: The severance benefit is as follows:

Years of Administrative Service
Bloomfield Hills Schools

10 years	15 years	18 years
$19,000	$21,500	$25,000

2. Eligibility: Eligibility for severance payment will be premised upon receipt, by the Human Resources Office, of a written resignation from the administrator, at least thirty (30) days prior to the effective date of resignation.

B. Use of Board Paid Tax Sheltered Contribution to Purchase Retirement Service Credit

Eligible employees who tender an irrevocable letter of resignation on or before February 1st of the applicable school year, with a June 30 effective resignation date, may receive Board paid contribution in advance of the retirement date to use for purchase of retirement service credit in compliance with current tax and pension law. The letter of resignation must be effective within six (6) months of the time the Board paid contribution is used to purchase retirement service credit.

C. Alternate Severance Plan

Administrative Council staff with service in another Bloomfield Hills Schools employee group having a severance benefit, have the option to elect the severance benefit provided by the other employee group. If the administrator elects this option, the administrator's total years of service to the Bloomfield Hills Schools (as a regular employee) will be considered in determining eligibility for severance benefits of the group of

which the administrator was previously a member. Eligibility for the severance program of a group other than Administrative Council will be premised on full compliance with that group's provisions.

An administrator will have access to only one District-paid severance provision.

D. Retirement Life

The Board shall pay the premium to provide group term life insurance in the amount of $25,000 to age 65 for each administrator who retires within the provisions of the Michigan Public School Employees Retirement System (MPSERS). The life insurance is discontinued upon the insured reaching age 65.

Article 11A Administrative Salary Schedule

2016-17 - Full Step - Off-Schedule Bonus for Top Step												
	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	Off Schedule Bonus
High School Principal	$119,262	$120,675	$122,087	$123,513	$124,940	$126,073	$127,206	$128,067	$128,928	$130,258	$137,604	$1,376.04
International Academy Principal	$119,262	$120,675	$122,087	$123,513	$124,940	$126,073	$127,206	$128,067	$128,928	$130,258	$137,604	$1,376.04
Middle School Principal	$107,529	$108,679	$109,829	$111,511	$113,193	$114,422	$115,652	$116,736	$117,820	$119,845	$127,440	$1,274.40
Alt HS/Model HS Principal	$107,529	$108,679	$109,829	$111,511	$113,193	$114,422	$115,652	$116,736	$117,820	$119,845	$127,440	$1,274.40
Elementary Principal	$101,835	$102,910	$103,984	$105,563	$107,141	$108,291	$109,441	$110,313	$111,185	$113,224	$120,532	$1,205.32
High School Associate Principal	$102,784	$104,027	$105,271	$106,494	$107,717	$108,812	$109,906	$110,842	$111,779	$112,986	$118,231	$1,182.31
International Academy Assistant Principal	$100,752	$101,967	$103,181	$104,375	$105,569	$106,636	$107,703	$108,616	$109,528	$110,706	$116,996	$1,169.96
Middle School Associate Principal	$98,720	$99,906	$101,091	$102,256	$103,420	$104,460	$105,501	$106,389	$107,278	$108,425	$114,579	$1,145.79
Supervisor of Wing Lake Center	$107,072	$108,409	$109,746	$111,144	$112,542	$113,590	$114,637	$115,395	$116,154	$117,883	$125,080	$1,250.80
Supervisor of Deaf/Hard of Hearing	$95,840	$96,873	$97,907	$98,596	$99,286	$100,319	$101,352	$102,386	$103,420	$104,454	$110,308	$1,103.08
IBO Coordinator/Supervisor/Teacher Leader-Reading Recovery	$90,883	$91,862	$92,841	$93,495	$94,149	$95,128	$96,108	$97,088	$98,068	$99,047	$104,598	$1,045.98
Nature Center Manager	$62,550	$63,587	$64,624	$66,014	$67,403	$68,791	$70,179	$71,564	$72,948	$74,619	$79,772	$1,000.00

2017-18 - Full Step - Off-Schedule Bonus for Top Step												
	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	Off Schedule Bonus
High School Principal	$119,262	$120,675	$122,087	$123,513	$124,940	$126,073	$127,206	$128,067	$128,928	$130,258	$137,604	$2,064.06
International Academy Principal	$119,262	$120,675	$122,087	$123,513	$124,940	$126,073	$127,206	$128,067	$128,928	$130,258	$137,604	$2,064.06
Middle School Principal	$107,529	$108,679	$109,829	$111,511	$113,193	$114,422	$115,652	$116,736	$117,820	$119,845	$127,440	$1,911.60
Alt HS/Model HS Principal	$107,529	$108,679	$109,829	$111,511	$113,193	$114,422	$115,652	$116,736	$117,820	$119,845	$127,440	$1,911.60
Elementary Principal	$101,835	$102,910	$103,984	$105,563	$107,141	$108,291	$109,441	$110,313	$111,185	$113,224	$120,532	$1,807.98
High School Associate Principal	$102,784	$104,027	$105,271	$106,494	$107,717	$108,812	$109,906	$110,842	$111,779	$112,986	$118,231	$1,773.47
International Academy Assistant Principal	$100,752	$101,967	$103,181	$104,375	$105,569	$106,636	$107,703	$108,616	$109,528	$110,706	$116,996	$1,754.94
Middle School Associate Principal	$98,720	$99,906	$101,091	$102,256	$103,420	$104,460	$105,501	$106,389	$107,278	$108,425	$114,579	$1,718.69
Supervisor of Wing Lake Center	$107,072	$108,409	$109,746	$111,144	$112,542	$113,590	$114,637	$115,395	$116,154	$117,883	$125,080	$1,876.20
Supervisor of Deaf/Hard of Hearing	$95,840	$96,873	$97,907	$98,596	$99,286	$100,319	$101,352	$102,386	$103,420	$104,454	$110,308	$1,654.62
IBO Coordinator/Supervisor/Teacher Leader-Reading Recovery	$90,883	$91,862	$92,841	$93,495	$94,149	$95,128	$96,108	$97,088	$98,068	$99,047	$104,598	$1,568.97
Nature Center Manager	$62,550	$63,587	$64,624	$66,014	$67,403	$68,791	$70,179	$71,564	$72,948	$74,619	$79,772	$1,250.00

