AGREEMENT

BETWEEN THE

NEW MILFORD BOARD OF EDUCATION

AND

NEW MILFORD
EDUCATIONAL SECRETARIES ASSOCIATION
CHAPTER OF LOCAL 136, I.F.P.T.E.

JULY 1, 2018 THROUGH JUNE 30, 2021

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PREAMBLE

The New Milford Board of Education (hereinafter referred to as the "Board") and the New Milford Educational Secretaries' Association, a Chapter of Local 136, International Federation of Professional & Technical Engineers, AFL-CIO, (hereinafter referred to as the "Union"), accept the provisions of this Agreement as commitments which they will cooperatively and in good faith honor, support and seek to fulfill, subject to the ability of the respective parties to perform under governing law.

The Union and the Board enter into this Agreement for the purpose of establishing equitable salary rates and working conditions for the employees covered by this Agreement; to provide for a mutually satisfactory settlement of grievances; and to contribute to the efficient operation of the school system.

This Agreement contains the full and complete agreement between the Board and the Union on all negotiable issues, and neither party shall be required during the term hereof to negotiate upon any issue, whether it is covered or not covered in this Agreement.

ARTICLE I – RECOGNITION

Section 1.1.

The Board recognizes the Union as the sole and exclusive collective bargaining representative with respect to wages, rates of pay, hours of work and other conditions of employment of all regular full-time and regular part-time secretarial/clerical/technical employees employed by the Board for twenty (20) or more hours per week in accordance with the certification of the Union issued by the Connecticut State Board of Labor Relations on March 29, 1984 in Case No. ME-8383 (Decision No. 2297) and in Case No. ME-20,301 (Decision No. 3650) as revised with job titles and appendixes herein. Excluded from the bargaining unit are the following: Administrative Assistant to the Superintendent; professional employees, including but not limited to the Network Administrator and the Technology Director; students; temporary employees; security personnel; supervisory employees; and all other employees excluded by the Act.

ARTICLE II – HOURS OF WORK AND WORK YEAR

Section 2.1. Work Year Definitions.

A. The term "Calendar Year Employee(s)" as used throughout this Agreement is hereby defined to mean any employee(s) assigned by the Superintendent to a normal work year of fifty-two (52) weeks in a fiscal year. Calendar year employees work twenty (20) to forty (40) hours each per week. During Leap Year employees shall be paid for the extra day worked.

B. The term "School Year Employee(s)" as used throughout this Agreement is hereby defined to mean any employee(s) assigned by the Superintendent to a normal work year of at least one hundred eighty (180) work days in a fiscal year. School year employees work twenty (20) to forty (40) hours each per week. When school year employees are assigned to work additional days, they shall be paid at their regular hourly rate.

C. The term "Full-Time Employee(s) as used throughout this Agreement is hereby defined to mean any calendar or school year employee(s) assigned by the Superintendent to work thirty (30) or more hours per week.

D. The term "Part-Time Employee(s) as used throughout this Agreement is hereby defined to mean any employee(s) assigned by the Superintendent to work at least twenty (20) but less than thirty (30) hours per week. The number of part-time bargaining unit positions shall be limited to six (6).

Section 2.2.

The basic work week shall be Monday through Friday, excluding Saturdays, Sundays and holidays when schools are not in session.

Section 2.3.

School year employees will be notified by July 10th of each year, or as soon thereafter as is feasible, of their work schedules for the coming year.

Section 2.4.

All employees shall have a duty-free paid lunch period of thirty (30) minutes in length.

Section 2.5.

Each employee, in addition to the duty-free paid lunch, will be entitled to a fifteen (15) minute break for each four (4) hours worked. Employees working less than eight (8) hours per day will be entitled to take only one (1) fifteen (15) minute work break. Employees working eight (8) hours a day may not schedule breaks combined unless approved by the employee's supervisor.

ARTICLE III – BOARD'S RIGHTS

Section 3.1.

Except as expressly provided otherwise by the specific terms of this Agreement, the Board, acting through itself or through the Superintendent or his/her designees, has and will continue to retain, whether exercised or not, the sole and unquestioned right, responsibility and prerogative to direct the public school system of the Town of New Milford in all its respects, including but not limited to the operation of the schools, the direction of the staff, the establishment of reasonable work rules and the power and authority conferred upon the Board by law. No action taken by the Board pursuant to this Article, other than in direct contravention of an explicit provision of this Agreement, will be subject to the grievance and arbitration procedure hereof.

ARTICLE IV – GRIEVANCE AND ARBITRATION PROCEDURE

Section 4.1. Definitions.

A. For the purpose of this Agreement, the term "grievance" shall mean any complaint by an employee, group of employees, or the Union involving the violations, interpretation or application of an explicit provision(s) of this Agreement.

B. As used in this Agreement, the term "grievant" shall mean any employee, group of employees, or the Union.

C. As used in this Agreement, the term "working days" shall mean those days when the Central School Administration offices are in operation.

D. For the purposes of this Agreement, responses by Board representatives including immediate supervisors and the Superintendent or designee in all Steps of the Grievance Procedure shall be given to the Union.

E. "Designee" shall mean any Board Representative designated by the Superintendent who is not the subject of the grievance.

F. As used in this Agreement, the term "notified in writing" shall include US postal mail or electronic communication to both personal and school e-mail accounts.

Section 4.2. Representation.

A. An employee shall have the right to be represented by the Union at every stage of the Grievance Procedure. No more than two people from those listed in sub-section (B) herein shall represent the employee, and said Union representatives need not be the same person(s) at each Step.

B. Those persons authorized to represent an employee in the Grievance Procedure shall include: Union officers, members of the Local's Grievance Committee, and staff members of the International Union.

C. An employee who is a grievant shall have the right to be present at, and participate in each Step of the Grievance Procedure.

Section 4.3. Informal Procedure – Immediate Supervisor.

A. The grievant shall, within fifteen (15) working days following the occurrence giving rise to the grievance, discuss the grievance with his/her immediate supervisor in an effort to resolve the problem informally.

B. The immediate supervisor shall attempt to resolve the grievance promptly, and shall respond verbally and in writing to the grievant within five (5) working days from the date of this discussion.

Section 4.4.

If the grievance affects a group or class of employees of the unit, or if it involves monetary matters such as wages and benefits, the grievance shall be submitted by the Union directly to the Superintendent or designee. Grievances filed by the Union shall be filed in writing with the Superintendent within fifteen (15) working days following the occurrence giving rise to the grievance. Following the filing of the Union's grievance, the same procedure and time limits as set forth in Section 4.5, sub-section (A) of this Article shall govern.

Section 4.5. Formal Procedure.

A. Superintendent or Designee. If the grievant is not satisfied with the answer of the immediate supervisor in the Informal Procedure, the grievant shall submit the grievance in writing to the Superintendent or designee within ten (10) working days after the immediate supervisor's verbal answer but in no case more than fifteen (15)working days following the occurrence giving rise to the grievance. The Superintendent or designee shall conduct a separate investigation of the grievance and shall schedule a meeting with the grievant and the Union representative(s) within seven (7) working days of the filing of the grievance by the grievant. The Superintendent or designee shall render an answer in writing to the grievant, with reasons therefor, within five (5) working days from the date of the meeting with the grievant and Union representatives.

B. Board of Education. If the grievance is not resolved to the satisfaction of the grievant or Union as a result of the Superintendent's or designee's answer, the grievant shall submit the written grievance to the Board through the Board Chairman, but must do so within five (5) working days after receipt of the Superintendent's or designee's answer. The Board Chairman and/or other Board members designated by the Board shall review the grievance, shall grant a hearing, and shall render an answer with reasons therefor in writing to the grievant within thirty (30) working days after the Board's receipt of the grievance.

C. Arbitration. If the grievance is not resolved to the satisfaction of the grievant or Union, the grievance may be submitted to arbitration by the Union, but must be done in accordance with all these provisions and conditions:

1. The grievance must involve the violation, interpretation, or application of a specific provision of this Agreement.

2. The submission to arbitration must be made in writing by the Union by certified mail, return receipt requested, with a copy of the submission to the Superintendent, both to be postmarked within fifteen (15) days immediately following the receipt by the grievant of the Board's written answer.

3. The submission to arbitration must be to the American Arbitration Association, in accordance with its current voluntary rules for labor arbitration. The party prevailing in the arbitration shall be reimbursed by the other party for its share of the filing fee.

4. The grievance submitted to arbitration must be the same grievance which was submitted to the Superintendent in the First Step of the Formal Procedure.

D. Selection and Procedure. The selection of the arbitrator and the procedure for conducting the arbitration process shall be in accordance with the Voluntary Labor Arbitration rules of the American Arbitration Association. The decision of the arbitrator shall be final and binding, subject to the right of either party to have the Award confirmed, vacated, or modified according to law. The arbitrator's authority shall be limited to determining whether the Board has violated, misapplied, or misinterpreted a specific provision or provisions of this Agreement. The Arbitrator shall not have any power or authority to add to, delete from or modify in any way any provision of this Agreement.

E. The cost of the arbitrators' services shall be borne equally by the Board and the Union.

Section 4.6. Time Limits.

