AGREEMENT

between

THE ENFIELD BOARD OF EDUCATION
ENFIELD PUBLIC SCHOOLS
ENFIELD, CONNECTICUT

and

LOCAL 1303-46 OF COUNCIL #4
AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES AFL-CIO
CLERICAL EMPLOYEES, LIBRARY ASSISTANTS & CAFETERIA EMPLOYEES

JULY 1, 2020 -JUNE 30, 2024

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ARTICLE I - RECOGNITION

1.0 The Board hereby recognizes and certifies the UNION as the exclusive bargaining representative for all employees in the unit consisting of all employees of the Board engaged in clerical or secretarial work, school library assistants and cafeteria workers in the Enfield Public District except those employed less than twenty (20) hours per week for the purpose of and with all the rights and privileges as provided by said Municipal Employee Relations Act. Unit, for the purpose of this section shall be defined as the total school system.

1.1 Seasonal and temporary employees working 20 or more hours per week shall become bargaining unit members and be entitled to all terms and conditions of the collective bargaining agreement after 120 calendar days of employment.

1.2 Temporary and substitute cafeteria employees shall not work more than four (4) hours in any one workday, at the same school, except for extenuating circumstances. Any such additional hours shall first be offered to a qualified bargaining unit member, at the member's regular rate of pay, who may exercise the right to work such hours as long as there is no significant disruption of the nutrition program or delivery of food services.

ARTICLE II - NONDISCRIMINATION

2.0 Neither the Board nor the Union shall discriminate against any employee on the basis of race, color, religion, national origin, age, sex, marital status, sexual orientation, physical or mental disability, union activity or political activity, or any other non-job-related characteristic.

Whenever the male or female gender is used in the Agreement it shall be construed to include equally both male and female employees.

ARTICLE III - MANAGEMENT'S RIGHTS

3.0 There are no provisions in this Agreement that shall be deemed to limit or curtail the Board in any way in the exercise of the rights, powers and authority which the Board had prior to the effective date of this contract unless and only to the extent that provisions of this Agreement specifically curtail or limit such rights, powers and authority. The Union recognizes that the Board's rights, powers and authority include but are not limited to the right to manage its operation, direct, select, decrease and increase the work force, including hiring, promotion, demotion, transfer, suspension, discharge or layoff; the right to make all plans and decisions on all matters involving its operations, the extent to which the facilities of any department thereof shall be operated, additions thereto, replacements, curtailments or transfers thereof, removal of equipment, outside purchases of products or services, the scheduling of operations, means and processes of operations, the materials to be used, and the right to introduce new and improved methods and facilities and to change existing methods and facilities; to maintain discipline and efficiency of employees, to prescribe rules to that effect; to establish and change production standards and quality standards, determine the qualifications of employees; regulate quality and quantity of production and to run the department efficiently.

ARTICLE IV - UNION SECURITY

4.0 During the term of this Agreement, employees in the bargaining unit, may pay membership dues.

4.1 The Union will furnish the Board with a signed statement by the employee that they authorize the Board to deduct from their wages Union dues. Dues deductions shall continue for the duration of this agreement.

4.2 The deduction of Union fees for any month will be made during the applicable month and shall be remitted to Council 4 AFSCME not later than the third (3rd) Thursday of the following month. The dues remittances to the Union will be accompanied by a list of names and addresses of employees from whose wages such deductions have been made.

4.3 The Board agrees to allow employees to contribute by way of payroll deduction to the AFSCME P.E.O.P.L.E. program.

4.4 The Council 4 staff representative shall receive from the Board three (3) signed copies of the agreement and an electronic version of the agreement. Within thirty (30) days after the

signing of this agreement, the Board shall provide the Union copies of this agreement in sufficient numbers to provide each bargaining unit employee a copy.

4.5 Two (2) Union officials shall be allowed the required time without loss of pay to attend Union conventions and conferences, not to exceed six (6) working days per year.

4.6 Five (5) employees as designated by the Union shall be allowed the necessary time off without loss of pay to engage in contract negotiations provided this activity occurs during the regular working hours.

ARTICLE V SENIORITY

5.0 Seniority for the purpose of this Agreement is defined as length of continuous service within the-bargaining unit. Seniority will not accrue to an employee for temporary or part-time labor.

5.1 Probationary Period of Employment:

a. There will be a probationary period of one hundred fifty (150) calendar days for all new clerical and library employees. All employees, after completion of this probationary period, shall acquire length of service records as of the date of employment.