Article 11A Administrative Salary Schedule continued…

2018-19 - Full Step - Off-Schedule Bonus for Top Step*												
	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	Off Schedule Bonus*
High School Principal	$119,262	$120,675	$122,087	$123,513	$124,940	$126,073	$127,206	$128,067	$128,928	$130,258	$137,604	$2,752.08
International Academy Principal	$119,262	$120,675	$122,087	$123,513	$124,940	$126,073	$127,206	$128,067	$128,928	$130,258	$137,604	$2,752.08
Middle School Principal	$107,529	$108,679	$109,829	$111,511	$113,193	$114,422	$115,652	$116,736	$117,820	$119,845	$127,440	$2,548.80
Alt HS/Model HS Principal	$107,529	$108,679	$109,829	$111,511	$113,193	$114,422	$115,652	$116,736	$117,820	$119,845	$127,440	$2,548.80
Elementary Principal	$101,835	$102,910	$103,984	$105,563	$107,141	$108,291	$109,441	$110,313	$111,185	$113,224	$120,532	$2,410.64
High School Associate Principal	$102,784	$104,027	$105,271	$106,494	$107,717	$108,812	$109,906	$110,842	$111,779	$112,986	$118,231	$2,364.62
International Academy Assistant Principal	$100,752	$101,967	$103,181	$104,375	$105,569	$106,636	$107,703	$108,616	$109,528	$110,706	$116,996	$2,339.92
Middle School Associate Principal	$98,720	$99,906	$101,091	$102,256	$103,420	$104,460	$105,501	$106,389	$107,278	$108,425	$114,579	$2,291.59
Supervisor of Wing Lake Center	$107,072	$108,409	$109,746	$111,144	$112,542	$113,590	$114,637	$115,395	$116,154	$117,883	$125,080	$2,501.60
Supervisor of Deaf/Hard of Hearing	$95,840	$96,873	$97,907	$98,596	$99,286	$100,319	$101,352	$102,386	$103,420	$104,454	$110,308	$2,206.16
IBO Coordinator/Supervisor/Teacher Leader-Reading Recovery	$90,883	$91,862	$92,841	$93,495	$94,149	$95,128	$96,108	$97,088	$98,068	$99,047	$104,598	$2,091.96
Nature Center Manager	$62,550	$63,587	$64,624	$66,014	$67,403	$68,791	$70,179	$71,564	$72,948	$74,619	$79,772	$1,500.00

*Subject to the Joint Scheduling Committee referred to in the BHEA Agreement achieving and the Board of Education implementing a minimum of $750,000 in scheduling efficiencies. If the minimum of $750,000 in scheduling efficiencies is not achieved, the parties will negotiate the salary for the 2018-19 school year.

B. Impact of Educator Effectiveness Ratings on Compensation

Administrators who receive an overall annual evaluation rating of "Highly Effective" or "Effective" will receive the full negotiated compensation each year of the contract. Administrators receiving an overall evaluation rating of "Minimally Effective" will receive one-half of the negotiated compensation. An administrator rated "Ineffective" will not receive the negotiated compensation.

C. Degree Differential

1. The degree differential for administrative staff will be as follows:

Master's Degree plus 30 Graduate Semester Hours	Doctorate
$3,000	$4,250

The degree differential for the Nature Center Manager is**:**

$3000 for Master's degree

D. Stipend for Certification by National Board for Professional Teaching Standards

1. Upon receipt of proper documentation, an administrator may receive a stipend for Board for Professional Teaching Standards Certification:
   Administrators who hold current certification from the National Board for Professional Teaching Standards shall receive $1500 in addition to the amount identified as their current salary step and schedule**.**

2. Procedure to Receive Stipend

   In order to receive the stipend, the administrator must provide the human resources office with a copy of the certification. The certification must be current in order to receive the stipend. Application for the stipend must be made prior to October 1 for the fall semester and March 1 for the spring semester. An administrator is eligible for only one stipend under this section.

ARTICLE 12 – EMERGENCY MANAGER

"Section 15 (7) of the Public Employment Relations Act (PERA) mandates that any contract entered into include a statement that allows an Emergency Manager appointed under the local Government and School District Fiscal Accountability Act to reject, modify, or terminate the collective bargaining agreement as provided in the Local Government and School District Fiscal Accountability Act. This provision is intended to satisfy this requirement. No grievances may be processed contesting actions taken by an Emergency Manager."

ARTICLE 13 - DURATION OF AGREEMENT

This agreement shall be effective as of July 1, 2016, and shall continue in full force and effect until June 30, 2019.

The Administrative Council ratified this agreement on June 27, 2016 and the Board of Education approved this agreement on June 29, 2016.