A. Any grievance which is not processed by the Grievant or the Union in strict compliance with the time limits set forth herein shall become null and void and shall be considered resolved. If a grievable situation continues or reoccurs within a fiscal year, such continuation or reoccurrence shall not extend the initial time for filing a grievance and shall not be considered a separate grievance.

B. Any response by the Board representatives, including immediate supervisors, Superintendent or designee, or Board of Education members, which is not given within the time limits set forth herein for such responses shall give the grievant the option to proceed to the next Step of the Grievance Procedure without waiting for such response.

C. Time limits set forth herein may be extended only by written agreement of the parties.

ARTICLE V – NON-DISCRIMINATION

Section 5.1.

Neither the Board nor the Union will discriminate against any employee because of membership or non-membership in the Union. Grievances brought under this Article are subject to the grievance procedure up to and not including arbitration.

ARTICLE VI – UNION MEMBERSHIP PROVISIONS

Section 6.1.

Upon receipt of an employee's written authorization on an authorized dues deduction card, the Board shall deduct on the first pay day of each month, or at a time mutually agreed upon by the parties, from the pay of such employee, Union dues in an amount that shall be specified by duly authorized Union officials. Dues collected by the Board shall be transmitted to the Union, accompanied by a list of names of those employees from whose pay deductions were made. The Union shall hold the Board harmless against any claims and any other forms of liability which may arise by reason of any action taken in making deductions for membership dues.

Section 6.2.

The Board agrees to supply each current employee with a copy of the Collective Bargaining Agreement between the Union and the Board, and to supply each new employee information regarding payroll options (tax sheltered annuities, credit union, bonds, etc.) along with a copy of the Agreement, and job description.

Section 6.3.

The Board shall make available to the Union each year within thirty (30) days after the signing of the Agreement, or the anniversary date of the Agreement, a list of employees within the bargaining unit, showing their dates of hire, job classifications, increment steps and hourly rate.

Section 6.4.

Within thirty (30) days after a new employee has been placed on the payroll, the Board shall notify the Union in writing of the name, date of hire, job classification and incremental step of such employee.

Section 6.5. The parties recognize that the Agency Shop provisions herein are subject to applicable law, and in the event these provisions are proscribed by law in the future, the provisions of this Section may be rendered null and void in whole or in part.

ARTICLE VII – UNION BUSINESS RIGHTS

Section 7.1.

Normally, it is agreed that all activities concerning Union Business shall be held before or after school hours, not during the work day.

Section 7.2.

Union business of an urgent nature may be conducted by Union officials during the course of the working day with the approval of the Superintendent or designee.

Section 7.3.

Negotiation and grievance sessions will be conducted at a time mutually convenient for the Board and the Union. Normally negotiations will not be held during working hours.

Section 7.4.

Union members meeting with Board of Education officials during work hours as set forth in Sections 7.2 and 7.3 of this Article will not incur a loss of pay.

ARTICLE VIII – COMPENSATION

Section 8.1.

Regular straight time hourly rates (hereinafter referred to as "base rates") payable to employees are set forth on the schedules contained in Appendix A.

Section 8.2.

No employee shall advance to a base rate of pay higher than that set for the maximum step or his/her salary schedule.

Section 8.3.

A. Employees hired within six (6) months prior to any July 1, who have not successfully completed their probationary periods of employment prior to July 1, will not advance to the next higher step until they have completed said probationary periods, subject to sub-section B below.

B. In years 1 and 2, there will be no step movement; each step will increase by 42¢ per hour in years 1 and 2, Year 1 wage increases shall be paid retroactively. There will be step movement in the third year of this Agreement and the people at max prior to the third year shall receive increases per Appendix A.

Section 8.4.

Employees shall be paid at their respective base rates for each hour they work up to a maximum of forty (40) hours, inclusive, in a payroll week.

Section 8.5.

All School Year Employees shall receive a minimum of twenty-two (22) paychecks per year. An employee who works a fraction of a pay period shall be paid for such time worked in that same pay period. All such payments shall be considered "paychecks". When an "emergency no school" day reduces the amount of time worked during a given pay period, school year employees shall be paid for the full pay period and shall make up any time lost at the end of the school year or as agreed upon by the building supervisor, without additional compensation. All payments will be made by direct deposit.

Section 8.6.

In the employment of new personnel, the Board reserves the right to grant full or partial credit for work experience in or out of the school system for placement on the Salary Schedule, but in no event shall any new employee be placed on a step higher than a current employee with the same number of years of experience as an employee of the New Milford Board of Education.

Section 8.7.

An employee who is assigned as a temporary substitute to a position with a higher classification after serving in that assignment for two (2) consecutive workdays shall be paid at the hourly rate of the higher classification in the step of the higher classification that corresponds to his/her own step, payable back to the first day.

Section 8.8.

When the Board requires the employees to attend in-service workshops or other training during a normal work day and/or a non-work day, the employees shall be compensated at their normal rate of pay.

Section 8.9.

All employees who are required by assignment to travel between schools within the work day shall be reimbursed at the published IRS rate.

ARTICLE IX – OVERTIME POLICIES

Section 9.1.

A. All approved overtime worked beyond eight (8) hours per day or forty (40) hours per week shall be paid at time and one-half the employee's straight time hourly rate except that all employees shall be paid at the rate of time and one-half for all time worked on Saturdays, and two times their regular rate of pay for all time worked on Sundays and holidays.

B. All approved overtime worked Monday through Friday up to eight (8) hours per day and/or forty (40) hours per week shall be paid at the employee's straight time hourly rate. No compensatory time shall be granted for this overtime work.

Section 9.2.

Any overtime work is to have the approval of the Superintendent or designee. Overtime is paid at time and one-half or double time.

ARTICLE X – LONGEVITY

The benefits set forth in this Article are only available to employees hired on or before January 1, 2013.

Section 10.1.

Upon completion of ten (10) years of service, a full-time employee shall receive five hundred dollars ($500.00), with annual increments of fifty dollars ($50.00) to a maximum of one thousand dollars ($1,000.00) upon completion of twenty (20) years of service and thereafter. Part-time employees who qualify shall receive the foregoing longevity benefits pro-rated at the rate of fifty per cent (50%).

Section 10.2.

Longevity pay shall be paid to an employee in a lump sum the first pay day following the anniversary date of his/her employment.

Section 10.3.

In the event of the death of an employee prior to the anniversary date of his/her employment, or in the event that an employee shall retire prior to said anniversary date, or in the event an employee resigns prior to said anniversary date, a longevity payment which would have become due upon the anniversary date of his/her employment following death, retirement or resignation shall be prorated based upon the number of months actually worked by the employee from the preceding anniversary date of his/her employment to the date of death, retirement or resignation.

ARTICLE XI – HEALTH, MEDICAL, DENTAL, LIFE AND DISABILITY BENEFITS

Section 11.1.

The Board shall make the following health, life and disability insurance coverage available to each eligible full-time employee:

A. Health Insurance Coverage.

1. The Board shall provide group health insurance coverage as described in Appendix D of the 2015-2018 collective bargaining agreement through 12/31/18; the Board shall provide group health insurance as described in the Medical and Dental Insurance Plans set forth in Appendix C of this Agreement, effective 1/1/19. The Board shall contribute 35% of the applicable HDHP deductible (funded 50% on January 1 and 50% on July 1).

2. An employee enrolled under the health insurance plan (medical, prescription drug and/or dental) will participate in premium sharing as follows:

	Effective 1/1/19	Effective 1/1/20	Effective 1/1/21
• Individual coverage	17%	18%	19%
• Two-Person coverage	17%	18%	19%
• Family coverage	17%	18%	19%

The Board shall maintain a "Section 125" Salary Reduction Agreement for the purpose of enabling eligible employees to divert a portion of their gross salaries, prior to reduction for federal income or social security taxes, by a minimum of $250 to a maximum of $1,000 per Plan Year for Health Reimbursement, and by a minimum of $250 to a maximum of $5,000 per Plan year for Dependent Care, into an account from which, during the course of the Plan Year, they can be reimbursed for Health Care costs and Dependent Care costs they or their covered dependents incur that are not covered by the Health Insurance Plans described in the Agreement between the Board and the Union, including, but not

limited to, their share of the premium costs for such Plans. The Board makes no representations or guarantees as to the initial or continued viability of such a Salary Reduction Agreement, and shall incur no obligation to engage in any form of impact bargaining in the event that a change in law reduces or eliminates the tax exempt status of employee insurance premium contributions. So long as the Board makes a good faith effort to comply with this paragraph, neither the Union nor any employee covered by this Agreement shall make any claim or demands, nor maintain any action against the Board or any of its members or agents for taxes, penalties, interest or other cost or loss arising from a flaw or defect in the Salary Reduction Agreement, or from a change in law which may reduce or eliminate the employee tax benefits to be derived therefrom. This waiver on the part of the Union shall not extend to acts which may be committed by the Board or its agent(s) other than acts in furtherance of the I.R.C. Section 125 plan.

3. Vision Care Plan as outlined in Appendix D.

B. Group Term Life Insurance. Group term life insurance coverage (employee only) is provided in face amounts depending on completed years of service as follows:

1. Each full-time employee with less than three (3) years of service shall be provided with term life insurance coverage in an amount equal to twenty-five percent (25%) of annual salary, at the expense of the Board.