An extension of an additional thirty (30) calendar days shall be subject to the mutual agreement of the parties and shall be requested in writing to the Union President.

b. New cafeteria employees shall serve a probationary period of ninety (90) calendar days and shall have no seniority rights during this period but shall be subject to all other provisions of this agreement except Article XIII in event of discharge before completion of the probationary period.

An extension of an additional fifteen (15) workdays shall be subject to the mutual agreement of the parties. A written request for same shall be forwarded to the Union President. All employees, after completion of the probationary period shall acquire length of service records as of the date of employment.

5.2 Promotions:

All new and vacant positions shall be posted in each school for a period of five (5) workdays prior to advertisement during the school year and seven (7) workdays prior to advertisement during the summer. Postings shall be emailed to all employees within the bargaining unit and mailed to employees' home addresses during the summer months. The posting information shall be retained in the personnel office and may be seen by the Union upon its request.

5.3 When a new or vacant position is created or when termination or retirement situations are anticipated in a reasonable period of time, the employee who is qualified and most senior shall be given the first opportunity to fill such position. The employee promoted shall be placed on the same step of the new position as they held in their prior position. The Board reserves the right to conduct examinations to determine qualifications of employees, provided that the elements to be examined shall be determined jointly by the parties.

5.4 All vacancies shall be filled within a reasonable period of time from the date of an employee vacating a position or of the establishment of a new position. Thirty (30) days shall be considered a reasonable period of time. The Union President shall be notified if the employer does not intend to fill a vacant position.

5.5 When an employee applies for and is accepted for a vacant or new position at a higher pay grade, there will be a thirty (30) day probationary period in which the supervisor of the position may decide that the employee is not qualified for the work involved. In this situation the employee will be returned to their original position and rate of pay (same step) without loss of seniority and the next senior employee who bids for the position shall be considered in the same manner and so on, until the list of those who have bid on the position is exhausted.

5.6 When an employee applies for and is accepted for a vacant or new position at the same or lower pay grade, there will be a thirty (30) day probationary period in which the employee or the supervisor of the position may decide that the employee is not qualified for the work involved. In this situation the employee will be returned to their original position and rate of pay (same step) without loss of seniority and the next senior employee who bids for the position shall be considered in the same manner and so on, until the list of those who have bid on the position is exhausted.

5.7 When an employee has been assigned by the supervisor to a temporary position in a higher classification and has completed three (3) days of satisfactory performance in the acting position, a temporary salary adjustment will be made retroactive to the first day. Such hourly adjustment shall be at step 2 of the salary for the acting position. Upon the return of the regular worker, the temporary worker will revert to their previous position.

5.8 In the situation where a non-union cafeteria manager is out of work for more than five Cafeteria working days (days where lunch is served), the Board agrees to discuss the impact of the absence with the Union President and/or designee. Typically, the additional work would be offered to the First Cook provided they are qualified for the work. Qualifications shall be determined by the Nutrition Services Director. The rate of pay for the additional work shall be determined jointly by the Director and the Union.

5.9 a. The Board shall provide the Union President with a semiannual listing (January and July), of employees by seniority and working hours.

b. In addition, as they occur, the Union President will be provided with a copy of all job postings, transfers, new hires, termination notices, approved leaves of absence, promotions and demotions.

5.10 An employee shall lose all seniority when he/she:

a. resigns

b. retires

c. is discharged for cause

5.11 JOB ELIMINATION/REDUCTION IN FORCE/LAYOFF:

FOR CLERICAL & LIBRARY EMPLOYEES:

a. Probationary and part-time personnel will be the first to be released based upon date of hire.

b. Permanent employees shall be released by seniority within 10 month or 12 month classifications. Employees subject to layoff shall be able to displace the least senior employee in their position. If there is no less senior employee in their position, they may displace the least senior employee in their grade and the least senior employees in the next and subsequent lower grades provided they are qualified to perform the job and more senior. This process shall be used in 10 and 12-month classifications respectively. The employee shall receive the same step for their new position as they held in their prior position.

c. Recalled employees shall receive the same step for the recalled position as they held in the position held prior to layoff.

1. 10-month positions within 10-month classification and 12-month positions within 12-month classification.

2. Laid off employees will be retained on a recall list for a period not to exceed two (2) years. An employee who accepts recall to a lower paying job shall maintain the remainder of the two (2) year recall period for recall to their former or equal paying job should there be an opening in the future.

