Agreement between Bloomfield Hills Schools and the Bloomfield Hills Association of Instructional Assistants

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July 1, 2018 through June 30, 2020

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ARTICLE 1 - PREAMBLE

This Agreement is entered into on the 7th day of December by and between 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 Instructional Assistants (hereinafter referred to as the "Association or Union").

ARTICLE 2 - RECOGNITION

In accordance with all applicable provisions of Act 379 of the Public Acts of 1965, as amended, the School Board recognizes the Instructional Assistants Association as the sole and exclusive representative for the purpose of collective bargaining with respect to wages, hours, and other terms and conditions of employment for the term of this Agreement for all instructional assistants assigned to SCI/SXI programs and excluding the program aide/instructional assistant special position and all other staff of the Bloomfield Hills Schools.

ARTICLE 3 - RESERVATION OF RIGHTS

A. The Board of Education 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:

1. The management and control of the school system and its properties and facilities, and the activities of its staff.

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

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

B. The exercise of the foregoing powers, rights, authority, duties, and responsibilities by the Board, the adoption of policies, rules and regulations and practices, and the use of judgment and discretion in connection therewith shall be limited only by the terms of this agreement.

ARTICLE 4 - STAFF MEMBER RIGHTS

A. Legal Obligations

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

B. Assignment Concerns

Instructional assistants may discuss assignment concerns with their immediate administrative supervisor or the Assistant Superintendent for Human Resources and Labor Relations.

C. Nondiscrimination

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

D. Personnel File

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

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

ARTICLE 5 – ASSOCIATION RIGHTS

A. Bulletin Boards and School Mail

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.

ARTICLE 6 – AGENCY SHOP

Membership is not Compulsory

Membership in the association is not compulsory. Instructional Assistants have the right to join, not join, maintain, or terminate their membership in the association as they see fit. Neither party shall coerce or discriminate against an instructional assistant as regards such matters.

ARTICLE 7 – WORKING HOURS AND ASSIGNMENT

A. Daily Schedule

The daily schedule will be a six and one-half hour day which shall include unpaid, duty-free one-half hour lunch periods. Any modification in the daily schedule must have the approval of the Director of Special Education.

B. Assignments

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 satisfactory attendance as determined by the employer, temperament, personality, and ability to work with a particular administrator, the public, or teachers and students in a harmonious relationship.

C. Posting of Available Positions

When practical, instructional assistant positions will be posted within ten (10) days of availability. Staff interested in posted, available positions shall apply in writing to the Human Resources Department.

Positions will be posted as defined above for five (5) calendar days. Individuals interested in another assignment shall indicate such in their written application and subsequent assignments will be made from the original posting. Assignment of an individual to a posted or other position will be at the sole option of the supervisor.

Staffing of a vacancy may not result in the posting of subsequent vacancies created by staffing of the initial position.

ARTICLE 8 – SENIORITY

A. Seniority Date

The seniority of all individuals 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 name and most recent date of hire of all staff members entitled to seniority.

2. The Board will keep the seniority list up to date by providing the Association with a current copy upon request.

C. Probationary Period

1. The first 180 full work days of employment shall be probationary. Leave days will be available for use by probationary employees after completion of 60 full work days and may be used as provided in Article 12. All benefits will commence for eligible probationary employees on the first day of the month after satisfactory completion of 60 calendar days from the date of hire. Probationary employees shall have no seniority, during the probationary period.

   If the employee is absent, the probationary period is extended by the number of days absent. During the probationary period, the employee may be terminated at the sole discretion of the Board of Education.

2. If employment is continued beyond the 180 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. Insurance benefits will commence in compliance with Article 14(A)(2).

D. Loss of Seniority

Individuals shall lose seniority and be terminated if they quit, if they are discharged, if they are absent without notice or approval for three (3) consecutive working days, if they fail to respond within ten (10) working days from date of mailing of recall letter to the individual's last known address as provided by the individual and shown on the individual's employment record, if they are laid off for a period of time exceeding one year, or if the employee does not return to work after a medical leave or worker's disability compensation leave within the time frames provided in Articles 14(F) and (G).

E. Seniority (Leaves of Absence)

Staff, while on approved short term disability (Article 14(E)), family medical leave (Article 13(B)), or child care (Article 13(C)) leaves of absences shall accumulate seniority.

ARTICLE 9 - DISCHARGE AND DISCIPLINE

A. Notice of Discharge or Suspension

The Board agrees, upon the discharge or suspension of an individual, to promptly notify the Association verbally or in writing. Disciplinary actions will be for cause.

B. Association Representation

Upon request, the Board or its designated representative, will discuss the discharge or suspension with the individual and the Association. The Board, likewise, will discuss written reprimands with the individual and the Association upon request. An individual shall be entitled to have present a representative of the Association during meetings concerning disciplinary action. When a request for such representation is made, no meeting will be conducted with respect to the individual until such representative of the Association 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 staff member or the Association consider the discharge or suspension to be improper, a complaint shall be presented in writing. The matter shall be reviewed per Article 10.

ARTICLE 10 - PROBLEM RESOLUTION

A. Concern to be Processed within Ten Working Days

Any complaint by an employee concerning the application**,** meaning, interpretation, or alleged violation of this Agreement, shall constitute a concern and shall be processed as follows. No concern shall be processed unless it is presented within ten (10) working days of its occurrence.