Contract Reopener

Either party may reopen the contract prior to the 2018-19 school year (or earlier, if needed) for the purpose of changing contractual provisions to comply with the Patient Protection & Affordable Care Act, by serving written notice of such intent upon the other party.

Board of Education

Ingrid Day, President

Howard Baron, Secretary

Robert Glass, Superintendent

Christine Barnett, Chief Negotiator

Administrative Council

Mary Hillberry, President

Appendix A-1

BLOOMFIELD HILLS BOARD OF ED
A0PFP5
67201 - All suffixes
007002956 - All Divisions
Simply Blue PPO 1300/2600 HSA with Rx
Effective Date: January 1, 2017
Benefits-at-a-glance

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

Preauthorization for Specialty Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when require, are preauthorized or approved by BCBSM except in an emergency

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select **Approving covered services.**

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility**.

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

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Appendix A-2

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

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

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$1,300 for a one-person contract or $2,600 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**	$2,600 for a one-person contract or $5,200 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**
	Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Deductibles may increase each calendar year. Please call your customer service center for an annual update.	
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount for most covered services
Annual out-of-pocket maximums-applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$2,300 for a one-person contract or $4,600 for a family contract (2 or more members) each calendar year	$4,600 for a one-person contract or $7,200 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam-includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening- laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Appendix A-3

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

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.000002416751

Appendix A-4

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

Diagnostic services

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

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% after in-network deductible	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible

Hospital care

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

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care- must be in a **participating** skilled nursing facility	100% after in-network deductible Limited to a maximum of 120 days per member per calendar year	100% after in-network deductible
Hospice care	100% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% after in-network deductible
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization-consult with your doctor	100% after in-network deductible	100% after in-network deductible

Appendix A-5

Surgical services

Benefits	In-network	Out-of-network
Surgery-includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Voluntary abortions	100% after in-network deductible	80% after out-of-network deductible

Human organ transplants

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

Mental health care and substance abuse treatment

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance treatment	100% after in-network deductible Unlimited days	80% after out-of-network deductible
Residential psychiatric treatment facility • covered mental health servics **must** be performed in a residential psychiatric treatment facility • treatment must be preauthorizd • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment-in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment-when rendered by an approved board-certified behavioral analyst-is covered through age 18, subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.000002416751

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Benefits	In-network	Out-of-network
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy-provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member, per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	100% after in-network deductible	100% after in-network deductible

Appendix A-7

BLOOMFIELD HILLS BOARD OF ED
A0PFP5
67201 - All Suffixes
007002956 - All Divisions
Simply Blue PPO 1300/2600 HSA with Rx
Effective Date: January 1, 2017
Benefits-at-a-glance

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

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum:

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

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay plus an additional 20% of the BCBSM approved amount

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Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	31 to 83-day period	No coverage	After deductible is met, you pay $10 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $50 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $100 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $100 copay	After deductible is met, you pay $100 copay	No coverage	No coverage

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

Covered services				
Benefits	**90-day retail network pharmacy**	*** In-network mail order provider**	**In-network pharmacy (not part of the 90-day retail network)**	**Out-of-network pharmacy**
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs - when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

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Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	Not covered	100% of approved amount	80% of approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance **plus** an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/ coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug

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

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.

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Features of your prescription drug plan	
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Appendix A-11

Bloomfield Hills Bd Of ED
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007002956
Simply Blue PPO 2000/4000 HSA with Rx
Effective Date: January 1, 2017
Benefits-at-a-glance

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

Preauthorization for Specialty Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when require, are preauthorized or approved by BCBSM except in an emergency

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select **Approving covered services.**

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility**.

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

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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

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

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$2,000 for a one-person contract or $4,000 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**	$4,000 for a one-person contract or $8,000 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount for most covered services
Annual out-of-pocket maximums-applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$3,000 for a one-person contract or $6,000 for a family contract (2 or more members) each calendar year	$6,000 for a one-person contract or $12,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam-includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening- laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible

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

Diagnostic services

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

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% after in-network deductible	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible

Hospital care

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

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care- must be in a **participating** skilled nursing facility	100% after in-network deductible Limited to a maximum of 120 days per member per calendar year	100% after in-network deductible
Hospice care	100% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% after in-network deductible
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization-consult with your doctor	100% after in-network deductible	100% after in-network deductible

Appendix A-15

Surgical services

Benefits	In-network	Out-of-network
Surgery-includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Voluntary abortions	100% after in-network deductible	80% after out-of-network deductible

Human organ transplants

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

Mental health care and substance abuse treatment

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance treatment	100% after in-network deductible Unlimited days	80% after out-of-network deductible
Residential psychiatric treatment facility • covered mental health servics **must** be performed in a residential psychiatric treatment facility • treatment must be preauthorizd • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment-in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment-when rendered by an approved board-certified behavioral analyst-is covered through age 18, subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered

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Benefits	In-network	Out-of-network
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy-provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	100% after in-network deductible	100% after in-network deductible

Appendix A-17

Bloomfield Hills Bd Of ED
A0PMX7
007002956
Simply Blue PPO 2000/4000 HSA with Rx
Effective Date: January 1, 2017
Benefits-at-a-glance

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

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum:

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

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay plus an additional 20% of BCBSM approved amount for the drug

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Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	31 to 83-day period	No coverage	After deductible is met, you pay $10 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	After deductible is met, you pay $50 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	After deductible is met, you pay $100 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $100 copay	After deductible is met, you pay $100 copay	No coverage	No coverage

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

Covered services				
Benefits	**90-day retail network pharmacy**	*** In-network mail order provider**	**In-network pharmacy (not part of the 90-day retail network)**	**Out-of-network pharmacy**
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs - when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

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Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance **plus** an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/ coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug

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

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.

