Bloomfield Hills
Schools

AGREEMENT BETWEEN

Bloomfield Hills Association of Educational Interpreters and Interveners

AND

Bloomfield Hills Schools

August 13, 2019
through
August 31, 2020

Christina Kostiuk, Interim Superintendent
7273 Wing Lake Road, Bloomfield Hills, Michigan 48301

Bloomfield Hills Schools

VISION
Bloomfield Hills Schools will lead the nation in educating and empowering every learner, every day, with compassion and integrity in a welcoming environment.

MISSION
Bloomfield Hills Schools delivers comprehensive, challenging, and inspiring education in a community that equips all learners to become architects of their futures.

Portrait *of a* Learner

A disposition to inquire about the world
A learner who inquires about the world can explore local and global connections, ask questions of significance that call upon critical thinking, frame problems and construct solutions. They seek information beyond familiar environments. They engage in analysis, synthesis, evaluation, creation, and application.

A disposition to understand multiple perspectives
A learner who understands multiple perspectives interacts with others whose paths differ greatly from their own, honoring the value of our shared human dignity. They recognize and resist stereotypes and understand multiple cultural contexts.

A disposition toward respectful dialogue
A learner who engages in respectful dialogue can communicate across differences and listen with intentionality. They express empathy for others while sharing courageously, openly and appropriately.

A disposition toward grappling with complexities
A learner who can grapple with complexities can persevere in the face of multi-layered processes, ideas, and problems. They can display resilience in the face of challenges and change.

A disposition toward taking responsible action
A learner who takes responsible action collaborates with others with the intent to mobilize ideas into action. They recognize that service to community is a form of action.

Contents

ARTICLE 1 - PREAMBLE

This Agreement is entered into on the 13th day of August, 2019 by and between the Board of Education, Bloomfield Hills Schools, County of Oakland, State of Michigan, the "Board or Employer", and the Bloomfield Hills Association of Educational Interpreters and Interveners **BHAEii** ("the Association").

ARTICLE 2 - RECOGNITION

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

Interpreters and Interveners. The bargaining unit does not include supervisors, temporary substitute staff, special education center program staff, deaf and hard of hearing program staff, instructional assistants, and all other staff members.

ARTICLE 3 - REPRESENTATION

A. Officer Notification

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

B. Association Representatives

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

C. Membership in the Association is not compulsory. Recognized employees 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 employee in regards to membership in the Association.

D. The Association shall have the privilege to use school building facilities after student hours for meetings on the same basis as any civic organization in the School District, as established by Board Policy. Arrangements for such use must be made with the building administrator, or the facilities management system.

ARTICLE 4 - MANAGEMENT RIGHTS

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

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

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

3. To determine the hours of employment and the duties, responsibilities, and assignment of staff members 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 in furtherance thereof, and the use of judgment and discretion in connection therewith shall be limited only by the terms of this agreement, and then only to the extent such specific and express terms are in conformance with the Constitution and laws of the State of Michigan.

ARTICLE 5 - COMPENSABLE LEAVE DAYS

A. Definition

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

B. Accumulation

Each individual, who works 20 hours or more per week, shall be entitled to a current leave day earning at the rate of one day per month of employment service. These leave days for the current year shall be placed at the disposal of each individual on July 1st. Unused leave at the end of the school year shall be accumulated to a maximum of one hundred twenty (120) days for ten-month staff.

C. Use of Leave Days

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

1. Personal Illness: Bona Fide involuntary physical incapacity to report for and discharge duties. It is understood that a staff member may be required to provide a physician's statement on a District provided form in cases of illness.

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

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

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

4. Personal Leave: Up to three (3) days per year from current leave days may be used for personal leave. Personal leave, in all cases except unforeseen emergency, requires at least two (2) days advance notice to the immediate supervisor. Personal leave cannot be utilized the day before or immediately following a holiday, vacation, recess or the beginning or ending of the school year unless approved by the Assistant Superintendent for Human Resources and Labor Relations.

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

6. An individual may be provided three days from current leave days, with prior approval from the program supervisor, for the purpose of completing required State or National certification.

D. Use of Accumulated Leave Bank

The individual's accumulated leave bank shall be available for use only for the reasons of

personal illness or bereavement, and illness in the family as defined above, and in accordance with the Family and Medical Leave Act (FMLA). A copy of the procedures for using the FMLA are attached as Appendix C.

A staff member may use one personal leave day from the accumulated leave bank if the current leave is depleted and no days have been used for personal leave from the current leave bank.

E. Leave Day Provisions

Leave days shall not be used for personal pleasure or extended vacations. Abuse of temporary leave shall be subject to one or more warnings, suspension and/or dismissal. All salary and fringe benefits of the individual are subject to being waived during the abused leave.

In the event that the service of an individual is interrupted by reason of discharge, termination, suspension, or leave, and said individual has utilized more sick leave days than have been accumulated on the monthly basis, then the value of the excess paid-for leave days shall be deducted from last paycheck due the individual at the time of interruption.

F. Payout of Unused Leave Days Upon Severance

Upon severance of employment after five (5) years' service, for reasons of death, retirement, or quit with proper notice of not less than two weeks, but not an individual who quits without notice or is discharged, a severance payment for each unused leave day, up to 120 days, will be made by the Board of Education as defined in the schedule described below.