B. Initial Presentation of Concern

The initial presentation of any concern shall consist of an informal discussion between the individual and immediate supervisor. At the option of the individual, a representative of the Association may participate in the discussion.

C. If Decision Not Satisfactory, Written Concern Presented to Assistant Superintendent for Human Resources and Labor Relations within Ten Working Days

If the decision is not satisfactory to the individual or the Association, the concern shall be reduced to writing and presented to the Assistant Superintendent for Human Resources and Labor Relations within ten (10) working days of the initial meeting. The Assistant Superintendent for Human Resources and Labor Relations shall respond, in writing, within five (5) working days of receipt of the concern.

D. If Decision Not Satisfactory, Written Concern Presented to Superintendent within Ten Working Days

If the decision of the Assistant Superintendent for Human Resources and Labor Relations is not satisfactory to the employee, an appeal may be made to the Superintendent. The appeal must be made in writing within ten (10) working days of the decision of the Assistant Superintendent for Human Resources and Labor Relations. An answer in writing shall be provided within twenty (20) working days of receipt of the concern.

E. If Decision Not Satisfactory, Written Concern Presented to Board of Education within Ten Working Days

If the decision of the Superintendent is not satisfactory to the employee, an appeal may be made to the Board of Education. The appeal must be made in writing within ten (10) working days of the decision of the Superintendent. Appeals of administrative decisions may be brought to the Board after a decision on the matter has been rendered by the Superintendent. The Board president may then choose to deny the appeal, assign the appeal to a subcommittee of the Board or have the full Board hear the appeal. The decision of the Board president, subcommittee of the Board or full Board is final.

F. Mutual Extension of Timelines

The timelines contained in this Article may be extended by mutual agreement of the parties.

ARTICLE 11 - PAID HOLIDAYS

The following holidays are acknowledged as paid holidays:

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

In order to qualify for holiday pay, the individual must work the immediate scheduled day before and after the holiday, or have an approved compensable leave.

ARTICLE 12 - PAID LEAVE DAYS

A. Use of Leave Days

Instructional Assistants shall earn one (1) leave day each month during the school year, to a maximum of twelve (12) days per year. The leave days for the current school year shall be placed at the disposal of each employee on the first day of each school year.

Leave days may be used in accordance with the following schedule and the Family and Medical

Leave Act (FMLA) procedures outlined in Appendix C. The employee must notify school administration when he/she first becomes aware of the need for the absence. It is agreed that the use of leave days will be confined to the purposes specified in the following schedules:

1. Sick Leave:
   a. Personal illness of the employee.

   b. Absence for illness in the immediate family.

   c. Definition of immediate family: For the purpose of this Article, the immediate family shall be defined as spouse, child, parent, brother or sister, grandparent, parent-in-law, or a relative living and making his/her home in the employee's household.

2. Personal Days: Up to two (2) personal days per year may be used for personal business that cannot be conducted other than during a scheduled work day. Personal days require prior approval of at least two work days.

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

4. Bereavement Leave: Up to three (3) days per year may be used for the purpose of attending to a death in the immediate family. Consideration may be given for other special circumstances at the sole discretion of the immediate supervisor.

5. School Closing
   On any day when school sessions are scheduled but that schedule is cancelled 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.

   a. 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.

   b. In the event a facility is 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.

   c. In the event that one or more of buildings housing the Wing Lake SCI/SXI programs are closed due to other conditions, but other buildings housing SCI/SXI programs are open, the employee may be reassigned at the supervisor's discretion. If the employee is reassigned, there will be no loss of

pay nor any charge against the employee's leave day accumulation.

B. Leave Day Provisions

1. Whenever possible, leave for personal days, religious holidays, as well as any other leave, must be requested and approved in advance of the leave day(s) requested. The request shall include a statement that the leave request is for a purpose authorized in this Article (Article 12). The instructional assistant may be requested to set forth a specific reason for such leave.

2. Leave days shall not be used for personal pleasure or extended vacations. Abuse of temporary leave shall be subject to one or more warnings, to suspension and/or dismissal.

   All salary and fringe benefits of the individual are subject to being waived during the abused leave.

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

C. Accumulation of Leave Days

The leave days may be accumulated up to a maximum of one hundred fifty (150) days.

D. 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 14E for the short term disability provisions.

E. Jury Duty

Staff summoned for jury duty examination and investigation must notify the Human Resources Department of receipt of such notice. If such individual then reports for jury duty, that individual

shall continue to receive the regular daily wage for each day on which the individual reports for or performs jury duty and on which the individual would otherwise have been scheduled to work. Such time spent on jury duty shall not be charged against leave days.

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. However, the supervisor of the Wing Lake Developmental Center may release the employee for the remainder of the work day.

To be eligible for the jury duty pay differential, the individual must furnish the Human Resources Department with a written confirmation of jury duty, the days on jury duty, and a check for the full amount of the jury fee paid, excluding any travel allowance paid to the individual by the court.

This payment by the individual shall be made to the Human Resources Department no later than two (2) weeks after the return from jury duty. Any individual found abusing this privilege shall not be entitled to the pay differential.

ARTICLE 13 - UNPAID LEAVE

A. Request a Maximum of Ten (10) Non-Compensable Days

Instructional Assistants may request a maximum of ten (10) non-compensable leave days during a school year, subject to the following conditions:

1. A request for a non-compensable leave must be approved by both the classroom teacher and the Supervisor of Wing Lake two full weeks prior to the leave.

