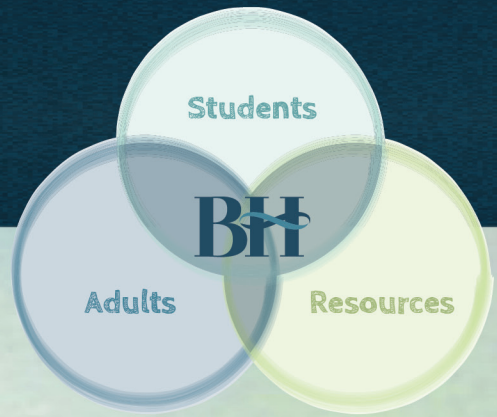
Paraeducator Agreement

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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ARTICLE 1 – PREAMBLE

This Agreement is entered into on June 17, 2016 by the Board of Education, Bloomfield Hills Schools, County of Oakland, State of Michigan (hereinafter referred to as the "Board/Employer"), and the Bloomfield Hills Association of Paraeducators (hereinafter referred to as the "Union").

ARTICLE 2 - RECOGNITION

In accordance with the applicable provisions of Act 379 of the Public Acts of 1965, as amended, the School Board recognizes the Union as the sole and exclusive representative for the purpose of collective bargaining with respect to wages, hours, and terms and conditions of employment for the term of this Agreement for employees of the School Board included in the Bargaining Unit described below:

Paraeducator personnel in K-12 regular and special education, excluding supervisors, temporary substitute employees, special education center program staff, instructional assistants, interpreters of the hearing impaired and all other employees.

ARTICLE 3 - REPRESENTATION

A. Officer Notification

The Union will furnish the Employer with lists of its officers, representatives and stewards who have dealings between the Employer and the Union, within five (5) working days after their appointment.

B. Union Representatives

Duly authorized local representatives of the Union shall be permitted to transact official union business on school property provided that this shall not interfere with nor interrupt normal school operations.

C. Carrying Out Investigation, Initiation and Presentation of Grievances

The investigation, initiation and presentation of grievances should be conducted outside working hours. In the event a Union representative must use working hours to investigate or present a grievance, the representative shall first have the approval of the Assistant Superintendent for Human Resources and Labor Relations and the building administrator and conduct the investigation or presentation of the grievance as expeditiously and with as little interruption of work as possible.

ARTICLE 4 - EMPLOYEE RIGHTS

A. Legal Obligations

The Union and Employer agree to recognize those applicable laws governing individuals in the work place.

B. Nondiscrimination

The provisions of this Agreement and the wages, hours, terms and conditions of employment shall be applied without discrimination based upon those classifications protected by applicable state and federal law.

C. Personnel File

1. Review of File

Any employee will have the right, per existing law, to review the contents of their personnel and payroll file, excluding pre-employment information; and to have a Union representative present during such review. The file review will be conducted at a time mutually agreeable to the parties.

2. Response to Adverse Inclusions

Information included in the file will be in compliance with current legal standards. In the event of adverse inclusions, the employee may submit a written response concerning such inclusion, which will also be included in the file. The employee signature on file contents will confirm only that such has been reviewed by the employee.

ARTICLE 5 - MANAGEMENT RIGHTS

A. Reservation of Rights

The Board of Education, on its own behalf and on behalf of the electors of the School District, hereby retains and reserves unto itself all powers, rights, authority, duties and responsibilities conferred upon and vested in it by the Constitution and laws of the State of Michigan, including, but without limiting the generality of the foregoing, the rights:

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

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

3. To determine the hours of employment and the duties, responsibilities, and assignment of employees with respect thereto, and the terms and conditions of employment.

B. Exercise of Rights

The exercise of the foregoing powers, rights, authority, duties and responsibilities by the Board, the adoption of policies, rules, and regulations and practices in furtherance thereof, and the use of judgment and discretion in connection therewith shall be limited only by the terms of this agreement, and then only to the extent such specific and express terms are in conformance with the Constitution and laws of the State of Michigan.

ARTICLE 6 - UNION RIGHTS

A. Bulletin Boards and School Mails

Bulletin Board space and mail facilities in each building, including mail boxes, may be made available to the union for official business. The Board, however, shall not assume the responsibility of, or any liability for, notices posted or to be delivered for Union purposes. Notices posted shall not speak or suggest any adverse attitude or action toward anyone or the District.

B. Use of Facilities and Equipment

With the approval of the administration, the Union may have the right to use school facilities and equipment for meetings, when such equipment and facilities are not otherwise in use. The Union shall pay for the cost of all materials and supplies incidental to such use and shall be responsible for proper operation of all such equipment. The use of District equipment and facilities will be subject to prior approval of the administration and within Board policy.

C. Information

The Employer will provide information to enable the Union to develop appropriate negotiation proposals as required under the law. It is understood that the foregoing shall not be construed to require the board to compile information or statistics not already compiled or to furnish a copy of any document which has not become a matter of public record.

ARTICLE 7 - SENIORITY

A. Seniority

The seniority of all employees on the seniority list shall commence with the most recent date of hire by the Board.

B. Seniority List

1. The seniority list will include the names, job titles, classification and most recent date of hire of all employees entitled to seniority.

2. The Board will keep the seniority list up to date and provide the Union with a current copy upon request.

C. Probationary Period

1. The first 120 work days are probationary

   The first 120 full work days of employment shall be probationary**.** During the first 60 full work days of employment, the employee shall have no temporary leave or other benefits*, except holiday pay, per Article 16. If the employee is absent, the probationary period is extended by the number of days absent. Any other extension of the probationary period will be by mutual agreement of the Board and the Union. *However, any benefit eligibility will be in compliance with current law (e.g. The Patient Protection & Affordable Care Act).

2. Leave days and other benefits begin after 60 full work days
   Leave days will be available upon the satisfactory completion of 60 full work days and may be used as provided in Article 14. Health*, dental, vision, life insurance, short term disability (STD), and long term disability (LTD) will be effective for eligible probationary employees on the first day of the month after satisfactory completion of the 60 full work days. *However, any benefit eligibility will be in compliance with current law (e.g. The Patient Protection & Affordable Care Act)

3. Seniority Status
   If the employee is continued in employment beyond the 120 day probationary period, the employee shall acquire the status of a seniority employee and seniority shall be established from the first day worked as a probationary employee.

4. Union Representation
   The Union shall represent probationary employees for purposes of collective bargaining in respect to wages, hours, terms and conditions of employment. Probationary employees may be summarily discharged and such discharge shall not be grievable.

D. Loss of Seniority

Staff members shall lose seniority and be terminated from employment if any of the following occurs:

1. The employee is discharged and the discharge is not reversed through the grievance procedure.

2. The employee is absent without notice or approval for three (3) consecutive working days.

3. The employee fails to respond to a recall letter within 10 working days from the date of mailing the letter to the employee's last known address in the employee's personnel file.