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Features of your prescription drug plan	
Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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BCN HSA℠ HMO $1,350 High Deductible Health Plan for Medical and Prescription Drug Coverage

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

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

Deductible **Note:** deductible is combined for both medical and prescription drug coverage. The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract	$1,350 per member, $2,700 per contract per calendar year
Fixed Dollar Copay **Note**: Copay amounts apply once the deductible has been met	None
Coinsurance **Note**: Coinsurance amounts apply once the deductible has been met	0% and 50% for select services as noted below
Out of Pocket Maximum – total amount paid toward medical and pharmacy services including deductible, copays and coinsurance.	$2,350 per member, $4,700 per contract per calendar year
Lifetime dollar maximum	None

Preventive Services

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – 100% after deductible
Consulting Specialist Care – when referred	Covered – 100% after deductible

Emergency Medical Care

Hospital Emergency Room	Covered – 100% after deductible
Urgent Care Center	Covered – 100% after deductible
Ambulance Services – medically necessary	Covered – 100% after deductible

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Diagnostic Services

Laboratory and Pathology Tests	Covered – 100% after deductible
Diagnostic Tests and X-rays	Covered – 100% after deductible
Radiation Therapy	Covered – 100% after deductible

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – 100%
Delivery and Nursery Care	Covered – 100% after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 100% after deductible
Outpatient Surgery – see member certificate for specific surgical coinsurance	Covered – 100% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible
Home Health Care	Covered – 100% after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – Male - 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Covered - 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 100% after deductible
Reduction Mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	Covered – 100% after deductible
Inpatient Substance Abuse Care	Covered – 100% after deductible
Outpatient Mental Health Care	Covered – 100% after deductible
Outpatient Substance Abuse Care	Covered – 100% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	Covered – 100% after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	Covered – 100% after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

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Other Services

Allergy Testing and Therapy	Covered – 100% after deductible
Allergy office visits	Covered – 100% after deductible
Allergy Injections	Covered – 100% after deductible
Chiropractic Spinal Manipulation – when referred	Covered – 100% after deductible; up to 30 visits per calendar year
Outpatient Therapy/Rehabilitation – subject to meaningful improvement within 60 days	Covered – 100% after deductible; limited to a benefit maximum of 60 consecutive days per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible
Durable Medical Equipment	Covered – 50% after deductible
Prosthetic and Orthotic Appliances	Covered – 50% after deductible
Diabetic Supplies	Covered – 100% after deductible

HDHPLG, 1350HD, 2350OM, VACR50

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Blue Care Network of Michigan

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

High Deductible Health Plan
Custom Drug List℠ $10/$30/$60/$80/20%/20%
Prescription Drug Coverage

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

Prescription Drugs

Deductible	The Deductible is combined for both medical and prescription drug coverage. The Deductible amount is listed with your medical benefits.
Tier 1A – Value Generics	$10 Copayment after Deductible
Tier 1B - Generics	$30 Copayment after Deductible
Tier 2 – Preferred Brand Drugs	$60 Copayment after Deductible
Tier 3 – Non-Preferred Drugs	$80 Copayment after Deductible
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount after Deductible (Maximum Copayment $200)
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount after Deductible (Maximum Copayment $300)
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount after Deductible
Contraceptives **Note:** Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	• Tier 1A – Covered in Full • Tier 1B – $30 Copay after Deductible • Tier 2 - $60 Copay after Deductible • Tier 3 - $80 Copay after Deductible
Preventive Medications	• Tier 1A – Covered in Full • Tier 1B Generic – Covered in Full • Tier 2 Preferred Brand – Covered in Full • Tier 3 Non-Preferred Drugs – Covered in Full
31-90 day supply for Mail-Order Pharmacy	Three times applicable copay minus $10 after Deductible
84-90 day supply for Retail Pharmacy	Three times applicable copay minus $10 after Deductible
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.

P136DL, 90D3X

Funding to the Administrators Health Saving or Flexible Savings Account

Admins 2017 plan year

	Single		Two Person		Full Family		
CAP	$6,344.80		$13,268.93		$17,304.02		
Cost of Insurance	$6,387.48		$15,329.88		$19,162.56		
Amount less than the CAP used to fund the Health Savings Acct	-$42.68		-$2,060.95		-$1,858.54		
Current coverage cost	$6,387.48		$15,329.88		$19,162.56		
Differential per person	**$42.68**		**$2,060.95**		**$1,858.54**		
Currently Enrolled	10		13		40	63	
Annual cost over/under hard cap	$426.80		$26,792.35		$74,341.60		**Annual Cost** **$101,560.75**

** Annual cost in excess of hard cap is calculated by subtracting the State CAP from the current coverage cost

Health Savings Account Funding					
Single	10	-$42.68	-$426.80		
Two Person	13	-$2,060.95	-$26,792.35		
Full Family	40	-$1,858.54	-$74,341.60		
	63		-$101,560.75		

						Amount to be paid by employee
Note: These numbers vary from		10	1300	$ 13,000.00		$ (875.52)
the information above. State law		53	2600	$ 137,800.00		$ (1,751.05)
requires us to count the cap differently				$ 150,800.00		
than BC for employee and child.						
			Percent of deduction funded	-67%		

Family and Medical Leave Act Regulation

1. PURPOSE

Basic Leave Entitlement. Bloomfield Hills Schools Family and Medical Leave Policy allows eligible employees to take up to 12 work weeks of unpaid leave per year for their own serious health condition, childbirth, or to provide care for the employee's newborn child, newly-adopted child, newly-placed foster child, or a child, parent or spouse with a serious health condition. Further, certain eligible employees may receive up to 12 work weeks of unpaid leave for military exigencies, and up to a total of 26 work weeks of unpaid leave to care for a covered military service member.