2. Each full-time employee with three (3) years or more of service shall be provided with term life insurance coverage in an amount equal to one hundred percent (100%) of annual salary, at the expense of the Board.

3. For life insurance purposes, the annual salary is rounded to the nearest multiple of $500.

C. Long Term Disability Insurance. Long-term disability insurance coverage is provided under which a full-time employee who becomes totally and permanently disabled shall receive monthly benefit payments equal to sixty-six and two-thirds percent (66-2/3%) of the employee's monthly salary beginning immediately after such disability has been certified by the employee and his/her physician, and continuing until either retirement (other than retirement for which disability benefits are paid to the employee) or age sixty-five (65). Such long-term disability insurance benefits shall be payable only after the employee has used up all his/her sick leave benefits, or three (3) months from the commencement of total disability, whichever is later. (Long-term disability insurance shall be implemented as soon as possible after signing of the Agreement.)

Section 11.2.

The Board reserves the right to change insurance carriers or to self-insure in whole or in part at any time provided the level of benefits in effect as of the date of this Agreement shall be equal to or better than existing levels of benefits. If any change in carriers is being considered, Board officials shall meet with the Union President to discuss such matter in advance of any decision on the matter. The size and scope of a preferred provider network of physicians, hospitals, pharmacies, etc. shall not be a factor in determining the duplication of benefits by an insurance carrier or managed care vendor. It is agreed that an alternative insurance carrier or

managed care vendor can be selected by the Board provided that the new insurance carrier or managed care vendor network includes 80% of the hospitals and physicians in Litchfield and Fairfield Counties of the current preferred provider network of hospitals and physicians.

Section 11.3.

Eligibility for benefits set forth in Section 11.1 hereof shall be determined exclusively in accordance with the provisions of the respective insurance policies acquired by the Board to provide said benefits, and any dispute relating to eligibility for or the amount of benefits paid in any individual case shall be processed by the employee directly with the respective insurance carrier and shall not subject the Board to any claim in any form, and shall not be subject to the Grievance and Arbitration Procedure.

Section 11.4. Annual Payment In Lieu of Health Insurance.

A. A full-time employee who is eligible for two-person or family health insurance coverage offered by the Board pursuant to Section 11.1. A. above may voluntarily elect to waive all such coverage provided the employee presents proof of comparable alternative insurance through a plan that is not a Board-sponsored insurance plan and not a Medicare plan. Any employee who wishes to waive dental insurance only may do so but shall not be eligible for any payment in lieu of dental insurance.

B. The procedures to elect a waiver of health insurance coverage are as follows:

1. The employee must complete an appropriate waiver of insurance form and provide evidence of existing comparable alternative health insurance coverage. The form and the evidence of insurance coverage must be completed during the open enrollment period and submitted to the Board's Business Office.

2. The waiver of insurance shall be in effect for one year. Once the waiver form has been filed with the Board, the waiver shall continue to be in effect from year-to-year thereafter until the employee elects to reenroll in the health insurance plan pursuant to sub-section E. below.

C. A full-time employee waiving health insurance coverage shall be paid the sum of $1,000 to be paid annually in the month following the twelve month period in which the insurance coverage was waived.

D. Newly hired full-time employees electing to waive health insurance coverage may do so upon commencing employment with the insurance waiver taking effect on the normal effective date for health insurance coverage. The first payment shall be made to the employee on a pro-rata basis.

E. In the event a full-time employee who has elected to waive health insurance coverage wishes to reinstate such coverage, the following shall apply:

1. Except as provided in 2. below, application for health insurance must be made during the enrollment period; coverage will be reinstated at the start of the next twelve month insurance period.

2. An employee who loses alternative health insurance due to a "qualifying event" may request to reenroll in the Board's health insurance plan. A request for reinstatement must be made in writing to the Business Office. Reinstatement of coverage shall be approved upon the employee's submitting satisfactory proof of loss of alternative health insurance coverage due to a "qualifying event". The health insurance will be reinstated as soon as the insurance provider is able to effectuate the coverage.

3. Any employee who has waived insurance coverage and then loses alternative health insurance due to a "qualifying event" shall be entitled to a prorated payment in the following year provided the coverage waiver was in effect for at least six months.

ARTICLE XII – HOLIDAYS

Section 12.1.

A. The following holidays are considered paid holidays for employees, and are subject to provisions set forth herein:

For Full-Time Calendar Year Employees (15.5)	For Full-Time School Year Employees (13)
Labor Day	Labor Day
Rosh Hashanah	Rosh Hashanah
Yom Kippur	Yom Kippur
Columbus Day	Columbus Day
Veterans Day	Veterans Day
Thanksgiving Day	Thanksgiving Day
Day after Thanksgiving	Day after Thanksgiving
Day before Christmas	
Christmas Day	Christmas Day
½ day New Year's Eve	
New Year's Day	New Year's Day
Martin Luther King Day	Martin Luther King Day
Presidents' Day	Presidents' Day
Day of Thanksgiving/Prayer	Day of Thanksgiving/Prayer
Memorial Day	Memorial Day
Independence Day	

B. Part-time Calendar Year employees shall be entitled to five (5) paid holidays. Part-time School Year employees are not entitled to holiday pay.

Section 12.2.

Each employee shall be given the day off without loss of pay (computed at his/her base rate times the number of straight time hours in his/her normal work schedule for that day) for each holiday listed for his/her group in Section 12.1 hereof.

Section 12.3.

To be eligible for holiday pay, the employee must work the last scheduled work day immediately preceding the holiday and the first scheduled work day following the holiday unless he/she is absent on such days because of illness or some compelling reason acceptable to the Superintendent.

Section 12.4.

If an employee is absent from work due to a short term illness (i.e. five days or less), on the day of a paid holiday, he/she will not be charged with a sick day for that day.

Section 12.5.

If a holiday should fall on Saturday, it shall be observed the preceding Friday, and if a holiday falls on a Sunday, it shall be observed on the succeeding Monday. However, employees who are assigned to the schools will not take holidays on any day when school is in session, in which case a substitute day will be designated by the Superintendent.

ARTICLE XIII – VACATIONS

Section 13.1.

A. Full-Time Calendar Year Employees shall be entitled to paid vacation time as follows:

1. Following completion of 6 months of continuous service in the New Milford Public School System: 5 days paid vacation each year.

2. Following completion of 2 years of continuous service in the New Milford Public School System: 10 days paid vacation each year.

3. Following completion of 5 years of continuous service in the New Milford Public School System: 15 days paid vacation each year.

4. For employees hired on or before January 1, 2013, following completion of 10 years of continuous service in the New Milford Public School System: 20 days paid vacation each year.

5. For employees hired on or before January 1, 2013, following completion of 20 years of continuous service in the New Milford Public School System: 25 days paid vacation each year.

B. Full-Time School Year Employees hired before January 1, 2008 shall be entitled to paid vacation time as follows:

1. Following completion of 1 year of continuous service in the New Milford Public School System: 3 days paid vacation each year.

2. Following completion of 2 years of continuous service in the New Milford Public School System: 5 days paid vacation each year.

3. Following completion of 5 years of continuous service in the New Milford Public School System: 10 days paid vacation each year.

4. Following completion of 10 years of continuous service in the New Milford Public School System: 15 days paid vacation each year.

5. Following completion of 20 years of continuous service in the New Milford Public School System: 20 days paid vacation each year.

Full-Time School Year Employees hired on or after January 1, 2008 are not entitled to paid vacation. Employees hired before January 1, 2008 shall not be permitted to increase paid vacation time after January 1, 2013.

C. Part-Time Calendar Year Employees shall be entitled to paid vacation time as follows:

1. Following completion of 5 years of continuous service in the New Milford Public School System: 1 day of paid vacation each year.

2. Thereafter, for each additional year of continuous service in the New Milford Public School System: An additional day of paid vacation to a maximum of 5 days of paid vacation each year.

Part-Time School Year Employees are not entitled to paid vacation.

D. Paid vacation days shall be scheduled by mutual agreement between the employee and his/her immediate supervisor. For employees assigned to schools, except calendar year employees at the High School, Schaghticoke, and Sarah Noble, paid vacation days shall not be taken on days when school is in session.

E. No employee may take more than two (2) weeks vacation time consecutively unless agreed to by his/her supervisor.

Section 13.2.

A. Employees shall begin to earn vacation credit from their most recent day of hire.

B. Calendar Year Employees shall have the right to carry over a maximum of two weeks of vacation leave due them or any fraction thereof to the following year provided the permission of the Superintendent or designee is obtained.

C. Employees who are eligible for paid vacation and who transfer from a calendar year to a school year position or from a school year position to a calendar year position shall carry their continuous service with them and shall receive paid vacation time according to the applicable schedule.

Section 13.3.

A. For each day of earned vacation taken, employees shall be paid at the base rate currently in effect multiplied by the number of hours per day for which they are scheduled.

B. Vacation pay shall be paid to the employee before the employee goes on vacation provided the employee follows established procedures for requesting such payment. In order to receive vacation pay prior to a scheduled vacation period of five (5) days or more, the employee should request the same at least one pay period in advance.