4. The employee is laid off for a period of time exceeding one year.

5. The employee does not return to work after a medical leave of absence or workers' compensation leave of absence within the time frame provided in Article 17 (C)(5)(e)(3) and 17 (C)(7)(f).

E. Seniority (Leaves of Absence)

Employees, while on approved compensable leave days (Article 14), short term disability (Article 17 (C)(5)(d)), or child care (Article 15 (B)) leaves of absences, shall accumulate seniority.

F. Seniority – Leaving the Bargaining Unit for another Position in the School District

Any employee who leaves the bargaining unit for another position in the school district shall have their accrued paraeducator seniority frozen at the amount earned as of the last day worked in the bargaining unit. If the employee returns to the bargaining unit, the paraeducator seniority shall be reinstated. An employee does not accrue bargaining unit seniority unless employed in a position covered by this Agreement.

ARTICLE 8 - REDUCTION/RECALL/POSTING

A. Least senior employee by category laid off first.

In the event of a reduction in staff, the least senior person, by category, will be removed and remaining staff will be reassigned as determined by the administration.

B. 14 days' notice of lay-off

Staff to be laid off for an indefinite period of time will be given at least 14 calendar days' notice of layoff. Copies of layoff notices will be sent to the local president.

1. Recall
   For purposes of recall, the most senior person, by category, will be recalled first. Notice of recall shall be sent to the individual at the last known address as provided by the individual and as shown on the employer's record, by registered or certified mail. If an individual fails to accept recall to work within 14 calendar days from date of mailing of notice of recall, the individual shall be terminated.

C. Initiation of reduction in staff

Reduction in staff may be initiated by the staffing need of the program or building as determined solely by the administration. Paraeducators who are affected by a reduction in staff may displace the least senior person in their category.

1. Retention based upon qualifications and then seniority
   Individuals will be retained based on qualifications and then seniority within their category. Assignment to another category may be initiated subject to approval of the Assistant Superintendent for Human Resources and Labor Relations.

2. If qualified, laid off staff placed prior to new hires
   Except for situations where the individual does not meet the job requirements as determined by the Assistant Superintendent for Human Resources and Labor Relations, the paraeducators on layoff will be placed prior to hiring a new person.

3. Must meet standards and be capable of performing the work
   Before an assignment is made, the individual must meet the standards and be capable of performing the work without a trial period. It is understood that "capable of performing" the work includes temperament, personality and ability to work with a particular administrator, or the public, or teachers and students in a harmonious relationship. It is also understood that meeting “the standards” includes meeting the qualifications of the No Child Left Behind Act (NCLB), Education YES and any amendments thereto, such as Every Student Succeeds Act (ESSA).

4. Category definitions
   Category definitions are defined per Appendix A.

D. Provide employer with change of address in writing

Individuals will not be excused for failure to report for work or recall if the individual fails to receive recall notice because of their own failure to advise the Employer in writing of change of address.

E. Posting of vacancies

1. During the two weeks immediately before and immediately after the beginning of the school year, vacancies shall be posted at each paraeducator work site for a period of three (3) working days. Vacancies, at times other than the beginning of the school year, shall be posted at each paraeducator work site for a period of five (5) working days.

F. Number of hours worked may vary

The number of hours a paraeducator is assigned to work may change (upward or downward) from year to year and during the school year.

ARTICLE 9 - GRIEVANCE PROCEDURE

A. Procedure

Any complaint by an employee concerning the application, meaning, interpretation or alleged violation of this agreement, or concerning any disciplinary action, shall constitute a grievance and shall be processed as follows.

No grievance shall be processed unless it is presented within ten (10) working days of its occurrence or knowledge of its occurrence. The time limits set forth in steps 1 and 2 may be extended by mutual consent of the parties. Further, any step in the procedure may be omitted upon mutual consent of the parties.

1. Step One

The initial presentation of any grievance shall consist of an informal discussion between the employee and immediate supervisor. At the option of the employee, representatives of the Union (2) may participate in the discussion at Step One. Other Employer representatives (2) may also participate.

If the decision is not satisfactory to the employee or the Union, the grievance shall be reduced to writing and presented to the immediate supervisor within five (5) working days of the Step One meeting. The immediate supervisor shall answer in writing within five (5) working days of receipt of the grievance.

2. Step Two

If the decision of the immediate supervisor is not satisfactory, the grievance, in writing, will be referred by the grievant to the Assistant Superintendent for Human Resources and Labor Relations within five (5) working days of receipt. A hearing date will be established within ten (10) working days.

Within five (5) working days after the hearing or its investigation, the Assistant Superintendent for Human Resources and Labor Relations shall advise the aggrieved employee(s) and the Union of the decision in writing.

3. Pre-arbitration

Within ten (10) working days after the Step Two answer, the Union or Employer may request a pre-arbitration hearing. This meeting must be held within ten (10) working days of the request for pre-arbitration.

4. Step Three (Arbitration)

a. Referral to Arbitration
If the alleged grievance is unresolved after Step Two, the matter may be referred to arbitration. The Union may refer the matter to arbitration provided that notice to refer the matter is given to the other party within ten (10) working days from the date of the written decision at Step Two or after

pre-arbitration is conducted. Within five (5) working days after the date of the written request for arbitration, designated representatives or the Employer and the Union shall make every reasonable effort to agree upon a mutually acceptable arbitrator.

b. If Parties Unable to Agree on Arbitrator
If the parties are unable to agree on an arbitrator within the time period set forth herein, the party seeking arbitration shall file a request with the American Arbitration Association to submit a list of qualified arbitrators. The arbitrator shall then be selected according to the rules of the American Arbitration Association.

c. Arbitrator To Render Decision Within 30 Days From Close of Hearing
The Arbitrator shall hear the grievance in dispute and shall render a decision in writing within thirty (30) calendar days from the close of the hearing. The Arbitrator's decision shall be final and binding upon the Employer, the Union, and the employee(s) involved.

d. Authority of Arbitrator
The Arbitrator shall have no authority except to pass upon alleged violations of the expressed provisions of this Agreement and to determine disputes involving the application or interpretation of such expressed provisions. The Arbitrator shall have no power or authority to add to, subtract from, or modify any of the terms of this agreement and shall not substitute his judgment for that of the Employer where the Employer is given discretion by the terms of this Agreement or by the nature of the area in which the Employer was acting. The Arbitrator shall not render any decision which would require or permit any action in violation of the Michigan School Laws.

e. Fees and Expenses
1. The Arbitrator's fees and expenses shall be shared by the Employer and the Union equally. The expenses and compensation for attendance of any employee, witness, or participant in the arbitration shall be paid by the party calling such employee, witness, or requesting such participant.