Additional information and forms relating to Family and Medical Leaves are available from the Human Resources Department.

2. DEFINITIONS

A. **"Leave Year".** The District has selected the following method for determining the "12-month period" for non-military related leave

The 12-month rolling backwards period. The 12-month rolling period is calculated backwards from the date the requested leave commences. This method determines FMLA leave entitlement based upon how much FMLA leave an employee has taken the preceding 12 months, measured backwards from the date the leave is to commence.

For "Military Caregiver Leave," the leave period begins the first day the leave begins, regardless of past non-military leave taken and regardless of the leave period for other FMLA qualifying leave.

B. **"*Spouse*"** means a husband or wife, but does not include unmarried domestic partners. If both spouses work for the school district, their total leave in any 12-month period may be limited to an aggregate of 12-weeks if the leave is taken for either the birth or placement for adoption or foster care of a child or to care for a sick parent. The aggregated amount of leave in a 12-month period is 26 weeks in situations where the leave is based on the care for a covered service member.

C. **"*Parent*"** means biological, adoptive, step or foster parent, or any other individual who stood *in loco parentis* to the employee when the employee was a child. A parent-in-law does not meet this definition.

D. **"*Child*"** means a son or daughter under age 18, or 18 years or older who is incapable of self-care due to mental or physical disability. Employees who are *in loco parentis* include those with day-to-day responsibility for care and financially supports the "child". A biological or legal relationship is not necessary.

"Incapable of self-care due to a mental or physical disability" means when an adult son or daughter "requires active assistance or supervision to provide daily self-care in three or more of the 'activities of daily living' or 'instrumental activities of daily living'." A parent will be entitled to take FMLA leave to care for a son or daughter 18 years of age or older, if the adult son or daughter meets the following four requirements:

1. Has a disability as defined by the ADA;

2. Is incapable of self-care due to that disability;

3. Has a serious health condition; and

4. Is in need of care due to the serious health condition

E. **"*Next of Kin of a Covered Service Member*"** means the nearest blood relative *other* than a spouse, parent, son, or daughter, in the following order: blood relatives who have been granted legal custody of the covered service member by court decree or statutory provision, brother and sister, grandparent, aunt and uncle, and first cousin, unless the covered service member designated in writing another blood family member as his or her nearest blood relative for purposes of military caregiver leave.

F. **"*Military Family Leave*"** means either "Military Caregiver Leave" or "Qualifying Exigency" Leave as set forth below:

(1) ***"Military Caregiver Leave."*** An eligible employee may take up to 26 weeks of leave to care for a covered service member during a single 12-month period. The covered service member must be a current member of the Armed Forces, which includes membership in the National Guard or Reserves. The covered service member must have sustained the serious injury or illness in the line of duty while on active duty which may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

(2) ***"Qualifying Exigency Leave."*** An eligible employee with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may also use their 12-week leave entitlement to address certain qualifying exigencies. The Department of Labor defines qualifying exigencies as: (1) short-notice deployment (up to seven days from date of notification), (2) military events and related activities, (3) childcare and school activities, (4) financial and legal arrangements, (5) counseling, (6) rest and recuperation (up to five days for each instance), (7) post-deployment activities occurring within 90 days following the termination of active duty status, and (8) additional activities arising from the service member's active duty or call to active duty not encompassed in the other categories, but agreed to by the employer and employee.

G. **"*Serious Health Condition*"** means an illness, injury, impairment, or physical or mental condition that makes the employee unable to perform the essential functions of his/her job and involves:

(1) inpatient care (an overnight stay);

(2) a period of incapacity from work requiring "continuing treatment" by a healthcare provider;

"Continuing treatment" by a healthcare provider must involve a period of incapacity of more than 3 ***full*** consecutive calendar days (including subsequent treatments or periods of incapacity relating to the same condition) that also involves either: (1) treatment of two or more times within 30 days of the first day of incapacity by a healthcare provider; or (2) treatment on at least one occasion by a healthcare provider which results in a "regimen of continuing treatment under the supervision of the a healthcare provider." (*e.g.,* a course of prescription drugs, physical therapy). The first (or only) in-person treatment visit to the healthcare provider must occur within 7 days of the first day of incapacity.

(3) a period of incapacity from work due to pregnancy or for prenatal care;

(4) a period of incapacity from work requiring treatment for chronic or permanent/long-term conditions (*e.g.*, asthma, diabetes, epilepsy, cancer); or

(5) a period of absence to receive multiple treatments by a healthcare provider for a non-chronic condition that, if left untreated, could result in a period of incapacity of more than 3 consecutive calendar days (*e.g.,* dialysis for kidney disease or chemotherapy for cancer).

Unless complications arise, the common cold, flu, upset stomach, headache, routine dental problems and cosmetic treatments do not meet the definition of "serious health condition."

Please contact the Human Resources Department for a more complete definition of "serious health condition."