Section 13.4.

For all vacation time unused at the time of an employee's retirement, termination, layoff or death, the employee (or his/her beneficiary or estate in the case of death) shall receive one day's pay for each unused day. This will include all days described in Section 13.2. B above.

ARTICLE XIV – LEAVES OF ABSENCE

Section 14.1. Sick Leave.

A. 1. Full-Time Employees employed prior to July 1, 1994 shall be entitled to fifteen (15) paid sick leave days per fiscal year that may accumulate to a maximum of one-hundred fifty (150) sick leave days.

2. Full-Time Calendar Year Employees hired on or after July 1, 1994 shall accrue paid sick leave credit at a rate of three-quarters of a day for each month worked to a maximum of nine (9) sick leave days during the first employment year. Thereafter, these employees shall be entitled to thirteen (13) paid sick days per fiscal year that may accumulate to a maximum of one hundred twenty (120) sick days.

3. Full-Time School Year Employees hired on or after July 1, 1994, shall accrue paid sick leave credit at the rate of two-thirds of a day for each month worked to a maximum of eight (8) paid sick days during the first employment year. Thereafter, these employees shall be entitled to nine (9) sick days per fiscal year that may accumulate to a maximum of eighty (80) sick leave days.

4. Part-Time Calendar Year Employees shall accrue paid sick leave credit at the rate of one-half (1/2) day per calendar quarter worked to a maximum of two (2) days during the first employment year. Thereafter, these employees shall be entitled to three (3) paid sick days per fiscal year. These paid sick days shall not accumulate.

5. Part-Time School Year Employees are not entitled to paid sick leave.

B. Sick leave days shall be used only for the employee's illness or injury, and shall be paid at the employee's normal daily rate of pay (employee's base rate of pay times the hours normally assigned on a work day).

C. Paid vacation time off pursuant to Article XIII shall be considered as time worked for purposes of accumulating sick leave credit under Section 14.1 A.

D. Paid sick leave days up to the number accumulated may be used for disabilities covered by the Workers' Compensation Commission. Any funds received as Workers' Compensation may be endorsed to the New Milford Board of Education Payroll Account as long as sick leave pay is available and received. If and when sick leave days become exhausted, the employee shall receive workers' compensation only.

Section 14.2.

Furthermore, all such authorized leaves of absence except leaves without pay specifically provided for in this Agreement shall be considered as time worked for purposes of computing the employee's weekly salary.

Section 14.3. Special Leave Days.

A. A special leave day is defined as a day off from work granted by the Superintendent or designee without loss of pay at the employee's regular straight time hourly rate to enable the employee to take care of some compelling business which cannot be taken care of during the employee's non-work time, such as a real estate closing; out of town travel to graduation of the employee or a member of his/her immediate family (as defined in Section 14.5); or some other similarly compelling reason acceptable to the Superintendent or designee.

B. Employees shall be entitled to paid special leave days in each fiscal year as follows:

Newly hired employees shall not be entitled to paid special leave days in their first year of employment. In the following fiscal year, the number of special leave days shall be pro-rated, based upon the employee's one year anniversary date.

Thereafter:

Full-Time Calendar Year Employees – 4.
Full-Time School Year Employees – 3.
Part-Time Employees – None.

The use of special leave days is subject to approval by the Superintendent or designee. For one special leave day each year, the employee is not required to give a reason. Requests for such leave must be made as far in advance as is practicable and at least twenty four (24) hours in advance of the requested day(s) off.

Section 14.4. Jury Duty.

Employees who are called to serve the courts as jurors shall receive for each day lost from work due to such time spent on jury duty, the difference between his/her regular daily compensation and the per diem received for jury duty, if the latter is less.

Section 14.5. Bereavement Leave.

In the event of death in the employee's immediate family, the employee shall be granted leave without loss of pay at the employee's regular straight time hourly rate not to exceed five (5) consecutive working days, including the day of the funeral. For the purpose of this Section, "immediate family" shall include: parent, sister, brother, spouse, significant other, child, mother and father of the spouse, grandparents and grandchildren. In the event of the death of a relative other than those specified in this Section and domiciled in the employee's home at the time of death, requests for bereavement leave with pay shall be made to the Superintendent or designee.

Section 14.6. Leaves Without Pay.

Leaves of absence for up to one (1) year without pay and benefits may be granted at the discretion of the Board for valid reasons such as family crisis or ill health. Upon return from this leave, the employee shall be assigned to his/her former position or an equivalent position, and shall return to the step of the Pay Plan he/she occupied at the time he/she went on leave. The employee may elect to continue health insurance coverage during the leave at his/her own expense. When the Federal Family and Medical Leave Act applies, the employee must continue to pay only his or her share of the premium for the FMLA period and 100% of the premium thereafter.

Section 14.7.

If school is in session and is closed early due to storm or emergency, all employees may be dismissed early at the Superintendent's discretion, with pay. If school openings are delayed, employees may report to work as soon as possible and no later than sixty (60) minutes after their regular starting time without loss of pay. If the employee believes that it is impossible to report to work due to road conditions or other safety issues based on, but not limited to, weather conditions, distance traveled, etc., then after giving notice to the Superintendent or designee, if the employee does not report to work, said employee shall have the option to use a personal day or vacation day rather than report to work.

Section 14.8.

A. Disabilities caused or contributed to by pregnancy, miscarriage, childbirth and recovery therefrom, shall be treated as temporary disabilities for all job-related purposes.

B. Unpaid disability leave beyond any accumulated sick leave shall be available for such reasonable further period of time as a female employee is determined by her physician to be disabled from performing the duties of her job because of pregnancy or conditions attendant thereto. The Board reserves the right to require an independent medical evaluation.

C. The employee shall notify the Superintendent in writing at least two (2) months before the anticipated commencement of disability due to pregnancy unless emergency medical conditions exist.

ARTICLE XV – SENIORITY

Section 15.1.

A. Seniority for employees within this bargaining unit prior to July 1, 1994, shall be an employee's continuous length of service with the Board measured from said employee's most recent date of hire as it pertains to job security, layoffs, transfers (voluntary or involuntary), longevity, and vacation.

B. Seniority for employees hired or transferred into this bargaining unit after July 1, 1994, as it pertains to longevity and vacation, shall be an employee's continuous length of service with the Board measured from said employee's most recent date of hire.

C. Seniority for employees hired or transferred into this bargaining unit after July 1, 1994, as it pertains to job security, layoffs, and transfers (voluntary/involuntary), shall be based solely on an employee's length of service within this bargaining unit measured from said employee's most recent date of hire into this bargaining unit.

Section 15.2.

Seniority shall be lost or terminated under the following conditions:

A. Resignation from employment;

B. Discharge for just cause;

C. After a layoff of more than eighteen (18) months;

D. Failure on the part of a laid-off employee to return to work within ten (10) working days from the date of receiving certified notification to report back to work.

Section 15.3.

The seniority of each employee shall continue to accrue during all authorized leaves of absence. In any calendar year, school-year employees shall accrue seniority equal to calendar year employees. School-year employees' seniority shall continue to accrue during the summer period. Part-time employees hired on or after July 1, 2007 shall accrue seniority at the rate of one-half a calendar year.

Section 15.4.

The term "probationary employee(s)" is hereby defined to mean any employee(s) who is in his/her first four (4) months of employment in a bargaining unit position. The probationary period may be extended for an additional thirty (30) working days upon mutual agreement of the parties. The Union shall be notified when the four (4) months probationary period has ended.

Probationary employees may be terminated at any time at the sole discretion of the Board. Benefits for all employees will begin thirty days after they are employed, or in the case of

insurance benefits, in accordance with the policies as provided by the Board. Seniority shall accrue from date of hire if the probationary period is successfully completed.

Section 15.5.

A. An employee who transfers outside the bargaining unit to another Board position shall, upon return to the unit, be credited with the Union seniority he/she held at the time he/she transferred out of the bargaining unit and with Board seniority for the purposes of longevity and vacation only.

B. An employee who is involuntarily transferred outside the bargaining unit to another Board position shall, upon return to the unit, be credited with Board seniority for all purposes.

C. A full-time employee who is transferred into a part-time position shall continue to accrue seniority while in the part-time position equal to a full-time employee.

D. As used in this Section, "Board seniority" shall mean continuous employment with the Board in a bargaining unit and/or non-bargaining unit position; "Union seniority" shall mean continuous employment in a bargaining unit position.

ARTICLE XVI – VACANCIES, PROMOTIONS AND TRANSFERS

Section 16.1. Notice of Vacancies.

The Superintendent or designee shall notify in writing the Union President or designee of all newly created or vacant positions within the bargaining unit at least three (3) days prior to the job posting. New or vacant jobs within the bargaining unit, which the Board desires to fill or establish, will be posted on the school district's website and in the Central Office and in all open schools. Such notice will be dated and will include the position title and classification, location, hours, primary duties, general qualifications, anticipated starting date and the application closing date. All notices shall be posted for a minimum of five (5) work days.

Section 16.2. Applicant Pool and Selection.