2. Unless otherwise agreed by the parties, if a scheduled arbitration is cancelled at the request of one party, the party requesting cancellation shall pay any of the arbitrator’s fees and expenses associated with the cancellation.

B. Individual Grievances

Notwithstanding the foregoing provisions, it is understood that any individual employee at any time shall have the right to process a grievance on their own behalf, excluding arbitration, and have the grievance adjusted, without intervention of the Union, if the adjustment is not inconsistent with the terms of this Agreement. The Union shall have the right to attend hearings on the matters and receive a copy of any disposition.

C. Monetary Awards

If a grievance is sustained, the aggrieved party shall be paid for financial loss, as determined in the final disposition. No claim for back wages shall exceed the amount of wages the employee would otherwise have earned at the regular rate and any wage settlement will be reduced by income earned from other sources.

ARTICLE 10 - TRANSFER AND ASSIGNMENT

A. Transfer

Paraeducator staff may request a transfer from one building to another by applying for a posted position. The decision to grant the transfer rests solely with the Assistant Superintendent for Human Resources and Labor Relations.

B. Assignment

An individual may assume a new assignment or increased hours within the same building during the school year subject to the approval of the Assistant Superintendent for Human Resources and Labor Relations.

C. Involuntary Reassignments (Permanent)

Involuntary reassignment shall not take place without prior discussion with the affected employee, in which any objections to the assignment by the employee shall be considered. If the employee objects to the reassignment, they shall have the right to a full review of the case by the Local President, BHOPPA's Executive Director, the Assistant Superintendent for Human Resources and Labor Relations and a second administrator.

ARTICLE 11 - DISCHARGE AND DISCIPLINE

A. Notice of Discharge or Suspension

If an employee is discharged or suspended, the Board will promptly notify the local president or designee of such action.

Disciplinary actions will be for cause.

B. Discussion of Discharge or Suspension

Upon request, the Board or its designated representative, will discuss the discharge or suspension with the employee and the Union. The Board, likewise, will discuss written reprimands with the employee and the Union upon request. An employee shall be entitled to have present a representative of the Union during meetings concerning disciplinary action. When a request for such representation is made, no meeting will be conducted with respect to the employee until such representative of the Union is present, unless said representative fails to appear within a twenty-four (24) hour period.

C. Appeal of Discharge or Suspension

Should the discharged or suspended employee or the Union consider the discharge or suspension to be improper, a complaint shall be presented in writing. The matter shall be referred to Step Two of the grievance procedure.

ARTICLE 12 - SPECIAL CONFERENCES

A. “Special Conferences” are established

There shall be established under this Article a closed forum, hereinafter called "Special Conferences," for the purpose of improving Employer/Employee relationships. It is understood by the parties, however, that the Special Conferences are not to be construed or utilized as a grievance or "gripe" session. It is to be utilized solely as a constructive basis for important matters. It is not to be considered as negotiations, except as provided elsewhere in this Agreement.

B. Arrangements for special conferences

Special Conferences will be arranged between the Local President and the Employer or its designated representatives by mutual consent of the parties. Such conferences shall be between two or three representatives of the Employer and two or three representatives of the Union. Arrangements for the conference shall be made in advance, and a written agenda of the matters to be taken up shall be presented at the time the conference is requested. The names of the persons to be present shall be submitted prior to the conference. Matters taken up at Special Conferences shall be confined to those included in the agenda. An employee shall not lose time or pay for time spent in a Special Conference during the regular work day.

C. Union may meet prior to special conferences

The representatives of the Union may meet at a place designated by the Employer on the Employer's premises for at least one-half hour (but not to exceed one hour) immediately preceding the special conference.

ARTICLE 13 - WORKING HOURS/WELCOME BACK DAY ACTIVITIES

A. Shift Hours

Shift hours will be determined by the Employer, and each shift will consist of up to eight (8) consecutive hours excluding a thirty-minute (30) unpaid lunch period.

B. Additional Days

Work beyond that normally scheduled may only be initiated with the prior approval of the building principal.

C. Overtime

Overtime will be paid at the rate of time and one-half for work over forty (40) hours per week. Overtime will be paid in compliance with the Fair Labor Standards Act.

Upon mutual agreement of the parties, compensable time at the earning rates defined above, may be taken in lieu of the hourly rate.

D. Welcome Back Day Activities

If the employer schedules "Welcome Back Day" activities, an employee will be paid for attendance at Welcome Back Day activities in the building, provided the employee participates in such activities. In order to be paid for the Labor Day holiday (see Article 16), an employee must participate in all (not part) of the scheduled Welcome Back Day activities, from start to finish, including any activities or assignments directed or requested by his/her supervisor and professional development activities provided for employees on Welcome Back Day. Any employee who attends part but not all of the Welcome Back Day activities will not receive holiday pay for Labor Day.

E. Professional Development

1. The district shall provide a program of professional development opportunities for paraeducators each school year. The program will be held on Welcome Back Day during the term of this Agreement. If the district determines that no Welcome Back Day will be held, the professional development day will be scheduled on another day during the school year.

2. A minimum of six (6) hours of professional development will be provided. Paraeducators attending professional development will be paid at their regular hourly rate.

3. The Association will establish a committee to select topics for a professional development program for submission to the Assistant Superintendent for Human Resources and Labor Relations for approval. The administration may propose subjects to the committee and may send one or more representatives to meet with the committee.

4. The Union will organize and be responsible for professional development activities for paraeducators on Welcome Back Day, subject to the approval of the Assistant Superintendent for Human Resources and Labor Relations. The Union will also be responsible for verifying the attendance of employees at the professional development activities. The Assistant Superintendent for Human Resources and Labor Relations will assist the Union in organizing the professional development activities.

5. Professional development opportunities may include:

a) Participation in all professional development provided to the teaching staff regarding the implementation of new, revised or updated curriculum or technologies in the district

b) Student management

c) Special Education

d) Such further issues found appropriate by the parties

ARTICLE 14 - COMPENSABLE LEAVE DAYS

A. Definition

Paid for leave time will be provided in order to protect the employee's income during periods of unavoidable absence. The Board's primary concern is for periods of personal illness; however, in appropriate circumstances compensable days for family illness, bereavement, emergencies and personal business constitute legitimate usage.

B. Accumulation

Each employee, upon satisfactory completion of sixty full work days shall be entitled to a current leave day earning at the rate of one day per month of employment service. Leave days for the current year shall be placed at the disposal of each employee who has completed the sixty full work days on July 1st and will be made available to the employee, on a pro rata basis, upon completion of the sixty work days. Unused leave at the end of the school year shall be accumulated to a maximum of one hundred (100) days for ten-month employees.

