COLLECTIVE BARGAINING AGREEMENT

By and Between

East Windsor Board of Education

and the

United Public Service Employees Union
East Windsor BOE Nurses
Local 424 - Unit 132

JULY 1, 2022 - JUNE 30, 2025

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ARTICLE I
RECOGNITION

1.1 The Board recognizes and certifies the East Windsor BOE Nurses, UPSEU Local 424, Unit 132 for the purposes of professional negotiations as the exclusive representative for all employees in the unit for the purposes of and with all rights and privileges as provided by Public Act No. 491 and General Statutes 7-467 and under certification by the Connecticut State Labor Relations Board under Case No. ME-34,516 dated December 16, 2021.

The recognition consists of employees of the East Windsor Board of Education employed as Registered Nurses and Licensed Practical Nurses, excluding the Nurse Leader.

ARTICLE II
GRIEVANCE PROCEDURE

2.1. Purpose

The purpose of this procedure is to secure, at the lowest possible administrative level, equitable solutions to problems which may arise affecting the welfare or working conditions of employees as expressed in this agreement. Both parties agree the proceedings shall be kept confidential as is appropriate.

2.2. Definitions

A. "Grievance" shall mean a claim of an employee that there has been a mis- interpretation or misapplication of the specific terms of this agreement.

B. "Employee" shall mean any member of the bargaining unit.

C. "Party in Interest" shall mean the person or persons making the claim, including their designated representatives as provided for herein.

D. "Days" shall mean when the Superintendent's office is open for business.

2.3. Time Limits

A. Since it is important that grievances be processed as rapidly as possible, the number of days indicated in each step shall be considered as a maximum. The time limit specified may, however, be extended by a written agreement of the parties, at which time new evidence may be introduced by written agreement of the parties.

B. If an employee does not file a grievance in writing within twenty-five (25) days after which he/she knew, or should have known, of the act on which the grievance is based, then the grievance shall be considered to have been waived.

C. A grievance filed during the last two (2) weeks of school shall be filed at formal Level Two and all preceding levels of the grievance procedure shall be waived by the parties.

D. When a grievance is filed under Section "C" above, the grievance shall be processed during the summer months unless the parties involved mutually agree in writing to suspend the grievance until the start of the next school year.

E. Failure by the aggrieved employee at any level to appeal to the next level within the specified time limits shall be deemed to be acceptance of the decision rendered at that level.

F. Failure by the administrator involved to render a decision within the specified time limits shall be deemed to be a denial of the grievance submitted.

2.4. **Informal Procedure**

A. If an employee feels that he/she may have a grievance, he/she will first discuss the matter with his/her supervisor in an effort to resolve the problem informally, with or without the assistance of the Union.

B. If an employee is not satisfied with such disposition of the matter, he/she shall have the right to have the Union assist him/her in further efforts to resolve the problem informally with the supervisor.

2.5. **Formal Procedure**

A. **Level One - Administrator/Supervisor**

1. If the employee is not satisfied with the outcome of informal procedures, he/ she shall submit his/her claim as a written grievance to his/her supervisor. The written statement of grievance shall contain a statement of the facts, the remedy requested and a reference to that provision of this Agreement which the employee claims has been violated.

2. The supervisor shall, within five (5) days after receipt of the written grievance, render his/her decision and the reasons therefore in writing to the employee, with a copy to the Union.

B. **Level Two - Superintendent of Schools**

1. If the aggrieved employee is not satisfied with the disposition of his/her grievance at Level One, he/she may, within ten (10) days after the decision, file the grievance to the Superintendent of Schools, with a copy to the Union.

2. The Superintendent shall, within five (5) days after the receipt of the grievance,

meet with the aggrieved employee and with a representative of the Union for the purpose of resolving the grievance.

3. The Superintendent shall, within five (5) days after the final hearing, render his/her decision and the reasons therefore, in writing to the aggrieved employee, with a copy to the Union.

C. **Level Three - Board of Education**

1. If the aggrieved employee is not satisfied with the disposition of his/her grievance at Level Two, he/she may, within ten (10) days after the decision, file a grievance to the Board of Education, with a copy to the Union.

2. The Board of Education shall, within ten (10) days after receipt of the appeal, meet with the aggrieved employee and with a representative of the Union for the purpose of resolving the grievance. Minutes of such hearing shall be kept by the Superintendent and made available to any party in interest upon written request.

3. The Board of Education shall, within ten (10) days after the final hearing render its decision and reasons therefore, in writing to the aggrieved employee, with a copy to the Union.

D. **Level Four-Arbitration**

1. In the event the grievance shall not have been satisfactorily settled, the Union or the Board may, within ten (10) days of the decision by the Board, submit the dispute to arbitration by the State Board of Mediation and Arbitration, whose decision shall be final and binding on the Board and the Union.

2. The arbitrator may only hear and decide grievances based upon an alleged misapplication or misinterpretation of the specific terms of this Agreement. The decision of the Board shall be final on all other matters. The arbitrator shall hear and decide only one grievance in each case. He/she shall have no power to add to, delete from, or modify in anyway, any of the provisions of this Agreement. If the Union or the Board submits the grievance to arbitration, the cost of arbitration shall be borne equally by the parties.

2.6. **Miscellaneous**

A. Employees and their representative shall not suffer any loss of pay when involved in processing of grievances.

B. Copies of all documents, communications and records dealing with the process of a grievance shall be filed separately from the personnel files of the participants.

C. Forms for filing and processing grievances are found in the Appendix attached hereto and are made a part of this Agreement. Forms shall be made available through the Union so as to facilitate operation of the grievance procedure.

D. Grievances shall be considered waived unless submitted within twenty-five (25) days of the date the aggrieved knew or should have known of the event or action upon which the grievance is based.

E. No reprisals of any kind shall be taken by either party or by any member of the East Windsor administration or the East Windsor Nurses against any participant in the grievance procedure by reason of such participation.

ARTICLE III
WAGE CLASSIFICATIONS

3.1 All employees who come under this Agreement will come under the following schedule:

Responsibility Group	Classification
I	Registered Nurse (RN)
II	Licensed Practical Nurse (LPN)

ARTICLE IV
WAGES

4.1 The wage schedule is set forth in Appendix "A" and "B" and is part of this contract.

4.2 All personnel shall be placed on a specific step of the wage schedule based on position classification as established in Article III.

4.3 **Wage Increases for RNs**

A. Effective and retroactive to July 1, 2022, all RNs shall receive a 3% General Wage Increase (GWI). Those RNs who did not already receive a 3% GWI shall receive a 3% GWI less the percentage they already received for this respective year to make them whole.

B. Effective and retroactive to July 1, 2023, the parties agree to implement a new four (4) step wage grid as outlined in Appendix A. Each wage step shall have 3% applied to each step, effective and retroactive to July 1, 2023. Each RN shall advance one step if not already at top step. RNs at top step shall receive a 3% GWI. Any RN making more than Step 4 (top step) shall be red circled and receive a 3% GWI.

C. Effective and retroactive to July 1, 2024, each wage step shall have 3% applied to each step. Each RN shall advance one step if not already at top step. RNs at top step shall receive a 3% GWI. Any RN making more than Step 4 (top step) shall be red circled and receive a 3% GWI.

4.4 **Wage Increases for LPNs**

A. Effective and retroactive to July 1, 2022, all LPNs shall be placed into the newly implemented four (4) step wage grid as outlined in Appendix B by rounding up to the next highest step.

B. Effective and retroactive to July 1, 2023, each wage step shall have 3% applied to each step. Each LPN shall advance one step if not already at top step. LPNs at top step shall receive a 3% GWI. Any LPN making more than Step 4 (top step) shall be red circled and receive a 3% GWI.

C. Effective and retroactive to July 1, 2024, each wage step shall have 3% applied to each step. Each LPN shall advance one step if not already at top step. LPNs at top step shall receive a 3% GWI. Any LPN making more than Step 4 (top step) shall be red circled and receive a 3% GWI.

4.5 Longevity payment shall be made to employees who qualify as follows:

10 years of consecutive service, as of September 10 of each year: $275.00
15 years of consecutive service, as of September 10 of each year: $375.00
20 years of consecutive service, as of September 10 of each year: $475.00
25 years of consecutive service, as of September 10 of each year: $525.00
30 years of consecutive service and thereafter, as of September 10 of each year: $800.00

4.6 All longevity payments made in one lump sum in the month of September of each fiscal year.

4.7 The designated Nurse Leader Back-Up shall receive a stipend totaling $2,000 paid bi-annually in the months of December and June.

4.8 Employees (RNs and LPNs) who possess a bachelor's degree shall receive a stipend in the amount of $1,000 paid bi-annually in the months of December and June. Employees (RNs and LPNs) who possess a master's degree shall receive a stipend in the amount of $1,500 paid bi-annually in the months of December and June.

4.9 Nationally certified school nurses shall receive a stipend of $500 at the time they become certified or recertified and shall be reimbursed for the cost of taking the exam.