2. The leave will be granted only if an approved substitute is pre-arranged by the staff member requesting the leave. The approval of the substitute shall be determined by the Supervisor of Wing Lake.

3. Only one instructional assistant per classroom may request a non-compensable leave at a time. If two instructional assistants from the same room request the same time for a leave, the request will be granted based on seniority.

4. The use of non-compensable days will be limited to four program staff members per month. Leaves taken in the summer will be from a rotating staff list based on seniority. (As an instructional assistant accepts the option one year, their name then drops to the bottom of the list for the next year.)

5. The Supervisor of Wing Lake may limit the use of non-compensable days immediately before and after a holiday, and may limit the total number of staff using such leave.

B. Family and Medical Leave Act

Basic Leave Entitlement: Bloomfield Hill Schools Family and Medical Leave Regulation allows eligible employees to take up to twelve (12) work weeks of unpaid leave per year for their own serious health condition, childbirth, or to provide care for the employee's newborn child, newly adopted child, newly placed foster child, or a child, parent or spouse with a serious health condition. Further, certain eligible employees may receive up to twelve (12) work weeks of unpaid leave for military exigencies, and up to a total of twenty-six (26) work weeks of unpaid leave to care for a covered military service member. Appendix C to this contract contains the regulation applicable to FMLA leave. Compensable absences and use of leave days are included in the calculation of the twelve (12) work weeks for FMLA.

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

C. Child Care Leave

1. 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) from the date the short term medical leave was effective. FMLA leave for the birth of a child or for placement of adoption or foster care must conclude within 12 months of the birth or placement.

2. An individual desiring to return from leave shall notify the Executive Manager of Human Resources and Payroll, in writing, and provide the appropriate FMLA *Physician's Release to Return to Work* form approving the return to work. Such notice shall be provided no less than 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. 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.

ARTICLE 14 - 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 or self-insurance 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.

Insurance benefits shall be effective the first day of the month following the Instructional Assistant's successful completion of 60 calendar days. Coverage shall remain in effect for the duration of this agreement as long as the Instructional Assistant is actively employed by the Board. Benefits shall terminate at the end of the month in which the individual last works or utilizes FMLA.

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

Duplication of hospitalization insurance is permitted as long as the District is self-insured. The employee must notify the Human Resources Department of any personal hospitalization coverage or coverage from spouse's hospitalization insurance plan.

<u>If District is Not Self-Insured</u>

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 Association shall encourage employees to abide by this policy and shall assist the Board in its enforcement.

C. Cafeteria Benefit Plan - *Educated Choices*

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 Association prior to implementation. If the District payments 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 Section C(10)(f) (of this article. In no event shall this Section be interpreted to require the District to make a payment which would cause it to violate the Publicly Funded Health Insurance Contribution Act.

The following benefits are considered as a fringe benefit for all bargaining unit members and as such include no provision for reimbursement for those members who do not qualify or do not select such benefits, except as outlined in the cafeteria benefit plan document. Carrier selection, including self-insurance, shall remain the prerogative of the Board of Education and coverage provisions indicated in this section may vary, but will be comparable to the coverage below.

1. Board Paid Medical Benefits - Full Time Staff

Effective January 1, 2017, the District will provide, either by self-insurance or a policy of insurance, the following group medical coverage to each full-time Instructional Assistant who makes proper application to participate in such coverage and to participate in the Bloomfield Hills Schools Flexible Benefits Plan. (A full time employee is defined as being regularly scheduled to work 6.5 hours per day).

a) Preferred Provider Organization (PPO) High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)--$1300/0%. ($1350/% for 2018)

b) Preferred Provider Organization (PPO) High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)--$2000/0%.

c) Health Maintenance Organization (HMO) High Deductible Plan (HDHP) with a Health Savings Account (HSA) $1350/0%. (The prescription co-pay for the HMO plan is summarized in the attached documents).

Deductibles – the deductibles combine deductible amounts under the PPO HDHP/HSA medical coverage and the prescription coverage. Further, the deductibles are subject to adjustment in accordance with the IRS rules and regulations.

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

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

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

- Rider PD-TTC $5/$25/$50 & PD-Rx-CM (open-formulary) – imposed a triple tier copay for prescription drugs.
- Included are provisions for up to a 90-day supply of prescription drugs, with a revised MAC and the mail order program.

- Rider PCD – prescription contraceptive devices
- Rider PD-CM – prescription contraceptive medication

*See specific In and Out of Network costs in Appendix B.

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 upon the formula described below. However, no contribution will be made by the school district if the contribution would make the District out of compliance with Public Act 152 of 2011.

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

i. Determine the number of staff members enrolled in the PPO HSA insurance plans for the applicable plan year. (Open enrollment counts will be used for this purpose).
ii. Use the illustrative rates from Blue Cross/Blue Shield of Michigan (BCBSM) for the applicable plan year and determine the cost of the PPO HSA and PPO HSA plans.
iii. Determine the "hard cap" amount for single, two persons and full family for the applicable plan year. Subtract the total BCBSM illustrative rates amount from the "hard cap" for the applicable plan year for single, two person and full family. These amounts represent the differential between the "hard cap" and the illustrative rates that are available to be used for the contribution to employee's individual HSAs. (NOTE: If no amount is available, there will be no contribution to the individual HSAs.)
iv. Divide the differential by the number of employees to calculate the amount contributed to the HSA per employee.
vi. See Appendix B for an example of the application of the formula.