3. Employees shall be recalled in reverse order to their layoff provided they notify the employer of their intent to return to work within five (5) working days of notification by mail and report to work not later than ten (10) working days thereafter. The Board may grant an extension to the time for reporting back to work. Recalled employees shall receive the same step for the recalled position as they held in the position held prior to layoff.

d. Management will attempt to provide at least four (4) weeks' notice of an impending layoff.

e. Employees on layoff status shall be offered available work provided they are qualified before new employees are hired. This provision shall not waive the employee's recall rights to the position held at time of layoff.

FOR CAFETERIA EMPLOYEES:

a. Job Reductions/Reduction-In-Force/Layoffs shall take effect in the following order:

i. Part time (working less than twenty (20) hours per week) temporary and substitutes.

ii. Probationary.

iii. Twenty (20) or more hour employees least senior first.

b. An employee due to be laid off under (iii) above shall be permitted to bump a less senior employee in the same classification. If there is no less senior employee in the same classification, the employee may bump into the next lower classification in which a less senior employee holds a position.

c. If an employee exercised bumping rights into a lower position, she/he shall be placed at the highest salary step of that position. If there is no bumping option available to the employee, she/he will be offered available employment under (i) above if such work continues to exist. Such rights as expressed above are not restricted to or limited to a particular school but are in effect district-wide and controlled by seniority.

d. Employees on layoff status shall be offered available work provided they are most qualified and suited, before new employees are hired. This provision shall not waive the employee's recall rights to the position held at time of layoff.

e. Employees with seniority rights shall be laid off in the order of their seniority, those with the least seniority being laid off first.

f. A laid off employee on the recall list shall be offered the opportunity to bid on a vacant position in accordance with Article 5 of this agreement provided they notify the employer of their intent to return to work within three (3) working days of notification that they were awarded the posted position by mail and report to work not later than five (5) working days thereafter. Extension of report to workdays may be granted by the Director of Food Services. Laid off employees shall be retained on a recall list for a period not to exceed two (2) years.

FOR ALL EMPLOYEES:

Prior to a Board decision to subcontract any portion of the work performed by employees covered hereunder, which would result in the layoff of any members of the bargaining unit, the Union will be given written notice of such proposal and an opportunity to discuss the same with the Board or its representatives. Any employee laid off as a result of a decision to subcontract shall be given one month notice of termination. The Board will make reasonable efforts to assist any such laid off employee to find other employment which will provide continuity of benefits.

5.12 The President, Vice President and Secretary and Treasurer of Local 130346 shall be granted superseniority under the collective bargaining agreement.

ARTICLE VI - HOURS OF WORK

6.0 The basic workday for clerical staff shall be seven (7) hours a day, five (5) days a week, Monday through Friday.

Work Hours:

Elementary	8:30 - 4:00, one-half hour for lunch
Middle School	7:45 - 3:15, one-half hour for lunch
Senior High	7:15 - 2:45, one-half hour for lunch
Administration*	8:30 - 4:30, one (1) hour for lunch
*(Summer Hours)	8:00 - 4:00, one (1) hour for lunch

The above hours may be altered at the discretion of the building administrator.

6.1 The basic workday for library staff shall be as follows:

K-2 8:25 - 3:55

3-5 8:00 - 3:30

6-8 7:45 - 2:45

Library staff shall be pulled for duties only as a last resort.

The above hours may be altered at the discretion of the building administrator.

6.2 The basic workday for cafeteria staff shall be as follows:

a. The normal work period for cafeteria workers will take place between the hours of 6:30 a.m. and 3:00 p.m. unless emergency conditions require otherwise.

b. The hours of work for all bargaining unit positions shall be posted within each school fifteen (15) workdays after commencement of each school year. A copy of this posting will be given to the Union at that time. Except in an emergency, the Union will be notified within five (5) workdays of any permanent change.

c. Employees requested to work Saturdays, Sundays, or on their days off, other than emergencies, shall be given sufficient notice.

d. When school lunch employees are required to provide cafeteria operation service to support "Teachers In-Service Days", the following procedure shall be followed:

i. The school selected by the administration to support the feeding program will be managed by the cafeteria manager of that school, or in his/her absence by the Supervisor of Cafeterias or his/her designee.

ii. The selected manager of the operation will not perform bargaining unit work except in case of emergency.