H. **"*Instructional Employee*"** means a person whose principle function is to teach and instruct students in a class, a small group or an individual setting. This term includes teachers or auxiliary personnel principally engaged in direct delivery of instruction (*e.g.,* signers for hearing impaired). This definition ***does not include*** auxiliary personnel such as counselors, teacher assistants, aides, psychologists, social workers, and non-instructional support personnel.

I. **"*District*"** means the Bloomfield Hills Schools. This regulation shall be implemented by the Superintendent or his/her designee.

3. <u>GENERAL</u>

A. ***Eligibility*.** An employee who has worked at least 1,250 hours during the 12-month period before commencement of the leave is eligible for FMLA leave after having completed at least 12 months of service, including previous service with the District up to 7 years before commencement of the leave. Instructional employees will not be eligible if it is clearly demonstrated that the employee did not work the requisite hours during the 12-month period.

B. Eligible employees may use FMLA leave for one or more of the following reasons:

(1) The birth of a child and care for a newborn;

(2) The care for a newly-adopted child or child recently placed in an employee's home for foster care;

(3) To care for a spouse, child (who is less than age 18, or 18 but incapable of self-care) or a parent (but not parent-in-law) who has a serious health condition;

(4) An employee's own serious health condition that makes the employee unable to perform one or more of the essential functions of his or her job; or

(5) To address certain qualifying exigencies or care giving associated with a covered service member. The employee may be required to provide information supporting the need for military family leave.

C. An eligible employee may take up to 12 weeks of unpaid leave during any 12-month period for a purpose which qualifies for a leave under the FMLA policy. As identified in Section 2.F.(1)., an eligible employee may take up to 26 weeks "Military Caregiver Leave" measured from the first day the military-related leave commences during a single 12-month period.

An eligible part-time employee is entitled to leave on a pro-rata basis.

If spouses are both employed by the District and both are eligible for FMLA leave, spouses may take up to a combined total of 12 weeks of leave for the birth and care of a newborn child, the placement of a child in the spouse's home for adoption or foster care, or the care of a seriously ill parent. This limitation does not apply to the care of a spouse or child with a serious health condition or to the employee's own serious health condition. For example, if spouses each take 4 weeks to care for a newborn child, each spouse will have eight weeks remaining within the 12-month period to use for other kinds of FMLA leaves, if necessary.

Family leave to care for a newborn child or for adoption or foster care placement of a child must be completed within 12 months of the birth, adoption, or placement of the child.

4. <u>NOTICE</u>

A. ***Notice by Employee*.** The employee shall give notice for FMLA leave according to the following:

(1) When the need for FMLA is *foreseeable* (*i.e.*, for birth of a child, adoption, foster placement, or planned medical treatment for yourself or a family member or to care for a covered service member) 30-days notice is required. If the employee fails to give 30-days notice with no reasonable excuse, the District reserves the right to delay the employee's FMLA leave until at least 30-days after the leave request is made.

(2) When the need for FMLA leave is *unexpected*, absent unusual circumstances, the employee must provide notice to the Employer either the same business day or the next business day after the employee learns of the need for the FMLA leave.

With respect to both foreseeable and unexpected leave, employees must comply with District policies, work rules, collective bargaining provisions, and customary time off or call-in notice procedures.

At the time of requesting leave from work, the employee is required to complete District-approved forms for leave utilization. The District will provide District-approved forms which advise the employee of his/her FMLA rights and responsibilities. When any leave from work is requested, the District will inquire about the circumstances to determine if the requested leave appears to qualify as FMLA leave. Any leave request determined by the District to qualify as FMLA leave will be credited against the employee's FMLA leave for the 12-month period described in Section 2.A. of this policy.

B. ***District Notification of FMLA Leave.*** Once the District receives sufficient notice that leave qualifies for FMLA leave, the District will (within 5 business days, absent extenuating circumstances) notify the employee, in writing, whether the employee is eligible for leave.

5. <u>SUBSTITUTION OF PAID LEAVE TIME</u>

Although FMLA leave is **unpaid,** there are several ways in which the District's policies or collective bargaining agreement (regarding salary continuation, sick days and vacation pay) may operate in conjunction with certain kinds of FMLA leaves to provide the employee with some income during the leave. If paid leave is available, and applicable, it shall run concurrently with the FMLA leave.

- ***Use of earned and/or accrued paid time off.*** When leave from work qualifies as FMLA leave is taken, an employee must first concurrently exhaust earned and/or accrued paid time off which will be credited against the FMLA leave. For example, if an employee has earned and/or accrued paid vacation or personal leave, the District may require that the employee first concurrently apply that leave time to his/her FMLA leave until the earned or accrued paid leave time is exhausted. The District may also require that any earned or accrued paid vacation or personal/sick leave be exhausted concurrently with the FMLA leave before the unpaid portion of the FMLA leave to care for the employee's own serious health condition or that of a spouse, child or parent (where permitted for the latter purpose under the contract or policy governing the employee). Any remaining FMLA leave to which the employee is entitled will then be taken on an unpaid basis.

6. MEDICAL CERTIFICATION

A. If an employee requests FMLA leave due to a serious health condition or to care for a parent, child, or spouse with a serious health condition, or to attend to specific matters concerning covered service member, the employee may be required to provide medical certification from a healthcare provider of the serious health condition involved and, if applicable, verification that the employee is needed to care for the ill family member and for how long.

B. The employee may be required to provide supporting information concerning military family leave. Forms for this purpose will be provided by the Administration when the employee notifies the District of the need for the leave. Employees must provide the requested medical certification within 15 days of being supplied with the necessary certification form from the Administration or a request for FMLA leave may be delayed or denied.

