AGREEMENT
BETWEEN
THE MANCHESTER BOARD OF EDUCATION
AND
AFSCME COUNCIL 4
LOCAL 818-49
MANCHESTER BOARD OF EDUCATION
BUILDING AND GROUNDS SUPERVISORS
COVERING THE PERIOD
JULY 1, 2017 THROUGH JUNE 30, 2021

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WORKING AGREEMENT
BETWEEN
THE MANCHESTER BOARD OF EDUCATION
AND
AFSCME COUNCIL 4, LOCAL 818-49

This Agreement is entered into by and between the Manchester Board of Education, hereinafter referred to as the "Board," and AFSCME Council 4 Local 818-49, hereinafter referred to as the "Union."

ARTICLE 1
RECOGNITION

Section 1.0 The Board, acting through its Superintendent of Schools, recognizes the Union as the sole and exclusive bargaining agent for the purpose of collective bargaining on matters of wages, hours of employment, working conditions, grievances, and other conditions of employment for all Supervisors of Buildings and Grounds Department of the Manchester Board of Education, as more fully described in the certification in Case No. ME-18,030, dated June 21, 1996.

ARTICLE 2
HOURS OF WORK

Section 2.0 The regular work day for employees in the bargaining unit is eight (8) hours per day, excluding a thirty-minute lunch period. The regular work week for employees in the bargaining unit is forty (40) hours per week. However, given the supervisory nature of the positions in this bargaining unit, the parties acknowledge that the professional responsibilities will sometimes extend beyond the regular work day and regular work week.

Section 2.1 Employees are subject to being called in for work outside of their normal work hours based upon emergency and other business necessity. Employees will not be required to remain at work for any minimum number of hours when they are called in and will be permitted to return home when their duties have been completed. When an employee is called in to work at a time not contiguous with the employee's regular work day based upon an emergency or other business necessity, the employee shall receive compensatory time in an amount equal to three (3) hours or the actual time spent in handling the emergency or other business necessity, whichever is greater.

All employees will rotate on-call service on a regular, weekly basis. On-call service is from Monday at 6:00 a.m. through the following Monday at 6:00 a.m. If a change in rotation is required, it is the responsibility of the employee to work out replacement with notification to the Facilities Manager. Employees will receive on-call pay of two hundred dollars ($200) per week of on-call service. Employees receiving on-call pay must be within reach at all times and must respond to all calls received. Employees may not travel out of the range of the cell phone provided. Failure to respond while on-call will subject the employee to disciplinary action. On-

call service will not count towards compensatory time; however, if called in for work sections 2.1 and 2.2 will apply.

Section 2.2 If an employee receives prior approval from his/her supervisor to continue working for more than thirty (30) minutes beyond the regular work day, the employee will be provided with compensatory time in an amount equal to the total amount of time exceeding thirty (30) minutes. All compensatory time must be utilized by the employee by June 30th of each year. Any remaining compensatory time not utilized by June 30th will be paid out at the employee's regular pay rate.

ARTICLE 3
WAGES

Section 3.0 Wage scales and job classifications shall be negotiated and made part of this Agreement. A complete list of job descriptions shall be furnished to the Union.

Section 3.1 The Board agrees to cover the employees under the provisions of the Workers' Compensation Laws of Connecticut. Employee will not suffer loss of income if injured or absent because of job-related injury while they are receiving Workers' Compensation for up to nine (9) months from the date of the injury. They will continue to receive their regular payroll checks, and in the event that compensation checks are sent directly to them, these checks will be signed over to the Board of Education.

Section 3.2 Employees shall receive longevity payments in recognition of their length of service on the following basis. Prior service as a regular, full-time Board of Education employee shall be included.

YEARS OF SERVICE	AMOUNT ANNUALLY
5 to 10 years	$300
10 to 15 years	$400
15 to 20 years	$600
20 or more years	$800

Longevity service increments will be paid as a lump sum on the payroll following employee's anniversary of hire. Employees hired on or after July 1, 2011, will not be eligible for longevity payments.

Section 3.3
All employees shall be paid by direct deposit.

ARTICLE 4
SENIORITY, PROBATION, PROMOTIONS, TRANSFERS

Section 4.0 Seniority shall commence upon the date that the employee begins as a full-time paid employee of this bargaining unit. The employee's earned seniority shall not be lost because of absence due to illness, pregnancy, maternity leave, bereavement, jury duty, personal leave, or other authorized leave, or while eligible for recall. Seniority and seniority rights will not be accrued during unpaid leaves of absence or layoff, but such rights will not be lost by the employee because of such leave or, if recalled, because of such layoff.

Section 4.1 An employee's seniority and his employment shall terminate upon any of the following:

1. Resignation
2. Discharge for Just Cause
3. Retirement
4. Death
5. Expiration of Recall Rights

Section 4.2 Seniority will be used to determine vacation preference and layoffs in the event of a reduction in force. An employee whose position has been abolished may assume the position of a less senior employee provided he/she is qualified to perform the duties of that position.

Section 4.3 Probationary Period: Employees shall be considered probationary during their first ninety (90) calendar days of employment, provided the employee works at least sixty (60) days within said probationary period. Otherwise a new probationary period shall commence. During such probationary period, the employee shall not attain seniority rights under this Agreement, and such probationary employee will be subject to discharge by the Board, in its discretion, without access to the Grievance Procedure. At the successful completion of the probationary period, seniority shall be retroactive to the commencement of employment.

Section 4.4 In the event an employee is recalled within eighteen (18) months of being laid off, the employee's seniority shall be reinstated, except that no credit shall be given for the period of non-employment. An employee on layoff wishing to remain on the recall list shall apply in writing by certified mail to the office of the Superintendent/designee for retention of his/her name on or before June of each year subsequent to his/her layoff. Failure to comply with these recall provisions will signify the termination of all said employee's recall rights. Once the recall period expires, the employee shall have no rights and shall be considered terminated.

Section 4.5

A. Notice of all bargaining unit vacancies to be filled and new positions shall be electronically mailed on a separate bulletin to employees. The posting shall remain open five (5) work days prior to any action taken by the Board to fill such vacancies and/or new positions. Employees wishing to fill such vacancies or new positions may personally, or through a Union official, submit their written request to the Personnel Office. Employees expressing a desire to fill the vacancy or new position and who

were not selected for such assignment, in accordance with the provisions of this Agreement, may appeal the action through the Grievance Procedure. Qualified Board employees will receive first consideration over applicants outside of Board employment. For internal candidates, the appointment will be made to the applicant determined by the Superintendent or his/her designee to be best qualified on an overall basis to perform the job. If the internal candidates have relatively equal qualifications, seniority shall govern.

B. Copies of the job posting, a list of persons bidding for the job and the name of the person appointed shall be sent to the Union President no later than seven (7) calendar days from appointment, unless there have been no bids submitted.

C. All vacancies shall be filled within ninety (90) calendar days from the date of an employee vacating a position or of the establishment of a new position. Management and Union shall negotiate salaries and working conditions within the jurisdiction of the Union to the extent required under MERA.

D. If the employee who bid into a bargaining unit position during the first fifteen (15) calendar days of his/her probationary period, wished to voluntarily return to the position held prior to his/her promotion, he/she may do so provided the position has not been filled and the Superintendent/designee is notified in writing.

Section 4.6 In the event of a layoff, the Union President shall be notified at least thirty (30) working days in advance of the effective date of the layoff. Notification shall include all details of the proposed layoff and shall allow an opportunity to negotiate the impact of the layoff.