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

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

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

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

Employees who elect, after the start of the Plan Year, to receive medical/hospitalization coverage under the District's High Deductible Health Plan, and to receive the District Health Savings Account contribution, due to a mid-plan year change in family status, a mid-plan year court order, or a mid-plan year change in eligibility for Medicaid or CHIP (Children's Health Insurance Program), 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.

2. Cash in Lieu of Health Insurance

The employer will provide a Cash in Lieu of Health insurance option each year for those individuals who do not elect the employer-provided hospital/medical insurance.

The amount is $600 for single subscribers, $800 for two person subscribers and $1000 for full family subscribers. The amount will be prorated for employees who do not work a full plan year or are no longer eligible for the cash in lieu of health insurance option.

3. Employee Contribution toward Health Insurance

   Each employee electing health insurance coverage shall make the following annual pre-tax contribution:

Single	$500
Two Person	$800
Full Family	$1000

4. Health Risk Assessment/Rebate

   a. Health Risk Assessment

      (1) Health Risk Assessment

      For each Cafeteria Benefits Plan year, 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, blood pressure, pulse and tests for the following as outlined on the Health Risk Assessment form:

      Fasting Glucose
      Hemogram
      Lipid Panel

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

      (2) Full Rebate of Pre-tax Contribution

      Employees and their spouses (if applicable) who participate in the annual health risk assessment are eligible to receive a full rebate of the employee pre-tax contribution provided in subparagraph C(3) above.

      Eligibility for the full rebate is based upon the receipt by the Human Resources Department of the completed health risk assessment form by September 15. If September 15 falls on a week-end, the following Monday will be the due date.

      Forms received after the due date will not qualify the employee for the partial rebate. *There will be no exceptions.*

      The full rebate is premised upon each adult (employee and spouse (if applicable)) participating in the annual health risk assessment. In the event only one adult in a two adult household participates, the rebate will be reduced by 50%. For example:

      - Employee participates and spouse participates – rebate = $1000

- Employee participates and spouse does not – rebate = $500
- Employee does not participate but spouse does – rebate = $500Neither employee nor spouse participates – rebate = $0.00

In the event of a one parent family electing full family coverage, where there is only one adult to participate in the annual health risk assessment, if the adult participates in the health risk assessment, the rebate will be $1000. If the adult does not participate, the rebate will be $0.00.

5. Vision Plan

The Board will pay the premium for up to full family vision care program for those individuals who are full time.

The vision care program will provide a percentage of reimbursement for services in the areas of vision care in accordance with the coverage schedules provided by the carrier and outlined in the *Educated Choices* workbook.

The plan shall provide for services including examination every 12 months, lenses, and a $35 cap on frames.

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

6. Dental Plan

The Board will pay the premiums for up to a full family dental program for those individuals who are full-time. The plan will pay 100% for Class I preventative care, 70**%** for Class II basic care, and 70**%** for Class III restorative care. Individual dollar expenditures per year in Classes I, II, and III shall not exceed $1,000/person. These percentages of reimbursements for dental care will be in accordance with the coverage schedule provided by the carrier and outlined in the *Educated Choices* Workbook.

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

7. Life Insurance

The Board shall select the insurance carrier who will provide each Instructional Assistant with a thirty- five thousand dollar ($35,000) group term life insurance policy. Such program shall pay to the Instructional Assistant's designated beneficiary, the sum of thirty-five thousand dollars ($35,000) upon death, with a provision for double indemnity in the event of accidental death. Effective January 1, 2019, the group term life insurance will increase to forty-five thousand dollars $45,000.

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

8. 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.

9. Dependent Life Insurance

Staff members will have the option to purchase life insurance for their spouses 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. Flexible Spending Account - *Educated Choices*

The option to enroll in a flexible spending account is available to every staff member. It is understood that, in accordance with Internal Revenue Service regulations, any staff member who is eligible to receive a cash payment in lieu of hospitalization insurance must enroll in the flexible spending account in order to receive this benefit.

1. Health Care Reimbursement Account

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

2. Dependent Care Reimbursement Account

Each staff member 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.

E. Short Term Disability

1. For off-the-job sickness and accident, after all leave days have been used or twentyfive (25) work days, whichever is later, the individual who qualifies for short term disability will be paid:

   a. Up to thirty (30) compensable days at 75% of the individual's current wages.

   b. Up to an additional 199 compensable days at 60% of the individual's current wages.

2. Those individuals who have more than twenty-five (25) leave days may elect to use a minimum of twenty-five (25) 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 twenty-five (25) will have access to unused leave days upon the return from leave.

3. Any short term disability claims that arise on or after January 1, 2018, will be subject to a 10-day waiting period instead of a 25-day waiting period. Accordingly, all references to 25 days in this section will change to 10 days effective January 1, 2018.

F. 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 individual 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 individual 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 individual'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 individual 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 six (6) months of the date of the commencement of the long-term disability leave, the employee will be given consideration for placement in a vacant Instructional Assistant position for which the employee is qualified. 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 six (6) months from the commencement of the

leave, the employee will be separated from employment with Bloomfield Hills Schools.