4.10 Direct deposit of paychecks shall be required for all employees.

ARTICLE V
INSURANCE

5.1 The Board shall annually offer each employee the opportunity to participate in the State Partnership 2.0 Plan (SPP) as outlined in Appendix C for health insurance for individual, employee + 1, family insurance or the employee may elect to waive medical insurance. The plan benefits shall be as set forth in the SPP, including any subsequent amendments or modifications made to the SPP by the state and its employee representatives. The administration of the SPP, including open enrollment, beneficiary eligibility and changes, and other administration provisions shall be as established by the SPP.

Additionally, the Board shall provide dental (as described in Appendix F) and vision (as described in Appendix G) insurance coverage as described for individual, employee + 1, family insurance or the employee may elect to waive dental and/or vision insurance. Employees may participate in the dental and/or vision insurance plan alone without participating in the health insurance plan. Such employees shall pay the same premium cost share percentage of the cost of the dental insurance as is set forth below.

a) The premium rates shall be set by the SPP. Participating employees shall pay premium cost through payroll deduction as follows:

2022-2023: 20%

2023-2024: 20%

2024-2025: 20%

b) The SPP contains a Health Enhancement Plan (HEP) component as outlined in Appendix D. All employees participating in the SPP are subject to the terms and provisions of the HEP. ln the event SPP administrators impose the HEP non-participation or noncompliance $100 per month premium cost increase or the $350 per participant to a maximum of $1,400 family annual deductible, those sums shall be paid 100% in their entirety by the non-participating or non-compliant employee. No portion or percentage shall be paid by the Board. The $100 per month premium cost increase shall be implemented through payroll deduction, and the $350/$1400 annual deductible shall be implemented through claims administration.

c) ln the event any of the following occur, the Board or the Union may reopen negotiations in accordance with Conn. Gen. Stat. Section 7-473b(c) as to the sole issue of health insurance, including plan design and plan funding, premium cost share and/or introduction of replacement medical insurance in whole or in part.

i. If the SPP in its current form is no longer available; or if the benefit plan design of the SPP is modified as a result of a change in the state's collective bargaining agreement with SEBAC, if such modifications would substantially increase the cost of the medical insurance plan offered herein. Reopener negotiations shall be limited to health insurance plan

design and funding, premium cost share and/or introduction of an additional optional health insurance plan; and/or

ii. If Conn Gen. Stat. Section 3-123rrr et seq. is amended, or if there are any changes to the administration of the SPP or if additional fees and/or charges for the SPP are imposed so as to affect the Board, any of which amendments, changes, fees or charges (individually or collectively) would substantially increase the cost of the medical insurance plan offered herein. Reopener negotiations shall be limited to health insurance plan design and funding, premium cost share and/or introduction of an additional optional health insurance plan; and/or

iii. If there is any material amendment to the ACA that would substantially increase the cost of the medical insurance plan offered herein. Reopener negotiations shall be limited to health insurance plan design and funding, premium cost share and/or introduction of an additional optional health insurance plan.

iv. If the SPP is revised to create different plan design options. Reopener negotiations shall be limited to health insurance plan design and funding, premium costshare and/or introduction of an additional optional health insurance plan.

Requests for participation must be submitted in writing to the Board within thirty (30) days after employment or the beginning of the school year and shall be binding for the balance of that school year. Any increase in the cost of said insurance shall be communicated to all participating employees not less than thirty (30) days before such increase is to become effective. ln the event the Board shall fail to notify any employee of such an increase and such employee then desires to cancel his/her coverage, the Board shall be responsible and indemnify the employee for any such increase for which he/she is obligated to pay until his/her termination is effective, or thirty (30) days whichever is shorter.

5.2 The Board shall provide and pay for the full cost of life insurance for each employee in the amount of $50,000.

5.3 Employees shall notify the East Windsor-Human Resource Department, in writing, of their choice for health insurance by the first day of June of each year.

5.4 The Board has the right to change carriers provided coverage is comparable and employee's out-of-pocket expense is no greater than it would have been in the absence of a change.

5.5 The Board and the Union agree to create the IRS Section 125 for premium costs.

5.6 School nurses will not be required to transport any child during the school day.

ARTICLE VI
JOB SECURITY

6.1 After an employee has successfully served a ninety (90) day probationary period, he/she shall be appointed to his/her position.

6.2 Probationary employees cannot utilize the grievance procedure during their period of probation.

6.3 Probationary periods may be extended by mutual agreement of the parties.

ARTICLE VII
EMERGENCY CLOSING OF SCHOOLS

7.1. If school has started, and there is an unscheduled early dismissal, Nurses will be sent home after students are dismissed and all school buses have departed and will receive their full pay for the day.

7.2. On scheduled early release days, nurses will be sent home after students are dismissed and all school buses have departed. However, if any nurse is required to stay in school and earn a full day's pay then all nurses shall be offered the same opportunity to remain at work and earn a full day's pay.

7.3. If the opening of school is delayed, employees shall report to work at the delayed time and shall receive full pay for the scheduled workday.

ARTICLE VIII
HOLIDAYS AND EARLY RELEASE TIME

8.1. LPNs shall receive ten (10) paid holidays, which will be Martin Luther King Day, Good Friday, Memorial Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Day, New Year's Day, President's Day, and a floating holiday*.

8.2. If a holiday falls on a Saturday or Sunday, it will be observed on the date as scheduled in the school calendar.

8.3. Employees shall be entitled to early release at the half-day dismissal time at the school they are assigned to without loss of pay, on the day before Thanksgiving, provided it is so scheduled in the school calendar.

8.4. In the event a payday occurs on a holiday when employees are not scheduled to work, paychecks will be issued on the last workday preceding the holiday.

*Upon prior approval by the Superintendent of Schools or his/her designee.

ARTICLE IX
SICK LEAVE

9.1. Employees will be allowed fifteen (15) days of absence due to personal illness without loss of pay. Unused sick leave may be accumulated to a maximum of one hundred fifty (150) days. Sick leave in the amount of fifteen (15) days will be added to any prior accrued sick leave each July 1st. Those Nurses starting after September 30th shall have their amount prorated and added upon their start date. Three (3) sick days of the allotted fifteen (15) per year, may be used for the care of immediate family, as defined in the Bereavement Leave Article.

9.2. A physician's certificate may be required by the Administration, after three (3) or more consecutive days of absence, or in the case of suspected abuse.

9.3. If an employee is absent because of an illness due to a childhood communicable disease definitely traceable to contact made in school, the absence shall not be charged against the employee's sick leave. The decision of the Superintendent regarding whether the disease is definitely traceable to contact made in school shall be final, and shall not be subject to the grievance procedure.

ARTICLE X
BEREAVEMENT LEAVE

10.1. In the event of a death in an employee's immediate family, it is recognized by the parties that the employee may need time off to grieve and/or attend the funeral service from the day of the death to the day of the funeral. If any of these days occur on the employee's scheduled working days, the employee shall suffer no loss in pay, exclusive of overtime, but not to exceed a maximum of three (3) days of absence for each occurrence.

10.2. Immediate family is defined as:

Spouse
Child
Parent
Sibling
Grandparent
Grandchild
Father-in-law and Mother-in-law
Brother-in-law and Sister-in-law
Any blood relative domiciled in employee's home

ARTICLE XI
JURY DUTY

11.1 Any employee who is called for jury duty shall receive the necessary leave to fulfill this legal

obligation. This leave shall not be deducted from sick leave or personal days. The amount of compensation received for duty, excluding traveling expenses, shall be deduct- ed from the staff member's wages. In any event, the employee shall not receive less than the normal day's pay. If the employee is excused from the court on any scheduled working day prior to 12:00 noon or who is not required to be in court on any scheduled working day while serving on jury duty, the employee shall report to school for work.

ARTICLE XII
PERSONAL LEAVE

12.1. In the event an employee has personal business which cannot be transacted other than during the school day, an annual maximum of three (3) days of leave may be granted at full pay. Such days may be taken on a half-day basis. All three (3) days shall be discretionary, requiring no notice to the employer of the reason for such leave.

12.2. Such leave is not cumulative from year to year.

12.3. Advance approval by the Superintendent of Schools or his/her designee is required.

12.4. Personal leave cannot be used to extend vacation periods or holidays.

ARTICLE XIII
EMERGENCY LEAVE

13.1. In cases of emergency which must be attended to during the school day, an annual maximum of one (1) day of leave will be granted.

13.2. Such leave is not cumulative.

13.3. Prior notification to the Nurse Leader is required where applicable and possible.

13.4. After the fact approval by the Superintendent or his/her designee is required.

ARTICLE XIV
NO WORK STOPPAGES

14.1 Neither the Union nor any of the employees in the bargaining unit shall call, authorize, instigate, sanction, condone or participate in any strike, slowdown, work stoppage, refusal to render services or any action against the Board which would impede the proper functioning of the school system at any time, nor shall there be any lockout by the Board in any part of the Board's operation.

ARTICLE XV
POSTING OF VACANCIES

15.1 Notice of vacancies and/or new positions shall be on the district's website for five days. Any

internal candidate applying shall be granted an interview. The Superintendent and/or designee shall select the successful candidate from among all applicants.

ARTICLE XVI
REVIEW OF PERSONNEL FOLDER

16.1 Employees desiring to review their official personnel folder will be permitted to do so by making an appointment with Human Resources.