A. All current employees as well as individuals outside the bargaining unit will have the opportunity to apply for new or vacant positions. All interested employees must submit a letter of interest or written application to the Superintendent or designee no later than the application closing date. All interested employees who have submitted a timely letter of interest or written application and who meet the minimum qualifications for the position shall be tested and interviewed by the Superintendent or designee before the position is filled.

B. Whenever an employee and an applicant from outside the bargaining unit demonstrate equal qualifications, the employee will be given preference and will be offered the position. The Board selecting official shall make the determination about applicant qualifications for the position.

C. The Board selecting official, when considering employees for a promotion, shall take into account the following: length of service in the New Milford school system, job

performance, special skills and training, and the ability to meet the requirements of the job. These criteria are not listed in any special order.

D. All interested employees who were tested and interviewed and who were not appointed to fill the position shall be given a brief written statement of the reason(s) why the employee was not selected. Said statement shall be sent by the Board selecting official within ten (10) work days of the position being filled.

Section 16.3. Trial Period.

Employees shall have a sixty (60) day trial period in a new position. Prior to or during the sixty (60) day trial period, the employee may return to his/her former-position. If, in the trial period, the employee is not making satisfactory progress, the employee and the Union shall be notified in writing, and the employee may be returned to his/her former position. In the event the former position is eliminated, Article XVII will prevail. Employees hired, promoted or transferred on or after January 1, 2008, who successfully complete the trial period, will not be eligible for another position for one year.

Section 16.4. Temporary Appointments.

The Superintendent or designee has the authority to fill vacancies on a temporary basis not to exceed sixty (60) continuous work days or the length of an employee's absence until that employee has been removed from the payroll and approved for long term disability insurance, whichever is the longer period of time.

Section 16.5. Summer Replacements, School Vacations, Special Projects.

Available employees, including those members on the recall list, shall be given an opportunity to apply for summer replacement and school vacation jobs in bargaining unit positions and for work on special projects (curriculum typing, etc.) An employee-applicant shall be given consideration in the filling of such jobs provided he/she is qualified to do the work in the opinion of the administrator to whom he/she will report. Employees interested in such work shall notify the Personnel Office of their desire to work by June 1 of the respective year. A "Skills and Availability Form" will be available in the Personnel Office for all interested employees.

Section 16.6. Transfers.

A. The Board shall notify the Union President or designee of any impending transfer as soon as possible. The Board shall then solicit volunteers from among the existing work force. Transfer announcements shall be posted on the school district's website and in the Central Office and in all open schools. Such announcements will be dated and will include the position title and classification, location, hours, primary duties, general qualifications, and the anticipated starting date. In the event the transfer is temporary, an anticipated return date will be included. Transfer announcements shall be posted for a minimum of five (5) work days.

B. Should there be no response, the Board shall meet with the Union President and the employee being transferred to review the transfer announcement and notify the

employee of the starting date. The Board shall make every effort to give the transferring employee at least five (5) days notice prior to implementing the transfer.

C. An employee transferred to a position in a higher classification shall be paid at the hourly rate of the higher classification in the step of the higher classification that corresponds to his/her own step. An employee transferred to a position in a lower classification shall retain his/her regular hourly rate of pay. No employee shall be transferred more than once in any given fiscal year (July to June).

D. No involuntary transfer shall be made without prior written notice to and discussion with the employee affected and the Union President.

ARTICLE XVII – LAYOFF, DISPLACEMENT AND RECALL PROCEDURE

Section 17.1.

In the event it is necessary to reduce the number of positions in the bargaining unit, the Union shall be given thirty (30) days written notice of the impending reduction in force. In addition, the Union will be provided with a list of the name(s) of employee(s) in the bargaining unit whose position(s) will be initially vacated or eliminated.

Section 17.2.

Regular school year, calendar year or part-time employees will not be laid off before all bargaining unit temporary and special employees have been affected.

Section 17.3.

Any employee laid off as a result of his/her position being eliminated may elect, in lieu of layoff, within three (3) days of the date the employee is notified that his/her position is being eliminated, to bump into an equal or lower classification in which the employee has worked, or another equal or lower classification in which the employee is judged by the supervisor as qualified and able to perform the work. The employee may bump the employee with the least seniority in such other classification. No employee shall be denied an equal or lower position if there is an employee remaining with less seniority unless he/she is judged not qualified or not able to perform the new position by the supervisor. Any employee who is laid off may be assigned to a vacant position in an equal classification instead of bumping.

Section 17.4.

An employee thus displaced may similarly elect to bump into another equal or lower classification in which the employee has worked, or another equal or lower classification in which the employee is judged able to perform the work by the supervisor, and is entitled to claim a position in such other classification by virtue of the employee's seniority, or the employee may elect to take a layoff and shall be placed on a rehiring list.

Section 17.5.

An employee who bumps into a different classification as a result of a layoff or displacement shall be paid at the same step that the employee was paid in the classification from which the employee was displaced.

Section 17.6.

Each laid off employee and each employee who has elected to bump into another classification shall have recall rights for a period equal to his/her respective period of employment, up to a maximum of twelve (12) months from the date of layoff. The Union shall be provided with a copy of the recall list. An updated list will be provided as changes occur. Employees on the recall list shall be offered available positions for which they are deemed qualified and able by the supervisor in order of seniority and must respond within five (5) days of receiving the offer. No new employee shall be hired into a bargaining unit position until all those on the recall list who are judged qualified and able to do the work have been recalled or have declined an offer of recall. Any employee who has declined an offer of recall shall be dropped from the recall list.

Section 17.7.

An employee who is rehired or transferred to a previous position from the recall list shall be paid the applicable salary at the step the employee was paid at the time of layoff or displacement.

ARTICLE XVIII – DISCIPLINARY ACTION

Section 18.1.

Written warning notices, suspensions and discharges shall be for just and sufficient cause only. Both the employee and the Union shall be informed verbally by the Superintendent or his/her designee of such written warning notice, suspension or discharge whenever possible on the same working day such action is taken, but in no event later than twenty-four (24) hours following such action. Such disciplinary action (written warning notices, suspensions or discharges) and the specific reasons for them shall be stated in writing and a copy forwarded to the employee and the Union as soon as possible but in no event later than two (2) working days after such disciplinary action.

Section 18.2.

Should there be any dispute between the Board and the Union concerning the existence of just and sufficient cause for such disciplinary action (written warning notices, suspensions or discharges), such disciplinary action shall be subject to the Grievance Procedure contained in this Agreement.

Section 18.3.

At the request of either the Union or the Board, grievances arising from disciplinary action shall be given priority over all other grievances then being processed.

Section 18.4.

Disputes over written warning notices, suspensions or discharges received by employees may be submitted to the step of the Grievance Procedure immediately above the step occupied by the Board official who issued the discipline, and shall thereafter be addressed as a grievance in accordance with the terms of the Grievance Procedure. Grievances that protest written warning notices shall not be subject to arbitration.

Section 18.5.

An employee desiring to review his/her official personnel folder shall be permitted to do so by making an appointment through his/her immediate supervisor with the Superintendent or the Superintendent's designated representative.

Section 18.6.

The Board agrees that the employee shall be notified if anything detrimental to the employee is placed in the employee's personnel file, and the employee shall be shown such detrimental item(s) by the Board.

Section 18.7.

In the event any unscheduled or scheduled meeting that may lead to disciplinary action is held between an employee and a supervisor, said employee shall have a right to request to have a Union representative present at such a meeting. The employee must be informed of this fact prior to proceeding with any such meeting by the supervisor, principal or Board representative. This shall not apply in those instances when a supervisor conducts a routine appraisal or discussion with the employee relative to said employee's work performance. At no time shall an employee be required to sign a written statement or form critical of his/her work performance or conduct or attitude without said employee's consent, and without a Union representative present.

Section 18.8.

The employee shall be afforded the opportunity within reason, to include a statement he/she wishes to make about unfavorable information contained in the employee's personnel folder.

ARTICLE XIX – TERMINATION OF EMPLOYMENT

Section 19.1.

Except in the case of discharge for cause, at least fourteen (14) calendar days written notice of termination of employment shall be given to the employee by the Board. When such notice is not possible, severance pay will be given under the following schedule: ten (10) days pay for a person employed up to three (3) years, and fifteen (15) days pay for any person employed more than three (3) years. Termination or suspension without such severance pay may be made with just cause. Any employee who voluntarily leaves shall give fourteen (14) calendar days written notice of resignation to the Board.

ARTICLE XX – PENSIONS

Section 20.1.

"The Pension Plan for Employees of the Town of New Milford, Connecticut", became effective July 1, 1964, for all employees who are eligible to be included under said plan. This Article is included for informational purposes only and this benefit is not subject to the grievance procedure.

ARTICLE XXI – TECHNOLOGICAL CHANGES

Section 21.1.

Should the Board introduce new equipment, methods or processes as a substitute for, or replacement of, present equipment, methods and processes, employees in jobs affected by such innovations shall be given a reasonable period of time to train in the use of such new equipment, methods and processes, such time as shall be determined by the Superintendent.

ARTICLE XXII – SAVINGS CLAUSE

Section 22.1.