iii. Volunteers will be requested to perform the functions required and priority consideration will be given to cafeteria workers from the school designated to support the food program. If the Supervisor of Cafeterias or his/her designee is not able to provide enough volunteers from the designated cafeteria then volunteers will be from other cafeterias in the system. Naturally if a specific qualification is required (e.g., baker, cook, etc.) the

Supervisor of Cafeterias or his/her designee will seek individuals qualified to perform the specific functions required.

e. Annually, prior to Labor Day or prior to the first day of school, a mandatory in-service training day will be held. Testing days and in-service days shall be a minimum of two (2) hours. Except in extreme circumstances, four (4) weeks' notice will be given for mandatory training.

f. The above hours may be altered at the discretion of the building administrator.

g. All overtime work shall be distributed equally among employees within classifications within schools.

6.1 Overtime

a. All work beyond seven (7) hours must receive prior written approval by the Supervisor.

b. For cafeteria staff, all overtime shall be distributed equally among employees within classifications within schools.

c. Time and one-half shall be paid for:

i. All scheduled work performed in excess of eight (8) hours in any one workday.

ii. All scheduled work performed in excess of forty (40) hours in any one work week.

iii. All scheduled work performed on Saturday.

d. Double time shall be paid for all scheduled work performed on Sunday and holidays in addition to holiday pay.

e. Straight time shall be paid for:

i. All scheduled work performed in excess of the established hours/day up to eight (8) hours in any one workday.

ii. All scheduled work performed in excess of the established hours/weeks up to forty (40) hours in any work week.

6.2 CLOSING OF SCHOOLS:

When schools are closed due to abnormal conditions, the following procedures will be in effect:

a. 10-month secretarial, clerical and library employees will not work and will not receive a day's pay for each day that schools are closed. Payment will be made when days are later made up so that 190 days of work per year will always be in effect. On delay openings, 10 month employees shall report when it is safe to do so and shall suffer no loss of pay.

b. For cafeteria staff, in the event of "Late School Openings" resulting in reduction of work hours of an employee and the essential functions are performed, such employee shall be paid his/her regular daily rate.

c. For cafeteria employees, when schools are closed due to abnormal conditions, the following procedure will be in effect. All employees will not work and will not receive a day's pay each day that school(s) is/are closed up to three (3) days, but payment will be made later when school days are made up. If these days are not going to be made up, employees can use any accrued time including sick leave. If closure is more than three (3) days affected employees will then be assigned work at another school.

d. For Cafeteria employees, if an employee reports to work during a scheduled workday and school is closed, they will be paid a minimum of two (2) hours at their regular rate of pay. This provision will not apply when an employee has received a full day's pay pursuant to sections above.

e. 12-month secretarial and clerical employees will work unless conditions are so extreme that the Superintendent of Schools deems it advisable to close all offices. On such days that schools are closed, but offices are open, any absence of a 12 month employee because of conditions prompting the closing of school may be regarded as a personal day or a sick day leave for that employee.

f. Emergency early closing of schools: Snowstorm, etc., clerical and library personnel shall be allowed to leave one-half hour after their respective school has closed. Central Administration clerical personnel may leave one-half hour after all schools have closed. No staff shall suffer a loss of pay.

g. If school is remote, all staff will work remotely and will be paid.

6.3 The Union President shall also receive prompt written notice of a change in working hours of bargaining unit employees.

ARTICLE VII - VACATIONS

7.0 12-MONTH PERSONNEL ONLY:

Vacation time shall be granted to 12-month employees only within the fiscal year (July 1st through June 30th) immediately following the fiscal year in which it has been earned. Such vacation time is not to accumulate from fiscal year to fiscal year.

The time for having a vacation must be approved by the appropriate supervisor.

7.1 a. An initially employed person with less than one (1) year of service in the bargaining unit at the time of the regular vacation period will be granted one (1) day of vacation for each full month of service, not to exceed ten (10) days. A full month of service is defined as at least fifteen (15) workdays, including any worker's compensation days.

b. Employees who have over one (1) year and less than five (5) years of service in the bargaining unit shall be entitled to a yearly vacation often (10) days annually.

c. Employees who have completed five (5) years of service in the bargaining unit shall be entitled to a vacation of fifteen (15) days annually.

d. Employees with over five (5) years but less than fifteen (15) years of service in the bargaining unit shall receive one (1) additional vacation day for each two (2) years of service completed after five (5) years to a maximum of four (4) weeks' vacation annually, after completing fifteen (15) years of service in the bargaining unit.