ARTICLE 5
LEAVE PROVISIONS

Section 5.0 Each employee shall have credited to their account sick leave at current base pay of twelve (12) working days during each fiscal year, with a maximum accumulation of one hundred eighty-four (184) days. Each employee shall be entitled to use such sick leave with full pay as has accrued to his/her credit. Each employee shall be notified of his/her accumulated sick leave on each payroll check.

Section 5.1

A. In exceptional cases, the Superintendent or designee may grant additional sick leave with or without pay, provided that the Superintendent's or his designee's decision in one case shall not establish or be claimed as a precedent in any other case(s). Requests for such additional sick leave shall be in writing and be signed by the employee, if possible.

B. After all sick leave has been exhausted, an expectant employee shall be permitted to use three (3) personal leave days pursuant to FMLA provisions, during or shortly after the pregnancy or adoption.

C. Employees are permitted to donate earned vacation days to a designated member of the bargaining group. Such donation must be in writing.

Section 5.2

Employees hired after June 30, 2001 will receive no pay out of accumulated sick leave upon retirement.

Section 5.3 Each employee shall be granted leave with full pay for the following reasons:

A. In the event of death in the immediate family of an employee, or the immediate family of his/her spouse, up to three (3) days of leave with pay shall be granted. Immediate family for purposes of this clause is defined as parents, grandparents, spouse, brother, sister, child, stepchild, grandchild, son-in-law, daughter-in-law, brother-in-law, sister-in-law, and any relative who is domiciled in the employee's household.

B. Each employee shall be granted necessary travel time, with approval of his/her Supervisor, not to exceed in the aggregate a total of three (3) days per contract year to fulfill the obligation of going to, attending, and returning from funerals of persons other than those covered under Section 5.3A.

C. To attend previously approved professional conferences or take courses of study which will contribute to, or increase the employee's knowledge with regard to betterment of the public service. Such approvals will be granted only where budgetary provisions have been made for the above-mentioned purposes.

D. Any employee called to jury duty shall be paid the difference between the employee's regular rate of pay and the fee received from serving as a juror. No employee shall receive more compensation than normally would have been received had he not served jury duty. An employee called to jury duty shall furnish the Board with a Notice to Serve immediately upon receipt. The employee shall return to work on the following day he/she is released from jury duty.

E. A maximum of five (5) personal days per year may be used for the following reasons:

1. For attendance at weddings in the employee's immediate family or immediate circle of friends, with at least 48 hours advance notice and the permission of the employee's supervisor.

2. For attendance at the graduation of someone in the employee's immediate family with at least 48 hours advance notice and the permission of the Superintendent or his/her designee.

3. Any personal emergency reason which cannot be conducted outside working hours.

Section 5.4 Union Leave

A. One (1) Union official may be designated on behalf of the bargaining unit to process grievances and other labor relations issues, and such member and grievant(s) shall be granted leave of duty with full pay for a reasonable period while engaged in processing said grievance, at each step of the procedure through arbitration.

B. Two (2) members of the Union may be granted a reasonable leave of absence from duty with pay not to exceed a total of ten (10) days a year to attend conventions or other Union business, but said employee shall not be granted or entitled to reimbursement by the Board for any expenses incurred in travel or otherwise. At least three (3) days written notice shall be required. This leave shall be non-cumulative. At no time shall two (2) members be on leave during the same time period.

C. During contract negotiations, the Union shall have the right to have two (2) bargaining unit members of its negotiating committee present for all meetings. When such meetings take place during scheduled work hours, the member shall suffer no loss of pay.

Section 5.5 Leave of absence without pay may be granted by the Superintendent for not longer than one (1) year. Requests for such leave shall be made in writing and shall include a statement of the reasons therefore and of the length of leave requested. Following such leave, the employee shall return to the position held at the time of said leave. Action by the Superintendent with respect to one leave request will neither establish nor be claimed as a precedent or practice for other request. Seniority shall not continue to accrue during any unpaid leave of absence.

Section 5.6

A. No employee shall lose any seniority standing because of any military service including service in the National Guard or organized reserves.

B. On return from military service, an employee shall be reinstated in his/her former job or one of like rank and pay including any increase granted during his/her absence on military service provided that he/she reports for duty within ninety (90) calendar days of his/her discharge from military service.

Section 5.7 The employee's accumulation of sick leave, upon leaving for military service or leave without pay, shall be retained to his/her credit when he/she returns.

Section 5.8 Any employee who becomes pregnant is requested to notify the administration in writing at least four (4) months prior to the expected date of delivery and shall thereafter provide a doctor's certificate indicating continued fitness for work as often as the school administration may require. Leave shall begin when, in the opinion of her doctor, the employee is no longer physically able to work and will end when, in the opinion of her doctor, the employee is physically able to return to work. Any disability resulting from pregnancy shall be considered sickness for the purpose of this Agreement. Except in the case of unusual medical difficulties, leave is not expected to continue more than six (6) to eight (8) weeks after delivery. It is

understood that employees disabled under the provisions of this Article shall return to the school system at the end of said disability. The Board of Education will comply with all Family Medical Leave Act (F.M.L.A.) provisions.

An employee absent on pregnancy leave who wishes to return to her same position must so notify the Superintendent or designee in writing, prior to the last scheduled work day. Such employee shall have up to ninety (90) unpaid calendar days from the date of the end of the six (6) to eight (8) weeks disability leave to return to work, which unpaid leave shall constitute child rearing leave. At least one months' written notice of intention to take unpaid child rearing leave must be given to the Superintendent or designee. Maternity/child rearing leave cannot exceed 12 (twelve) weeks. NOTE: Accrued paid vacation time may be credited towards the 90 days.

Section 5.9 During periods of leave without pay, except for military leave and FMLA leave, the employee shall not continue to accrue seniority credit and shall not be credited with time for the purpose of accruing sick leave or vacation leave.

A. Any Employee who is on a leave of absence without pay shall not be paid for any leave benefits during the period of absence and shall not accumulate vacation time or other leave benefits during the leave period. Any vacation time due an employee at the time of taking a leave of absence without pay may be paid at that time. Authorized leaves of absence for one month or less will not be used as a basis for reducing employees' benefits.

Section 5.10 Accumulated sick time of employees will be listed on the employee's pay check.

Section 5.11 Sick Leave Bank

A. Each member of the Union shall be permitted to contribute any two (2) days from his/her sick leave accumulation reserve each school year to a "Sick Leave Bank" which shall be established to aid members who suffer prolonged illness and whose sick leave accumulation has been exhausted. The bank shall be build up to a maximum of two hundred fifty (250) days. No more days shall be added until the bank is depleted to approximately one hundred twenty-five (125) days. Then the bank will be built up again using the same process. Generally an employee must be a contributing member for at least one year before being permitted to apply for benefits.

B. When an employee has exhausted all available sick leave, application for additional sick leave time from the Emergency Sick Leave Bank may be submitted, accompanied by a physician's statement describing the illness and offering a prognosis for a date of return to work.

The Sick Bank Committee may grant up to thirty (30) days from the Emergency Sick Bank. If the thirty (30) days are exhausted, the employee may request an additional grant of up to twenty (20) days. These may be granted following a five-day waiting period. An up-to-date physician's statement is required. An additional twenty (20) half-days may be granted in extreme cases and must be accompanied by an up-to-date physician's statement. All fees required by a physician are to borne by the employee.