5 years through 10 years	40% of employee's daily rate
11 years through 20 years	60% of employee's daily rate
21 years or more	70% of employee's daily rate

G. Extended 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 8(c)(12).

H. Jury Duty

Individuals who are summoned for jury duty examination and investigation must notify the Human Resources Office within twenty-four (24) hours 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. An employee who is released from jury duty and who has sixty (60) minutes or more remaining on their work day, is required to report to work**.** Such time spent on jury duty shall not be charged against leave days.

To be eligible for jury duty pay differential, the individual must furnish the Human Resources Office with a written statement from the appropriate public official listing amounts of pay received, the days on jury duty, and a check for the full amount of the jury fee paid, excluding any travel allowance paid to the individual by the court. This payment by the employee shall be made to the Human Resources Office 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.

I. Inclement Weather Days

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

1. In the event of inability to reach work due to inclement weather, 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. An individual who reports to work when school is cancelled due to inclement weather (i.e. snow day) will be paid for all hours worked provided he/she engages in work as mutually agreed upon between the individual and the Supervisor of the Deaf and Hard of Hearing (DHH) program.

2. In the event a facility must be shut down after the school day has begun and the individual has reported for work, the individual may be released from work upon the supervisor's direction, with no loss of pay or leave day for the remainder of the day. If the facility is closed additional days, the individual may be reassigned to another facility**,** and if not, 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 time missed.

3. Closing Before Beginning of Work Day for "Other Conditions"
If a facility is closed before the beginning of the work day for "other conditions" such as a water main break, heating problem, etc., the individual may be reassigned to another facility, and if not, the employee is not expected to report to work and 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.

ARTICLE 6 - LEAVES OF ABSENCE (noncompensable)

A. Family and Medical Leave Act

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

Appendix C to the contract contains the regulation applicable to FMLA leave.

B. Child Care Leave

1. Child care leave shall be considered a non-paid leave. A child care leave of absence will be granted for a maximum of one year (12 months) from the date the short term leave was effective. Family and Medical Leave Act (FMLA) (See Appendix C) 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 employee desiring to return from leave shall notify the Human

Resources Office (Human Resources Manager) in writing and provide the appropriate personnel *(Physician's Release to Return to Work***)** form approving the return to work and indicating the employee's ability to resume his/her position. Such notice shall be provided no less than fifteen (15) calendar days prior to the desired return date.

3. 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 employee is qualified. 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 employee is qualified. There shall be no layoff to provide a vacancy.

4. In accordance with this section, a 12-month unpaid leave of absence is available in cases of adoption.

C. Military Leave

Reinstatement from Military Leave

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

An individual who enters the Armed Forces will have seniority equal to the time spent in the Armed Forces.

D. Leave for Association Business

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

E. Conditions for Return from Leave

1. The Board of Education reserves the right to have any individual returning from a leave of absence examined by a Board-appointed physician to verify

their ability to return to work and perform the essential duties of the assigned position. Should no vacant position exist, the individual will be considered as unassigned staff.

2. An individual who is on a leave of absence, and does not return upon the expiration of the leave, will be considered to have voluntarily terminated their employment.

F. Absences without Pay

Absences without pay may be approved by the Assistant Superintendent of Human Resources upon request. Absences without pay will not be approved for the purpose of serving in another capacity, e.g., outside employment for any reason during the regularly scheduled work year.

ARTICLE 7 - HOLIDAYS

A. A maximum of nine (9) paid holidays per year will be granted to each staff member. To be eligible for holiday pay, the employee must work the scheduled hours on the working days immediately previous to and following the holiday, except where the individual has received permission from the Assistant Superintendent for Human Resources and Labor Relations, in advance, or is on a compensable leave as defined in Article 5 of this Agreement.

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

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

When one of the enumerated holidays falls on a Saturday or Sunday, the individual will be provided an alternative paid leave day. The holiday work calendar will be determined by the employer.

For staff members who would not normally be scheduled to work on the day of the designated holiday, holiday pay will be equal to the regularly scheduled weekly hours divided by five (5).

ARTICLE 8 – INSURANCE BENEFITS

A. Benefit Eligibility

1. Compliance with insurance company regulations

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

2. Commencement and duration of coverage

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

An individual shall be eligible for insurance benefits effective the first day of the month after the month in which employment was initiated.

3. Board reserves the right to change insurance carriers

The Board of Education reserves the right to change carriers and use alternative funding methods. 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.

B. Duplication of Insurance

<u>Duplication of Hospital/Medical Coverage Permitted While District is Self-Insured</u>
Duplication of hospital/medical 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 hospital/medical insurance plan.

<u>No Duplication of Medical/Hospitalization Insurance if District is Not Self-Insured</u>
In the event the District is no longer self-insured, there shall be no duplication of medical/hospitalization insurance. The Human Resources Department will notify employees in writing, if the District is no longer self-insured. The staff member must notify the Benefits Coordinator of any personal medical/hospitalization coverage or coverage from a spouse's hospital/medical insurance plan. It is agreed that staff shall not knowingly cause the Board to provide hospital/medical insurance coverage that is a duplication of

such coverage already held by the employee. The Association shall encourage staff to abide by this policy and shall assist the Board in its enforcement.