C. After an employee submits the required medical certification, the District may require, at its option and expense that a medical certification be obtained from a healthcare provider of the District's own choosing to verify the need for the requested FMLA leave. If the first and second certifications differ, the District may require (at its option and expense) that a third certification be obtained from a third healthcare provider who is jointly selected by the prior two healthcare providers. The third medical certification will be final and binding on both parties. If the employee refuses to be examined by the third healthcare provider or refuses to cooperate in the examination, the employee will be bound by the second certification.

D. The District may request medical recertification for leave taken because of an employee's own serious medical condition or the serious medical condition of a family member. Recertification may be requested pursuant to the following:

(1) The District may request recertification no more often than every 30 days and only in connection with the absence by the employee, unless paragraphs 2 or 3 below apply.

(2) If the initial medical certification indicates that the minimum duration of the condition is more than 30 days, the District will wait until the minimum duration expires or 6 months, whichever is less, before requesting a recertification, unless paragraph 3 applies.

(3) The District may request recertification in less than 30 days if: (a) an employee requests an extension of leave; (b) circumstances described by the previous certification have changed significantly; or (c) the District receives information that cast doubt upon the employee's stated reason for the absence or the continuing validity of the certification.

The employee must provide the requested recertification to the District within15 calendar days unless it is not practicable under the particular circumstances to do so despite the employee's diligent good faith efforts. The District may ask for the same information as that permitted for the original certification. The employee has the same obligations to participate and cooperate in the recertification process as in the initial certification process. Any recertification requested by the employer shall be at the employee's expense.

7. INTERMITTENT/REDUCED LEAVE SCHEDULE

A. If an employee requests intermittent leave or a reduced leave schedule, the District may require the employee to explain why the intermittent/reduced leave schedule is necessary. An employee must meet with the District and attempt to work out a leave schedule which meets the employee's needs for leave without unduly disrupting the District's operations. The employee should meet with the District before treatment is scheduled. If the meeting takes place after treatment has been scheduled, the District may, in certain instances, require an employee to attempt to reschedule treatment.

B. The District may assign an employee to an alternative position with equivalent pay and benefits, but not necessarily equivalent job duties that better accommodate the employee's intermittent or reduced leave schedule. The District may also transfer the employee to a part-time job with the same rate of pay and benefits. A "light-duty" assignment, however, will not be considered FMLA leave. Where benefits (*e.g.,* vacation) are based on the number of hours worked, the employee will receive appropriate benefits, based upon hours worked. When a transfer to a part-time position has been made to accommodate an intermittent or reduced-leave schedule, the District will continue group health benefits on the same basis as provided for full-time employees until the 12 (or 26 weeks for the care of a covered service member) weeks of FMLA leave are used.

C. An intermittent and/or reduced leave schedule is available for an eligible employee to attend to a serious health condition requiring periodic treatment by a healthcare provider, or because the employee (or family member) is incapacitated due to a chronic serious health condition. An employee on pregnancy leave (unless a serious health condition is involved) or leave for care of an adopted, foster, or newborn child is not eligible for intermittent leave.

D. If an eligible instructional employee requests intermittent or a reduced leave schedule to care for a family member having a serious health condition, or for the employee's own serious health condition, which is foreseeable based on planned medical treatment, and the instructional employee would be on leave for more than 20% of the total number of working days over the leave period, the District may require the instructional employee to choose either to:

(1) take leave for a period or periods of a particular duration, not greater than the duration of the planned treatment; or

(2) transfer temporarily to an available alternative position for which the instructional employee is qualified, which has equivalent pay and benefits and which better accommodates recurring leave periods than does the instructional employee's regular assignment.

8. BENEFITS

A. During the period of an approved FMLA leave, the District will continue the employee's health insurance premium uninterrupted. If the employee makes a contribution toward coverage, the employee must make arrangements to continue his or her contributions during the leave to continue the basic health insurance coverage at its existing level. An employee's failure to pay his or her share of health insurance premium during FMLA leave may result in loss of coverage if the employee's contribution is more than 30 days late. If the employee's premiums are in arrears, the District will provide the employee at least 15 days written notice that coverage will be dropped prior to cancelling coverage.

(1) Except as required under COBRA, the District's obligation to maintain health benefit premium contributions for an employee on FMLA leave ceases when: a) the employment relationship would have terminated, irrespective of the FMLA leave (*e.g.,* reduction in force); b) when the employee advises the District of his or her intent not to return from leave; or c) when the FMLA leave expires and the employee has not returned from leave.

(2) Employee contributions will be required either through payroll deduction or by direct payment to the District. The employee will be advised in writing at the beginning of the leave as to the amount and method of payment. Employee contribution amounts are subject to any change in premium rates that occur while the employee is on leave.

(3) If the District remits any employee premium contributions in arrears from the employee while on FMLA leave, the employee will be required to reimburse the District for delinquent payments (through authorized payroll deduction or otherwise) upon return from leave. If the employee fails to return from unpaid leave for reasons other than: a) the continuation, recurrence, or onset of a serious health condition of the employee or a covered family member, or b) circumstances beyond the employee's control, the District may seek reimbursement from the employee for the portion of the premiums paid by the District on behalf of that employee (also known as the "employer contribution") during the leave period, excluding the period where the District or the employee has substituted paid leave for FMLA leave.