ARTICLE XVII
DISPLAY OF UNION MATERIAL

17.1 The Board shall provide space in each school office and the Central office for the display of Union material.

ARTICLE XIII
UNION MEETINGS

18.1 The Union may call meetings in each school whenever necessary, providing they do not leave their work stations before all nurses have completed their duties, including emergency duties, prior to the commencement of the meeting. The Union shall comply with the Board policy concerning reservation of rooms.

ARTICLE XIX
HOURS OF EMPLOYMENT

19.1. Employees shall work student school days plus at least four (4) days and up to nine (9) days, the exact number of days to be left to the nurse's discretion with consultation with the nurse leader. Work days shall fall between Monday and Friday. Employees are required to attend professional development sessions scheduled by the Board on early release days and on the day prior to the start of school.

19.2. All employees are entitled to a 30-minute uninterrupted lunch period.

19.3. Nurses are required to attend all professional development training unless notified by Administrators. Attendance for professional development trainings not deemed required by administrators shall be optional, individuals who attend shall be paid their regular hourly rate.

19.4. The starting time for school nurses shall be 15 minutes prior to the scheduled start of the students' school day and the dismissal time shall be the later of either the 15 minutes following the dismissal of students or the departure of the last regular East Windsor school bus. In cases of emergency the decision of the Superintendent will supersede.

19.5. If the Board lengthens the student school day and/or nurse work day beyond the work day set forth above, or requires work on non-student school days, then the Board and the Union will

immediately commence impact bargaining over any substantial impacts identified by the Union as a result of the Board's implementation of a longer student school day and/or nurse work day. Any agreed upon resolution as to the impact of the Board's implementation of a longer student school day and/or nurse work day shall be retroactive to the date of implementation.

ARTICLE XX
MISCELLANEOUS

20.1. This Agreement may be reopened at any time on any matter providing the Board and the President of the Union agree that it should be reopened. Any modification of this Agreement will be ineffective until approved by both the Board and the Union and made an addendum or amendment to the existing Agreement.

20.2. Since continuous professional growth must be recognized and encouraged, if the system is to remain vital and capable of meeting all its challenges, an amount not to exceed $3,500 per year shall be made available to the nursing staff. The funds are to be used accordingly:

a. Tuition costs of nurses seeking a degree in nursing or allied health.

ARTICLE XXI
PENSION

21.1 All bargaining unit members shall participate in the Board of East Windsor Pension Plan. The Board does not control or administer this Plan.

ARTICLE XXII
DURATION

22.1 The terms of this Agreement shall be effective as of the first day of July, 2022 and shall continue and remain in full force and effect to and including the 30th day of June, 2025.

22.2 If either the Board or the Union desires to meet for the purpose of negotiating changes or modifications in the provisions of this Agreement, either shall give written notice of such desire to the other by certified or registered mail not less than one hundred twenty (120) days prior to the expiration of the Agreement.

ARTICLE XXIII
SAVINGS CLAUSE

23 .1 It is agreed that if any section, clause or phrase of this Agreement is found illegal, then such findings will have no effect on any of the remaining portions or provisions of this Agreement.

ARTICLE XXIV
LAYOFF, RECALL AND TRANSFERS

24.1 In the event it becomes necessary to eliminate positions, the following procedure shall be followed in selecting the employees to be laid off. The Union shall be notified in writing of the need for position elimination by July 31st or as soon as possible following the adoption of a Board budget and before any determination shall be made of the individual employee to be laid off. Layoffs shall occur within classification only, with the least senior employee in the affected classification to be laid off first.

A. Retirement, resignations, transfer requests and termination for cause among personnel will first be reviewed to determine if the staff may be reduced in sufficient number or adjusted to avoid further layoff of employees.

B. If additional employees must be released, the probationary employees shall be terminated on a system wide basis before any permanent employees shall be terminated, provided that the permanent employee is qualified to perform the duties of the available position as set forth in subsection D below. In determining who, among two (2) or more employees in the area of reduction, shall be laid off, seniority as well as performance and ability shall be considered.

C. If, after the above steps, it is necessary to terminate the employment of permanent employees, the least senior employee within the responsibility group classification when the layoff will occur shall be terminated first.

D. Permanent employees who are laid off shall be entitled to replace probationary employees outside of their responsibility group classification assignment provided that the permanent employee is qualified by experience or training to perform the duties of the probationary employee.

E. Any employee that is terminated shall be notified in writing by the Superintendent of Schools.

24.2 Seniority is defined as the total number of complete years of service in the East Windsor School system, starting with the first full month of employment. In the event that two or more employees shall have started work in the same month and thus have the same seniority date, then the identity of the employee to be laid off shall be determined by a review of performance and ability as evidenced by the most recent written evaluations contained in the employee's personnel file. If such review indicates that the performance and ability of the employees with the same seniority dates is substantially equal, the actual date of hire shall control.

24.3 Nothing herein shall require the transfer or promotion of an employee to a higher responsibility group classification or to a higher rate of pay.

24.4 Recall Procedure:

A. The name of any employee who has been laid off because of the elimination of a position or a reduction in personnel shall be placed upon a reappointment list and remain on such a list for two (2) years, provided such employee does not refuse an appointment.

B. Any employee on the reappointment list shall receive a written offer of reappointment, by certified mail to the employee's last known address and by email to the employee's personal email address, with the labor relations representative copied on that email, at least fifteen (15) days prior to the date of reemployment. The employee shall accept or reject the appointment within ten (10) days. If he/she accepts the appointment, he/she shall receive written notice at least five (5) days prior to the date of reemployment, where possible.

C. An employee who is recalled shall retain credit for all previous years of service for retirement and seniority purposes and shall also retain credit for all other accrued time, benefits and rights existing on the date of layoff.

24.5 When it is necessary or desirable to transfer a bargaining unit member, including part- timers, from one school to another, the notice of transfer shall be given in writing with reason(s) to the bargaining unit member involved as soon as practicable and under normal circumstances not later than July 1st, if the transfer is to take place in the next school year. Notification of the anticipated assignment may be changed during the summer if circumstances arise which necessitate the change. In that event the bargaining unit member will be notified in writing as soon as practicable which notice shall state the reason or reasons for such change. An employee who has successfully completed the probationary period and who requests a transfer shall only be required to submit an abbreviated application together with names of references.

24.6 When an employee is involuntarily transferred and the Board seeks to fill a position, the Board will fill the position the employee was involuntarily transferred into, not the position the employee was transferred from. Once the position is filled, the employee will be restored to his/her original position. Nothing herein shall prohibit the employee from applying for the position he/she was involuntarily transferred into.

ARTICLE XXV
UNION SECURITY

25.1 During the life of this Agreement, an employee retains the freedom of choice whether or not to become a member of the Union.

25.2 Union dues shall be deducted by the Board of Education from the paycheck of each employee who signs and remits to the Board a written authorization form. Such deduction shall be discontinued upon notification from the Union.

25.3 The parties acknowledge and agree that the term "written authorization" as provided in this

Agreement includes authorizations created and maintained by use of electronic records and electronic signatures consistent with state and federal law. The Union, therefore, may use electronic records to verify Union membership, authorization for voluntary deduction of Union dues and fees from wages or payments for remittance to the Union, subject to the requirements of state and federal law. The Board shall accept confirmations from the Union that the Union possesses electronic records of such membership and give full force and effect to such authorizations as "written authorization" for purposes of this Agreement.

25.4 Upon receipt of a membership list submitted by the Union, the Board agrees to verify within ten (10) days via electronic notification that the Board's records accurately reflect the membership status of each employee listed in the membership list provided by the Union. The Board shall identify any discrepancies between the membership list and its records.

25.5 The amount of dues deducted under this Article shall be remitted on or before the last day of the month following the calendar month in which deductions are made to UPSEU, 3555 Veterans Highway, Ste H, Ronkonkoma, NY 11779, together with a list of all bargaining unit employees, jobs classification, amount of dues deducted and their addresses for whom any such deduction is made.

25.6 The organization agrees to indemnify and to hold the Board harmless against any and all claims, demands, suits or other forms of liability that shall, or may arise out of, or by reason of, action taken by the Union for the purpose of complying with the provisions of this Article.

25.7 The East Windsor Board of Education and the Union agree not to discriminate in any way against employees covered by the Agreement on account of race, religion, creed, color, national origin, age, or political affiliation.

25.8 The Board shall comply with all applicable laws regarding union access to employees, as amended from time to time.

25.9 The Employer shall provide the UPSEU Labor Relations Representation in writing via email within ten (10) days the following information as it relates to new hires: (1) first & last name; (2) job title/work location/department; (3) pay rate (4) work phone number; (5) work email address; and (6) home address.

25.10 In accordance with Public Act 21-25, the above information shall also be provided to the Union for all employees as well and additionally the following shall be applicable:

- The above information shall be provided in an editable digital file format via Microsoft Excel. If possible, the District shall also provide the information with real-time electronic transmission of new hire data, but no later than 10 days after the employee was hired or the first pay period of the month after the employee was hired, whichever is earlier.

- The Union shall be given access to new employee orientations.