In the event any Article(s), Section(s) or portion(s) of this Agreement is declared invalid by a tribunal or court of competent jurisdiction, the remainder of this Agreement shall remain valid and in full force and effect. Should the parties agree that substitute language is necessary for the portion(s) declared invalid, they shall meet at a mutually acceptable time for the purpose of negotiating such substitute language.

ARTICLE XXIII – NO-STRIKE PROVISION

Section 23.1.

The Union shall not call, support, or participate in any strike, work slow-down, or any other concerted activity (with the exception of informational picketing as long as it does not interfere with the normal operation of the school system) which is detrimental to the operation of the Board's offices or the schools during the period of this Agreement or any extension thereof. In the event an individual employee engages in activity proscribed herein on their own initiative, the Union shall make every effort to persuade the employee to discontinue such activity.

Individual or concerted employee job action shall be just cause for termination of employment of the employee or employees participating in such action. The Grievance and Arbitration Procedure contained herein can be utilized by the employee(s) or the Union under this Article only with respect to the issue of whether or not the employee(s) is guilty of having participated in any action proscribed by this Article.

ARTICLE XXIV – MISCELLANEOUS

Section 24.1. Substitutes.

In the event that a regular employee is absent from work, the Board will make every reasonable effort to employ a substitute.

Section 24.2. Out-of-Title Work.

All employees shall be assigned work appropriate to and within their job classification. The assignment of out-of-title work on other than an incidental basis shall be avoided. If the out-of-title work assignment is in a higher classification, the employee shall receive the applicable rate of pay for the higher classification.

Section 24.3. Training.

In an effort to encourage ongoing training, the Board will enable each employee to enroll in one (1) job related course in the New Milford Adult Education Program each year. This training will be tuition free. Employees must receive prior approval from the Department of Human Resources and meet registration requirements and deadlines. There will be no compensation for this time.

Section 24.4. New Bargaining Unit Positions.

The impact of a newly created classification shall be the subject of discussion and agreement between the parties as such new classifications are created.

Section 24.5. Performance Evaluation.

All employees shall receive an annual performance evaluation by his/her immediate supervisor or his/her designee. All performance evaluations shall be completed in writing with a copy given to the employee. After receiving the performance evaluation, the employee may write comments pertaining to the evaluation or add relevant materials that may supplement or enhance the evaluation. Such written comments or materials from the employee shall be attached to the performance evaluation and placed in the employee's personnel file.

ARTICLE XXV – DURATION OF AGREEMENT

Section 25.1.

This Agreement contains the full and complete Agreement between the Board and the Union and shall become effective upon signing, except that salary shall be retroactive to 7/1/18 and shall remain in the full force and effect through the 30th day of June 2021.

Section 25.2.

If this Agreement expires while negotiations for a new Agreement are under way, the terms of this Agreement shall remain in full force and effect until a Successor Agreement has been executed.

Section 25.3.

This Agreement may not be altered, amended, or modified, except in writing, signed by the Board and the Union, which amendment shall be appended hereto and become part of this Agreement.

In witness whereof, the parties hereto have set their hands on the date(s) indicated below.

NEW MILFORD EDUCATIONAL SECRETARIES ASSOCIATION, CHAPTER OF LOCAL 136, I.F.P.T.E.

President

Date: 4/23/19

NEW MILFORD BOARD OF EDUCATION

Chairman

Date: 4-23-2019

APPENDIX A
WAGE SCHEDULE

No step movement. Each step gets $0.42 added from previous year.

Year 1 - Fiscal Year 2018/2019

Class	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9
I	$ 18.94	$ 19.57	$ 20.44	$ 21.29	$ 22.25	$ 23.20	$ 24.41	$ 25.49	$ 26.72
II	$ 17.93	$ 18.53	$ 19.34	$ 20.07	$ 21.13	$ 21.98	$ 23.16	$ 24.30	$ 25.47
IIA	$ 17.42	$ 18.04	$ 18.84	$ 19.68	$ 20.61	$ 21.46	$ 22.67	$ 23.83	$ 24.96
III	$ 16.99	$ 17.57	$ 18.34	$ 19.19	$ 19.98	$ 20.84	$ 22.16	$ 23.25	$ 24.46
Tech I	$ 21.40	$ 21.83	$ 22.25	$ 22.68	$ 23.14	$ 23.59			
Tech II	$ 23.19	$ 23.65	$ 24.11	$ 24.59	$ 25.04	$ 25.57			

No step movement. Each step gets $0.42 added from previous year.

Year 2 - Fiscal Year 2019/2020

Class	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9
I	$ 19.36	$ 19.99	$ 20.86	$ 21.71	$ 22.67	$ 23.62	$ 24.83	$ 25.91	$ 27.14
II	$ 18.35	$ 18.95	$ 19.76	$ 20.49	$ 21.55	$ 22.40	$ 23.58	$ 24.72	$ 25.89
IIA	$ 17.84	$ 18.46	$ 19.26	$ 20.10	$ 21.03	$ 21.88	$ 23.09	$ 24.25	$ 25.38
III	$ 17.41	$ 17.99	$ 18.76	$ 19.61	$ 20.40	$ 21.26	$ 22.58	$ 23.67	$ 24.88
Tech I	$ 21.82	$ 22.25	$ 22.67	$ 23.10	$ 23.56	$ 24.01			
Tech II	$ 23.61	$ 24.07	$ 24.53	$ 25.01	$ 25.46	$ 25.99			

Those not at top step shall advance one step. All step values remain the same from previous year.

Year 3 - Fiscal Year 2020/2021

Class	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9
I	$ 19.36	$ 19.99	$ 20.86	$ 21.71	$ 22.67	$ 23.62	$ 24.83	$ 25.91	$ 27.14
II	$ 18.35	$ 18.95	$ 19.76	$ 20.49	$ 21.55	$ 22.40	$ 23.58	$ 24.72	$ 25.89
IIA	$ 17.84	$ 18.46	$ 19.26	$ 20.10	$ 21.03	$ 21.88	$ 23.09	$ 24.25	$ 25.38
III	$ 17.41	$ 17.99	$ 18.76	$ 19.61	$ 20.40	$ 21.26	$ 22.58	$ 23.67	$ 24.88
Tech I	$ 21.82	$ 22.25	$ 22.67	$ 23.10	$ 23.56	$ 24.01			
Tech II	$ 23.61	$ 24.07	$ 24.53	$ 25.01	$ 25.46	$ 25.99			

*** Those already at the top step prior to 7/1/2020 will be paid at a rate of 2.75% above the top step rate shown for 2020/2021. That rate will be for those specific employees only, and is not intended to be an additional, attainable, step above the top step rate shown for 2020/2021.**

APPENDIX B

JOB TITLES

CLASSIFICATION I

Administrative Secretary – Assistant Superintendent
Administrative Secretary – Director of Fiscal Services and Operations
Administrative Secretary – Facilities Manager
Administrative Secretary – Director of Pupil Personnel and Special Services
Administrative Secretary – Director of Human Resources
Secretary/Bookkeeper – Director of Food and Nutrition Services
Bookkeeper - Accounts Payable
Bookkeeper – Payroll

CLASSIFICATION II

Computer Scheduler (Middle School, High School)
Secretary – Career Center (High School)
Secretary - Principal (Elementary Schools, Intermediate School, Middle School, High School)
Secretary/Receptionist – Guidance (High School)
Business Office Secretary
District Wide Secretary
Secretary/Superintendent's Office

CLASSIFICATION IIA

Secretary – Assistant Principal (Elementary Schools, Intermediate School, Middle School, High School)
Secretary – Special Education (High School)
Secretary – Special Education/Guidance (Middle School)

CLASSIFICATION III

Library Clerk (Elementary Schools, Intermediate School, Middle School, High School)
Receptionist (High School)
Receptionist/Attendance Clerk (Intermediate School)

COMPUTER TECHNICIANS

Technology – Tech I (Elementary Schools, Intermediate School, Middle School, High School)
Tech II (District Wide)

APPENDIX C – Effective 1/1/19

SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - New Milford: Town and Board of Education
Choice Fund Open Access Plus HSA Plan Secretaries

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 - $875 Family - $1,750

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: $2,500 Family: $5,000	Individual: $2,500 Family: $5,000

- The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.
- Plan deductible always applies before any copay or coinsurance.
- 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
Calendar Year Out-of-Pocket Maximum	Individual: $2,500 Family: $5,000	Individual: $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.
- 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.
- All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Physician Services		
Physician Office Visit – Primary Care Physician (PCP)/Specialist • All services including Lab & X-ray	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist)		
Surgery Performed in Physician's Office	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Allergy Treatment/Injections Performed in Physician's Office	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Allergy Serum • Dispensed by the physician in the office	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Cigna Telehealth Connection Services • 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)	After the plan deductible is met, your plan pays 100%	Not Covered
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.	Plan pays 100%	After the plan deductible is met, your plan pays 80%
Immunizations	Plan pays 100%	After the plan deductible is met, your plan pays 80%
Mammogram, PAP, and PSA Tests • 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.	Plan pays 100%	Plan pays based on place of service.