In determining a grant of sick days, the Committee will consider such criteria as: the employee's statement of illness, the physician or medical professional's submitted statement(s), employment records, history of the use of sick time, the results of Committee investigations and such additional materials as are available to the Committee.

The Committee has the right to require a second physicians opinion, chosen by the Board of Education members of the Committee, and a third physician's opinion chosen by the Union members of the Committee.

C. The following conditions shall apply:

1. Additions to the bank shall be made at the beginning of the school year.

2. A person withdrawing membership in the bank will not be able to withdraw the contributed days.
3. Persons withdrawing sick leave days from the bank will not have to replace these days except as a regular contributing member of the bank.

4. Sick leave shall mean the leave a staff member has for that year plus his/her accumulation.

D. The Committee will be composed of three (3) members selected by the Union leadership (one of whom will be the President) and three (3) members selected by the Superintendent.

Decisions of the Committee are final and not subject to arbitration.

The Committee may promulgate further guidelines assuming that such guidelines are in concert with the conditions of the contract and the policies of the Manchester Board of Education.

ARTICLE 6
HOLIDAYS

Section 6.0The following holidays shall be observed as days off with full pay:

New Year's Day	Independence Day	Veteran's Day
Martin Luther King Day	Labor Day (if schools have been made ready for the opening of school)	Thanksgiving Day
President's Day		Day after Thanksgiving
Good Friday		Christmas Day
Memorial Day	Columbus Day	Employee's Birthday (with one week's notice)

Section 6.1

A. Holidays occurring on Saturday will be observed on the preceding Friday if there is no school on said Friday. If school is in session, the employees shall be granted a day off at a time mutually agreeable.

B. Holidays occurring on Sunday will be observed on the following day if there is no school on said Monday. If school is in session, the employees shall be granted a day off at a time mutually agreeable.

Section 6.2 Whenever any of these holidays shall occur during the paid vacation of an employee, he/she shall be entitled to that holiday with pay and shall not have a vacation day charged to vacation records.

Section 6.3 Whenever any of these holidays shall occur while an employee is out on paid sick leave, the employee shall be granted an additional day off at a time mutually agreeable provided that a doctor's note verifying the sickness has been presented.

ARTICLE 7
VACATIONS

Section 7.0 Employees shall be entitled to vacation with full pay on the following basis:

A. An employee with less than one (1) year of service shall be entitled to one (1) vacation day for each month of service, except that they shall not be entitled to any vacation until after two (2) complete months of service.

B. Employees who have completed one (1) year of service shall be entitled to ~~a~~ vacation with pay of ten (10) working days annually.

C. Employees hired prior to July 1, 2017 who are in their fifth (5^{th}) year of service shall be entitled to vacation with pay of twenty (20) working days annually. Employees hired on or after July 1, 2017 who have completed five (5) years of service shall be entitled to vacation with pay of fifteen (15) working days annually.

D. Employees hired on or after July 1, 2017 who have completed ten (10) years of service shall be entitled to vacation with pay of twenty (20) working days annually.

Section 7.1 The employee's anniversary date of employment will be used to determine the amount of vacation time due. Employees must take all vacation time earned or two (2) weeks, whichever is less, during the year following the anniversary date on which it is earned. Any additional earned vacation time may be carried over from one vacation year to the next, up to a maximum accumulation of not more than six (6) weeks.

Effective June 30, 2018, the maximum vacation accumulation shall be reduced from six (6) weeks to four (4) weeks, provided that if an employee has more than four (4) weeks of accumulated, unused vacation remaining as of June 30, 2018, each such day in excess of four (4) weeks shall be paid out at the employee's regular per diem pay rate for 2017-18.

Effective June 30, 2019, the maximum vacation accumulation shall be reduced from four (4) weeks to three (3) weeks, provided that if an employee has more than three (3) weeks of accumulated, unused vacation remaining as of June 30, 2019, each such day in excess of three (3) weeks shall be paid out at the employee's regular per diem pay rate for 2018-19.

For the purposes of computing vacation time, the school year (July 1 through June 30) will be used.

Section 7.2

A. Vacation days may be taken consecutively or otherwise.

B. Employees shall submit written vacation requests as far in advance of the vacation as possible. Whenever there shall be a conflict in requested vacation dates, preference shall be given to the employees according to their seniority within this bargaining unit. All vacations must be approved in advance by the Facilities Manager.

Section 7.3Any additional vacation due an employee the first year after qualifying for such additional vacation may be taken, subject to the provisions of Section 7.0C, any time two (2) months prior to or two (2) months after qualifying.

Section 7.4An employee, upon termination of his/her services with the Board, shall be entitled to full pay for any vacation time due him/her including pro-rata time to date of termination. In the event of an employee's death, such payment shall be made to his/her dependent survivor, beneficiary, or estate if there is no dependent survivor.

Section 7.5In the event of illness during an employee's vacation period, the employee shall be given an option of charging the sick days to his/her sick leave, provided that a doctor's certificate verifies the illness.

ARTICLE 8
INSURANCE AND PENSION

Section 8.0

A. For the period July 1, 2017 through June 30, 2018, the Board shall provide and pay for coverage under one of the following insurance plans for each employee and their dependents.

   Effective July 1, 2018, the HSA Plan shall be the core insurance plan. For any employee who remains enrolled in the OAP$20 plan during the 2018-19 contract year, the Board will pay the same total dollar amount toward the premium cost for the OAP$20 plan as the Board pays toward the premium cost for the HSA Plan for an employee enrolled at the same coverage level (individual, two-person or family). The employee shall pay 100% of the difference between the Board's total dollar premium contribution and the total premium cost for the OAP$20 plan.

Effective July 1, 2019, the only plan offered to employees in the bargaining unit shall be the High Deductible/HSA health insurance plan ("HSA Plan").

1. Open Access $20

The Open Access $20 plan shall be eliminated, effective June 30, 2019.

2. HSA Plan

Bargaining unit employees may participate in the following HSA Plan. The HSA Plan shall be the sole plan offered to employees in the bargaining unit, effective July 1, 2019.

	In-Network	Out-of-Network
Annual Deductible (individual/aggregate family)	$2,000/4,000	
Co-insurance	N/A	20% after deductible up to co-insurance maximum
Co-insurance Maximum (individual/aggregate family)	N/A	$3,000/$6,000
Cost Share Maximum (individual/aggregate family)	$5,000/10,000	
Lifetime Maximum	Unlimited	
Preventive Care	Deductible not applicable	20% co-insurance after deductible, subject to co-insurance limits
Prescription Drug Coverage	Treated as any other medical expense, subject to post-deductible drug co-payments as set forth below.	

Following exhaustion of the deductible, prescription drugs shall be subject to post-deductible co-payments of $10/25/40 (retail), and a two times co-payment for mail order.

For each eligible employee, the Board will fund fifty percent (50%) of the applicable deductible amount. For the 2018-19 contract year only, the full amount of the Board's contribution toward the HSA plan deductible will be deposited into the HSA accounts in July, 2018. For each contract year thereafter, one-half of the Board's contribution toward the HSA plan deductible will be deposited into the HSA accounts in September, and the remaining one-half of the Board's contribution will be deposited into the HSA accounts in January. The Board's contribution toward the funding of the deductible shall not be deemed an element of the underlying insurance plan. Rather, the Board's contribution toward the funding of the deductible shall relate solely to the manner in which the deductible shall be funded for actively employed buildings and grounds supervisors. The Board shall have no obligation to fund any portion of the deductible for retirees or other individuals upon their separation from employment.