C. Cafeteria Benefits Plan – "Educated Choices" Group Coverage

1. Publicly Funded Health Contribution Act

The Publicly Funded Health Contribution Act (Public Act 152 of 2011) provides that the District shall pay no more than the annual cost or illustrative rates 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" as defined by the Public Act 152. As provided in the "Act", the "hard cap" amounts will be adjusted annually by the State treasurer by October 1 of each year for the following plan year which begins January 1 based on the change in the medical care component of the U.S. Consumer Price Index for the following plan year which begins January 1. If the District payment for the annual cost or illustrative rates for medical benefit plans offered by the District to employees (including any Additional Payments) exceed the "hard cap" maximums established by the State treasurer, employees will be required to pay the amount over the hard cap by payroll deduction. The District will discuss such deduction with the Association prior to implementation. If the District payment for the annual cost or illustrative rates for medical benefit plans offered by the District to employees (including any Additional Payments) are less than the "hard cap" maximums, the District will contribute to the employees' Health Savings Account (HSA) or Flexible Savings Account (FSA). In no event shall this Section be interpreted to require the district to make a payment which would cause it to violate the Publicly Funded Health Insurance Contribution Act.

2. Coverage for Interpreters/Interveners Who Work 32.5 or More Hours Per Week

The District will provide a Cafeteria Benefit plan which will encompass all fringe benefits and will include the following options for interpreters/interveners who work 32.5 or more hours per week, and who make proper application to participate in the Bloomfield Hills Schools Flexible Benefits Plan.

Effective January 1, 2014, the District will provide, either by self-insurance or a policy of insurance, group medical coverage to each eligible interpreter/intervener.

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. 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 – the Publicly Funded Health Contribution Act.

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

a). Other Factors

Contributions Cannot Exceed IRS Limits
The combined employee and District HSA contributions shall not exceed the annual calendar year limits established by the IRS for such contributions. See IRS Publication 969 for eligibility.

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

Flexible Spending Account
Those employees who are not eligible to participate in an HSA due to IRS established age restrictions, currently age 65 and over, or employees who do not elect to participate in a HSA, will receive the employer contribution (if any) into a Flexible Spending Account.

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

an amount equal to the District HSA contribution associated with any period in which the Employee was not covered by the District's HDHP. Similarly, if an Employee otherwise ceases coverage under the District's HDHP before the end of the Plan Year, the District may deduct from the Employee's pay following the election to cease coverage, in one or more installments, an amount equal to the District HSA contribution associated with any period in which the Employee was not covered by the District's HDHP.

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

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

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

    a) <u>Employee Contribution Toward Health Care</u>
    Each employee electing health insurance coverage shall make the following annual pre-tax contribution toward the cost of health care. The amount will be prorated if the employee does not work a full plan year:

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

    b) <u>Health Risk Assessment/Rebate</u>

1. Health Risk Assessment: Employees (and their spouses, if applicable) are expected to participate in an annual health risk assessment with his/her health care provider.

   The Health Risk Assessment form is available on the Bloomfield Hills Schools/Human Resources Department intranet and will be available in the Human Resources Department upon request.

2. Rebate of Pre-tax Contribution: Employees and their spouses (if applicable) who participate in the annual health risk assessment (HRA) are eligible to receive a rebate of the full amount of the employee pre-tax contribution provided in subparagraph C(3)(a) above. Eligibility for the rebate is based upon receipt by the Benefits Coordinator, in the Human Resources Department of the completed health risk assessment form by September 15 of each year, unless that date falls on a weekend or holiday in which the district is closed. In such case, the Health Risk Assessment form will be due by the close of business on the following Monday.

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

c) Cash Payment in Lieu of Medical/Hospitalization Insurance

The District will provide a Cash in Lieu of Health coverage option under the Bloomfield Hills Schools Flexible Benefits Plan for each full plan year for those employees who are eligible for but do not elect the employer-provided medical/hospitalization coverage. The co-payment will be prorated if the employee does not work a full plan year. Staff who do not have medical/hospitalization coverage from another source are not eligible for this benefit.

Single Opt Out	$600
Two-Person Opt Out	$800
Full Family Opt Out	$1,000

4. Dental Care

Classes I, II, and III which includes preventive basic care and prosthetics, a dental plan of Class I - 90%, Class II - 75%, and Class III - 60%, with a maximum per person per year of $1,000. The percentage of reimbursement for dental care will be in accordance with the coverage and schedule provided by the carrier outlined in the *Educated Choices* workbook.

5. Vision

The vision care program with a $35.00 cap on frames, will provide services including examination, lenses and frames premised on a co-pay program with established reasonable and customary fee limitations.

6. Benefits for Employees who Work 25 Hours or More Per Week

For each individual who works 25 hours or more per week, the Employer will self-insure or pay the premium for the following: single subscriber hospital/medical, life insurance, temporary disability and salary continuation, and long term disability insurance, as provided for and according to the same terms, as employees working 32.5 hours per week or more. This includes the employee contribution toward health care, eligibility for rebate of contribution for participation in the annual health risk assessment, eligibility for a district contribution to a HSA (or FSA), proration of any over payment into a HSA, all as provided in Article 8(c)(2)(3)(a),(b),(c) and(7)-(14).

7. Life Insurance

The Employer shall pay the premium for a life insurance and, accident and dismemberment policy for each individual. The life insurance policy shall pay the employee's designated beneficiary the sum of $40,000 upon death with a provision for double indemnity in the event of accidental death.

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

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

10. 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.

11. 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.