G. Worker's Compensation

1. Benefit

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

2. 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.

3. No Eligibility for Short Term Disability

Should the individual continue to be off work beyond a period of 120 days, the individual shall not then be eligible for short term disability benefits under Article 14(E). After the 120-day period, current and bank days may be used, per Article 12. No district supplement will be made after 120 days, as defined above.

4. Doctor Visits

Any individual 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 individual. 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 individual is scheduled to work, unless approved by the immediate supervisor.

5. Benefits Beyond One Year

Any benefits beyond one year shall be payable only under the terms of the Worker's Compensation Act and Long-Term Disability Insurance Coverage of the District, provided under Article 14(F).

6. Separation from Employment

If an employee on Worker's 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 18 months of the date of the commencement of the worker's compensation leave, the employee will be given consideration for placement in a vacant Instructional Assistant 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 or 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 physician or medical facility, paid by the District, may examine the employee, and this decision will be final. If the employee retires during this time period, this paragraph does not apply.

If the employee does not return to work within 18 months of the date of the commencement of the leave, the employee will be separated from employment with Bloomfield Hills Schools.

ARTICLE 15 - HEALTH

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

A. At the time of hiring, each individual shall provide a certificate from a physician showing that the individual is able to fulfill the essential functions of the Instructional Assistant position, with or without reasonable accommodation.

B. 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 16 - MILEAGE

A. Staff 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 individual must submit a mileage form in accordance with the established district procedures.

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

ARTICLE 17 - TUITION REIMBURSEMENT

Reimbursement for college tuition will be provided for those individuals required or approved to attend school, providing course work is completed with a grade of "B" or better. Reimbursement is subject to the course work being related to the individual's 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 unit will not exceed one thousand five hundred dollars ($1,500).

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 requests, there may be a proration.

ARTICLE 18 – PAID VACATION

A. Vacation Day Earning

Regular full-time Instructional Assistants will earn up to fifteen (15) paid vacation days per year. Up to five (5) of the earned days may be used during the school year, subject to the sole approval of administration. The paid vacation days cannot be used in conjunction with the unpaid leave days provided in Article 13(A). The remaining earned vacation days will be paid out at the close of the school year.

B. Vacation Day Proration

Those individuals who have not completed a full year will have paid vacation days prorated based on the portion of the year actually worked. Upon termination, with timely notice of at least one week, vacation earned to date will be paid.

C. Additional Vacation Days for Perfect Attendance

As an incentive for perfect attendance, Instructional Assistants who are present every day during one or both of the six-month periods will earn an additional vacation day for each six-month period he/she has perfect attendance. The six-month periods are July 1 to December 31 and January 1 - June 30. Days taken for funeral leave, snow days, or if the building is closed, or for approved days taken without pay in accordance with Article 13(A), will not be counted against the employee for determining eligibility for the additional days.

A maximum of two (2) days will be added to the vacation day payment at the close of the school year. An instructional assistant must have worked the full six-month period to be eligible for the additional vacation day incentive.

ARTICLE 19 – SEVERANCE

A. Payout of Unused Leave Days Upon Severance

Upon severance of employment after five (5) full years of service, for reasons of death, retirement, or quits with proper notice of not less than two weeks, but not an individual who is discharged or quits without two weeks' notice, a severance payment for each unused leave day, up to a maximum of one hundred fifty (150) days, will be made by the Board of Education at 50% of the employee's daily rate.

ARTICLE 20 - SALARY SCHEDULES

2018-19 base schedule (218 days x 6.5 hours = 1417.0 hours) includes 9 paid holidays
3% + Step

	No Degree	Hourly	Associates Degree	Hourly	Bachelors Degree	Hourly
0	$22,707.63	$16.03	$23,026.60	$16.25	$23,584.80	$16.64
1	$23,897.42	$16.86	$24,216.38	$17.09	$24,774.58	$17.48
2	$25,054.09	$17.68	$25,373.06	$17.91	$25,931.25	$18.30
3	$25,808.64	$18.21	$26,127.61	$18.44	$26,685.81	$18.83
4	$26,528.90	$18.72	$26,847.87	$18.95	$27,406.06	$19.34
5	$27,383.98	$19.33	$27,702.95	$19.55	$28,261.15	$19.94
6	$28,237.88	$19.93	$28,556.85	$20.15	$29,115.05	$20.55
7	$28,992.44	$20.46	$29,311.41	$20.69	$29,869.61	$21.08
8	$29,730.44	$20.98	$30,049.41	$21.21	$30,607.60	$21.60
9	$30,350.17	$21.42	$30,669.14	$21.64	$31,227.33	$22.04
10	$35,160.16	$24.81	$35,479.13	$25.04	$36,037.33	$25.43

2019-20 base schedule (218 days x 6.5 hours = 1417.0 hours) includes 9 paid holidays
3% + Step