Benefit	In-Network	Out-of-Network
Inpatient		
Inpatient Hospital Facility	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, 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	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Outpatient		
Outpatient Facility Services	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Short-Term Rehabilitation - PCP	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Short-Term Rehabilitation - Specialist	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Calendar Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Care – 50 days • Cardiac Rehabilitation - Unlimited days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
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 • Includes outpatient private duty nursing subject to medical necessity with a separate maximum of $15,000 per Calendar year	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 180 days maximum per Calendar Year	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Durable Medical Equipment • Unlimited maximum per Calendar Year	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%

Benefit	In-Network	Out-of-Network
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%	After the plan deductible is met, your plan pays 80%
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Routine Foot Disorders Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered	Not Covered
Hearing Aid • Unlimited maximum devices per Calendar Year • Includes testing and fitting of hearing aid devices. • Coverage through age 12	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Wigs • Unlimited maximum per Calendar Year	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Medical Specialty Drugs		
Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges.	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, 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
Laboratory	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 100% ^	Plan pays 80% ^	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 100% ^	Plan pays 80% ^
Radiology	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 100% ^	Plan pays 80% ^
Advanced Radiology Imaging	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Outpatient Facility Services	Covered same as plan's Outpatient Facility Services

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.

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% ^		Not Applicable*	

*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

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	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 100% ^	Plan pays 80% ^	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	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)	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office 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% ^
Family Planning - Men's Services	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office 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%^
Includes surgical services, such as vasectomy (includes reversals)										
Family Planning - Women's Services	Plan pays 100%	Covered same as plan's Physician's Office 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%^
Includes surgical services, such as tubal ligation (includes reversals) Contraceptive devices as ordered or prescribed by a physician.										

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
Infertility	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office 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% ^
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.										
Lifetime Limit: Unlimited										
Bariatric Surgery	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office 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% ^
Surgeon Charges Lifetime Maximum: Unlimited										
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		
	Cigna LifeSOURCE Transplant Network ® Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Cigna LifeSOURCE Transplant Network ® 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 Maximum - Cigna LifeSOURCE Transplant Network® 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	No charge ^	Plan pays 80% ^	No charge ^	Plan pays 80% ^	No charge ^	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	No charge ^	Plan pays 80% ^	No charge ^	Plan pays 80% ^	No charge ^	Plan pays 80% ^

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

Notes: 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 Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy; also Partial Hospitalization.

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 0% Preferred Brand: You pay 0% Non-Preferred Brand: You pay 0% **Retail (per 90-day supply):** Generic: You pay 0% Preferred Brand: You pay 0% Non-Preferred Brand: You pay 0% **Home Delivery (per 90-day supply):** Generic: You pay 0% Preferred Brand: You pay 0% Non-Preferred Brand: You pay 0%	**Retail:** You pay 20% Your plan pays 80% **Home Delivery:** Not Covered

Pharmacy	In-Network	Out-of-Network

- 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.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- 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 are covered - limited to sexual dysfunction.
- Oral Fertility drugs are covered.

Pharmacy Program Information

Pharmacy Clinical Management

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements.
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- 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.

eVisits
Relay Health provides an online consultation service, or "eVisit," with doctors. The eVisit guides patients through an interactive interview that delivers to doctors the information they need to respond to non-urgent conditions. Individuals pay a predetermined copay or coinsurance based on their benefit plan design. After the eVisit is completed, a claim is automatically submitted to Cigna for reimbursement.

Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health Assessments • Health and Wellness Coaching • Gaps in Care Coaching • Treatment Decision Support • Educate and Refer	Included

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.

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner 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.

When a person is eligible for Medicare A and B as described above, this plan 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 and 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.

Additional Information

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 covered expenses or $500 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- 50% penalty applied to any admission reviewed by Cigna Healthcare and not certified.
- 50% penalty applied to 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.
Place of service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
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 or pharmacy 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 Expense (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 Expense, 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 relating 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 or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - 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;
  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections 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" sections of this plan.
- In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: Acupressure;Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or non-surgical treatment of TMJ disorders.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics,

Exclusions

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 teeth are covered provided a continuous course of dental treatment is started within six months of an accident.

- 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.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- 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 inpatient 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, dentures.
- Aids or devices that assist with non-verbal 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 contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription 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.
- Cosmetics, dietary supplements and health and beauty aids.

Exclusions

- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- 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 non-Participating Provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating 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.

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: CT

SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - New Milford: Town and Board of Education
Choice Fund Open Access Plus HRA Plan Secretaries Calendar Year

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 employer has established a health reimbursement account that you can use to pay for eligible out-of-pocket expenses during the Calendar Year.

Employer Contribution	Employee - $875 Family - $1,750

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: $2,500 Family: $5,000	Individual: $2,500 Family: $5,000

- The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.
- Copays always apply before plan deductible and coinsurance.
- 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
Calendar Year Out-of-Pocket Maximum	Individual: $2,500 Family: $5,000	Individual: $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. • 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. • All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%. • This plan includes a combined Medical/Pharmacy out-of-pocket maximum.		
Benefit	**In-Network**	**Out-of-Network**
Physician Services		
Physician Office Visit – Primary Care Physician (PCP)/Specialist • All services including Lab & X-ray	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist)		
Surgery Performed in Physician's Office	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Allergy Treatment/Injections Performed in Physician's Office	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Allergy Serum • Dispensed by the physician in the office	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Cigna Telehealth Connection Services • 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)	After the plan deductible is met, your plan pays 100%	Not Covered
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.	Plan pays 100%	After the plan deductible is met, your plan pays 80%
Immunizations	Plan pays 100%	After the plan deductible is met, your plan pays 80%
Mammogram, PAP, and PSA Tests • 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.	Plan pays 100%	Plan pays based on place of service.

Benefit	In-Network	Out-of-Network
Inpatient		
Inpatient Hospital Facility	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, 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	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Outpatient		
Outpatient Facility Services	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Short-Term Rehabilitation - PCP	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Short-Term Rehabilitation - Specialist	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Calendar Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Care – 50 days • Cardiac Rehabilitation - Unlimited days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
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 • Includes outpatient private duty nursing subject to medical necessity with a separate maximum of $15,000 per Calendar year	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 180 days maximum per Calendar Year	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Durable Medical Equipment • Unlimited maximum per Calendar Year	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%

Benefit	In-Network	Out-of-Network
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%	After the plan deductible is met, your plan pays 80%
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Routine Foot Disorders Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered	Not Covered
Hearing Aid • Unlimited maximum devices per Calendar Year • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share. • Coverage through age 12	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Wigs • Unlimited maximum per Calendar Year	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Medical Specialty Drugs		
Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges.	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 80%
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, 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
Laboratory	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 100% ^	Plan pays 80% ^	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 100% ^	Plan pays 80% ^
Radiology	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 100% ^	Plan pays 80% ^
Advanced Radiology Imaging	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Outpatient Facility Services	Covered same as plan's Outpatient Facility Services

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

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% ^		Not Applicable*	

*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
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	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 100% ^	Plan pays 80% ^	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	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)	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office 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% ^
Family Planning - Men's Services	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office 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%^
Includes surgical services, such as vasectomy (includes reversals)										
Family Planning - Woman's Services	Plan pays 100%	Covered same as plan's Physician's Office 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%^
Includes surgical services, such as tubal ligation (includes reversals) Contraceptive devices as ordered or prescribed by a physician.										

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
Infertility	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office 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% ^
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. Lifetime Limit: Unlimited										
Bariatric Surgery	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office 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% ^
Surgeon Charges Lifetime Maximum: Unlimited										
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		
	Cigna LifeSOURCE Transplant Network ® Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Cigna LifeSOURCE Transplant Network ® 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 Maximum - Cigna LifeSOURCE Transplant Network® 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	No charge ^	Plan pays 80% ^	No charge ^	Plan pays 80% ^	No charge ^	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	No charge ^	Plan pays 80% ^	No charge ^	Plan pays 80% ^	No charge ^	Plan pays 80% ^

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

Notes: 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 Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy; also Partial Hospitalization.

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 0% Preferred Brand: You pay 0% Non-Preferred Brand: You pay 0% **Retail (per 90-day supply):** Generic: You pay 0% Preferred Brand: You pay 0% Non-Preferred Brand: You pay 0% **Home Delivery (per 90-day supply):** Generic: You pay 0% Preferred Brand: You pay 0% Non-Preferred Brand: You pay 0%	**Retail:** You pay 20% Your plan pays 80% **Home Delivery:** Not Covered

Pharmacy	In-Network	Out-of-Network

- 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.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- 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 are covered - limited to sexual dysfunction.
- Oral Fertility drugs are covered.

Pharmacy Program Information

Pharmacy Clinical Management
Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements.
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- 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.

eVisits
Relay Health provides an online consultation service, or "eVisit," with doctors. The eVisit guides patients through an interactive interview that delivers to doctors the information they need to respond to non-urgent conditions. Individuals pay a predetermined copay or coinsurance based on their benefit plan design. After the eVisit is completed, a claim is automatically submitted to Cigna for reimbursement.

Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health Assessments • Health and Wellness Coaching • Gaps in Care Coaching • Treatment Decision Support • Educate and Refer	Included

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.

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner 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.

When a person is eligible for Medicare A and B as described above, this plan 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 and 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.