12. Temporary Disability and Salary Continuation (Short Term Disability)

For each eligible staff member, the following disability and salary continuation coverage shall be provided:

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

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

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

(2) Any staff member who is absent for five consecutive days will contact the Human Resources Manager and complete the necessary forms provided by the Human Resources Office.

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

13. Long-Term Disability

(1) Benefit

Such disability insurance shall provide benefit of 66 2/3% of the monthly earnings up to a maximum payment of $1,500.00 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 from 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 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 interpreter/intervener 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 6 months from the commencement of the leave, the employee will be separated from employment with Bloomfield Hills Schools.

14. Workers' Compensation (provided for all employees)

Benefit

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

No Leave days charged for 120 days

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.

No Eligibility for Short Term Disability

Should the individual continue to be off work beyond a period of 120 days, the employee shall not then be eligible for short-term disability benefits under Article 8. After the 120-day period, current and bank days may be used, per Article 5. No District supplement will be made after 120 days, as defined above.

Doctor Visits

Any staff member 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.

Benefits Beyond One Year

Any benefits beyond one year shall be payable only under the terms of Workers' Disability Compensation Act and Long-Term Disability Insurance Coverage of the District, provided under Article 8. No other employer provided benefits will be paid for the individual if the individual continues to be off work after one (calendar) year.

Separation from Employment

If an employee on Workers' Disability Compensation leave does not return to work upon the conclusion of one calendar year from the date of the commencement of the leave, the employee's position will not be held open for the employee. However, if the employee is medically able to return within 18 months of the date of the commencement of the workers' compensation leave, the employee will be given consideration for placement in a vacant interpreter/intervener 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 physical 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 for employment with Bloomfield Hills Schools.

ARTICLE 9 - HEALTH

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

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

2. As a condition of continued employment, if requested by the Board, each individual shall be required to file the results of a chest x-ray examination or the tuberculin skin test showing negative results. The results of the test must be filed with the Human Resources Office.

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

ARTICLE 10 - MILEAGE

A. Staff members 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 sheet in accordance with the established district procedures.

B. Mileage is submitted on a monthly basis.

C. Mileage is payable as follows:

1. Mileage will not be paid for travel to the employee's assigned building.

2. Employees will be paid for required travel between buildings during the school day.

3. Mileage will be paid for out-of-district assignments from the school to the

assignment and return to school. However, if the employee returns to a location other than school (such as home) then the mileage will be paid to whatever destination has less mileage.

4. When an employee leaves from school to interpret at an in-district supplemental assignment, no mileage is paid.

5. Employees cannot be paid for "supplemental time" and mileage at the same time. (See Article 11(D) – Extended Day Provisions).

6. If the employee is able to ride the bus or take district provided transportation, the employee will not be paid mileage. Exception: If the employee is not required to remain at the event for the purpose of providing interpreting/intervener services, the employee may elect to provide their own transportation and will receive mileage. If there is a dispute about the necessity of remaining at the event, the Supervisor of the Deaf and Hard of Hearing program will make the determination.

D. Mileage on non-school days in and out of district assignments:

1. The round trip daily commute mileage from home to work must be subtracted from daily round trip miles driven for that day excluding personal mileage. *

2. A MapQuest map from the employee's home to the building site and a MapQuest map for the round trip mileage to the assignment site may also be required.

3. A Mileage Log must also be submitted (available in Shared Forms Folder)

   For example: Round trip mileage from the employee's home to work is 30 miles. Round trip mileage for the day, less any personal miles, is 35 miles. The reimbursable mileage is 5 miles.

4. If the mileage to the assignment site from home is less than the daily commute, no reimbursement will be issued for mileage.

   For example: Round trip mileage from the employee's home to work is 30 miles. Round trip mileage for the day, less any personal miles, is 25 miles. No reimbursement will be issued.

*Personal mileage includes running errands, going out for lunch, etc.

ARTICLE 11 - WAGES

A. Salary

1. Interpreter Wage Schedule

INTERPRETER PAYSCALE 2018-2019

STEPS	MINIMUM EIPA 3.5-3.9	1 EIPA 4.0-5.0	2 EIPA 4.0-5.0	2 EIPA 4.0-5.0 PLUS CURRENT STATE/ NATIONAL CERTIFICATION*
0	17.25	19.00	21.00	21.21
1	18.11	19.95	22.05	22.27
2	19.02	20.95	23.15	23.38
3	19.97	21.99	24.31	24.55
4	20.97	23.09	25.53	25.79
5	22.02	24.25	26.80	27.07
6	23.12	25.46	28.14	28.42
7	23.81	26.23	28.99	29.28
8	24.52	27.01	29.86	30.16
9	25.26	27.82	30.75	31.06
10	25.89	28.52	31.52	31.84
11	26.54	29.23	32.31	32.63
12	27.20	29.96	33.12	33.45
13	27.88	30.71	33.94	34.28
14	28.58	31.48	34.79	35.14
15	29.29	32.27	35.66	36.02
16	29.58	33.51	36.92	37.29
17	29.88	33.85	37.29	37.66
18	30.18	34.19	37.66	38.04
19	30.48	34.53	38.04	38.42
20	30.78	34.88	38.42	38.80