	No Degree	Hourly	Associates Degree	Hourly	Bachelors Degree	Hourly
0	$23,388.86	$16.51	$23,717.40	$16.74	$24,292.34	$17.14
1	$24,614.34	$17.37	$24,942.87	$17.60	$25,517.82	$18.01
2	$25,805.71	$18.21	$26,134.25	$18.44	$26,709.19	$18.85
3	$26,582.90	$18.76	$26,911.44	$18.99	$27,486.38	$19.40
4	$27,324.76	$19.28	$27,653.30	$19.52	$28,228.25	$19.92
5	$28,205.50	$19.91	$28,534.04	$20.14	$29,108.98	$20.54
6	$29,085.02	$20.53	$29,413.56	$20.76	$29,988.50	$21.16
7	$29,862.21	$21.07	$30,190.75	$21.31	$30,765.70	$21.71
8	$30,622.35	$21.61	$30,950.89	$21.84	$31,525.83	$22.25
9	$31,260.67	$22.06	$31,589.21	$22.29	$32,164.15	$22.70
10	$36,214.97	$25.56	$36,543.51	$25.79	$37,118.45	$26.20

A. Salary Schedule Placement

Per the above schedule, for those individuals who have an Associate Degree or sixty semester hours with a C average or better are eligible for an additional $0.20/hour that will be granted upon request. Those individuals who hold a Bachelor Degree from an accredited institution of higher learning will be eligible for an additional $0.55/hour upon request. Requests shall be made in writing to the Assistant Superintendent for Human and Resources and Labor Relations and must be verified by submission of transcripts.

Increments will be determined at the beginning of each school year. Those individuals employed prior to December 1 will be given a full increment; staff whose first day of work is after December 1, but on or before April 1, will receive a half-step increment. Credit for experience will be given to individuals who have developmental center experience.

B. Longevity

Staff who have completed six (6) years of service as of June 30 of the previous year will receive a longevity payment of $500. Staff who have completed fifteen (15) years of service as of June 30 of the previous year will receive a longevity payment of $1500. This payment will be made prior to the Thanksgiving recess.

C. Advancement on Salary Schedule

a) Employees will receive an annual evaluation from Administration. Employees may be evaluated more frequently at the discretion of Administration.

b) To advance a step on the Salary Schedule, an employee must achieve no rankings below "meets expectations" on his/her evaluation for the previous school year.

c) The supervisor of Wing Lake Developmental Program, or designee will determine if the employee is eligible for a step increase based on the evaluation.

d) Employees not achieving a yearly advancement will be provided goals for improvement to address identified concerns.

e) An employee who disagrees with the determination of the supervisor, or designee, may request a meeting with the supervisor and/or the Assistant Superintendent for Human Resources and Labor Relations. A member of the Association may be present at the meeting, at the employee's request. Within five (5) working days after the meeting, the employee will be advised if the evaluation will be revised. The determination of Administration is final and is not subject to the Problem Resolution provision of Article 10 of this Agreement.

f) Advancement on the Salary Schedule is subject to the date of employment provisions of Article 20(A) – Salary Schedule Placement.

ARTICLE 21 - REDUCTION/RECALL

A. In the event there is a reduction in staff, probationary employees will be laid off first, then the least senior Instructional Assistant will be placed on layoff, and the remaining staff will be reassigned as determined by the administration.

B. Staff to be laid off for an indefinite period of time will be given at least ten (10) working days' notice of layoff. For purposes of recall, the most senior person 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 report for work within ten (10) days from date of mailing of notice of recall, the individual shall be terminated.

C. Each individual is responsible for keeping the Employer advised in writing of any changes of address and 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.

ARTICLE 22 – EMERGENCY MANAGER

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

ARTICLE 23- EFFECT OF AGREEMENT

A. Addendum to Contract

The School Board and the Association 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 Association 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 Association and the staff 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 July 1, 2018 and shall continue in full force and effect until June 30, 2020. 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 ninety (90) days prior to June 30, 2020 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.

The Letter of Understanding upon which this Agreement was based was ratified by the Bloomfield Hills Association of Instructional Assistants on November 30, 2017 and was approved by the Board of Education on December 7, 2017.

Contract Reopener

Either party may reopen the contract prior to the 2019-20 school year (or earlier, if needed) for the purpose of changing contractual provisions to comply with the Patient Protection & Affordable Care Act any amendments thereto, or similar law, by serving written notice of such intent upon the other party.

BOARD OF EDUCATION

By _____
President

By _____
Secretary

By _____
Superintendent

By _____
Chief Negotiator

BLOOMFIELD HILLS ASSOCIATION OF INS

By _____
President

By _____
MEA Uniserv Director

APPENDIX

1. APPENDIX A ..... Benefits-at-a-Glance/Agreement/Riders

2. APPENDIX B ..... Family and Medical Leave Regulation

BLUE CROSS/BLUE SHIELD

MEDICAL

PPO $1,350/$2,700

Blue Cross Blue Shield of Michigan

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

BLOOMFIELD HILLS BOARD OF ED
A0TCZ9
67201660
0070029560000
Simply Blue PPO HSA℠ ASC with Rx
Effective Date: On or after January 2018
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.	$1,350 for a one-person contract $2,700 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.	$2,700 for a one-person contract $5,400 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	$2,250 for a one-person contract $4,500 for a family contract (2 or more members) each calendar year	$4,500 for a one-person contract $9,000 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
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	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
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	100% after in-network deductible	80% after out-of-network deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
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	100% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% after in-network deductible	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)	
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

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

Benefits	In-network	Out-of-network
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 use disorder treatment

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance treatment	100% after in-network deductible Unlimited days	80% after out-of-network deductible
Residential psychiatric treatment facility • covered mental health services **must** be performed in a residential psychiatric treatment facility • Treatment must be preauthorized • 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**
• Online visits **Note:** Online visits by a vendor are not covered.	100% after in-network deductible	80% after out-of-network deductible
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder 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
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 BOARD OF ED
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Simply Blue HSA with Prescription Drugs
Effective Date: On or after January 2018
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 you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are require 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 HAS 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
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

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
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.
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**.