The value of the leave day is based on the number of hours the employee is scheduled to work when the leave day is used.

1. Severance

Upon severance of employment after five (5) years' service, for reasons of death, retirement, or quit with proper notice of not less than two weeks, but not an employee who quits without notice or is discharged, a severance payment for each unused leave day, up to a maximum of 100 days, will be made by the Board of Education as defined in the schedule described below:

5 years through 10 years	40%
11 years through 20 years	60%
21 years through 30 years	70%
31 years, plus	80%

The value of the leave day is based on the number of regularly scheduled hours immediately preceding the payout.

2. Leaving the Bargaining Unit for another Position in the School District

   An employee who leaves the bargaining unit for another position in the school district has the option of:

   a. Receiving any earned severance benefit as provided by this article, or

   b. Having any earned leave days transferred to the employee's leave bank in his/her new position in the school district.

   c. Seniority is determined by the number of years in the bargaining unit.

C. Use of Leave Days

Leave days may be used, in accordance with the following schedule and the Family and Medical Leave Act (FMLA) procedures outlined in Appendix E. For all absences the employee is required to notify the school administration upon first knowledge of the necessity for the absence. It is agreed that the use of leave days will be confined to the legitimate purposes specified as follows:

1. Personal Illness: Bona Fide involuntary physical incapacity to report for and discharge duties. It is understood that an employee may be required to provide a physician's certificate in cases of illness.

2. Family Illness: Bona Fide pressing need due to illness of an employee's spouse, children or parents.

3. Bereavement: Up to three (3) days will be approved for death in the immediate or secondary family. Additional paid days will be approved dependent on family relationships, circumstances, and/or travel involved as determined by the Human Resources Department provided such additional leave days are available in the current or accumulated leave bank.

   An employee's immediate family shall include spouse, parents, children, or persons living in the employee's household. Secondary family is considered to include the employee's grandparents, brothers**,** sisters**,** aunts and uncles.

4. Personal Leave: Up to two (2) days per year from current leave days may be used for personal leave. Personal leave, in all cases except unforeseen emergency, requires at least two (2) days advance notice to**,** and approval of the immediate supervisor. Personal leave cannot be utilized the day before or immediately following a holiday, vacation, recess at the beginning or ending of the school year**,** or to extend vacations. Approval for the use of such days may be granted for special circumstances, if approved by the Assistant Superintendent for Human Resources and Labor Relations.

5. Religious Holidays: Up to two (2) days per year from current leave days may be used for observance of religious holidays.

D. Use of Accumulated Leave Bank

1. Illness or Bereavement
   The employee's accumulated leave bank shall be available for use only for the reasons of personal illness or bereavement, and illness in the family as defined above.

2. One Personal Leave Day from Bank
   An employee may use one personal leave day from the accumulated leave bank if the current leave is depleted and no days have been used for personal leave from the current leave bank.

3. Illness in the Family
   Leave days for illness in the family may be used from the leave bank for serious illness of a family member**.**

E. Leave Day Provisions

1. Abuse of Leave Days

   Abuse of temporary leave shall be subject to one or more warnings, to suspension and/or dismissal. All salary and fringe benefits of the employee are subject to being waived during the abused leave.

2. Interruption of Service
   In the event that the service of an employee is interrupted by reason of discharge, termination, suspension, or leave, and said employee 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 last pay check due the employee at the time of interruption.

F. Extended Medical Leaves of Absence

1. The employee, upon learning of the need for an extended medical leave of absence must notify the Human Resources Department (Benefits Coordinator). The required leave forms will then be forwarded to the employee. The employee and the physician must complete the forms verifying the estimated date the leave will commence, and the employee's ability to continue employment prior to the leave. Statements from the employee's physician will be provided by the employee to the Human Resources Department on a monthly basis, on the district's form, regarding the employee's ability to continue employment prior to the leave. An employee who desires to remain on the job must maintain a satisfactory attendance record and must provide verification from the physician of ability to perform the functions of the job. If the conditions are not met, administration will initiate the leave. The extended medical leave (or short term disability leave) shall begin as soon as the physician completes the

appropriate forms certifying the employee is unable to perform the functions of the job. See Article 18(C)(3)(d) for the short term disability provisions.

G. Jury Duty

1. Notify Human Resources Office
   Employees who are summoned for jury duty must notify the Human Resources Office within twenty-four (24) hours of receipt of such notice. If the employee then reports for jury duty, the employee shall receive jury duty pay. On release from jury duty, if the employee has sixty (60) minutes or more remaining on the employee's regular shift, the employee shall report to work provided however, the employee's building administrator or supervisor may release the employee for the remainder of the work day. Jury duty pay is the regular daily wage for each day on which the individual reports for or performs jury duty and on which the employee would otherwise have been scheduled to work. Time spent on jury duty shall not be charged against leave days.

2. Jury Duty Pay
   To be eligible for jury duty pay, the employee must furnish the Human Resources office with written verification 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 employee by the court. This payment by the employee shall be made to the Human Resources Department no later than two (2) weeks after the return from jury duty. Any employee found abusing this privilege shall not be entitled to the pay differential.

H. School Closing

On any day when school sessions are scheduled but that schedule is canceled by the Superintendent due to weather or other conditions, and this official closing is announced on radio and television stations or through a program established by the administration, employees will not report for work. Other conditions include, but are not limited to, loss of power, heat, water, or safety issues.

1. When school sessions are cancelled due to inclement weather or other conditions, the individual has the option of protecting income by charging that day against unused leave time should it be available. Should there be no leave days available, a docking of pay would be initiated for the time missed.

2. In the event a facility must be shut down after an individual's scheduled start time and after the employee has reported to work, the employee may be released from work upon the supervisor's direction, with no loss of pay or leave day for the remainder of the day.

ARTICLE 15 - LEAVES OF ABSENCE (noncompensable)

A. Family and Medical Leave Act

Basic Leave Entitlement: Bloomfield Hills Schools' Family and Medical Leave Policy 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 D to the contract contains the regulation applicable to FMLA leave.

B. Child Care Leave

1. Non-Paid Leave
   Child care leave shall be considered a non-paid leave. The unpaid child care leave of absence will be granted for a maximum of one year (12 months). FMLA leave for the birth of a child or for placement of adoption or foster care must conclude within twelve (12) months of the birth or placement.

2. Return from Leave
   An individual desiring to return from leave shall notify the Human Resources, in writing, and provide the appropriate personnel form approving the return to work and indicating that the employee is able to perform the functions of the position. Such notice shall be provided no less that fifteen (15) calendar days prior to the desired return date. Provided the leave does not extend beyond the number of weeks for which the employee is eligible under the FMLA, reinstatement shall be to the same or a comparable position and one for which the individual is qualified.