7.2 a. Pro-rata accumulated annual vacation pay shall be granted to an employee in the event he/she terminates employment.

b. In case of death of the employee, payment for vacation time already accumulated and any due salary shall be paid to the deceased employee's beneficiary.

7.3 When a holiday falls during an employee's vacation, the employee will not be charged vacation time for that day.

7.4 In determining eligibility for vacations, credit for prior services for a 10-month employee entering a 12-month position will be granted at one (1) full year for each 10month period of continuous service.

7.5 a. The rate of vacation pay shall be the employee's rate of pay in effect for the employee's regular position on the payday immediately preceding the employee's vacation period.

b. Employees shall receive their vacation pay in the pay period prior to the start of their vacation providing they notify accounting two (2) weeks prior to the start of their vacation.

ARTICLE VIII - HOLIDAYS

8.0 A 12-month employee shall be entitled to the following paid holidays providing such an employee is on duty the working days immediately before and after a particular holiday, or produces evidence from a physician that the cause of absence on those days was illness or injury, if required by the Superintendent of Schools:

New Year's Day	Labor Day	Christmas Day
Martin Luther King Day	Columbus Day	First working day after
President's Day	Veteran's Day Christmas	Memorial Day
Good Friday	Thanksgiving Day	Day after Thanksgiving
Independence Day		

8.1 A 10-month employee, including cafeteria staff, shall be entitled to the following paid holidays providing such an employee is on duty the working days immediately before and after a

particular holiday or produces evidence from a physician that the cause of absence on those days was illness or injury, if required by the Superintendent of Schools:

New Year's Day	Columbus Day
Martin Luther King Day	Veteran's Day
President's Day	Thanksgiving Day
Good Friday	Day after Thanksgiving
Memorial Day	Christmas Day
Labor Day	

8.2 Holidays falling on a Saturday shall be celebrated on the preceding day. Holidays falling on a Sunday shall be celebrated on the following Monday.

8.3 If school is in session on a holiday, the employees shall be granted a day off at a time mutually agreeable to the department head and the employee. If subsequent time off is not possible, the employee shall be paid for the day at the employee's regular rate.

8.4 Whenever any of the holidays listed occur when an employee is absent from work on extended leave and his/her accumulated sick leave has expired, the employee will not be entitled to the holiday pay.

8.5 A day with pay will also be granted whenever schools are closed because of state statute or governor's proclamation.

ARTICLE IX - LEAVE WITH PAY

9.0 SICK LEAVE:

a. 12 Month Employees:

On initial employment, sick leave will be effective immediately. During the first year of employment, a 12-month employee shall be entitled to 1 sick day a working month. After July 1st of the first year of employment, a 12-month employee shall be entitled to twelve (12) days of sick leave each year with a maximum accumulation of one hundred eighty (180) days. A day shall be defined as the normal working hours of an employee. Employees hired prior July 1, 2001 will continue to accrue fifteen (15) sick days per fiscal year. Each employee shall be notified of the accumulated sick leave at the beginning of each fiscal year on their paystubs.

b. 10 Month Employees including cafeteria employees:

On initial employment, sick leave will be effective immediately. During the first year of employment a 10-month employee shall be entitled to one (1) sick day per working month. After July 1st of the first year of employment, a 10 month employee shall be entitled to ten (10) days of sick leave each year with a maximum accumulation of one hundred eighty (180) days. Allowable sick leave will be granted for workdays occurring within the period from Monday before Labor Day to June 30th of each school year. A day shall be defined as the normal working hours of an employee. Each employee shall be notified of the accumulated sick leave at the beginning of each fiscal year on their paystubs.

c. Employees shall be covered by Public Act 11-52 concerning use of paid sick leave for purposes of family illness, diagnosis, treatment, family violence matters, and other issues as contained in the act.

9.1 Sick leave may be used for the following purposes:

a. Personal illness or physical incapacity of employee or immediate family member with approval of Human Resources Director or their designee.

b. Enforced quarantine in accordance with health regulations.

c. Sick leave may be taken in increments of one (1) hour.

9.2 The Board of Education reserves the right to extend sick leave to any employee under extenuating circumstances. Request for such additional sick leave shall be submitted in writing to the Superintendent of Schools. Upon request of the Superintendent of Schools, any person on sick leave shall furnish a report from the attending physician certifying the cause of absence.