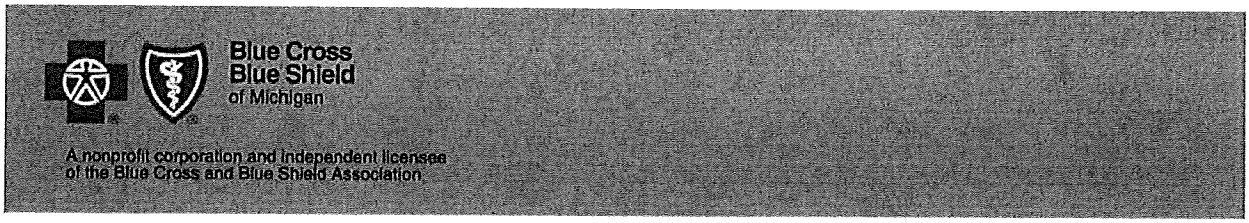
Features of your prescription drug plan

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.

BLUE CROSS/BLUE SHIELD

Medical

PPO $2,000/$4,000



BLOOMFIELD HILLS BD OF ED
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Effective Date: 01/01/2018

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.

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 "lowaccess 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.

Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
Sponsored dependents	• Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.

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 $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 $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 $6,000 for a family contract (2 or more members) each calendar year	$6,000 for a one-person contract $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

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

Benefits	In-network	Out-of-network
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
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
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	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

Benefits	In-network	Out-of-network
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
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	100% after in-network deductible	80% after out-of-network deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
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	100% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% after in-network deductible	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)	

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

Benefits	In-network	Out-of-network
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 use disorder 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 services **must** be performed in a residential psychiatric treatment facility • Treatment must be preauthorized • 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

Benefits	In-network	Out-of-network
Outpatient substance use disorder 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
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

Simply Blue HSA with Prescription Drugs

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 you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are require 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 HAS 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
	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

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 $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
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

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 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**.
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.

BLUE CARE NETWORK

Medical

HMO $1,350/$2,700

Blue Care Network of Michigan

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

Client: Bloomfield Hills Schools

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

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

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

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

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

Preventive Services

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

Physician Office Services

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

Emergency Medical Care

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

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

Traditional Plus Dental Coverage
Benefits-at-a-Glance for Bloomfield Hills Board of Education
67201/665 Instructional Assistant

This is intended as an easy-to-read summary. **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 Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Network access information

- **DenteMax PPO network** – DenteMax PPO dentists agree to accept our approved amount as payment in full and participate on all claims. DenteMax is an independent company that leases its network to BCBSM to provide access to Blues members. You'll also receive discounts on noncovered services when you use PPO dentists. You can choose from more than 83,000 dentist access points* nationwide where dental services are available through our partnership with the **DenteMax** PPO network. To find a **DenteMax** dentist, please call 800-752-1547 or go to the DenteMax Web site at **dentemax.com.**

  ** A dentist access point is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two locations would be two access points.*

- **Blue Par Select℠** – Most dentists participate with the Blues on a "per claim" basis, so you should ask your dentist if he or she participates before every procedure. These dentists accept payment in full from BCBSM for covered services and you pay the dentist only applicable copays and deductibles, and any fees for noncovered services. You won't be balanced billed for any difference between our approved amount and the dentist's charge. We call this arrangement "Blue Par Select." To find a dentist who may participate with BCBSM, go to **bcbsm.com.** Select the **Dental Professionals** subsection of **"Where You Can Go for Care"** page.

Note: If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.

Member's responsibility (copays and dollar maximums)

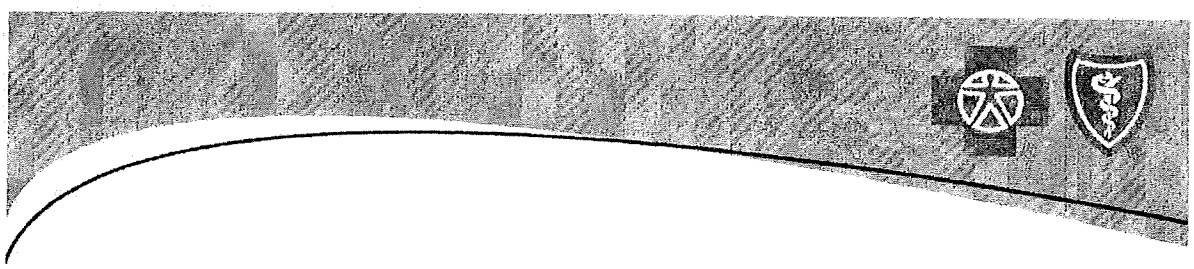
Copays	30% for Class II and III services
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,000 per member
• Lifetime maximum (for Class IV services)	N/A

Class I services

Oral exams	Covered – 100%, twice per calendar year
A set (up to 4) of bitewing x-rays	Covered – 100%, twice per calendar year
Full-mouth and panoramic x-rays	Covered – 100%, once every 60 months
Prophylaxis (teeth cleaning)	Covered – 100%, twice per calendar year
Pit and fissure sealants – for members age 19 or under	Covered – 100%, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	Covered – 100%
Fluoride treatment	Covered – 100%, two per calendar year
Space maintainers – missing posterior (back) primary teeth	Covered – 100%, once per quadrant per lifetime, for members under age 19