3. Return from Leave Exceeding FMLA Eligibility Amount
   If the leave exceeds the amount of leave an employee is eligible for under FMLA, the return to work is contingent upon a vacancy being available for which the individual is qualified. There shall be no layoff to provide a vacancy.

4. Adoption or Paternity
   In accordance with this section, a twelve (12) month unpaid leave of absence is available in cases of adoption or paternity. The leave of absence in such cases shall commence on the date of placement for adoption or birth of the child.

C. Military Leave

Reinstatement from Military Leave

Any employee who enters into active service of the Armed Forces of the United States and, upon the termination of such honorable service, shall be offered re-employment, provided the individual reports for work within ninety (90) days after discharge. Employment may be in the previous position held or a similar position of like status and pay, unless the circumstances have changed as to make it impossible or totally unreasonable to do so. In this event, the individual will be offered employment in line with seniority as may be available, and which the individual is capable of doing.

A probationary employee who enters the Armed Forces and meets the foregoing requirement must complete the probationary period and, upon successfully completing it, will have seniority equal to the time spent in the Armed Forces.

D. Leave for Union Business

A maximum of eight (8) days per year, not for consecutive use, may be used for the conduct of union business. The use of these noncompensable days will be considered only when the operation can be continued with no interruption, and is finally contingent on the approval of the immediate supervisor. These days will not be used in combination with other leave days or vacation.

E. Conditions for Return from Leave

1. An employee released by a physician for return to work will be assigned to the first vacancy for which the individual is qualified. Should no vacant position exist, the employee will be considered as unassigned staff until a vacancy occurs.

2. The Board of Education reserves the right to have any employee returning from a leave of absence examined by a Board-appointed physician to verify their ability to return with no limitations.

3. An employee who is on a leave of absence, and doesn't return upon the expiration of the leave, will be considered a termination.

ARTICLE 16 - HOLIDAYS

A. Eligibility for Holiday Pay

A maximum of nine (9) paid holidays per year will be granted to each employee. To be eligible for holiday pay, the employee must work the scheduled hours on the working days immediately previous to and following the holiday, except where the employee has received permission from the Superintendent or designee in advance, or is on a compensable leave as defined in Article 14 of this Agreement.

Holiday pay will be based on the employee's hourly rate and regular work day (not to exceed eight (8) hours) immediately previous to the holiday.

B. The following days will be celebrated as paid holidays:

New Year's Day	Thanksgiving
Good Friday	Friday following Thanksgiving
Memorial Day	Christmas Eve
*****Labor Day	Christmas
	New Year's Eve

When one of the enumerated holidays falls on a Saturday or Sunday, the employee will be provided an alternative paid leave day. The holiday work calendar will be determined by the employer.
*Labor Day: To receive pay for Labor Day, the employee must "work" on Welcome Back Day. "Work" means attending all scheduled Welcome Back Day activities, any building activities directed or requested by his/her supervisor and professional development activities provided for paraeducators on Welcome Back Day. Any employee who attends part but not all of the scheduled activities will not receive holiday pay for Labor Day. (See Article 13 (D) – Welcome Back Day Activities)

If the employer does not schedule Welcome Back Day activities, employees will not receive pay for Labor Day unless the employee is requested to work and works the scheduled hours ***immediately*** previous to and following the holiday.

C. Employees not scheduled to work on the holiday

For employees who are not scheduled to work on the day of a designated holiday, the following shall occur:

1. Employees Scheduled Less than Five Days
   Holiday pay for employees who are scheduled less than five days per week will be equal to their scheduled hours per day should the holiday fall on a day they are regularly scheduled to work.

2. Employees Not Normally Scheduled to Work on Day of Holiday
   Employees who are not normally scheduled on the working day on which the holiday falls will receive a holiday pay equal to the total hours they are regularly scheduled per week divided by five.

D. Floating Holiday

Each employee shall receive one floating holiday per year. Use of the day is subject to the following provisions:

1. The day may only be taken at a time when school is not in session.

2. If the day is not utilized by June 30, it will not be carried over to the next school year and will be forfeited.

3. New employees shall be eligible for the floating holiday on the July 1 immediately following employment in the bargaining unit.

4. Requests to use the floating holiday shall be made in advance on Temporary Leave Request forms. When completing the form, the employees should note that the day is the floating holiday. Use of the day is subject to the approval of the immediate supervisor.

ARTICLE 17 - INSURANCE BENEFITS

A. Benefit Eligibility

1. Compliance with insurance company regulations

The Board shall provide a cafeteria benefit plan *(Educated Choices)* that includes coverages and benefits defined in this Article for eligible employees. Employees must fully comply with insurance company regulations regarding qualification for benefits in order to receive benefits.

2. Commencement and duration of coverage

Commencement and duration of coverage, nature and amount of benefits, and all other aspects of coverage shall be as set forth in the group policy and the rules and regulations of the carrier. The Employer's only responsibility shall be payment of the premiums for the benefits specified in this Article.

An employee will be eligible for insurance benefits upon satisfactory completion of sixty (60) full working days or satisfies current law for benefit eligibility (e.g. The Patient Protection and Affordable Care Act, (PPACA)). The coverage for eligible employees shall be effective the first day of the month following completion of the sixty (60) full working days (subject to PPACA). Coverage shall remain in effect for the duration of this agreement as long as the paraeducator is actively employed by the Board. Benefits shall terminate at the end of the month in which the employee last works or exhausts Family and Medical Leave Act leave. Benefits also terminate when an employee commences long term disability leave or has been on worker disability compensation leave exceeding 1 year.

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

1. 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.

2. If District Not Self Insured

In the event the District is no longer self-insured, duplication of medical/hospitalization insurance will not be permitted. The Human Resources Department will notify employees, in writing, if the District is no longer self-insured. In that event, employees shall not knowingly cause the Board to provide medical/hospitalization insurance coverage that is a duplication of such coverage already held by the employee. The Union shall encourage employees to abide by this policy and shall assist the Board in its enforcement.

C. Cafeteria Benefit Plan - *Educated Choices* Group Coverage

1. Publicly Funded Health Contribution Act

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 on 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 Union 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 (C)(2)(d) 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.

2. Coverage for Paraeducators Who Work 30 or More Hours per Week

The District will provide a Cafeteria Benefit plan which will encompass all fringe benefits and will include the following options for paraeducators who work 30 or more hours per week, and who make proper application to participate in the Bloomfield Hills Schools Flexible Benefits Plan.