- The District shall provide the Union with access to the Nurses, including the right to:

    - Meet with individual employees on the District's premises during

workdays to investigate and discuss grievances, workplace-related complaints, and other workplace issues;

- Conduct worksite meetings on the District's premises before and after the workday and during meal periods and other paid or unpaid breaks; and

- Meet with a newly hired employee within the bargaining unit, without charge to the employee's pay or leave time, for between 30 and 120 minutes within 30 calendar days after the employee is hired, during orientations, or if the employer does not hold orientations, at individual or group meetings.

ARTICLE XXVI
OVERTIME

26.1 LPNs shall receive one and one-half times the hourly rate of pay for all hours worked in excess of 40 hours per week.

ARTICLE XXVII
RIGHTS AND RESPONSIBILITIES OF THE BOARD OF EDUCATION

27.1 Unless expressly and specifically limited, modified, abridged or relinquished by a specific provision of this Agreement, and whether exercised or not, the rights, powers, and authority heretofore held by the Board of Education, pursuant to any charter, general or special statutes, ordinance, regulation, or other lawful provision, under the complete operations, practices, procedures, and regulations with respect to employees of the Board, shall remain solely and exclusively in the Board, including, but not limited to the following:

To determine the standards of service to be offered by Board employees; to determine the standards of selection for Board employment; direct its employees; take disciplinary action; relieve its employees from duty because of lack of work or other legitimate reasons; issue rules and regulations; maintain efficiency of governmental operations; determine work schedules; determine the methods, means, and personnel by which the Board's operations are to be conducted; determine the content of job classifications; exercise complete control and discretion over its organization and technology of performing its work; and fulfill its legal responsibilities.

Such rights, powers, and responsibilities shall be exercised in a reasonable manner so as not to be arbitrary or capricious. If any conflict occurs between this Article and any other Articles in this Agreement, the latter shall govern. The Board agrees to comply with the Municipal Employees Relations Act in regard to its obligations to negotiate with the Union over mandatory subjects of bargaining.

ARTICLE XXVIII
KEYFOBS

28.1 All employees shall be issued a key fob to their respective building upon the passing of their

probationary period.

ARTICLE XXVIX
DISTRIBUTION OF NEW HIRE PACKET

29.1 The Board and the Union agree that the Board shall provide, at the time of hire, a Union New Hire Packet to all new employees. The Union New Hire Packet may include, but shall not be limited to, a welcome letter, Local Union history, this Agreement and any memoranda of understanding, a membership application, a list of member-only benefits, con- tact information of local union officers and stewards, and new employee FAQs that explain this Agreement. The Union New Hire Packet will be furnished by the Union.

If an employee chooses to complete a membership application during the new hire process, the Board shall collect the membership application and transmit it to the Union.

SIGNATURE BLOCK

In witness whereof, the parties hereunto have caused these presents to be executed by their prop- er officers, hereunto duly authorized and their seals affixed hereto as of the date and year first above written.

East Windsor Board of Education

By: Patricia Tudyn 4/24/23
Superintendent of Schools Date

By: 4/24/2023
Chairman, Board of Education Date

East Windsor BOE Nurses
UPSEU Local 424, Unit 132

By: 4/10/23
UPSEU President Date

By: MaryAnn Straney 4/18/23
Unit President Date

APPENDIX A – RN WAGES

RNs

A. Effective and retroactive to July 1, 2022, all RNs shall receive a 3% General Wage Increase (GWI). Those RNs who did not already receive a 3% GWI shall receive a 3% GWI less the percentage they already received for this respective year to make them whole.

B. Effective and retroactive to July 1, 2023, the parties agree to implement a new four (4) step wage grid as outlined below with a starting point (prior to GWI) of Step 1 being $52,000, Step 2 being $54,000, Step 3 being $56,000 and Step 4 being $58,000. Each wage step shall then have 3% applied to each step, effective and retroactive to July 1, 2023. Each RN shall be placed into the newly implemented four (4) step wage grid as outlined below by rounding up to the next highest step. Each RN shall advance one step if not already at top step. RNs at top step shall receive a 3% GWI. Any RN making more than Step 4 (top step) shall be red circled and receive a 3% GWI.

STEP	Salary
1	$53,560
2	$55,620
3	$57,680
4	$59,740

C. Effective and retroactive to July 1, 2024, each wage step shall have 3% applied to each step. Each RN shall advance one step if not already at top step. RNs at top step shall receive a 3% GWI. Any RN making more than Step 4 (top step) shall be red circled and receive a 3% GWI.

STEP	Salary
1	$55,167
2	$57,289
3	$59,410
4	$61,532

APPENDIX B – LPN WAGES

LPNs

A. Effective and retroactive to July 1, 2022, each LPN shall be placed be placed into the newly implemented four (4) step wage grid as outlined below by rounding up to the next highest step.

STEP	Hourly Rate
1	$24.00
2	$26.00
3	$28.00
4	$30.00

B. Effective and retroactive to July 1, 2023, each wage step shall have 3% applied to each step. Each LPN shall advance one step if not already at top step. LPNs at top step shall receive a 3% GWI. Any LPN making more than Step 4 (top step) shall be red circled and receive a 3% GWI.

STEP	Hourly Rate
1	$24.72
2	$26.78
3	$28.84
4	$30.90

C. Effective and retroactive to July 1, 2024, each wage step shall have 3% applied to each step. Each LPN shall advance one step if not already at top step. LPNs at top step shall receive a 3% GWI. Any LPN making more than Step 4 (top step) shall be red circled and receive a 3% GWI.

STEP	Hourly Rate
1	$25.46
2	$27.58
3	$29.71
4	$31.83

APPENDIX C – SPP 2.0 PLAN OVERVIEW

A Great Opportunity for Very Valuable Healthcare Coverage

Welcome to the Connecticut (CT) Partnership Plan—a low-/no-deductible Point of Service (POS) plan now available to you (and your eligible dependents up to age 26) and other non-state public employees who work for municipalities, boards of education, quasi-public agencies, and public libraries.

The CT Partnership Plan is the same POS plan currently offered to State of Connecticut employees. You get the same great healthcare benefits that state employees get, including $15 in-network office visits (average actual cost in CT: $150*), free preventive care, and $5 or $10 generic drug copays for your maintenance drugs. You can see any provider (e.g., doctors, hospitals, other medical facilities) you want—in- or out-of network. But, when you see in-network providers, you pay less. That's because they contract with Anthem Blue Cross and Blue Shield (Anthem)—the plan's administrator—to charge lower rates for their services. You have access to Anthem's State Bluecare POS network in Connecticut, and access to doctors and hospitals across the country through the BlueCard® program.

When you join the CT Partnership Plan, the state's Health Enhancement Program (HEP) is included. HEP encourages you to get preventive care screenings, routine wellness visits, and chronic disease education and counseling. When you remain compliant with the specific HEP requirements on page 5, you get to keep the financial incentives of the HEP program!

Look inside for a summary of medical benefits, and visit www.anthem.com/statect to find out if your doctor, hospital or other medical provider is in Anthem's network. Information about the dental plan offered where you work, and the amount you'll pay for healthcare and dental coverage, will be provided by your employer.

*Source: Healthcare Bluebook: healthcarebluebook.com

www.osc.ct.gov/ctpartner

CONNECTICUT PARTNERSHIP PLAN

POS MEDICAL BENEFIT SUMMARY

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
Preventive Care (including adult and well-child exams and immunizations, routine gynecologist visits, mammograms, colonoscopy)	$0	20% of allowable UCR* charges
Annual Deductible (amount you pay before the Plan starts paying benefits)	Individual: $350 Family: $350 per member ($1,400 maximum) ***Waived for HEP-compliant members***	Individual: $300 Family: $900
Coinsurance (the percentage of a covered expense you pay ***after*** you meet the Plan's annual deductible)	Not applicable	20% of allowable UCR* charges
Annual Out-of-Pocket Maximum (amount you pay before the Plan pays 100% of allowable/UCR* charges)	Individual: $2,000 Family: 4,000	Individual: $2,300 (includes deductible) Family: $4,900 (includes deductible)
Primary Care Office Visits	$15 copay ($0 copay for Preferred Providers)	20% of allowable UCR* charges
Specialist Office Visits	$15 copay ($0 copay for Preferred Providers)	20% of allowable UCR* charges
Urgent Care & Walk-In Center Visits	$15 copay	20% of allowable UCR* charges
Acupuncture (20 visits per year)	$15 copay	20% of allowable UCR* charges
Chiropractic Care	$0 copay	20% of allowable UCR* charges
Diagnostic Labs and X-Rays[1] ** High Cost Testing (MRI, CAT, etc.)	$0 copay (your doctor will need to get prior authorization for high-cost testing)	20% of allowable UCR* charges (you will need to get prior authorization for high-cost testing)
Durable Medical Equipment	$0 (your doctor may need to get prior authorization)	20% of allowable UCR* charges (you may need to get prior authorization)

1 IN NETWORK: Within your carrier's immediate service area, no co-pay for preferred facility. 20% cost share at non-preferred facility.
Outside your carrier's immediate service area: no co-pay.

1 OUT OF NETWORK: Within your carrier's immediate service area, deductible plus 40% coinsurance.
Outside of carrier's immediate service area: deductible plus 20% coinsurance.