Class II services

Fillings – permanent teeth	Covered – 70%, replacement fillings covered after 24 months or more after initial filling
Fillings – primary teeth	Covered – 70%, replacement fillings covered after 12 months or more after initial filling
Onlays, crowns and veneer fillings – permanent teeth	Covered – 70%, once every 60 months per tooth, payable for members age 12 and older
Recementing of crowns, veneers, inlays, onlays and bridges	Covered – 70%, three times per tooth per calendar year after six months from original restoration



Class II services, *continued*

Oral surgery including extractions	Covered – 100%
Root canal treatment – permanent tooth	Covered – 100%, once every 12 months for tooth with one or more canals
Scaling and root planing	Covered – 100%, once every 24 months per quadrant
Limited occlusal adjustments	Covered – 100%, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	Covered – 100%, once every 12 months
General anesthesia or IV sedation	Covered – 100%, when medically necessary and performed with oral or dental surgery
Adjustment of dentures	Covered – 100%, six months or more after it is delivered
Relining or rebasing of partials or complete dentures	Covered – 100%, once every 36 months per arch
Tissue conditioning	Covered – 100%, once every 36 months per arch
Repair and adjustments of partial or complete dentures	Covered – 100%

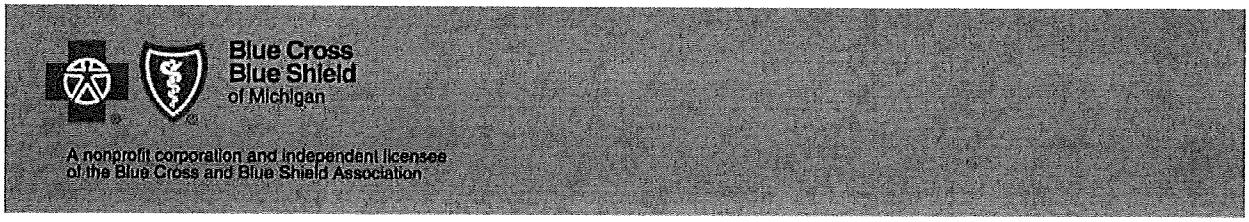
Class III services

Removable dentures (complete and partial)	Covered – 70%
Bridges (fixed partial dentures) – for members age 16 or older	Covered – 70%, once every 60 months after original was delivered
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant placement	Covered – 70%, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Covered – 60%
Minor treatment to control harmful habits	Covered – 60%
Interceptive and comprehensive orthodontic treatment	Covered – 60%
Post-treatment stabilization	Covered – 60%
Cephalometric film (skull) and diagnostic photos	Covered – 60%

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.



BLOOMFIELD HILLS BD OF ED
A0TDZ7
67201683
0070029560015
Vision Coverage
Effective Date: On or after January 2018
Benefits-at-a-glance : Teachers, Admin., Clerical, Instructional Asst., Paras, Job Coach

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. 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.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance ***plus*** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

Member's responsibility (copays)		
Benefits	**VSP network doctor**	**Non-VSP provider**
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

Eye exam		
Benefits	**VSP network doctor**	**Non-VSP provider**
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $45 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$7.50 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$50 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less less $7.50 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $50 less $10 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$7.50 copay	Reimbursement up to $210 less $7.50 copay (member responsible for any difference)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$35 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses per pair (member responsible for any cost exceeding the allowance)	$35 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses per pair (member responsible for any cost exceeding the allowance)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	

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. <u>GENERAL</u>

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

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

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

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

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

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

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

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

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

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

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

4. NOTICE

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. INTERMITTENT/REDUCED LEAVE SCHEDULE

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

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

employees until the 12 (or 26 weeks for the care of a covered service member) weeks of FMLA leave are used.

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

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

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

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

8. BENEFITS

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

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

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

(3) If the District remits any employee premium contributions in arrears from the employee while on FMLA leave, the employee will be required to reimburse the District for delinquent payments (through authorized payroll deduction or

otherwise) upon return from leave. If the employee fails to return from unpaid leave for reasons other than: a) the continuation, recurrence, or onset of a serious health condition of the employee or a covered family member, or b) circumstances beyond the employee's control, the District may seek reimbursement from the employee for the portion of the premiums paid by the District on behalf of that employee (also known as the "employer contribution") during the leave period, excluding the period where the District or the employee has substituted paid leave for FMLA leave.

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

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

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

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

9. RETURN TO WORK

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

B. Periods Near the Conclusion of an Academic Team

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

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

3. Leave three weeks before end of term for reasons other than employee's serious health condition: An instructional employee who begins a leave for a purpose other than his/her own serious health condition during the three-week period before the end of the term and

the duration of the leave is more than five working days may be required to continue on leave until the end of the term.

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

10. KEY EMPLOYEES

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

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

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

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

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

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

11. FAILURE TO RETURN FROM LEAVE

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

12. FORMS

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

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

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

WH-381 Notice of Eligibility and Rights & Responsibilities

WH-382 Designation Notice

WH-384 Certification of Qualifying Exigency For Military Family Leave

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

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

Date Adopted: April 24, 2009
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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.