Effective with the 2019-20 contract year, the Board will not process employee

contributions into employees' Health Savings Accounts on a pre-tax basis, unless the Board and the Association mutually agree otherwise.

Health Reimbursement Account: A Health Reimbursement Account ("HRA") shall be made available for any employee who is precluded from participating in a Health Savings Account ("HSA") because the employee receives Medicare and/or veterans' benefits. The annual maximum reimbursement by the Board for employees participating in the HRA shall not exceed the dollar amount of the Board's annual HSA contribution for employees enrolled in the HSA. The Board shall have no responsibility for any administrative and/or monthly costs associated with the set-up and/or administration of the HRA.

Premium Contributions: Eligible employees shall contribute the following premium contributions for the cost of health insurance and basic dental coverage:

	Effective and Retroactive to July 1, 2017	Effective July 1, 2018	Effective July 1, 2019	Effective July 1, 2020
OAP$20	15.0%	N/A	N/A	N/A
HAS	14.0%	12.5%	13.0%	13.5%

The Patient Protection and Affordable Care Act ("PPACA"; Public Law 111-148) has set forth and codified under the Internal Revenue Code (IRC) §4980I, or similar statute if amended, the imposition of an excise tax related to employer provided health insurance plans that exceed certain value thresholds. Should any Federal statute or regulation pertaining to IRC §4980I be mandated to take effect during the term of this Agreement, triggering the imposition of an excise tax, or similar if amended, with respect to any of the contractually agreed upon insurance plans offered herein, the parties agree to commence mid-term negotiations. During such mid-term negotiations, the parties will reopen the health insurance provisions of Article VIII for the purpose of addressing the impact of the excise tax, or similar if amended. No other provision of the contract shall be reopened during such mid-term negotiations.

C. The Board shall provide a Full Service Dental Plan, including rider for unmarried children, with Plan same or similar to that provided by Delta Dental, with same or similar being defined as the benefits arrangements provided by an alternative health insurance benefit carrier being such that the size of the service network offered must be 80% of that currently offered. Dental riders A, B and C will be provided to employees at the group rate, provided the employee pays the full costs of such riders.

D. The Board reserves the right to change health insurance plans to a plan that is the same or similar to the plans currently provided, with same or similar being defined as the benefits arrangements provided by an alternative health insurance benefit carrier being such that the size of the network offered must be 80% of that currently offered with similar geographic patterns. The following will be excluded in determining whether a plan is similar or not: out-of-state reciprocal arrangements for routine care (non-emergencies), except that at least one plan option shall include such out-of-state

reciprocal arrangements; claims processing; payment methods and plan documents definitions and language. The Superintendent shall give notice to the Union of the intention to make a change, simultaneous to his/her receipt of notice from the Town of Manchester but in no event shall the notice be less than 15 days.

If the Union disapproves of any change pursuant to the written statement noted above, it may submit the issue to arbitration within fifteen (15) calendar days of receipt of notice from the Superintendent that the Board intends to implement the new plan. Arbitration in accordance with the rules of the American Arbitration Association will be the exclusive method for deciding the above issue.

E. Life Insurance and an ADD policy in the amount of one times the employee's salary, rounded up to the nearest thousand.

Section 8.1Bargaining unit members will be covered by applicable provisions of the Town of Manchester Defined Benefit Pension Plan in accordance with its terms. The percent of contribution is 6.4%. This shall also be inclusive of the combo "rule of 80" (combination of age years and years of service) retirement provisions which will enable employees to retire without reduction and will count as a normal retirement under the plan.

Employees hired on/after July 1, 2011 will only be eligible for the Town of Manchester Defined Contribution Plan. The percent of contribution is 6%.

Section 8.2Pursuant to Connecticut State Board of Labor Relations decisions, the Union shall be entitled to give notice to the Town to negotiate concerning pension issues.

Section 8.3Retiree Insurance

A. Employees hired by the Board on or after July 1, 1998, and who retire under the Town pension plan shall be provided the same health insurance benefits as active employees and shall pay the full cost of these benefits.

B. In order to receive health insurance benefits after retirement as provided above, the employees must have a minimum of fifteen (15) years of service in the Manchester Public Schools as an employee of the Board prior to their retirement under the Town pension plan. For employees who receive a disability retirement, the minimum years of service provision shall be waived.

C. When a Supervisor retires under paragraph "A" above and they become eligible for Medicare, they shall be provided the "Medicare supplement plan" for which the retiree must pay 100% of the premium.

Section 8.4Upon the death of an employee, the Board shall afford the surviving spouse (and any dependent children under the age of 25) the opportunity to purchase insurance at the same rate as active employees through June 30th of the fiscal year in which the employee became deceased. Thereafter, the surviving spouse (and any dependent children under the age of 25) will be entitled to benefits under COBRA for the statutory period.

ARTICLE 9
SAFETY & HEALTH

Section 9.0The President of the Union shall designate an employee to serve on the Board Safety Committee.

Section 9.1The Board will provide employees who work outside in inclement weather foul weather gear, i.e, rain coats or rain suits, rain hats, boots, gloves, etc., for their care and maintenance. These items are not for personal use.

Section 9.2The Board shall provide, free of charge to employees, medical injections for the prevention and treatment of contagious diseases such as flu, tetanus, and hepatitis, etc., as may be approved by the Board's medical advisor.

Section 9.3The Board shall supply safety shoes, or supply a payment therefore, and safety glasses, including prescription glasses when required, for all members of the Bargaining Unit whose duties require them to wear such safety equipment.

Section 9.4 The Board shall furnish each employee, at no cost to the employee, with eleven (11) sets of uniforms provided & maintained by a uniform service. Employees are required to be in a Board provided uniform at all times while on duty during normal working hours.

ARTICLE 10
DISCIPLINARY PROCEDURE

Section 10.0

A. All disciplinary actions shall be for just cause.

B. Disciplinary action shall include:

1. A verbal warning;
2. Written warning;
3. Suspension without pay; and
4. Discharge,

and shall normally follow this order. The Superintendent or his/her designee reserves the right to deviate from the above procedure in appropriate cases.

C. Whenever any such action is taken, the Superintendent shall, at the time of suspension or discharge, furnish the President of the Union, in writing, a statement of the reasons for such action and the period of time for which any such suspension is to be effective.

D. Any disciplinary action or measure imposed upon an employee may be processed as a grievance through the grievance procedure.

E. Upon the written request of an employee, verbal and/or written warnings issued to the employee shall be cleared after two (2) years, provided that no disciplinary action has been imposed upon the employee during such two-year period.

F. If the employer has reason to reprimand an employee, it shall be done in a manner that will not embarrass the employee before other employees or in public.

ARTICLE 11
PRIOR PRACTICE

Section 11.0 Nothing in this Agreement shall be construed as abridging any right, benefit, or condition of employment that employees and/or the Board have enjoyed heretofore unless it is specifically stated that said practice has been superseded by a provision of this Agreement.

ARTICLE 12
UNION SECURITY

Section 12.0 The Board agrees to deduct from the pay of all its employees, who authorize in writing such deductions from their wages, such membership dues, agency fees, initiation fees and reinstatement fees as may be fixed by the Union. Such deductions shall continue for the duration of this Agreement or any extension thereof.