(continued on next page) 2

CONNECTICUT PARTNERSHIP PLAN

POS MEDICAL BENEFIT SUMMARY

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Care	$250 copay (waived if admitted)	$250 copay (waived if admitted)
Eye Exam (one per year)	$15 copay	50% of allowable UCR* charges
**Infertility (based on medical necessity)		
Office Visit	$15 copay	20% of allowable UCR* charges
Outpatient or Inpatient Hospital Care	$0	20% of allowable UCR* charges
**Inpatient Hospital Stay	$0	20% of allowable UCR* charges
Mental Healthcare/Substance Abuse Treatment		
**Inpatient	$0	20% of allowable UCR* charges (you may need to get prior authorization)
Outpatient	$15 copay	20% of allowable UCR* charges
Nutritional Counseling (Maximum of 3 visits per Covered Person per Calendar Year)	$0	20% of allowable UCR* charges
**Outpatient Surgery	$0	20% of allowable UCR* charges
**Physical/Occupational Therapy	$0	20% of allowable UCR* charges, up to 60 inpatient days and 30 outpatient days per condition per year
Foot Orthotics	$0 (your doctor may need to get prior authorization)	20% of allowable UCR* charges (you may need to get prior authorization)
Speech therapy: Covered for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx	$0	Deductible plus Coinsurance (30 visits per Calendar Year)
Medically necessary treatment resulting from other causes is subject to Prior Authorization	$0 (30 visits per Covered Person per Calendar Year)	Deductible plus Coinsurance (30 visits per Calendar Year)

*Usual, Customary and Reasonable. You pay 20% coinsurance based on UCR, plus you pay 100% of amount provider bills you over UCR.

** Prior authorization required: If you use in-network providers, your provider is responsible for obtaining prior authorization from Anthem. If you use out-of-network providers, you are responsible for obtaining prior authorization from Anthem

Be the picture of health

Check out these programs and services to be your healthy best

Need a doctor? Choose a State of Connecticut preferred doctor and save

When you see a Primary Care Physician (PCP) or specialist in your State of Connecticut preferred network (also referred to as Tier 1 in your health plan), there's no office visit copay. These doctors cost less than doctors outside of your plan.

- Visit **anthem.com/statect** and choose **Find a Doctor.**
- Call the Enhanced Member Service Unit at 1-800-922-2232, for more information or to find out if your doctor is in Tier 1.

Use Site-of-Service providers to get 100% coverage for lab tests, X-rays, and high-cost imaging

Site-of-Service (SOS) providers give you 100% coverage with a $0 copay. Your plan will cover only 80% of the cost when you get these services from other providers.

- Call the Enhanced Member Service Unit at 1-800-922-2232 to learn more.

Find support for mental health issues

If you or a family member needs mental health or substance use care or treatment, we have specialists and designated programs that can help and/or direct you to the type of care that you need.

- Call an Anthem Behavioral Health Care Manager at 1-888-605-0580.
- Visit **anthem.com/statect.**

See a doctor, psychologist or therapist from home or work with LiveHealth Online

With LiveHealth Online you can see a board-certified doctor on your smartphone, tablet or computer with a webcam. Doctors can assess your health, provide treatment options and send a prescription to the pharmacy of your choice, if needed.[2] If you're feeling stressed, worried or having a tough time, you can see a licensed psychologist or therapist through LiveHealth Online Psychology. It's private and in most cases you can see a therapist within 4 days or less.[3]

- Learn more and enroll at **livehealthonline.com** or use the free mobile app.

How to find care right away when it's not an emergency

The emergency room shouldn't be your first stop — unless it's a true emergency (then, call 911 or go to the ER). Depending on the situation, there are different types of providers you can see if your doctor isn't available.

- Visit a walk-in doctor's office, retail health clinic or urgent care center.
- Have a video visit with a doctor through LiveHealth Online.
- Call 24/7 NurseLine at 1-800-711-5947 to speak with a nurse about symptoms or get help finding the right care.

Get access to care wherever you go

If you travel out of Connecticut, but are in the U.S., you have access to doctors and hospitals across the country with the BlueCard® program. If you travel out of the U.S., you have access to providers in nearly 200 countries with the Blue Cross and Blue Shield Global Core® program.

- Call 1-800-810-BLUE (2583) to learn more about both programs. If you're outside the U.S., call collect at 1-804-673-1177.[3]

It's easy to manage your benefits online and on the go

- Find a doctor, check your claims and compare costs for care near you at anthem.com/statect.
- Use our free mobile app (search "Anthem Blue Cross and Blue Shield" at the App Store℠ or Google Play™) for benefit information and to show your ID card, get directions to a doctor or urgent care center and much more

Customer service helps you get answers and much more

The State of Connecticut Enhanced Member Service Unit can give you information on benefits, wellness programs and services and everything mentioned in this flier.

- Call them at 1-800-922-2232.
- Visit **anthem.com/statect.**

1 Designated as Tier 1 in our Find a Doctor tool. Eligible specialties include allergy and immunology, cardiology, endocrinology, ear nose and throat (ENT), gastroenterology, OB/GYN, ophthalmology, orthopedic surgery, rheumatology and urology.
2 Prescription availability is defined by physician judgment and state regulations
3 Appointments subject to availability of therapist.
4 Blue Cross Blue Shield Association website Coverage Home and Away (accessed March 2019): bcbs.com/already-a-member/coverage-home-and-away.html.
LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
59142CTHENABS Rev. 03/19

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With LiveHealth Online you can see a board-certified doctor on your smartphone, tablet or computer with a webcam. Doctors can assess your health, provide treatment options and send a prescription to the pharmacy of your choice, if needed.[2] If you're feeling stressed, worried or having a tough time, you can see a licensed psychologist or therapist through LiveHealth Online Psychology. It's private and in most cases you can see a therapist within 4 days or less.[3]

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2 Prescription availability is defined by physician judgment and state regulations.
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CONNECTICUT PARTNERSHIP PLAN

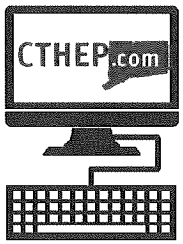
HEALTH ENHANCEMENT PROGRAM

The Health Enhancement Program (HEP) is a component of the medical plan and has several important benefits. First, it helps you and your family work with your medical providers to get and stay healthy. Second, it saves you money on your healthcare. Third, it will save money for the Partnership Plan long term by focusing healthcare dollars on prevention.

Health Enhancement Program Requirements

You and your enrolled family members must get age-appropriate wellness exams, early diagnosis screenings (such as colorectal cancer screenings, Pap tests, mammograms, and vision exams). Here are the 2022 HEP Requirements:

PREVENTIVE SCREENINGS	AGE						
	0 - 5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50-64: Every 3 years 65+: Every 2 years
Dental Cleanings	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 5 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	N/A	**1 screening between age 45-49**	As recommended by physician
Cervical Cancer Screening	N/A	N/A	**Pap smear every 3 years (21+)**	**Pap smear every 3 years**	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	40-44: N/A 45+: Colonoscopy every 10 years, Annual FIT/FOBT to age 75 or Cologuard screening every 3 years	



The Health Enhancement Program features an easy-to-use website to keep you up to date on your requirements.

CONNECTICUT PARTNERSHIP PLAN

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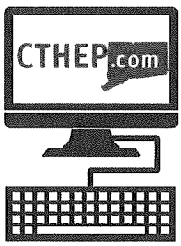
Dental Cleanings	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 5 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	N/A	**1 screening between age 45-49**	As recommended by physician
Cervical Cancer Screening	N/A	N/A	**Pap smear every 3 years (21+)**	**Pap smear every 3 years**	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	40-44: N/A 45+: Colonoscopy every 10 years, Annual FIT/FOBT to age 75 or Cologuard screening every 3 years	



The Health Enhancement Program features an easy-to-use website to keep you up to date on your requirements.

Additional Requirements for Those With Certain Conditions

If you or any enrolled family member has 1) Diabetes (Type 1 or 2), 2) asthma or COPD, 3) heart disease/heart failure, 4) hyperlipidemia (high cholesterol), or 5) hypertension (high blood pressure), you and/or that family member will be required to participate in a disease education and counseling program for that particular condition. You will receive free office visits and reduced pharmacy copays for treatments related to your condition.

These particular conditions are targeted because they account for a large part of our total healthcare costs and have been shown to respond particularly well to education and counseling programs. By participating in these programs, affected employees and family members will be given additional resources to improve their health.

If You Do Not Comply with the requirements of HEP

If you or any enrolled dependent becomes non-compliant in HEP, your premiums will be $100 per month higher and you will have an annual $350 per individual ($1,400 per family) in-network medical deductible.

Care Management Solutions, an affiliate of ConnectiCare, is the administrator for the Health Enhancement Program (HEP). The HEP participant portal features tips and tools to help you manage your health and your HEP requirements. You can visit www.cthep.com to:

- View HEP preventive and chronic requirements and download HEP forms
- Check your HEP preventive and chronic compliance status
- Complete your chronic condition education and counseling compliance requirement
- Access a library of health information and articles
- Set and track personal health goals
- Exchange messages with HEP Nurse Case Managers and professionals

You can also call Care Management Solutions to speak with a representative.