- The medical benefits outlined in the March 22, 2013 through July 31, 2016 collective bargaining Agreement 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 eligible paraeducator.

a) *Preferred Provider Organization (PPO), High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)-$1300/0% (See appendix B 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 B for a summary of the benefits).

c) *Health Maintenance Organization (HMO), High Deductible Health Plan (HDHP) with a Health Saving Account (HSA)-$1350/0% (except as noted in the plan document). The Prescription drug coverage for the HMO plan is summarized in Appendix B and is provided for informational purposes only. (See appendix B for a summary of the benefits).

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

d) PPO/HDPP/HSA Prescription Drug Coverage – Triple Tier Copayment

The PPO/HDPP/HSA prescription drug benefit, including mail order drugs, are subject to the same deductible and same annual co-insurance/copay dollar maximums as the HSA medical coverage. Benefits are not payable until the annual deductible has been met. After the deductible has been satisfied, the applicable copays 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.

Please refer to the prescription drug coverage summary in Appendix B for additional information. Appendix B is provided for informational purposes only and is not part of the contract.

e) 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 on the formula 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.

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

1. Determine the number of staff members enrolled in the medical insurance plans for the applicable plan year. (Open enrollment counts will be used for this purpose).
2. Use the annual list or illustrative rates for the applicable plan year and determine the annual cost of the plans.
3. Determine the "hard cap" amount for single, two person and full family for the applicable plan year.
4. Subtract the annual cost or illustrative rates 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.
5. The percentage contribution to the individual HSAs will be determined as follows:

    a) Calculate total sum of HSA funding
        I. Take the number of single subscribers x the respective differential (calculated in #4 above).
        II. Take the number of two person subscribers x the respective differential (calculated in #4 above).
        III. Take the number of full family subscribers x the respective differential (calculated in #4 above).
        IV. Take the sum of I, II, III.
    b) Calculate total employee deductible expense
        I. Take the number of single subscribers x the deductible.
        II. Take the number of two person and full family subscribers x the deductible.
        III. Take the sum of I and II.
    c) Divide (a) by (b) to calculate percent of deductible contributed to the HSA per employee.
6. See Appendix C for an example of the application of the formula.

g) Other Factors

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.

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.

Those employees who are not eligible to participate in an HSA due to IRS established age restrictions, currently age 65 and over, or employees

who do not elect to participate in a HSA, will receive the employer contribution into a Flexible Spending Account.

h) Proration of District Contribution to Health Savings Account

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.

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

a) Employee Contribution toward Health Care

Each employee electing health insurance coverage shall make the following annual pre-tax contribution toward the cost of health care. The amount will be prorated if the employee does not work a full plan year:

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

b) Health Risk Assessment/Rebate

1. 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:

    1. Fasting Glucose
    2. Hemogram
    3. Lipid Panel

    b. The Health Risk Assessment form will be available from the Human Resources Department.

2. 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 C (3) (a) above. Eligibility for the rebate is based upon receipt by the Human Resources Department of the completed health risk assessment 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%.

c) 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 for those employees who are eligible for but do not elect the employer-provided medical/hospitalization coverage. The co-payment will be prorated if the employee does not work a full plan year. Staff who do not have medical/hospitalization coverage from another source are not eligible for this benefit.

Single Opt Out	$600
Two-Person Opt Out	$800
Full Family Opt Out	$1000

d) Dental Care

Classes I, II, and III which includes preventive basic care and prosthetics, a dental plan of Class I - 90%, Class II - 75%, and Class III - 60%, with a maximum per person per year of $1,000. The percentage of reimbursement for dental care will be in accordance with the coverage schedule provided by the carrier and outlined in the *Educated Choices* Workbook. Employees may purchase, with pre-tax dollars, two person or full family dental coverage through the Cafeteria Benefit Plan.

It is agreed and understood that the Board of Education reserves the right to change carriers or to self-insure.

e) Vision

The plan shall provide for services including an annual examination, lenses, with a $35.00 cap on frames, premised on a co-pay program with established reasonable and customary fee limitations. Employees may purchase, with pre-tax dollars, two person or full family vision coverage through the Cafeteria Benefit Plan.

Carrier selection shall remain the prerogative of the District and coverage provisions indicated above may vary, but will be comparable to the above.

4. 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 2(a) &(b) above and permit employee and employer Health Savings Account contributions, subject to applicable tax requirements.

5. Coverage For Paraeducators Who Work Twenty-five (25) or More Hours Per Week

For each paraeducator who works twenty-five (25) hours or more per week, the Employer will pay the premium for the following: life insurance, short term disability coverage, and long term disability insurance.

a. Life Insurance: The Employer shall pay the premium for a life insurance and, accident and dismemberment policy for each employee. The life insurance policy shall pay the employee's designated beneficiary the sum of $30,000 upon death with a provision for double indemnity in the event of accidental death.

b. Additional Life Insurance: Each staff member will have the option to purchase additional 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. (The ability to purchase additional life insurance with pre-tax dollars will remain in effect as long as the IRS permits such purchase).

c. Dependent Life Insurance: Each staff member will have the option to purchase life insurance for their 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.

d. Short Term Disability

For each employee who has satisfactorily completed sixty (60) working days, the following short term disability (STD) coverage will be provided:

1. Benefit: For off-the-job sickness and accident, after all leave days have been used or ten (10) work days, whichever is later, the employee will be paid:

   (a) Up to thirty (30) work days at 75% of the employee's current wages;

   (b) Up to an additional 210 work days at 60% of the employee's current wages.

   (c) The amount received from the District will be reduced by any primary remuneration received, or for which the employee is eligible, during the last 120 work days, from the Michigan Public School Employees' Retirement Fund, the Federal Social Security Act (both primary and dependent), the Railroad Retirement Act, Veterans' benefits or other such pensions.

   (d) Those individuals who have more than ten (10) leave days may elect to use a minimum of ten (10) days or all available in current and leave bank prior to temporary disability coverage being initiated. Individuals who elect to maintain those days in excess of ten (10) will have access to unused leave days upon the return from leave.

e. Long Term Disability

1. Benefit: Such disability insurance shall provide benefit of 60% of the monthly earnings up to a maximum payment of $1,000.00 per month to the employee 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 and shall be payable until the employee returns to work, reaches age 65, or is deceased,

whichever comes first. For the purposes of the long term disability coverage, monthly earnings shall be the employee's regular salary divided by 12.

2. Offset: The amount received from the insurance company will be reduced by any primary remuneration received, or for which the employee is eligible, during the benefit period from the employer, the Michigan Public School Employees' Retirement Fund, the Federal Social Security Act (both primary and dependent), the Railroad Retirement Act, Veteran's Benefits or other such pensions.