Section 12.1 The deduction for any month will be made during each pay period of said month and shall be remitted to the Financial Officer of the Union not later than the last day of said month. The monthly remittances to the Union will be accompanied with a list of names of employees from whose wages such deductions have been made and the amount deducted from each employee.

Section 12.2 All full-time permanent employees shall, within thirty (30) days of the signing of this Agreement or within thirty (30) days of the date of hire, as a condition of employment, remain or become and remain a member of the Union and shall pay to the Union monthly Union dues in an amount uniformly required of its members. In lieu thereof, any current employees, or any employee hired after the effective date of this Agreement may choose not to become a member of the Union, in which case such employee shall, as a condition of employment, pay a monthly service fee to the Union which shall be in an amount determined by the Union in accordance with law. Should an employee not comply with the conditions of this section, his/her employment will be terminated within thirty (30) days after notice by the Union to the Supervisor or his/her designee.

Section 12.3 During the term of this Agreement, the Board shall furnish the Union upon request with an up-to-date list of bargaining unit employees. When a new employee is hired, the Board shall notify the Union and furnish the Union with the name, date of employment, position and rate of pay of the new employee. When the employment of an employee terminates, the Board shall notify the Union and furnish the name and date of termination of the employee.

ARTICLE 13
MANAGEMENT RIGHTS

Except where such rights, powers and authority are specifically relinquished, abridged, or limited by the provisions of this Agreement, the Board has and will continue to retain, whether exercised or not, all of the rights, power and authority held by the Board before the negotiating and signing of this contract, and except where such rights, powers, and authority are specifically relinquished, abridged, or limited by the provisions of this Agreement, it shall have the sole and unquestioned right, responsibility, and prerogative of management of the affairs of the Board and direction of the working force:

A. To determine the care, maintenance, and operation of equipment and property used for and on behalf of the purposes of the Board.

B. To establish or continue policies, practices, and procedures for the conduct of Board business and, from time to time, to change or abolish such policies, practices, or procedures. However, where such policies, practices, or procedures impact wages, hours or conditions of employment, the Board shall notify the Union and offer to negotiate regarding such changes to the extent required by the MERA.

C. To establish or discontinue positions, classifications, processes or operations.

D. To select and to determine the number and types of employees required.

E. To employ, transfer, promote, or demote employees, or to lay-off, terminate, or otherwise relieve employees from duty for lack of work or other legitimate reasons when it shall be in the best interest of the Board or the Department.

F. To prescribe and enforce rules and regulations for the maintenance of discipline and for the performance of work in accordance with the requirements of the Board, provided such rules and regulations which impact wages, hours or conditions of employment have been furnished to the Union and the Union has been given an opportunity to negotiate such rules and regulations to the extent required by MERA.

G. To ensure that incidental duties connected with any department operations shall be performed by employees.

ARTICLE 14
SAVINGS CLAUSE

Section 14.0 Should any Article, Section, or portion thereof of this Agreement be held unlawful and unenforceable by any court of competent jurisdiction, such decision of the court shall apply only to the specific Article, Section, or portion thereof directly specified in the decision. Upon the issuance of such a decision, the parties agree immediately to negotiate a substitute for the invalidated Article, Section or portion thereof.

ARTICLE 15
GRIEVANCE PROCEDURE

Section 15.0 The Superintendent or his/her designee and the Union shall meet periodically at a time mutually convenient for the purpose of discussing matters of mutual interest, performance of work, employee behavior, and working conditions with the intent to avoid the necessity of individual recourse to the formal grievance procedure and to generally promote a satisfactory relationship.

Section 15.1 The purpose of this procedure is to provide an orderly method for adjusting grievances. Grievances arising out of matters covered by this Agreement and disputes and consultations on any questions arising out of employer-employee relationships will be processed in the following manner:

Step 1 – The aggrieved employee and/or his/her Union Steward shall take up the grievance or dispute with the employee's immediate superior. The immediate superior shall adjust the matter at once, or notify the employee and his/her Steward of his/her decision within five (5) days from the date the matter is presented. If the grievance is presented in writing at Step 1, the response shall be written.

Step 2 – If the matter has not been settled, it may be presented in writing (such presentation must be made within fifteen (15) days of receipt of the Step 1 response) by the Steward and/or the President of the Union to the Superintendent. The Superintendent shall, within ten (10) days from the date the matter is submitted to him/her, arrange a meeting with all those concerned to review the facts, and notify the employee, the President of the Union, and AFSCME Council 4 of his decision in writing, within ten (10) days after the date of the meeting.

Step 3 – If the matter is still unsettled, the parties may present the grievance in writing (such presentation must be made within fifteen (15) days of receipt of the Step 2 response) to the Board of Education. Each party reserves the right, however, to waive this step of the grievance procedure and proceed to Arbitration. The Board of Education or designated committee of the Board of Education shall review the grievance within thirty (30) days after its submission to the Board, and shall afford the parties an opportunity to present their positions on the grievance. The Board of Education or its designated committee, as the case may be, shall issue a decision concerning the grievance in writing within ten (10) days after the date it was presented to the Board of Education.

Arbitration – If the matter is still unsettled, the Union may submit the matter to arbitration by the State Board of Mediation and Arbitration (such presentation must be made within thirty (30) days of Step 2). The decision of the Arbitrator(s) shall be final and binding on both parties. Termination (discharge) cases may be referred by the Board in its discretion to the American Arbitration Association for arbitration in accordance with its Voluntary Labor Arbitration rules, provided the Board pays all costs of the arbitration charged by the AAA and the Arbitrator. The decision of the arbitrator shall be final and binding upon both parties as provided by law.

Section 15.2 Failure of the employee, the Board or the Union to insist upon compliance with any provision of this Agreement at any given time or times under any given set or sets of circumstance shall not operate to waive or modify such provision, or in any manner whatsoever to render it unenforceable, as to any other time or times or as to any other occurrence or occurrences, whether the circumstances are, or are not, the same.

Section 15.3 No grievance may be initiated more than twenty (20) calendar days after the occurrence of one or both of the following events:

A. The knowledge of the occurrence of the condition giving rise to the grievance;

B. Written notice of said condition to the employee or employees involved.

ARTICLE 16
GENERAL PROVISIONS

Section 16.0 Employees are allowed a meal allowance of ten dollars ($10.00) when required by the Board to work at least three (3) hours beyond their normal quitting time.

Section 16.1 It is understood that the supervisor shall continue to serve under the direction of the Superintendent of Schools or his/her designee(s) and in accordance with Board and administrative policies, rules and regulations, provided that the provisions of this agreement shall supersede and prevail over any conflicting provisions.

Section 16.2

A. Board may require evidence that medical attention was obtained by employees who are absent for five (5) or more consecutive work days or who exhibit a pattern of habitual absenteeism. Employees should be prepared to present such medical documentation. The Board of Education may require an employee to undergo a physical examination at Board expense.

B. The Board of Education will require newly hired employees to undergo a physical examination prior to or at a time of initial employment.

Section 16.3 There shall be no alteration, variation or amendment of the terms and conditions of this Agreement, unless made and agreed to in writing by both parties. Any agreement must be approved by the Union membership and the Board of Education in order to become effective.

Section 16.4 If there is any previously adopted policy, rule, or regulation of the Board which is in conflict with any provision of the Agreement, said Agreement provision shall prevail during the term of this Agreement.