***RID/BEI/NAD which is registered on the Michigan Online Interpreters System.**

INTERPRETER PAYSCALE 2019-2020

STEPS	NEW STEP	MINIMUM EIPA 3.5-3.9	1 EIPA 4.0-5.0	2 EIPA 4.0-5.0	2 EIPA 4.0-5.0 PLUS CURRENT STATE/ NATIONAL CERTIFICATION*
~~0~~		~~17.25~~	~~19.00~~	~~21.00~~	~~21.21~~
~~1~~		~~18.11~~	~~19.95~~	~~22.05~~	~~22.27~~
~~2~~		~~19.02~~	~~20.95~~	~~23.15~~	~~23.38~~
~~3~~		~~19.97~~	~~21.99~~	~~24.31~~	~~24.55~~
~~4~~		~~20.97~~	~~23.09~~	~~25.53~~	~~25.79~~
~~5~~	1	22.02	24.25	26.80	27.07
~~6~~	2	23.12	25.46	28.14	28.42
~~7~~	3	23.81	26.23	28.99	29.28
~~8~~	4	24.52	27.01	29.86	30.16
~~9~~	5	25.26	27.82	30.75	31.06
~~10~~	6	25.89	28.52	31.52	31.84
~~11~~	7	26.54	29.23	32.31	32.63
~~12~~	8	27.20	29.96	33.12	33.45
~~13~~	9	27.88	30.71	33.94	34.28
~~14~~	10	28.58	31.48	34.79	35.14
~~15~~	11	29.29	32.27	35.66	36.02
~~16~~	12	29.58	33.51	36.92	37.29
~~17~~	13	29.88	33.85	37.29	37.66
~~18~~	14	30.18	34.19	37.66	38.04
~~19~~	15	30.48	34.53	38.04	38.42
~~20~~	16	~~30.78~~ 31.08	~~34.88~~ 35.23	~~38.42~~ 38.80	~~38.80~~ 39.19

***RID/BEI/NAD which is registered on the Michigan Online Interpreters System.**

2. Intervener Wage Schedule

INTERVENER WAGE SCHEDULE 2018-2019

STEP	MINIMUM	NATIONAL INTERVENER CREDENTIAL
0	$15.85	$16.85
1	$16.64	$17.69
2	$17.47	$18.58
3	$18.35	$19.51
4	$19.27	$20.48
5	$20.23	$21.51
6	$21.24	$22.58
7	$21.88	$23.26;
8	$22.53	$23.96
9	$23.21	$24.67
10	$23.79	$25.29
11	$24.39	$25.92
12	$24.99	$26.57
13	$25.62	$27.24
14	$26.26	$27.92
15	$26.92	$28.61
16	$27.19	$28.89
17	$27.46	$29.18
18	$27.73	$29.47
19	$28.01	$29.77
20	$28.29	$30.07

INTERVENER WAGE SCHEDULE 2019-2020

STEP	MINIMUM	NATIONAL INTERVENER CREDENTIAL
0	$15.85	$16.85
1	$16.64	$17.69
2	$17.47	$18.58
3	$18.35	$19.51
4	$19.27	$20.48
5	$20.23	$21.51
6	$21.24	$22.58
7	$21.88	$23.26;
8	$22.53	$23.96
9	$23.21	$24.67
10	$23.79	$25.29
11	$24.39	$25.92
12	$24.99	$26.57
13	$25.62	$27.24
14	$26.26	$27.92
15	$26.92	$28.61
16	$27.19	$28.89
17	$27.46	$29.18
18	$27.73	$29.47
19	$28.01	$29.77
20	$28.57	$30.37

B. Increments and Experience Credit

1. Salary schedule progress will be initiated on July 1 of each school year; however, if the hire date is on or after March 2, a step increment will be given July 1st of the following year. Eligible members will receive one step advancement for the 2019-2020 school year.

    a. Salary scales reflect an increase of 1% on schedule at the top step for the 2019-2020 school year.

2. Credit may be granted for outside work and/or district experience.

3. Additional Certification Pay: Upon appropriate documentation, interpreters/interveners may receive one of the following additional certification pay increments as reflected on the wage schedule:

a. Interpreters (only)
Educational Interpreter Performance Assessment (EIPA) certification with a score of 4.0 or above. An interpreter is eligible for placement on the EIPA-1 wage schedule if he/she has one EIPA certification (elementary or secondary). The interpreter is eligible for placement on the EIPA-2 wage schedule if he/she obtains the other EIPA certification (either elementary or secondary).

Two Educational Interpreter Performance Assessment (EIPA) Certifications with a score of 4.0 or above plus a State or National certification. Interpreters are eligible for placement on the EIPA-2 Plus wage schedule if he/she has an elementary and secondary EIPA certification with a score of 4.0 or above, which is registered and reflected on the Michigan On-line Interpreters System website and has current State or National certification which is registered and reflected on the Michigan On-Line Interpreters System website.

Appropriate documentation must be provided to the Human Resources Department before a schedule change will be made.

b. An additional stipend of $500.00 will be paid for those interpreters who hold a legal and/or a medical endorsement with the understanding that any persons receiving this stipend are “on call” and may be pulled with little notice to serve in the required capacity on a district wide basis.

c. An additional stipend of ($300.00) will be paid to any interpreter assigned to serve as a mentor on an as needed basis to be determined by the supervisor.

d. Interveners (only)
An Intervener is eligible to be placed on the National Intervener Credential wage schedule if he/she has current National Intervener Certification and provides appropriate documentation to the Human Resources Department.