Care Management Solutions
(877) 687-1448 Monday – Thursday, 8:00 a.m. – 6:00 p.m. Friday, 8:00 a.m. – 5:00 p.m.

Office of the State Comptroller, Healthcare Policy & Benefit Services Division

www.osc.ct.gov/ctpartner
860-702-3560

Anthem Blue Cross and Blue Shield

www.anthem.com/statect
Enhanced Dedicated Member Services: ***1-800-922-2232***

Caremark (Prescription drug benefits)

www.caremark.com
1-800-318-2572

CIGNA (Dental and Vision Rider benefits)

www.cigna.com/stateofct
1-800-244-6224

Health Enhancement Program (HEP) Care Management Solutions
(an affiliate of ConnectiCare)

www.cthep.com
1-877-687-1448

For details about specific plan benefits and network providers, contact the insurance carrier. If you have questions about eligibility, enrolling in the plans or payroll deductions, contact your Payroll/Human Resources office.

8

APPENDIX D – SPP 2.0 SUMMARY OF BENEFITS & COVERAGE

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
State of Connecticut: Standard Access Partnership Plan

Coverage Period: 7/01/2022 – 06/30/2023
Coverage for: Individual/Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.osc.ct.gov/anthemctpartner. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.cciio.cms.gov or call Anthem Blue Cross and Blue Shield at 1-800-922-2232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$350**/individual; **$1,400**/family; **waived for HEP members** Out-of-network: **$300**/Individual; **$900**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Once you or a family member meets the individual deductible amount, the plan begins to pay for you or that family member. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network primary care and specialist office visits, in-network preventive care, prescription drugs, emergency room care, in-network urgent care, in-network mental health and substance abuse outpatient services, and in-network eye exams are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: In-network: **$2,000**/individual; **$4,000**/family; Out-of-network **$2,300**/individual; **$4,900** family Prescription drugs: **$4,600**/individual; **$9,200**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.osc.ct.gov/anthemctpartner or call 1-800-922-2232 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copay** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Preferred In-Network Provider (You will pay the least)	What You Will Pay: In-Network Provider	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge. Deductible does not apply.	$15 copay/visit. Waived if no in-state preferred provider. Deductible does not apply.	20% coinsurance	None.
	Specialist visit	No charge. Deductible does not apply.			
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.		You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	40% coinsurance	Prior authorization required to avoid penalty: lesser of $500/20% of cost.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.osc.ct.gov/benefits/pharmacy.htm	Generic drugs	Preferred generic: Retail: $5 copay/fill; Mail order & maintenance drugs: $5 copay/fill. Non-preferred generic: Retail: $10 copay/fill; Mail order & maintenance drugs: $10 copay/fill.		20% coinsurance for non-participating pharmacy	Retail: 30-day supply; Mail order: 90-day supply. Deductible does not apply to prescription drugs. Check details of your Rx coverage at: www.osc.ct.gov/benefits/pharmacy.htm. Maintenance drugs must be filled by mail order or by Maintenance Network pharmacy after first retail fill. Penalty may apply if brand name drug is requested when a generic is available. Some drugs require prior authorization. No charge for preventive care drugs or FDA-approved generic contraceptives (or brand name contraceptives if generic is medically inappropriate).
	Preferred brand drugs	Retail: $25 copay/fill; Mail order & maintenance drugs: $25 copay/fill.		20% coinsurance for non-participating pharmacy	
	Non-preferred brand drugs	Retail: $40 copay/fill; Mail order & maintenance drugs: $40 copay/fill.		20% coinsurance for non-participating pharmacy	
	Specialty drugs	No charge for specialty drugs if enrolled in PrudentRx program. Same as non-preferred brand drugs if not enrolled in PrudentRx program.		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
	Physician/surgeon fees	No charge			
If you need immediate medical attention	Emergency room care	$250 copay/visit. Deductible does not apply.		$250 copay/visit. Deductible does not apply.	Copay waived if admitted or if no reasonable medical alternative.
	Emergency medical transportation	No charge		No charge	None.
	Urgent care	$15 copay/visit. Deductible does not apply		20% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. No coverage in excess of cost of a semi-private room unless medically necessary.
	Physician/surgeon fees	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit. Deductible does not apply.		20% coinsurance	None.
	Inpatient services	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
If you are pregnant	Office visits	$15 copay/first visit only. Deductible does not apply.		20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copay, coinsurance, or deductible may apply. Maternity care may include tests & services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge		20% coinsurance	Prior authorization required for stay in excess of 48 hours (96 hours for cesarean delivery) to avoid penalty of lesser of $500 or 20% of covered services.
	Childbirth/delivery facility services				

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge		20% coinsurance	Limit: 200 visits/calendar year.
	Rehabilitation services	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. In-network speech therapy limit: 30 visits/calendar year. Limit does not apply to treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of oropharynx. Out-of-network physical, occupational, chiropractic, speech & autism therapy limit: 30 visits/condition/calendar year.
	Habilitation services	No charge		20% coinsurance	None.
	Skilled nursing care	No charge		20% coinsurance	Out-of-network limit: 60 visits/ year/ person Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
	Durable medical equipment	No charge		20% coinsurance	Prior authorization required for items over $500 to avoid penalty of lesser of $500 or 20% of covered services.
	Hospice services	No charge		20% coinsurance	Inpatient services: prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. Out-of-network inpatient services limit: 60 days/person/calendar year. Out-of-network in-home services limit: 200 visits/calendar year

Common Medical Event	Services You May Need	What You Will Pay: Preferred In-Network Provider (You will pay the least)	What You Will Pay: In-Network Provider	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	$15 copay/visit. Deductible does not apply		50% coinsurance	Limit: 1 visit/calendar year performed as part of an exam.
	Children's glasses	Not covered		Not covered	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered		Not covered	You must pay 100% of this service, even in-network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (adult and child)
- Non-emergency care when traveling outside the United States (urgent care covered)
- Long-term care
- Routine foot care (except when medically necessary for treatment of diabetes)
- Weight loss programs (except as required by law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limit: 20 visits per calendar year)
- Bariatric surgery (prior authorization required)
- Chiropractic care (limit: 30 visits per calendar year for out-of-network services)
- Hearing aids (limit: 1 set per 36 month period; prior authorization required)
- Infertility treatment (prior authorization required)
- Non-emergency care when traveling outside the United States (urgent care only)
- Private-duty nursing (prior authorization required)
- Routine eye care (adult, limit: 1 exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

Anthem Blue Cross and Blue Shield
108 Leigus Road
Wallingford, CT 06492
1-800-922-2232

CVS/Caremark
Prescription Claim Appeals MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

Additionally, a consumer assistance program can help you file your appeal. Contact the Connecticut Office of the Health Care Advocate at 1-866-466-4446

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 1-800-922-2232.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-922-2232.
如果需要中文的帮助，请拨打这个号码1-800-922-2232.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-922-2232.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copays and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$350**
Specialist copayment	**$15**
Hospital (facility)	**$0**
Other	**$0**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost **$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copays	$25
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$435**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$350**
Specialist copayment	**$15**
Hospital (facility)	**$0**
Other	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost **$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copays	$190
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$310**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$350**
Specialist copayment	**$15**
Hospital (facility)	**$0**
Other	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost **$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copays	$320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$670**

NOTE: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please visit http://osc.ct.gov/benefits.htm

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

APPENDIX E – HEALTH ENHANCEMENT PROGRAM (HEP)

HEALTH ENHANCEMENT PROGRAM (HEP)

FAQ

Q: What is HEP?

A: HEP stands for "Health Enhancement Program." It encourages employees and their enrolled family members to take charge of their health and their health care by providing guidelines to follow for preventive and chronic care management. By signing up for and fulfilling all HEP requirements, you can save $100 per month in premiums ($1,200 per year) and become eligible for a waiver of an annual in-network deductible of $350 per member (up to a maximum of $1,400 per family).

Q: What are the requirements?

A: There are two parts to HEP: age/gender appropriate preventive requirements and chronic condition education requirements.

Preventive requirements:

2022 HEP REQUIREMENTS MORE INFO: WWW.CTHEP.COM | (877) 687-1448

PREVENTIVE SCREENINGS	AGE 0-5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50-64: Every 3 years 65+: Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 5 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	N/A	1 screening between age 45-49**	As recommended by physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Pap smear only every 5 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years to age 65
Colorectal Cancer Screening†	N/A	N/A	N/A	N/A	N/A	40-44: N/A 45+: Colonoscopy every 10 years, Annual FIT/FOBT to age 75 or Cologuard screening every 3 years	

* Dental cleanings are required for family members who are participating in a dental plan sponsored by your employer
** Or as recommended by your physician
† NEW: colorectal screening age requirements lowered to 45 years of age for calendar year 2022 as recommended by US Task Force on Preventive Services

For those with a chronic condition: **The household must meet all preventive and chronic requirements to be compliant.**

Chronic condition education:

We provide support and education for participants with asthma, chronic obstructive pulmonary disorder (COPD), coronary artery disease (CAD), diabetes, heart failure, hypertension (high blood pressure), and hyperlipidemia (high cholesterol).