Section 16.5 When an employee is required by the Board to use his/her own vehicle to perform Board business, he/she shall be reimbursed at the IRS rate.

Section 16.6 The Union's business representative shall be permitted to visit specific job sites where bargaining unit members are employed. Notice is first given to the Superintendent or his/her designee, and such visits are to be at normal business hours and not interfere with the operation of the department.

Section 16.7 Any employee who is required by law or the Board to attend any training or conferences shall be reimbursed for enrollment fees, meals (where applicable), travel, and lodging (where applicable) in accordance with current Board policy.

Section 16.8 Credit Union payroll deductions shall be made for those employees who desire to be members of an available Credit Union.

Section 16.9 At least one (1) bulletin board or space on a bulletin board shall be placed, in an accessible place for the use of the Union for the posting of official Union notices or announcements.

Section 16.10 The Board will provide each employee with a copy of this Agreement within thirty (30) days after the date of the signing of this Agreement. New employees will be provided with a copy of this Agreement at the time of hire.

Section 16.11 Second shift employees may attend Union meetings with the stipulation that such meetings occur within Town limits after first arranging for any necessary coverage.

Section 16.12 All members of this bargaining unit who supervise one or more employees shall be provided with training concerning supervisory responsibilities and human rights and opportunities law.

Section 16.13 Any complaint made against a supervisor or person from whom he is administratively responsible for, shall promptly be called to the attention of the supervisor. In no case shall any anonymous complaint be formalized. No unsubstantiated complaint shall be placed in the employee's file. Employees shall be given copies of any complaint.

Section 16.14 Bargaining unit work should be performed by members of the unit.

Section 16.15 Evaluations: Employees of the bargaining unit shall be subject to annual evaluations. Employees may grieve such evaluations if they do not agree with any or all of their evaluations. The evaluation form to be used is attached as Appendix III.

Section 16.16 Vehicle Usage:

A. Members of this bargaining unit recognize that at times they will be Emergency Responders and, as such, will be allowed to use a Board of Education vehicle to and from school and during school days.

B. Any employee who is required to use his/her personal automobile on approved Board business will be reimbursed at the applicable IRS rate.

ARTICLE 17
WEARING APPAREL/REPLACEMENT

Section 17.0 The Board will pay for glasses broken or damaged on the job due to job conditions and not due to the employee's negligence.

Section 17.1 The Board of Education shall replace or reimburse the employee for personal items damaged or lost in the course of employment. The sum of such claims for the bargaining unit shall not exceed $2,000 annually.

ARTICLE 18
EDUCATION REIMBURSEMENT

Section 18.0 The Board of Education will reimburse employees for 85% of the tuition and lab fees for courses taken to enhance job skills, provided that the employee earns a passing grade. These courses must have prior administrative approval and be limited to one (1) per semester.

ARTICLE 19
DURATION

Section 19.0 This agreement shall become effective on July 1, 2017 and shall remain in effect through the 30th day of June, 2021. The parties shall provide notice to re-negotiate the terms of this Agreement pursuant to the Municipal Employee Relations Act (MERA).

IN WITNESS WHEREOF, the parties hereto have set their hands this _____ day of _____ _____, 2017.

FOR MANCHESTER BOARD OF EDUCATION

FOR LOCAL 818-49 OF COUNCIL 4 AFSCME, AFL-CIO

Matthew Geary
Superintendent of Schools

David Grande
Union President Local 818-49

Victoria Lynn DeFrank
Council 4 AFSCME

APPENDIX I
WAGES

Salary Schedule

Position	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Projects Supervisor	$85,371	$87,078	$88,820	$90,596
Maintenance Supervisor	$85,371	$87,078	$88,820	$90,596
Custodial Supervisor	$85,371	$87,078	$88,820	$90,596
Assistant Custodial/Maintenance Supervisor-2nd Shift	$69,360	$70,747	$72,162	$73,605

The salary rates for 2017-18 shall be applied retroactively to July 1, 2017.

A. Employees hired after the signing of this contract into any on of the bargaining unit positions will receive the stated salary, less six percent (6%), for the probationary period. At the end of the probationary period, the employee will receive the stated salary, less five percent (5%), until the completion of one-year of service. Upon completion of one-year of service, the employee will receive the stated salary.

B. There are currently two pay grades. Any changes to this structure will be negotiated with the Union.

APPENDIX III
Buildings and Grounds Supervisory Annual Evaluation

Name: _____

Title: _____ Date of Review: _____

INSTRUCTIONS:

2. Evaluate all factors on the basis of the approved job description for the position.
3. State the performance standard level of satisfactory (average performance).
4. Comments may be made on each factor, positive or negative or both.
5. Before signing off on the appraisal, a personal interview should be held with the employee for the purpose of giving appropriate praise, suggestions, and/or constructive criticism where needed.

1. JOB KNOWLEDGE: Consider the understanding and knowledge necessary to perform duties of a supervisor.

   __Needs Training __Unsatisfactory __Satisfactory __Above Average __Exceptional

   Comments: _____

   _____

2. QUALITY OF WORK: Consider the ability to supervise repairs, cleaning and the neatness, accuracy and completeness which are shown.

   __Needs Training __Unsatisfactory __Satisfactory __Above Average __Exceptional

   Comments: _____

   _____

3. QUANTITY OF WORK: Consider the volume of work produced under normal circumstances.

   __Needs Training __Unsatisfactory __Satisfactory __Above Average __Exceptional

   Comments: _____

   _____

4. INITIATIVE: Consider if the employee undertakes activities related to their job on their own. Also consider if the employee offers suggestions to improve the job environment and acts as a team player.

   __Needs Training __Unsatisfactory __Satisfactory __Above Average __Exceptional

   Comments: _____

   _____

5. COOPERATION: Consider the employee's cooperation toward work with co-workers, faculty and students. Also consider the ability to respond to requests from staff members and dedication.

__Needs Training __Unsatisfactory __Satisfactory __Above Average __Exceptional

Comments: _____

_____

6. ATTENDANCE: Consider the employee's frequency of absences.

__Needs Training __Unsatisfactory __Satisfactory __Above Average __Exceptional

Comments: _____

_____

7. SAFETY: Measures to protect persons and structures from hazards, code violations, OSHA regulations and basic safety factors.

__Needs Training __Unsatisfactory __Satisfactory __Above Average __Exceptional

Comments: _____

_____

8. OVERALL EVALUATION OF EMPLOYEE'S PERFORMANCE:

__Needs Training __Unsatisfactory __Satisfactory __Above Average __Exceptional

Comments: _____

_____

9. LEADERSHIP PERFORMANCE: Consider the ability of the supervisor to motivate, train, direct and supervise the daily activities of the department or employees.

__Needs Training __Unsatisfactory __Satisfactory __Above Average __Exceptional

Comments: _____

_____

EMPLOYEE'S COMMENTS: _____

_____

_____ _____

Administrator or Manager Date

I have received the above evaluation but my signature does not mean I agree with it and I'm aware that I can proceed through the Union grievance procedure.

_____ _____

Signature of Employee Date

SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Manchester Town and Board of Education
Open Access Plus Plan-OAP30/31 $20 OV 7/1/17

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	Your plan pays 100%	Your plan pays 80%
Maximum Reimbursable Charge	Not Applicable	300%
Calendar Year Deductible	Individual: None Family: None	Individual: $200 Family: $500

- Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses only counts toward your out-of-network deductible.
- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.