In order to receive additional certification pay, an interpreter/intervener shall submit his/her request in writing to the Assistant Superintendent for Human Resources and Labor Relations along with documentation (satisfactory to the Assistant Superintendent for Human Resources and Labor Relations) that the EIPA/State/National certification (Interpreters) or National Intervener Credential (Interveners) has been completed. For the RID/NAD, full certification must be completed (i.e. passing both the written and performance tests).

4. Pay Differential for Interpreter Coordinator and Lead Interpreter: A differential of $1.50 per hour will be paid to the individual designated as interpreter coordinator and a differential of 50 cents per hour will be paid to the building lead interpreter.

   These positions will be subject to appointment as determined by the supervisor of the Deaf and Hard of Hearing program. A posting announcing a vacancy in the above positions will be provided to each interpreter.

5. The Senior All Night Party will be paid at double time.

C. Supplemental Activities

Interpreters and Interveners will be paid at the rate of time and one-half for time worked in excess of 8 hours per day. The purpose of this provision is to provide compensation to interpreters and interveners who return to Bloomfield Hills Schools for after-school activities.

D. Work Schedule

Length of Work Year: Employees will be scheduled to work when students are in session. In-service or other professional activities will be scheduled by the District for employees on non-student/teacher work days, with the exception of after school professional development, teacher record days, the October 31 On Your Own (OYO), and the last day of school for K-12 students once students are dismissed. Interpreters and Interveners are to plan the professional development in conjunction and with the approval of Deaf & Hard of Hearing Supervisor.

Working Hours: The daily schedule shall include an unpaid duty-free, one-half hour lunch period. Any modification in the daily schedule must have the approval of the appropriate administrator. Efforts will be made to provide forty-five (45) minutes of preparation time per full school day with students. However, if that time is not provided, the employee is not entitled to compensation for missed preparation time.

Extended Day Provisions: Staff members who are required to return or make a separate trip in order to provide services to a student, will be guaranteed pay for two (2) hours, or the actual hours worked if greater than two hours. If the supplemental starts within fifty-nine (59) minutes after the end of the regular work day, the staff member will be paid from the end of the regular work day through the end of the supplemental. If the supplemental starts one hour or more after the end of the regular work day, then the supplemental is subject to the two-hour minimum payment requirement.

ARTICLE 12 - 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. Loss of Seniority

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

1. The employee quits.

2. The employee is discharged.

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

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

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

6. The employee does not return to work after a medical leave or workers' compensation leave within the time frame provided in Article 8(C)(13) (long-term disability) and Article 8(C)(14) (workers' compensation).

7. The employee fails to maintain current State required qualifications.

C. Seniority (Leaves of Absence)

Staff, while on approved short term disability (Article 8(C)(12)) or child care (Article (6)(B)) leaves of absences, shall accumulate seniority.

ARTICLE 13 - REDUCTION/RECALL

A. In the event there is a reduction in staff, administration will consider the following in determining which staff will be laid off:

1. Qualifications of the staff for existing or remaining positions (as determined by

administration);
2. Job performance of the staff (as determined by administration);
3. Attendance (as determined by administration); and
4. Seniority

The administrative decision about which staff to lay off is final and is not subject to review under Article 15 - Problem Resolution. The Board reserves unto itself all management rights provided under Article 4 to determine the conditions under which employees will be laid off and recalled.

B. Staff to be laid off for an indefinite period of time will be given at least 30 calendar days notice of layoff. For purposes of recall, administration will consider the factors outlined in (13)(A) above to determine the order of staff recall. Notice of recall shall be sent to the employee at the last known address as provided by the employee and as shown on the employer's record, by registered or certified mail. If an employee fails to report for work within ten (10) days from the date of mailing of notice of recall the employee shall be terminated.

C. Each employee 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 employee fails to receive recall notice because of their own failure to advise the Employer in writing of change of address.

ARTICLE 14 - TUITION REIMBURSEMENT

Reimbursement for college tuition and State or National Certification such as RID/BEI/EIPA or National Intervener Credential will be provided for those individuals required or approved to attend school, providing course work is completed with a grade of "B" or better, or certification is acquired. Reimbursement is subject to the course work being directly related to the individual's assignment, and having written approval prior to enrollment from the Assistant Superintendent for Human Resources and Labor Relations. Approved workshop and conference tuition or conference registration may be reimbursed on the same basis. The total annual reimbursement for the entire bargaining unit will not exceed four thousand ($4000).

Application and supporting information for tuition or RID/BEI (or Test for English Proficiency)/EIPA/National Intervener Credential Certification or approved workshops/conferences reimbursement shall be filed with the Human Resources Office by June 30 of each year. Contingent on the total reimbursement request, there may be a proration.

ARTICLE 15 - PROBLEM RESOLUTION

A. Concern To Be Processed Within 10 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 employee and immediate supervisor. At the option of the employee, 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 10 Working Days

If the decision is not satisfactory to the employee, 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. An answer in writing shall be provided within five (5) working days of receipt of the concern.

D. Decision of Assistant Superintendent for Human Resources and Labor Relations

The decision of the Assistant Superintendent for Human Resources and Labor Relations will be final in matters concerning oral and written reprimands, suspensions, other terms and conditions of employment, or interpretation of this agreement. If the decision of the Assistant Superintendent for Human Resources and Labor Relations is not satisfactory to the individual and the matter concerns a termination of employment an appeal may be made to the Superintendent, in accordance with Board of Education Policy 2400. 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.