Additional Information

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 covered expenses or $500 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- 50% penalty applied to any admission reviewed by Cigna Healthcare and not certified.
- 50% penalty applied to 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.
Place of service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
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 or pharmacy 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 Expense (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 Expense, 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 relating 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 or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - 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;
  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections 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" sections of this plan.
- In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: Acupressure; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or non-surgical treatment of TMJ disorders.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics,

Exclusions

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 teeth are covered provided a continuous course of dental treatment is started within six months of an accident.

- 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.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- 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 inpatient 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 non-verbal 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 contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription 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.
- Cosmetics, dietary supplements and health and beauty aids.

Exclusions

- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- 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 non-Participating Provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating 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.

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: CT

Dental Insurance

Individual Comprehensive Dental Plan providing coverage for preventive services at 100%, general services at 80%, and major services at 50%, subject to an annual deductible for general and major services of $50 and a maximum benefit of $1,000 per calendar year. The annual family deductible for general and major services is $150. Members shall elect family coverage pursuant to this sub-paragraph by the first week of any school year

APPENDIX D

Humana Vision 100 — CONNECTICUT

New Milford Public Schools

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $55	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	$100 allowance 20% off balance over $100	$50 allowance
Standard plastic lenses[4]		
• Single vision	$25	Up to $25
• Bifocal	$25	Up to $40
• Trifocal	$25	Up to $60
• Lenticular	$25	Up to $100
Covered lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$25	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[4] (applies to materials only)		
• Conventional	$100 allowance, 15% off balance over $100	$80 allowance
• Disposable	$100 allowance	$80 allowance
• Medically necessary	$0	$200 allowance

Humana Vision 100

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
[3] Discounts may be available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis.[1]

[1] Thompson Media Inc.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Humana

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235 or if you use a TTY, call 711.

If you believe that **Humana Inc. and its subsidiaries** have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 - 4618

If you need help filing a grievance, call 1-877-320-1235 or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services,** Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-1235 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 (TTY: 711).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-320-1235 (TTY：711) まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-877-320-1235 (TTY: 711).

APPENDIX E – For Informational Purposes Only

§ 10-235. Indemnification of teachers, board members, employees..., CT ST § 10-235

Connecticut General Statutes Annotated
Title 10. Education and Culture (Refs & Annos)
Chapter 170. Boards of Education (Refs & Annos)

C.G.S.A. § 10-235

§ 10-235. Indemnification of teachers, board members, employees and certain volunteers and students in damage suits; expenses of litigation

Effective: June 30, 2015
Currentness

(a) Each board of education shall protect and save harmless any member of such board or any teacher or other employee thereof or any member of its supervisory or administrative staff, and the State Board of Education, the Board of Regents for Higher Education, the board of trustees of each state institution and each state agency which employs any teacher, and the managing board of any public school, as defined in section 10-183b, including the governing council of any charter school, shall protect and save harmless any member of such boards, or any teacher or other employee thereof or any member of its supervisory or administrative staff employed by it, from financial loss and expense, including legal fees and costs, if any, arising out of any claim, demand, suit or judgment by reason of alleged negligence or other act resulting in accidental bodily injury to or death of any person, or in accidental damage to or destruction of property, within or without the school building, or any other acts, including but not limited to infringement of any person's civil rights, resulting in any injury, which acts are not wanton, reckless or malicious, provided such teacher, member or employee, at the time of the acts resulting in such injury, damage or destruction, was acting in the discharge of his or her duties or within the scope of employment or under the direction of such board of education, the Board of Regents for Higher Education, board of trustees, state agency, department or managing board; provided that the provisions of this section shall not limit or otherwise affect application of section 4-165 concerning immunity from personal liability. For the purposes of this section, the terms "teacher" and "other employee" shall include (1) any person who is a cooperating teacher pursuant to section 10-220a, teacher mentor or reviewer, (2) any student teacher doing practice teaching under the direction of a teacher employed by a local or regional board of education or by the State Board of Education or Board of Regents for Higher Education, (3) any student enrolled in a technical high school who is engaged in a supervised health-related field placement program which constitutes all or part of a course of instruction for credit by a technical high school, provided such health-related field placement program is part of the curriculum of such technical high school, and provided further such course is a requirement for graduation or professional licensure or certification, (4) any volunteer approved by a board of education to carry out a duty prescribed by said board and under the direction of a certificated staff member including any person, partnership, limited liability company or corporation providing students with community-based career education, (5) any volunteer approved by a board of education to carry out the duties of a school bus safety monitor as prescribed by said board, (6) any member of the faculty or staff or any student employed by The University of Connecticut Health Center or health services, (7) any student enrolled in a constituent unit of the state system of higher education who is engaged in a supervised program of field work or clinical practice which constitutes all or part of a course of instruction for credit by a constituent unit, provided such course of instruction is part of the curriculum of a constituent unit, and provided further such course (i) is a requirement for an academic degree or professional licensure or (ii) is offered by the constituent unit in partial fulfillment of its accreditation obligations, and (8) any student enrolled in a constituent unit of the state system of higher education who is acting in the capacity of a member of a student discipline committee established pursuant to section 4-188a.

(b) In addition to the protection provided under subsection (a) of this section, each local and regional board of education and each charter school shall protect and save harmless any member of such local or regional board of education or charter school governing council, or any teacher or other employee thereof or any member of its supervisory or administrative staff from financial loss and expense, including legal fees and costs, if any, arising out of any claim, demand or suit instituted against

such member, teacher or other employee by reason of alleged malicious, wanton or wilful act or ultra vires act, on the part of such member, teacher or other employee while acting in the discharge of his duties. In the event such member, teacher or other employee has a judgment entered against him for a malicious, wanton or wilful act in a court of law, such board of education or charter school shall be reimbursed by such member, teacher or other employee for expenses it incurred in providing such defense and shall not be held liable to such member, teacher or other employee for any financial loss or expense resulting from such act.

(c) Legal fees and costs incurred as a result of the retention, by a member of the State Board of Education, the Board of Regents for Higher Education or the board of trustees of any state institution or by a teacher or other employee of any of them or any member of the supervisory or administrative staff of any of them, or by a teacher employed by any other state agency, of an attorney to represent his or her interests shall be borne by said State Board of Education, Board of Regents for Higher Education, board of trustees of such state institution or such state agency employing such teacher, other employee or supervisory or administrative staff member, as the case may be, only in those cases wherein the Attorney General, in writing, has stated that the interests of said board, Board of Regents for Higher Education, board of trustees or state agency differ from the interests of such member, teacher or employee and has recommended that such member, teacher, other employee or staff member obtain the services of an attorney to represent his interests and such member, teacher or other employee is thereafter found not to have acted wantonly, recklessly or maliciously.

Credits

(1949 Rev., § 1494; 1949, Supp. § 163a; 1951, Supp. § 329b; 1955, Supp. § 951d; 1959, P.A. 521, § 1, eff. June 16, 1959; 1965, Feb.Sp.Sess., P.A. 330, § 43, eff. July 1, 1965; 1971, P.A. 344; 1972, P.A. 201, § 1, eff. May 16, 1972; 1973, P.A. 73-651; 1977, P.A. 77-573, § 24, eff. Aug. 1, 1977; 1978, P.A. 78-54; 1978, P.A. 78-65; 1978, P.A. 78-208, § 30, eff. July 1, 1978; 1978, P.A. 78-218, § 167; 1979, P.A. 79-63; 1980, P.A. 80-197, § 3; 1981, P.A. 81-450, § 2; 1982, P.A. 82-218, § 37, eff. March 1, 1983; 1984, P.A. 84-241, § 2, eff. May 24, 1984; 1988, P.A. 88-273, § 7, eff. May 6, 1988; 1990, P.A. 90-230, § 15, eff. June 8, 1990; 1990, P.A. 90-325, § 21, eff. June 6, 1990; 1993, P.A. 93-259, § 1, eff. June 28, 1993; 1995 P.A. 95-79, § 186, eff. May 31, 1995; 1996, P.A. 96-214, § 7; 2011, P.A. 11-48, § 285, eff. July 1, 2011; 2012, P.A. 12-116, § 87(a), (b), eff. July 1, 2012; 2013, P.A. 13-122, § 6, eff. June 18, 2013; 2015, P.A. 15-215, § 5, eff. June 30, 2015.)

Notes of Decisions (32)

C. G. S. A. § 10-235, CT ST § 10-235

The statutes and Constitution are current with enactments from the 2015 Regular Session and the June Special Session.

End of Document

APPENDIX F

MEMORANDUM OF AGREEMENT

Full Time School Year employees shall be entitled to paid vacation time in accordance with the schedule outlined in Article 13 Section 1B.

Should an employee be involuntarily transferred from Full-Time School Year to Full-Time Calendar year, said employee may have the choice of one of the following options for the year in which the transfer occurs:

- payment of entitled days as a Full-Time School Year Employee before the transfer occurs with no available vacation days to be used in the new position of Full-Time Calendar Year Employee; request to take unpaid vacation time will be considered which shall not be unreasonably denied.

- no payment of entitled vacation days and carry them over to the Full-Year Calendar position.

New Milford Board of Education

Date: 4/23/19

New Milford Educational Secretaries Association, Local 136-5, IFPTE

Date: 4-23-2019