Note: Services where plan deductible applies are noted with a caret (^)

Calendar Year Out-of-Pocket Maximum	Individual: $5,100 Family: $10,200	Individual: $1,200 Family: $2,500

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- Plan deductible contributes towards your out-of-pocket maximum.
- All copays and benefit deductibles contribute towards your out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Physician Services		
Physician Office Visit • All services including Lab & X-ray • Plan pays 100% after you pay copay	$20 Primary Care Physician (PCP) copay or $20 Specialist copay	Your plan pays 80% ^
Surgery Performed in Physician's Office	Your plan pays 100%	Your plan pays 80% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 100%	Your plan pays 80% ^
Cigna Telehealth Connection services	$20 copay	Not Covered
• Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com).		
Allergy Treatment/Injections	Your plan pays 100%	Your plan pays 80% ^
Preventive Care		
Preventive Care	Your plan pays 100%	Your plan pays 80% ^
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. • Includes well-baby, well-child, well-woman and adult preventive care		
Immunizations-Includes travel related immunizations	Your plan pays 100%	Your plan pays 80% ^
Mammogram, PAP, and PSA Tests	Your plan pays 100%	Your plan pays 80% ^
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.		
Inpatient		
Inpatient Hospital Facility	$200 per admission copay, then your plan pays 100%	Your plan pays 80% ^
Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
Inpatient Hospital Physician's Visit/Consultation	Your plan pays 100%	Your plan pays 80% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100%	Your plan pays 80% ^
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible	$100 per facility visit copay, then your plan pays 100%	Your plan pays 80% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100%	Your plan pays 80% ^
Short-Term Rehabilitation	Your plan pays 100%	Your plan pays 80% ^
• Includes Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehabilitation and Cognitive Therapy. • 60 days maximum per Calendar Year (all therapies combined and reduced by any days used for Chiropractic Care) Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
Cardiac Rehabilitation • 36 days maximum per occurrence	$20 PCP or $20 Specialist copay	Your plan pays 80% ^
Chiropractic Care	$20 PCP or $20 Specialist copay	Your plan pays 80% ^
• 60 days maximum per Calendar Year (reduced by any days used for Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehabilitation and Cognitive Therapy. • Includes maintenance and massage therapy when in conjunction with Chiropractic Care		
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • Unlimited days maximum per Calendar Year • 16 hour maximum per day	Your plan pays 100%	Your plan pays 80% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 180 days maximum per Calendar Year	Your plan pays 100%	Your plan pays 80% ^
Durable Medical Equipment • Unlimited maximum per Calendar Year	Your plan pays 100%	Your plan pays 80% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies	Your plan pays 100%	Your plan pays 80% ^
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	Your plan pays 100%	Your plan pays 80% ^
Nutritional Formula • Birth to 12 years of age	Your plan pays 100%	Your plan pays 100% of billable charges
Osteopaths	$20 Specialist copay; then your plan pays 100%	$20 per visit deductible, then your plan pays 100% of billable charges
Naturopath	$20 Specialist copay; then your plan pays 100%	$20 per visit deductible, then your plan pays 100% of billable charges
Routine Foot Disorders	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Hearing Aid • $1,000 maximum per Calendar Year • Includes testing and fitting of hearing aid devices. • Coverage through age 12	Your plan pays 100%	Your plan pays 80% ^
Hearing Exams • 1 exam every 24 months	$20 PCP or $20 Specialist copay; then your plan pays 100%	Your plan pays 80% ^
Oral Surgery - Impacted Wisdom Teeth	Your plan pays 100%	Your plan pays 80% ^
Vision Care • Eye exam once every 24 months	$20 PCP or $20 Specialist copay; then your plan pays 100%	$20 per visit deductible, then your plan pays 100% of billable charges
Wigs • $350 maximum per Calendar Year	Your plan pays 100%	Your plan pays 100% of billable charges

Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lab and X-ray	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%		Plan pays 100%	Plan pays 80% ^
Advanced Radiology Imaging	Plan pays 100%	Plan pays 80% ^	Not Applicable	Not Applicable	Plan pays 100%		Plan pays 100%	Plan pays 80% ^

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.
Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

- Non Par Labs paid according to in-network OV, OP, IP and Independent Lab places of service.

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	$75 per visit (copay waived if admitted)		Plan pays 100%		Plan pays 100%	
Urgent Care	$50 per visit (copay waived if admitted)		Plan pays 100%		Plan pays 100%	

*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Bereavement Counseling	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^

Note: Services provided as part of Hospice Care Program

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity	$20 PCP or $20 Specialist copay	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	$20 PCP or $20 Specialist copay	Plan pays 80% ^	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Abortion (Elective and non-elective procedures)	$20 PCP or $20 Specialist copay	Plan pays 80% ^	$200 per admission copay, then plan pays 100%	Plan pays 80% ^	$100 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Family Planning - Men's Services	$20 PCP or $20 Specialist copay	Plan pays 80% ^	$200 per admission copay, then plan pays 100%	Plan pays 80% ^	$100 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
Infertility	$20 PCP or $20 Specialist copay	Plan pays 80% ^	$200 per admission copay, then plan pays 100%	Plan pays 80% ^	$100 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Unlimited lifetime maximum • Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.										
Dental Care	$20 PCP or $20 Specialist copay	Plan pays 80% ^	$200 per admission copay, then plan pays 100%	Plan pays 80% ^	$100 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.										
TMJ, Surgical and Non-Surgical	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Bariatric Surgery	$20 PCP or $20 Specialist copay	Plan pays 80% ^	$200 per admission copay, then plan pays 100%	Plan pays 80% ^	$100 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision										
Note: Services where plan deductible applies are noted with a caret (^)										

Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network
Organ Transplants	$200 per admission copay	$200 per admission copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 100%	Plan pays 80% ^
• Travel Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant						
Note: Services where plan deductible applies are noted with a caret (^)						

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	$200 per admission copay, then plan pays 100%	Plan pays 80% ^	$20 copay	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Substance Use Disorder	$200 per admission copay, then plan pays 100%	Plan pays 80% ^	$20 copay	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^

Note: Services where plan deductible applies are noted with a caret (^)

Note: Detox is covered under medical

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient, behavioral telehealth consultation and group therapy.

Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.

Pharmacy

Pharmacy benefits not provided by Cigna

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Maximum Reimbursable Charge

Out-of-Network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (300%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.

Additional Information

Medicare Coordination

Cigna will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B as permitted by the Social Security Act of 1965** as follows:

(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);

(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Cigna will pay as the Secondary Plan to Medicare Part A and B **regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Pre-Certification - Continued Stay Review - PHS Inpatient - required for all inpatient admissions

In Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- The lesser of 50% or $250 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are reduced by 50% for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are reduced by 50% for any additional days not certified by Cigna Healthcare.

Pre-Existing Condition Limitation (PCL) does not apply.

Your Health First - 200

Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or related to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
    - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
    - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or

Exclusions

- The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; Rhinoplasty; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or nonsurgical treatment of TMJ disorders.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or intellectual disabilities.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of eyeglasses or contact lenses for treatment of keratoconus or post cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered

Exclusions

drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.

- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under the benefit section.
- Reversal of male and female voluntary sterilization.