3. Separation from Employment: On the date an employee commences long term disability leave, the employee's position will no longer be held open for the employee. However, if the employee is medically able to return to work within one year of the date of the commencement of the long term disability leave, the employee will be given **c**onsideration for placement in a vacant paraeducator position for which the employee is qualified. Seniority does not accrue during long term disability leave. The Assistant Superintendent for Human Resources and Labor Relations will determine whether an employee is qualified for a vacant position. The employee must supply a physician's authorization permitting the employee 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 employee's physician and the district's physician or medical facility do not agree that the employee is medically able to return to work, an independent physician or medical facility, paid by the District, may examine the employee, and this decision will be final. This paragraph does not apply to an employee who retires.

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

6. Flexible Spending Account - *Educated Choices*

The option to enroll in a flexible spending account is available to every employee who is regularly scheduled to work 20 hours or more per week. In accordance with Internal Revenue Service regulations, any staff member who is eligible to receive cash payment in lieu of hospitalization insurance must enroll in the flexible spending account in order to receive this benefit.

a. Health Care Reimbursement Account

Eligible employees 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.

b. Dependent Care Reimbursement Account

Eligible employees 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.

7. Worker's Disability Compensation (Available to all employees)

a. Benefit: In the event an employee is absent from work due to a job-related accident, the employee will be paid, for a period not to exceed 120 days from the date of the accident, the difference between the employee's full salary and such monies as may be received from Worker's Disability Compensation benefits (loss-of-time benefits.)

b. No Leave Days Charged: It is understood that no leave days shall be charged for absences related to a compensable job-related accident during the 120-day period defined above.

c. No Eligibility for Short Term Disability: Should the employee continue to be off work beyond a period of 120 days, the employee shall not then be eligible for short term disability benefits under Article 17. After the 120-day period, current and bank days may be used, per Article 14. No District supplement will be made after 120 days, as defined above.

d. Doctor Visits: Any employee 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 employee. 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 employee is scheduled to work, unless approved by the immediate supervisor.

e. Benefits Beyond One-Year: Any benefits beyond one year shall be payable only under the terms of Worker's Disability Compensation Act and Long Term Disability Insurance Coverage of the District, provided under Article 18.

f. Separation from Employment: If an employee 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 employee's position will not be held open for the employee. However, if the employee is medically able to return to work within two years of the date of the commencement of the workers' compensation leave, the employee will be given consideration for placement in a vacant paraeducator position for which the employee is qualified. The Assistant Superintendent for Human Resources and Labor Relations will determine whether the employee is qualified for a vacant position. The employee must supply a physician's authorization permitting the employee to return to work and may be required to have a return-to-work examination by a physician for medical facility designated by the District. If the employee's physician and the district's physician do not agree that the employee is medically able to return to work, an independent physical or medical facility paid by the District, may examine the employee,

and this decision will be final. If the employee retires during this period, this paragraph does not apply.

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

ARTICLE 18 - HEALTH

To provide continuing health and safety protection for students and school personnel, employees shall provide health certificates and submit to physical examinations as follows:

1. At the time of hiring, each employee shall provide a certificate from a physician showing that the employee is able to fulfill the assigned duties and, if required by the Board, that they are free from active tuberculosis and other communicable diseases.

2. If required by the Board, as a condition of continued employment, each employee shall be required to file the results of a chest x-ray examination or the tuberculin skin test showing negative results. The results of the test must be filed with the Human Resources Department.

3. The employer may require that an individual have medical or psychological examinations by a physician of its choice. In the event that an examination is required, the expense for the examination will be paid by the Board of Education.

ARTICLE 19 - RATES FOR NEW JOBS

The Board of Education will have the right to establish new positions in the bargaining unit as may be required. The employer and the union shall meet to negotiate wages, hours, terms and conditions of employment.

ARTICLE 20 - DEFINITIONS

A. Temporary Employees

Temporary employees (those hired for a period of sixty (60) working days or less) are not part of the bargaining unit and are not covered by any of the provisions of this Agreement. Any employee hired on a temporary basis, but who works more than sixty (60) consecutive working days, shall be considered to be a regular employee and shall be covered by the provisions of the Agreement.

B. Substitute Employees

Any temporary employee hired to substitute for a regular employee who is on a compensable sick leave shall be allowed to exceed the sixty (60) consecutive

work day limit only as a replacement for the regular employee. This does not apply to temporary employees hired as additional temporary help.

ARTICLE 21 - MILEAGE

A. Employees required to use their personal vehicles as a necessary part of the job shall be paid the current IRS rate. To qualify for mileage payment, the employee must submit a mileage sheet in accordance with the established district procedures.

B. In the event the monthly mileage is less than fifty (50) miles per month, the mileage sheet shall be held by the employee until the end of the month in which fifty (50) miles have been accumulated.

ARTICLE 22 – WAGES

A. Salary

PARAEDUCATORS
2016- 2019

	No Degree	2016-17 1%	2017-18 1% No Step	2018-19 No Impr. No Step	Associates Degree	2016-17 1%	2017-18 1% No Step	2018-19 No Impr. No Step	Bachelors Degree	2016-17 1%	2017-18 1% No Step	2018-19 No Impr. No Step
0		$10.91	$11.02	$11.02		$11.23	$11.34	$11.34		$11.39	$11.51	$11.51
1		$11.07	$11.18	$11.18		$11.39	$11.51	$11.51		$11.55	$11.67	$11.67
2		$11.33	$11.45	$11.45		$11.66	$11.77	$11.77		$11.81	$11.92	$11.92
3		$11.89	$12.01	$12.01		$12.21	$12.33	$12.33		$12.37	$12.50	$12.50
4		$12.89	$13.02	$13.02		$13.20	$13.33	$13.33		$13.36	$13.50	$13.50
5		$13.69	$13.82	$13.82		$14.01	$14.15	$14.15		$14.17	$14.31	$14.31
6		$16.71	$16.87	$16.87		$17.03	$17.20	$17.20		$17.19	$17.36	$17.36
8 YR BASE		$18.38	$18.57	$18.57		$18.73	$18.91	$18.91		$18.88	$19.07	$19.07
8L		$18.43	$18.62	$18.62		$18.78	$18.96	$18.96		$18.93	$19.12	$19.12
11L		$18.53	$18.72	$18.72		$18.88	$19.07	$19.07		$19.03	$19.22	$19.22
16L		$18.73	$18.92	$18.92		$19.08	$19.27	$19.27		$19.23	$19.42	$19.42

B. Longevity

Upon completion of the following consecutive years of service, employees will receive the following additional pay which will be added to the hourly rate defined above as 8 years. The longevity rate of pay has been included in the above rates of pay.

Amount in addition to the 8-year base rate	
8 to 10 years of service	$.05 per hour
11 to 15 years of service	$.15 per hour
16 + years	$.35 per hour

C. Increments and Experience Credit

1. Any annual step increases and applicable longevity pay will be given based on the employees most recent date of hire. .