ARTICLE 16 - VACATION

A. Vacation Earnings

Employees will earn vacation in one year for use in the following year.

Regular full time employees (32.5 hours per week) will earn up to ten (10) paid vacation days per year.

Earned vacation may be used during the winter, mid-winter or spring recess**,** or other non-student (unpaid) days for eligible staff. Vacation request forms must be completed and are available from the Human Resources Department.

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, unused vacation earned to date will be paid.

B. Additional vacation days for perfect attendance

As an incentive for perfect attendance, employees who are present every day during one or both of the following time periods will earn an additional vacation day for each time period he/she has perfect attendance. The time periods are the first reporting day in August to December 31 and January 1 to the end of school year in June. Days taken for funeral leave, snow days, if the building is closed, for approved days taken without pay or for approved days for job required testing in accordance with Article 5(C)(6) 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 employee must have worked the full six-month period to be eligible for the additional vacation day incentive.

ARTICLE 17 - 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 members 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.

C. Emergency Manager Legislation

An emergency manager appointed under the local government and school district fiscal accountability act may reject, modify or terminate the collective bargaining agreement as provided within the local government and school district fiscal accountability act.

ARTICLE 18 – CONTRACT REOPENER

Either party may reopen the contract, for the purpose of revising contractual provisions to comply with current law (e.g. the Patient Protection & Affordable Care Act) by serving written notice of such intent upon the other party.

ARTICLE 19 - DURATION OF AGREEMENT

This Agreement shall be effective as of August 13, 2019 and shall continue in full force and effect until August 31, 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 sixty (60) days prior to setting forth the intention to cancel, terminate, or reopen the Agreement as the case may be. Such notice shall be served in writing in the event of a timely notice, the parties shall promptly arrange to meet for the purpose of negotiating a successor Agreement.

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

A tentative Agreement was reached by the parties on June 26, 2019. This Agreement was ratified by the Bloomfield Hills Association of Interpreters and Interveners on and approved by the Bloomfield Hills Schools Board of Education on.

BHAEii

Erin Seipke-Brown, President

Grat Dalton, Executive Director

District

Paul Kolin, President

Christina Kostiuk, Interim Superintendent

Kelly Bohl, Assistant Superintendent HR

Appendix

APPENDIX A		Benefits-at-a Glance/Riders
APPENDIX B		Example of District Contribution to Health Savings Account
APPENDIX C		Family and Medical Leave Act Procedures
APPENDIX D		Guidelines for Posting Vacancies & Transfer Requests/ Interpreter Transfer Request

Appendix A

BLUE CROSS/BLUE SHIELD

MEDICAL

PPO $1,300/$2,600

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

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

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

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

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

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

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

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

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

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

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

Preventive care services

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

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

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

Physician office services

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

Emergency medical care

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

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

Diagnostic services

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

Maternity services provided by a physician or certified nurse midwife

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

Hospital care

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

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

Surgical services

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

Human organ transplants

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

Mental health care and substance abuse treatment

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

Autism spectrum disorders, diagnoses and treatment

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

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

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

Other covered services

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

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

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

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

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

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

Member's responsibility (copays and coinsurance amounts)

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

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

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

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

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

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

Covered services

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

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

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

Features of your prescription drug plan

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

Features of your prescription drug plan

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

BLUE CROSS/BLUE SHIELD

Medical

PPO $2,000/$4,000

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

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

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

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

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

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

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

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

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

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

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

Preventive care services

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

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

Physician office services

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

Emergency medical care

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

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

Diagnostic services

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

Maternity services provided by a physician or certified nurse midwife

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

Hospital care

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

Alternatives to hospital care

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

Surgical services

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

Human organ transplants

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

Mental health care and substance abuse treatment

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

Autism spectrum disorders, diagnoses and treatment

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

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

Other covered services

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

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

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

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

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

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

Member's responsibility (copays and coinsurance amounts)

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

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

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

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

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

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

Covered services

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

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

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

Features of your prescription drug plan

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

Features of your prescription drug plan

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

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

Blue Care Network of Michigan

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

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

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Prescription Drugs

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

Definitions

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

Traditional Plus Dental Coverage
Benefits-at-a-Glance for Bloomfield Hills Board of Education

Group: 007002956 BPID: 0001 INTERP/INTERVENER STAFF

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**[SM] – 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	10% for Class I services, 25% for Class II services, and 40% for Class 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 – 90%, twice per calendar year
A set (up to 4) of bitewing x-rays	Covered – 90%, twice per calendar year
Full-mouth and panoramic x-rays	Covered – 90%, once every 60 months
Prophylaxis (teeth cleaning)	Covered – 90%, twice per calendar year
Pit and fissure sealants – for members age 19 or under	Covered – 90%, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	Covered – 90%
Fluoride treatment	Covered – 90%, two per calendar year
Space maintainers – missing posterior (back) primary teeth	Covered – 90%, once per quadrant per lifetime, for members under age 19

Class II services

Fillings – permanent teeth	Covered – 75%, replacement fillings covered after 24 months or more after initial filling
Fillings – primary teeth	Covered – 75%, replacement fillings covered after 12 months or more after initial filling
Onlays, crowns and veneer fillings – permanent teeth	Covered – 75%, once every 60 months per tooth, payable for members age 12 and older
Recementing of crowns, veneers, inlays, onlays and bridges	Covered – 75%, three times per tooth per calendar year after six months from original restoration