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

EHB State: UT

SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Manchester Town and Board of Education
Choice Fund Open Access Plus HSA BOE OAP38/39 - 2K/4K HSA Active 7/1/2017

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.	
Employer Contribution	Employee - $1,000 Family - $2,000

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	Your plan pays 100%	Your plan pays 80%
Maximum Reimbursable Charge	Not Applicable	300%
Contract Year Deductible	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000

- The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.
- All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.
- This plan includes a combined Medical/Pharmacy plan deductible.

Note: Services where plan deductible applies are noted with a caret (^)

Plan Highlights	In-Network	Out-of-Network
Contract Year Out-of-Pocket Maximum	Individual: $5,000 Individual - In a Family: $5,000 Family: $10,000	Individual: $5,000 Individual - In a Family: $5,000 Family: $10,000

- The amount you pay for all covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.
- Plan deductible contributes towards your out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.
- Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Physician Services		
Physician Office Visit • All services including Lab & X-ray	Your plan pays 100% ^	Your plan pays 80% ^
Surgery Performed in Physician's Office	Your plan pays 100% ^	Your plan pays 80% ^
Allergy Treatment/Injections	Your plan pays 100% ^	Your plan pays 80% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 100% ^	Your plan pays 80% ^
Cigna Telehealth Connection services	Your plan pays 100% ^	Not Covered
• Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com).		
Preventive Care		
Preventive Care	Your plan pays 100%	Your plan pays 80% ^
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Immunizations - Includes Travel Immunizations	Your plan pays 100%	Your plan pays 80% ^
Mammogram, PAP, and PSA Tests	Your plan pays 100%	Your plan pays 80% ^
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.		
Inpatient		
Inpatient Hospital Facility	Your plan pays 100% ^	Your plan pays 80% ^
Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
Inpatient Hospital Physician's Visit/Consultation	Your plan pays 100% ^	Your plan pays 80% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100% ^	Your plan pays 80% ^
Outpatient		
Outpatient Facility Services	Your plan pays 100% ^	Your plan pays 80% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100% ^	Your plan pays 80% ^
Cardiac Rehabilitation • 36 days maximum per contract year	Your plan pays 100% ^	Your plan pays 80% ^
Short-Term Rehabilitation Contract Year Maximums: o Includes Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehabilitation and Cognitive Therapy o 60 days maximum per Contract Year for all therapies combined o Includes Chiropractic Therapy (Includes chiropractors) Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	Your plan pays 100% ^	Your plan pays 80% ^
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • Unlimited days maximum per Contract Year • 16 hour maximum per day	Your plan pays 100% ^	Your plan pays 80% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 180 days maximum per Contract Year	Your plan pays 100% ^	Your plan pays 80% ^
Durable Medical Equipment • Unlimited maximum per Contract Year	Your plan pays 100% ^	Your plan pays 80% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies	Your plan pays 100%	Your plan pays 80% ^
External Prosthetic Appliances (EPA) • Unlimited maximum per Contract Year	Your plan pays 100% ^	Your plan pays 80% ^
Naturopaths	Your plan pays 100% ^	Your plan pays 80% ^
Osteopaths	Your plan pays 100% ^	Your plan pays 80% ^
Routine Foot Disorders Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered
Hearing Exam 1 exam every 2 contract years	Your plan pays 100%^	Your plan pays 80%^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Hearing Aid • $1,000 maximum per Contract Year • Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level • Coverage through age 12	Your plan pays 100% ^	Your plan pays 80% ^
Eye Care Services • Eye Exam every 24 months	Your plan pays 100% ^	Your plan pays 80% ^
Nutritional Formula • Birth to 12 years of age	Your plan pays 100% ^	Your plan pays 80% ^
Oral Surgery - Impacted Wisdom Teeth Inpatient Facility	Your plan pays 100% ^	Your plan pays 80% ^
Wigs • $350 maximum per Contract Year	Your plan pays 100% ^	Your plan pays 80% ^

Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lab and X-ray	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^		Plan pays 100% ^	Plan pays 80% ^
Advanced Radiology Imaging	Plan pays 100% ^	Plan pays 80% ^	Not Applicable	Not Applicable	Plan pays 100% ^		Plan pays 100% ^	Plan pays 80% ^

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.
Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit
- Non Par Labs paid according to in-network OV, OP, IP and Independent Lab places of service.

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	Plan pays 100% ^		Plan pays 100% ^		Plan pays 100% ^	
Urgent Care	Plan pays 100% ^		Plan pays 100% ^		Plan pays 100% ^	

*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^
Bereavement Counseling	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Note: Services provided as part of Hospice Care Program				
Note: Services where plan deductible applies are noted with a caret (^)				

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Note: Services where plan deductible applies are noted with a caret (^)								

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)										
Abortion (Elective and non-elective procedures)	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^
Family Planning - Men's Services	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
Infertility	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.										
Unlimited lifetime maximum										
Bariatric Surgery	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

Note: Services where plan deductible applies are noted with a caret (^)

Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered.
The following are excluded:

- medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity.
- weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision

Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network
Organ Transplants	Plan pays 100% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 80% ^

- Travel Lifetime Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant per Lifetime

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^
Substance Use Disorder	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^

Note: Services where plan deductible applies are noted with a caret (^)

Note: Detox is covered under medical

- Unlimited maximum per Contract Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient, behavioral telehealth consultation and group therapy.

Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy	In-Network	Out-of-Network
Cost Share and Supply		
Cigna Pharmacy Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply	**Retail (per 30-day supply):** Generic: You pay $10 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $40 **Retail (per 90-day supply):** Generic: You pay $20 Preferred Brand: You pay $50 Non-Preferred Brand: You pay $80 **Home Delivery (per 90-day supply):** Generic: You pay $20 Preferred Brand: You pay $50 Non-Preferred Brand: You pay $80	**Retail (per 30-day supply):** You pay 20% Your plan pays 80% **Home Delivery:** Not Covered

- Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.
- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan.
- Patient is responsible for the applicable cost share based upon the tier of the dispensed medication
- Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.
- If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.

Drugs Covered

Prescription Drug List:

Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

Some highlights:

- Coverage includes Self Administered injectables and optional injectable drugs – but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered
- Lifestyle drugs covered - limited to sexual dysfunction
- Non-Sedating Anti-histamines are covered
- Oral Fertility drugs covered
- Prescription vitamins covered
- Prescription weight loss drugs covered
- Prescription smoking cessation drugs covered
- Ulcer Drugs (Proton Pump Inhibitors/PPI) are covered

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications.
- Prior authorization is required on specialty medications but quantity limits may apply.
- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health and Wellness Coaching • Gaps in Care coaching for select conditions • Preference Sensitive Care/Treatment Decision Support Coaching	Included

Additional Information

Maximum Reimbursable Charge

Out-of-Network services are subject to a Contract Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (300%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.

Medicare Coordination

Cigna will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B as permitted by the Social Security Act of 1965** as follows:

(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);

(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Cigna will pay as the Secondary Plan to Medicare Part A and B **regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Pre-Certification - Continued Stay Review - PHS Inpatient - required for all inpatient admissions

In Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- The lesser of 50% of $250 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are reduced by 50% for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are reduced by 50% for any additional days not certified by Cigna Healthcare.

Pre-Existing Condition Limitation (PCL) does not apply.

Additional Information

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.

Exclusions

- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or related to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
    - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
    - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
    - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; Rhinoplasty; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or nonsurgical treatment of TMJ disorders.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

Exclusions

- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or intellectual disabilities.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of eyeglasses or contact lenses for treatment of keratoconus or post cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under the benefit section.
- Reversal of male and female voluntary sterilization.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

EHB State: UT