(4) An employee is not entitled to seniority or benefits accrual (*e.g.,* holidays, vacations) during the unpaid leave, unless otherwise specified by the collective bargaining agreement or individual employment contract. An employee who takes FMLA leave will not lose any seniority or employment benefits that accrued before the date leave began.

B. ***Disability Plans and FMLA Leave:***

(1) ***Workers' Compensation Leave.*** If the employee has a work-related illness or injury that qualifies as a "serious health condition" under this policy, leave from the job for which the employee receives workers' compensation payments will be considered FMLA leave. The employer and employee may agree to have paid leave supplement worker's compensation benefits, *i.e.,* where worker's disability compensation benefits provide replacement income for only a portion of the employee's salary.

(2) ***Disability Plan Leave.*** The District may designate any employer-sponsored disability plan leave as FMLA leave.

9. RETURN TO WORK

A. Upon conclusion of FMLA leave, an employee will be returned to the same position the employee held when leave began or to an equivalent position with equivalent benefits, pay, and other terms and conditions of employment, provided the position remains.

B. Periods Near the Conclusion of an Academic Team

1. Leave five weeks before end of term: An instructional employee who begins a leave more than five weeks before the end of an academic term (semester) may be required to continue on leave until the end of the term if the leave will last at least three weeks, and the return to work would occur within the last three weeks of the term.

2. Leave five weeks before the end of term for reasons other than employee's serious health condition: An instructional employee who begins a leave for a purpose other than his/her own serious health condition during the five-week period before the end of a term may be required to continue on leave until the end of the term if the leave will last more than two weeks, and the return to work would occur within the last two weeks of the term.

3. Leave three weeks before end of term for reasons other than employee's serious health condition: An instructional employee who begins a leave for a purpose other than his/her own serious health condition during the three-week period before the end of the term and the duration of the leave is more than five working days may be required to continue on leave until the end of the term.

C. ***Fitness-for-Duty Certification.*** An employee shall submit a written statement from a physician which addresses the employee's ability to return to work and perform the essential functions of the position, consistent with District policy or collective bargaining agreement at least one (1) day prior to the scheduled return. In the case of intermittent or reduced schedule leave, where reasonable job safety concerns exist, the District may require the employee to provide a fitness-for-duty certification up to once every 30 days before he or she may return to work.

10. KEY EMPLOYEES

A. ***Definition*.** A "key" employee is an eligible salaried FMLA-eligible employee who is among the highest paid 10% of District employees.

B. ***Job Restoration.*** While the District will not deny FMLA leave to an eligible key employee, the District may deny job restoration to a key employee when the restoration to employment will cause the District substantial and grievous economic injury or substantial, long-term economic injury.

C. ***Qualifications.*** Each employee who is designated as a "key" employee will be notified of that fact when he/she requests FMLA leave, or at the commencement of such leave, whichever occurs first; or if the notice cannot be given then because of the need to determine whether the employee is a key employee, as soon thereafter as practical.

In any situation in which the District determines that it will deny restoration or employment to a key employee, the District will issue a hand-delivered or certified letter to the key employee explaining the finding that the required injury to the District exists. Additionally, the District will inform the key employee of the potential consequences with respect to reinstatement and maintenance of health benefits should employment restoration be denied. When practical, the District will communicate this determination before the commencement of the FMLA leave; the key employee may then take FMLA leave or forego it. If the FMLA leave has already begun, the key employee will be provided a reasonable time in which to return to work after being notified of the District's intention – the decision cannot be made until the employee seeks to return to deny reinstatement.

D. ***Timelines.*** If a key employee does not return to work in response to the District's notification of its decision to deny restoration of employment, the District will continue to provide the key employee with health benefits (to the extent of the FMLA leave period) and the District will not seek to recover its cost of health benefit premiums. A key employee's FMLA rights will continue until the employee gives notice that he/she no longer wishes to return to work or until the District denies reinstatement at the end of the leave. The key employee has the right, at the end of the FMLA leave, to request reinstatement and the District will reevaluate the extent of its injury due to the requested reinstatement based on the facts at that time.

If the District again determines that the reinstatement will still cause the injury, the key employee will be notified in writing by hand-delivered or certified letter of the denial of his/her reinstatement to employment. If the District finds that reinstatement will not result in the required injury, the key employee will be granted reinstatement.

11. FAILURE TO RETURN FROM LEAVE

An employee's failure to return to work upon expiration of FMLA leave will subject the employee to termination unless an extension is granted, as required by law or under a collective bargaining agreement. An employee who requests an extension of FMLA leave due to the continuation, recurrence, or onset of her or his own serious health condition, or of the serious health condition of the employee's spouse, child, or parent, must submit a written request for an extension to the Assistant Superintendent for Human Resources and Labor Relations. This written request should be made as soon as the employee realizes that she or he will not be able to return at the expiration of the leave period. Medical certification or recertification will be required to support any request for leave extension.

12. FORMS

The following forms, where applicable, must be filed with the Administration in accord with District policies and procedures:

WH-380-E Certification of Health Care Provider for Employee's Serious Health Condition

WH-380-F Certification of Health Care Provider for Family Member's Serious Health Condition

WH-381 Notice of Eligibility and Rights & Responsibilities

WH-382 Designation Notice

WH-384 Certification of Qualifying Exigency For Military Family Leave

WH-385 Certification for Serious Injury or Illness of Covered Service Member For Military Family Leave

WH-385-V Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave

Legal Authority: Family and Medical Leave Act of 1993, 29 USC § 2601 et. seq.; Americans with Disabilities Act of 1990, as amended, 42 USC § 12101, et. seq.

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