Class II services, *continued*

Oral surgery including extractions	Covered – 75%
Root canal treatment – permanent tooth	Covered – 75%, once every 12 months for tooth with one or more canals
Scaling and root planing	Covered – 75%, once every 24 months per quadrant
Limited occlusal adjustments	Covered – 75%, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	Covered – 75%, once every 12 months
General anesthesia or IV sedation	Covered – 75%, when medically necessary and performed with oral or dental surgery
Adjustment of dentures	Covered – 75%, six months or more after it is delivered
Relining or rebasing of partials or complete dentures	Covered – 75%, once every 36 months per arch
Tissue conditioning	Covered – 75%, once every 36 months per arch
Repair and adjustments of partial or complete dentures	Covered – 75%

Class III services

Removable dentures (complete and partial)	Covered – 60%
Bridges (fixed partial dentures) – for members age 16 or older	Covered – 60%, 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 – 60%, 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	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

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.

Vision Care (A80) Coverage
Benefits-at-a-Glance for Bloomfield Hills Board of Education

Group: 007002956 BPID: 0001 INTERP/INTERVENER STAFF

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.

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

	Participating provider	Nonparticipating provider
Member's responsibility (copays)		
Eye exam	$5 copay	$5 copay
Prescription glasses (lenses and/or frames)	A **combined** $7.50 copay	A **combined** $7.50 copay
Medically necessary contact lenses	$7.50 copay	Member responsible for difference between approved amount and provider's charge
Eye exam		
Eye exam by a physician or optometrist	Covered – $5 copay	Covered – $5 copay
	One eye exam in any period of 24 **consecutive** months	
Lenses and frames		
Standard lenses, not to exceed 65 mm in diameter, when prescribed or dispensed by a physician, optometrist or optician	Covered – $7.50 copay (one copay applies to both lenses and frames)	Covered – $7.50 copay (one copay applies to both lenses and frames)
	One pair of lenses, with or without frames, in any period of 24 **consecutive** months	
Standard frames	Covered – $7.50 copay (one copay applies to both frames and lenses)	Covered – $7.750 copay (one copay applies to both frames and lenses
	One frame in any period of 24 **consecutive** months	
Contact lenses		
Medically necessary contact lenses (must meet criteria of medically necessary)	Covered – $7.50 copay	Covered – up to predetermined amount
	One pair of contact lenses in any period of 24 **consecutive** months	
Elective contact lenses that improve vision (prescribed, but do **not** meet criteria of medically necessary)	Covered – up to a maximum payment of $35 per pair (member responsible for difference)	Covered – up to a maximum payment of $35 per pair (member responsible for difference)
	One pair of contact lenses in any period of 24 **consecutive** months	

INTRP, INTERVNRS			**2018 Hard Caps**								
Cost or Funding of HSA or HRA											
										If (+) ER Pays	
										If (-) EE Pays	
1350 PPO							Annual				***Comments:***
		Annual	Annual	Differential	Total Annual		Medical Plan	Total Annual		**Smoothing Result**	***- Insurance cost is above hardcap***
	#Ees	Hard Cap	Cost of Insurance	Per Employee	Differential		Deductible	Ded. Exposure		**PEPY**	***- Employees pay additional cost***
Single	1	$6,560.52	$6,460.68	$99.84	$99.84	Individual	**1350**	$1,350.00	Individual	**($716.91)**	
Two Person	2	$13,720.07	$15,506.04	-$1,785.97	-$3,571.94	2Per/Fam	**2700**	$10,800.00	2Per/Fam	**($1,433.82)**	
Family	2	$17,892.36	$19,382.40	-$1,490.04	-$2,980.08						
					-$6,452.18			**$12,150.00**	**-53%**		
2000 PPO							Annual				
		Annual	Annual	Differential	Total Annual		Medical Plan	Total Annual		**Smoothing Result**	***- Insurance cost is below hardcap***
	#Ees	Hard Cap	Cost of Insurance	Per Employee	Differential		Deductible	Ded. Exposure		**PEPY**	***- District funds HSA or HRA up to hardcap.***
Single	1	$6,560.52	$5,861.64	$698.88	$698.88	Individual	**2000**	$2,000.00	Individual	**$141.53**	
Two Person	1	$13,720.07	$14,067.84	-$347.77	-$347.77	2Per/Fam	**4000**	$16,000.00	2Per/Fam	**$283.06**	
Family	3	$17,892.36	$17,584.80	$307.56	$922.68						
					$1,273.79			**$18,000.00**	**7%**		
1350 HMO							Annual				
		Annual	Annual	Differential	Total Annual		Medical Plan	Total Annual		**Smoothing Result**	***- Insurance cost is below hardcap***
	#Ees	Hard Cap	Cost of Insurance	Per Employee	Differential		Deductible	Ded. Exposure		**PEPY**	***- District funds HSA or HRA up to hardcap.***
Single	1	$6,560.52	$5,003.52	$1,557.00	$1,557.00	Individual	**1350**	$1,350.00	Individual	**$1,449.78**	
Two Person	0	$13,720.07	$12,008.64	$1,711.43	$0.00	2Per/Fam	**2700**	$16,200.00	2Per/Fam	**$2,899.55**	
Family	6	$17,892.36	$15,010.68	$2,881.68	$17,290.08						
					$18,847.08			**$17,550.00**	**107%**		