In order to meet the chronic education requirement, you have a few options. One option is to register on the portal at CTHEP.com and take a short survey, read a fact sheet, or watch a video on your specific condition. Another option is to call our care team at 1-877-687-1448.

If one of our dedicated nurse care managers calls you, you are required to have at least one conversation. If the nurse recommends that you participate in a support program, that decision is entirely up to you. It is not a requirement, but it is highly encouraged.

Q: When does the program start?
A: The program runs on a calendar year basis so each year on January 1st a new compliance year begins. Your requirements for the year are based on your age on that day. So, if you are 49 on January 1st, you are held to the requirements for a 49-year-old, even though you turn 50 in that calendar year.

Q: How does Care Management Solutions determine compliance?
A: Each year, CMSI loads your age appropriate preventive and chronic requirements to your HEP portal. As you obtain your required screenings, CMSI receives the claims data from your insurance carrier and uploads that data to your HEP portal. As the claims come in you will see your requirements marked as complete.

Q: How can I track my progress toward my requirements?
A: The best way is to register on CTHEP.com. Once you sign in, your home page will display your requirements based on your age and gender. You will also see any chronic condition(s) requirements that apply to you. You can see any dependents' information, too. If they are under age 18, you will be able to view specific requirements and progress. If they are over age 18, you will be able to review a summary to see how many requirements they have and how many have been completed.

Q: How do I know if my family members are compliant?
A: As mentioned above, if you register at **CTHEP.com**, you will be able to view specific requirements for dependents under age 18, for dependent over 18 you can view a summary. Dependents over age 18, can create their own secure login to see their individual status in the HEP program. If they would like you to have access to their individual requirements, they can sign a **personal health information** (PHI) release form that would grant you access.

Q: I am a new employee. I tried to register at CTHEP.com, but it doesn't recognize me.
A: It takes about 45 days for CMSI to receive your enrollment information. We recommend you wait until the middle of the month after your insurance goes into effect.

Q: I don't have access to a computer. How will I know if I am missing a requirement?
A: Everyone is notified by mail towards the end of the compliance year of any missing requirements. Dependents ages 18 and over will receive their own letters. You typically receive the first letter at the end of September and will continue to receive letters until we receive the claims showing the requirement(s) have been completed. You can also call the dedicated customer service team at CMSI at 1-877-687-1448 to discuss your compliance status.

Q: A service is required less frequently than every year – every 2, 3, 4, 5, 7, and even 10 years. Do I have that long to complete it?
A: Here's how those work: We will look back at claims the appropriate number of years to see if the requirement has been completed. Requirements are measured using the current compliance year. For example, for Compliance year 2020, if you are 45 years old, and a vision exam is required once every four years, on Dec. 31, 2020 we will look back to see if it was completed in either 2017, 2018, 2019, or 2020.

Q: I had a service that I needed before this insurance went into effect. Do I have to have it again?
A: No, you do not. Have your health care provider fill out a provider notification form (PNF) with the date the service was done and submit it to us (instructions are on the form). For example: you are a new employee (or a new Partnership group) who is 57 years old and had your colonoscopy seven years ago. That satisfies your requirement for a colonoscopy, but you must submit the PNF. You can access a PNF at any time at CTHEP.com under "FORMS" at the top of the home page.

Q: I had my physical in December of last year, and my doctor is telling me I cannot get one sooner than December of this year because of the insurance. What do I do? I am afraid if it gets cancelled due to weather I will be out of compliance.
A: You do NOT have to wait 365 days to schedule a preventive visit. Your insurance pays for one every calendar year, regardless of when in the calendar year you have it. If your provider has a question about this, they should contact your health insurance company.

Q: Are there any alternate options to a colonoscopy?
A: While a colonoscopy is the most accurate way to test for colon cancer, we know that it is not appropriate for everyone. If your doctor agrees, you can take an annual FIT or FOBT test, or you may take a COLOGUARD® test every 3 years.

Q: I can't do one of the requirements because I have dentures, had a hysterectomy, or had a mastectomy.
A: Have your doctor fill out a PNF indicating that you should be exempt from the service. Be sure they indicate it is a permanent exemption. When we receive the form, we'll remove the requirement for you.

Q: My doctor does not feel I need to have one of the requirements. Why do I have to do it?
A: If your doctor feels one of the requirements is not appropriate for you, they can fill out a PNF. This will be required every year unless it is a permanent exemption, as in the cases above.

Q: My physician checks my eyes during my annual physical wellness exam. Does that count toward the required vision exam?
A: Your in-office vision exam counts long as your doctor submits a claim to your insurance company with a procedure code indicating they completed an eye exam as part of your wellness exam. If your doctor does not bill or submit a claim for the vision exam, you will need to have him/her fill out a PNF.

Q: I went to the doctor. Why am I still showing non-compliant with a requirement?
A: We typically receive claims one to two weeks after they are processed by your insurance company. This can, however, vary with doctors' offices and their billing processes. If a couple of months has passed and the portal continues to reflect that you're noncompliant for a screening that you have already completed, then call CMSI so one of our representatives can assist you.

Q: I went to the doctor months ago. Why am I still showing as non-compliant for my preventive visit?
A: Going to a doctor for a problem, such as a sore throat or headaches, or a medicine check for a chronic condition does not satisfy the preventive requirement. The visit has to be specifically for a preventive exam, which is also referred to as a routine physical or well visit. For an adult, it typically includes lab work and screenings. For a child, it typically incudes immunizations. Preventive visits are intended to prevent illness or detect problems before you have symptoms.

Q: Why does it seem like I always have to submit a provider notification form (PNF)?
A: There are only a few situations that require you to submit a PNF:

1. Your dependents have other insurance, and that insurance is primary. In this case we will never receive a claim for preventive services, and you will always have to submit a form. You should bring the form at the time of service and ask the provider to complete it and send us a copy.
2. You had the service done before this insurance went into effect. Since we do not have past claims history, you will need to submit a PNF as proof you had the service.
3. You just had the service, but the compliance deadline is two months away. We recommend submitting a PNF rather than waiting for the claim to be processed and sent to us.

Q: If I'm showing one of the chronic conditions, how do I complete the requirement?
A: The chronic condition requirement is an educational requirement that is separate from a doctor's visit or bloodwork for that condition. The education can be done in one of these ways:

1. You create an account on CTHEP.com, then take a survey, read a factsheet, or watch a video. After you finish, simply hit the "submit" button.
2. If you prefer not to register, you can print a factsheet from the log-in page. You click the chronic conditions button, select the appropriate condition, print the fact sheet, fill it out and send it in to us.
3. You can call us at 877-687-1448 and a representative will help you take a quiz over the phone.

This is an annual requirement due by December 31 along with the preventive requirements. Please remember, too, that if one of our dedicated HEP nurses calls you, you must accept the call to be considered in compliance.

Q: I didn't get the mailing you sent. It went to my old address.
A: Make sure you notify your employer of your address change through your benefit officer, payroll officer, benefit administrator, or human resources department. They will send the change to us. This could take up to six weeks, depending on when we receive the notice.

Q. Why does my child have to be compliant? He/she will be turning 26 and coming off my health plan before the end of the year.
A: The state changed medical coverage requirements for dependents in 2019. Dependents who turn 26 during the year now stay on a parent's plan until the end of the calendar year instead of the first of the month following their 26th birthday.

Q: My spouse is a state retiree on Medicare and doesn't have to comply with HEP. If it's his policy, why do I have to meet the requirements?
A: If you are under 65 and a dependent of a retiree in the Medicare Advantage plan who based on retirement date (10/2/2011 and later) would otherwise be required to meet the requirements of HEP, the benefit provided to you includes all the components of HEP. You must be compliant with the requirements to continue to receive the financial benefits of the program.

Q: I am a new employee -- do I have to be compliant with HEP? Or, I just added a dependent -- do they have to be compliant with HEP?
A: HEP compliance is measured once you are in the program for a full year. For example, if the effective date of your insurance is Jan. 1, 2019, you must be compliant by Dec. 31, 2019. If the effective date of your insurance July 1, 2019, you must be compliant by Dec. 31, 2020.

Q: I am divorced and have no contact with my children who are in HEP.
A: You may download and print a non-custodial parent form from CTHEP.com. Find it under the "Forms" tab. Follow instructions on the form to complete and return it.

Q: My child is serving in the military. How can I get him/her to comply?
A: You may download and print a military exemption form from CTHEP.com. Find it under the "Forms" tab. Follow instructions on the form to complete and return it.

Q: Why can't I see my dependents' requirements? I pay for the insurance.
A: The Health Insurance Portability and Accountability Act (HIPAA) prevents us from disclosing this information without express consent from your dependent. Your dependent may give us permission by going to CTHEP.com and clicking on the "Help, Forms & Contact" box. Download and print the release of personal health information (PHI) form and follow the instructions.

Your dependent may also give consent for us to talk to you by registering at CTHEP.com. Then, he or she can sign in and click on the "Contact" information tab, scroll to the bottom, and fill out the HIPAA release section. Make sure to "save" before navigating away from the page.