   Hire date between July 1 and December 31: For eligible employees hired between July 1 and December 31, annual step increases and longevity pay will be given on the following July 1.

   Hire date between January 1 and June 30: For eligible employees hired between January 1 and June 30, annual step increases and longevity pay will be given on the following January 1.

D. Additional Education Pay

For those individuals who have an Associates Degree, or sixty semester hours with a C average or better, an additional $.30/hour will be granted upon request. Such request shall be by submission of transcripts. Those individuals who hold a Bachelor's Degree from an accredited institution of higher learning will be eligible for an additional $.45/hour upon request. Such request shall be made in writing to the Assistant Superintendent for Human Resources and Labor Relations and must be verified by submission of transcripts.

E. Tuition and Professional Development Reimbursement

Reimbursement for tuition and books will be provided for those individuals required or approved to attend professional development or school**.** The course work for school must be completed with a grade of "B" or better. Proof of attendance at the professional development must be provided. Reimbursement is subject to the course work or professional development being directly related to the individual's current assignment, and having written approval prior to enrollment from the Assistant Superintendent for Human Resources and Labor Relations. The total annual reimbursement for the entire bargaining unit will not exceed $2,500.

Application and supporting information for tuition reimbursement shall be filed with the Human Resources Department by June 30 of each year. Contingent on the total reimbursement requested, there may be a proration.

F. Substitute Teaching

In the event a paraeducator is assigned to perform substitute teaching services during the course of the work day, the employee will be paid the permanent substitute hourly rate or the paraeducator hourly rate, whichever is higher. The decision to place the paraeducator in a substitute teaching position is that of the building administrator. This paragraph is not subject to the grievance procedure of Article 10.

ARTICLE 23 - EFFECT OF AGREEMENT

A. Addendum to Contract

The School Board and the union mutually agree that the terms and conditions set forth in this Agreement represent the full and complete understanding and commitment between the parties hereto which may be altered, changed, added to, deleted from, or modified only through the voluntary, mutual consent of the School Board and the Union in an amendment hereto which shall be ratified and signed by both parties.

B. Conformity to Law

This Agreement is subject in all respects to the laws of the state of Michigan with respect to the powers, rights, duties and obligations of the Employer, the Union and the employees in the bargaining unit, and in the event that any provision of this Agreement shall at any time be held to be contrary to law by a court of competent jurisdiction from whose final judgment or decree no appeal has been taken with the time provided for doing so, such provision shall be void and inoperative; however, all other provisions of this Agreement shall continue in effect.

ARTICLE 24 - DURATION OF AGREEMENT

This Agreement shall be effective as of August 1, 2016 and shall continue in full force and effect until July 31, 2019. In the event that either party should desire to cancel, terminate, modify, amend, add to, subtract from, or change the Agreement, notice of such intent shall be served by the moving party upon the other no later than sixty (60) days prior to setting forth the intention to cancel, terminate, or reopen the Agreement as the case may be. Such notice shall be served in writing in the event of a timely notice, the parties shall promptly arrange to meet for the purpose of negotiating a successor Agreement.

In the event that neither party serves upon the other a timely notice of desire to reopen the Agreement in the manner set forth herein, then in such event the Agreement shall automatically be extended for a period of one (1) additional year until July 31, 2020, which extension shall be subject to the reopening and extension provisions set forth herein.

Contract Ratification and Approval

A tentative Agreement was reached by the parties on July 12, 2016. The Agreement was ratified by the Bloomfield Hills Association of Paraeducators on August 17, 2016 and was approved by the Board of Education on August 18, 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 current law (e.g., The Patient Protection & Affordable Care Act), by serving written notice of such intent upon the other party by registered or certified mail.

ARTICLE 25 – 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."

The parties have executed this Agreement by their duly-authorized representatives designated below:

BLOOMFIELD HILLS
BOARD OF EDUCATION

By _____
Ingrid Day, President

By _____
Howard Baron, Secretary

By _____
Robert Glass, Superintendent

By _____
Christine Barnett, Chief Negotiator

BLOOMFIELD HILLS
PARAEDUCATORS, MEA/NEA

By _____
Debra Shoultz, President

By _____
Lilly Meek, Vice President

By _____
Steve Amberg, Executive Director

APPENDIX A

The following categories are those established for all staffing as it concerns transfer, layoff and recall.

Category I - Elementary, Middle School and High School including kindergarten, regular education classroom, GERT, elementary media/science/computer, noon supervisor, office, computer, physical education, media center, bilingual, ESL, PAGES, farm, and community service.

Category II - Middle School and High School including parking lot, audio visual, hall monitor, school store, career center, study hall and attendance.

Category III - Elementary, Middle School and High School positions in the hearing impaired program.

Category IV – Special Education positions (Preschool, Elementary, Middle School and High School – excluding positions in the Deaf & Hard of Hearing program.

Appendix B

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.

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

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

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

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	80% after out-of-network deductible
	Unlimited days	
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

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

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

BLOOMFIELD HILLS BOARD OF ED
A0PFP5
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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

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

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.

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.

Bloomfield Hills Bd Of ED
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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.

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

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

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

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	80% after out-of-network deductible
	Unlimited days	
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

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

Blue Cross Blue Shield of Michigan

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

Bloomfield Hills Bd Of ED
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Simply Blue PPO 2000/4000 HSA with Rx
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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

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

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**.

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.

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

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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

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

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

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

Appendix C

Funding to the Paraeducators Health Saving or Flexible Savings Account								
PARAEDUCATORS 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	19		11		32	62		
							Annual Cost	
Annual cost over/under hard cap	$810.92		$22,670.45		$59,473.28		**$82,954.65**	
							** Annual cost in excess of hard cap is calculated by subtracting the state cap from the current coverage cost	
Health Savings Account Funding								
Single	19	-$42.68	-$810.92					
Two Person	11	-$2,060.95	-$22,670.45					
Full Family	32	-$1,858.54	-$59,473.28					
	62		-$82,954.65					
							Amount to be paid by employ	
Note: These numbers vary from the information above. State law requires us to count the cap differently than BC for employee and child.		19	1300		$ 24,700.00		$ (790.04)	
		43	2600		$ 111,800.00		$ (1,580.09)	
					$ 136,500.00			
			Percent of deduction funded		-61%			

Regulation 4400.1

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. GENERAL

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. SUBSTITUTION OF PAID LEAVE TIME

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. <u>INTERMITTENT/REDUCED LEAVE SCHEDULE</u>

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. <u>BENEFITS</u>

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. <u>RETURN TO WORK</u>

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.

Date Adopted: April 24, 2009
Revised: March 15, 2013