Q: How do I get access to my adult dependents' requirements/status?
A: There are several ways:

- Have your dependent fill out a PHI release form (see above).
- Have your dependent register on the portal and give us permission (see above).
    - These two options allow you to call us and get information on your dependents.
- Have all your dependents 17 and over fill out the PHI release form and complete the cover sheet. This allows you access to their requirements thru the portal at CTHEP.com. This must be done annually.

Q: Why did I have extra money taken out of my paycheck?
A: When you are placed into a non-compliant status, your premium contribution increases by $100 a month. You should check CTHEP.com and get your missing requirement(s) done as quickly as possible. Once you've completed them, fill out the reinstatement form (find it on the portal) and send to CMSI. It can take one or two pay cycles before you see the change in your paycheck.

Q: If I'm out of compliance and being penalized, will I automatically be reinstated once I complete the requirement?
A: No, you won't be automatically reinstated. If you've completed a requirement, you must have a **reinstatement form** filled out by a health care provider and sent to us right away. That begins the reinstatement process. Claims for the service alone will not automatically reinstate you.

Q: I removed a non-compliant person from my insurance. Why wasn't I reinstated?
If you have removed a non-compliant person, please contact us right away so we can verify it and start the reinstatement process.

Q: I just completed my missing requirement and sent in my reinstatement form. When will I be reinstated?
A: You will be reinstated the first day of the month following receipt of a completed reinstatement form.

Q: Do I have to wait until open enrollment to be reinstated?
A: No, you don't have to wait. Please send us a **reinstatement form** with proof of your missing requirements right away. Once you (and any family members) are 100% compliant, we will send your name for reinstatement. That reinstatement is effective on the first day of the month following when you send in the reinstatement form. If you find that you're compliant but are being charged, please contact us immediately so we can assist you with the reinstatement process. It is your responsibility to know your compliance status in HEP.

Q: There are so many different forms – I don't know which one to use
A: There are a number of different forms that address very different circumstances –

- Provider Notification Form (PNF) – this formed is used to report a service you have had done and must be signed by your provider

- Reinstatement Form – Looks similar to a PNF, but this form is used if you are currently in a non-compliance status and are being penalized. This form must be signed by your provider if you are missing a preventive requirement. If you are missing the chronic condition education and you completed it on the portal, no provider signature is required

- Non-Custodial Parent Form – This form is to be used if you have a dependent child on your insurance plan and you do not have custody, so you cannot ensure his/her requirements are complete.

- Military Exemption Form – This is to be used if you have a dependent on your insurance plan that is actively deployed in the military.

- Religious Exemption Form - This form should be used to claim an exemption from the requirements of the Health Enhancement Program based upon your adherence to religious beliefs.

- Permission to Release PHI – This is the form a participant would fill out to release their Protected Heath Information (PHI). If you want to be able to speak to a customer service representative about your spouses or overage dependents specific requirements they need to complete this form and follow the instructions to return to us.

- Permission to View PHI - This is the form you must fill out and submit with a Permission to Release PHI (above) in order to view your spouse and overage dependents requirements on the portal. Everyone on your plan that is 17 or over must complete the required forms for this option. This must be done on an annual basis

All of these forms can also be found at CTHEP.com by clicking on the Help, Forms & Contact button, or by clicking on the forms tab.

CARE
MANAGEMENT
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A DIVISION OF WELLSPARK

APPENDIX F – DENTAL SUMMARY OF BENEFITS

Cigna Dental Benefit Summary
East Windsor Board of Education - Full A Plan
Plan Renewal Date: 07/01/2022

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental PPO				
Network Options	*In-Network:* **State of Connecticut Network**		*Non-Network:* **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II and III expenses	Unlimited		Unlimited	
Calendar Year Deductible Individual Family	$0		$0	
Benefit Highlights	*Plan Pays*	*You Pay*	*Plan Pays*	*You Pay*
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Oral Surgery: minor Repairs: Dentures Crowns: prefabricated stainless steel / resin	100% No Deductible	No Charge	100% No Deductible	No Charge
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: permanent cast and porcelain Space Maintainers: non-orthodontic Oral Surgery: major	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 85th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Late Entrant Limitation Provision	No coverage until next open enrollment. This provision does not apply to new hires.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. This provision does not apply to fillings.

Oral Health Integration Program*	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 16.
Space Maintainers	Limited to non-orthodontic treatment for children under age 14.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Brush Biopsy
- Anesthetics
- Minor and Major Periodontal services
- Relines, Rebases, Adjustments, Repairs- Bridges, Crowns and Inlays
- Bridges, Dentures and Partials
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

APPENDIX G – VISION SUMMARY OF BENEFITS

Summary of Benefits Cigna Health and Life Insurance Company

Cigna Vision
East Windsor Board of Education
C1 - Custom PPO Comprehensive Plan

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	**In-Network Benefit**	**Out-of-Network Benefit**	**Frequency Period ****
Exam Copay	$15	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$0	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $40 Up to $65 Up to $75 Up to $100	 12 months 12 months 12 months 12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	 Up to $360 Covered 100%	 Up to $345 Up to $345	 12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to $175	Up to $126	12 months
** Your Frequency Period begins the day after your last visit (Date of service basis)			
Definitions: **Copay:** the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses). **Coinsurance:** the percentage of charges Cigna will pay. Customer is financially responsible for the balance. **Allowance:** the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance. **Materials:** eyeglass lenses, frames, and/or contact lenses.			
• To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders. • If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.			
In-Network Coverage Includes: • One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses; • One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms) o Polycarbonate lenses for children under 18 years of age o Oversize lenses o Rose #1 and #2 solid tints o Minimum 20% savings on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults) all tints/photochromic (glass or plastic); and lens styles. o Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;			

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- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

Healthy Rewards® - Vision Network Savings Program:

- When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription eyeglasses, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

1. Log in to **myCigna.com**, go to your Cigna Vision coverage page and select "View Details." Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to **myCigna.com**? Go to **Cigna.com** and click on the orange Find a Doctor tab at the top. Then select "Vision Directory", for routine eye exams and eyewear services, from the Other Directories listed below.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision

customer service representative.

2. Schedule an appointment
Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:
- Go to **Cigna.com** and go to Forms, Vision Forms
- Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

ATTENTION: language assistance services, free of charge, are available to you. Call 1-877-478-7557 (TTY: 800-428-4833).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-478-7557 (TTY: 800-428-4833).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-478-7557（TTY：800-428-4833）

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-478-7557 (TTY: 800-428-4833).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-877-478-7557 (TTY: 800-428-4833) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

Tumawag sa 1-877-478-7557 (TTY: 800-428-4833).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-478-7557 (телетайп: 800-428-4833).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-478-7557 [(رقم هاتف الصم والبكم: 800-428-4833).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-478-7557 (TTY: 800-428-4833).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-478-7557 (ATS: 800-428-4833).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1-877-478-7557 (TTY: 800-428-4833).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-478-7557 (TTY: 800-428-4833).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-478-7557（TTY: 800-428-4833）まで、お電話にてご連絡ください。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-478-7557 (TTY: 800-428-4833).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-478-7557 (TTY: 800-428-4833).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 800-428-4833) 1-877-478-7557 تماس بگیرید.

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MEMORANDUM OF UNDERSTANDING
Between
East Windsor School District
And
United Public Service Employees Union (UPSEU), Unit 132 – East Windsor Nurses

This Memorandum of Understanding ("MOU") is entered into by and between the **East Windsor Board of Education** (hereinafter referred to as the "District") and the **United Public Service Employees Union (UPSEU), Unit 132 – East Windsor Nurses** (hereinafter referred to as the "Union").

Purpose:

The purpose of this MOU is to confirm the agreement between the parties regarding a one-year extension of the current collective bargaining agreement (CBA), which is scheduled to expire on **June 30, 2025**, and to incorporate a general wage increase and agreed-upon language modification.

Terms of Agreement:

1. **Contract Extension**
   - The parties agree to extend the current collective bargaining agreement for **one (1) year**, through **June 30, 2026**, under the same terms and conditions, except as specifically modified herein.
2. **Wages**
   - Effective **July 1, 2025**, all bargaining unit members shall receive a **3% (three percent)** general wage increase applied to the base wage rates in effect as of June 30, 2025.
3. **Contract Language Modification**
   - 19.1 Employees shall work student school days plus at least four (4) days and up to nine (9) days, **the exact number of days to be determined at the discretion of the nurse leader, provided the district has sufficient work available for the nurses to perform.** Work days shall fall between Monday and Friday. Employees are required to attend professional development sessions scheduled by the Board on early release days and on the day prior to the start of school.
4. **No Other Changes**
   - Except as specifically modified by this MOU, all other terms, provisions, and conditions of the current collective bargaining agreement shall remain in full force and effect during the extended term.

Execution:

This MOU shall be effective upon execution by both parties and shall be incorporated into and considered part of the collective bargaining agreement.

IN WITNESS WHEREOF, the parties have caused this Memorandum of Understanding to be executed by their duly authorized representatives on the dates below:

For the East Windsor Board of Education:
Signature: Kathryn Carey-Tull
Name: Kathryn Carey-Tull
Title: Board Chair
Date: 7/23/2025

For UPSEU, Unit 132 – East Windsor Nurses:
Signature:
Name: Stella Cochran
Title: Labor Relations S UPSEU
Date: 8/19/25