9.3 Any employee absent from duty shall report promptly to their immediate supervisor the cause of such absence and state its probable duration.

9.4 Employees with five (5) or more years of service with the Board shall receive payment of $50.00 per day of unused accrued sick days up to 100 days upon separation from the Board. Employees with less than five (5) years of service shall receive $10.00 per day up to 50 days upon separation. In case of death, this payment shall be paid to spouse or beneficiary.

9.5 In the event an employee is exposed to COVID or any other pandemic related illness the Board will at minimum adhere to all Federal and State guidelines.

9.6 SICK LEAVE POOL:

a. The recipient employee or his/her designated representative should make application in writing to the personnel office requesting that he/she be considered for eligibility for donations of sick days.

b. A committee, comprised of two bargaining unit representatives and two management representatives, will be established to certify the eligibility of the recipient employee, based on:

i. The nature and duration of the illness.

ii. The number of sick days remaining in the employee's own account.

c. An eligible illness should be categorized as extended and catastrophic. Illnesses that fall into this category include, but are not limited to, cancer, cardiovascular illness, illness needing surgery and/or extended recuperation, debilitating infections (i.e., T.B., meningitis, etc.) or disabling musculoskeletal difficulties. Pregnancy and acute, short-term illnesses are excluded.

d. A pool will be formed which will contain days from which the eligible employee may draw. This pool will be formed with voluntary contributions of the bargaining unit staff, up to a maximum of five (5) days per year, per volunteering employee.

e. The maximum number of pooled days which an employee can use will be limited to 183.

9.7 INJURY LEAVE:

a. Injury leave as distinguished from sick leave shall mean paid leave given to an employee due to absence from duty caused by an accident or injury that occurred while the employee was engaged in the performance of his/her duties. Employees of the Board are covered by Worker's Compensation Insurance and are paid stated amounts due to injuries sustained on the job.

b. The Board of Education in case of injury leave shall supplement the payments of the insurance company so that the employee will receive full pay during the absence for a period not to exceed six (6) months. In the case of injuries on the job causing temporary disability and absence and for absences of less than seven (7) days, the Board of Education shall pay the employee's regular salary for such period since payments are not normally made under worker's compensation for such accidents.

9.8 PERSONAL LEAVE:

a. Bereavement

Three (3) days special leave with pay shall be granted for each occurrence of a death in the immediate family of an employee, or in the immediate family of an employee's spouse or domestic partner. Immediate family, for the purpose of this leave is defined as parents, grandparents, siblings, child, grandchild or stepchild, spouse, domestic partner and any relation which is domiciled in the employee's house or any other relative who to the satisfaction of the Human Resources Director is considered to be a member of the immediate family.

b. Personal Leave

An employee shall be allowed time office with pay for a maximum five (5) days per year for a compelling personal cause. Compelling cause means quarantine, summons to court as a witness, serious illness of a relative or member of a household, attendance at marriage of a

brother, sister, or child, or cause approved by the Human Resources Director except in an emergency and whenever possible such leave shall be requested before the time for it to occur.

An employee shall be allowed time off with pay for one (1) day per year for no reason given.

In case of extenuating circumstances, the Superintendent of Schools is empowered to grant additional days.

9.9 JURY DUTY:

a. Special leave shall be granted for bona fide jury duty with the Board paying the difference between the employee's regular pay and his/her compensation for said jury duty providing the employee notified the Human Resources Director immediately upon being notified of jury duty.

b. The Superintendent of Schools may request a waiver for jury duty at his/her discretion.

9.10 LEAVE WITHOUT PAY:

a. An employee, upon request, shall be granted maternity leave to commence when, in the opinion of her doctor she is no longer physically able to work. The Superintendent or Human Resources Director may request a statement from the employee's doctor certifying fitness to continue working. An employee on maternity leave is eligible for paid sick leave in accordance with Article IX, Section 9.0(a) and (b) of this Agreement.

An employee who intends to return to her same position must so notify her department head, in writing, prior to the last scheduled workday. Such employee shall have up to ninety (90) days from the date of the birth of the child to return to her position.

Any employee who is unable to return to employment at the end of the 90-day postpartum period may apply to the Superintendent or his designee for a leave of absence without pay in accordance with Section 9.10(b) below.

b. The Board may grant a leave of absence without pay not to exceed a period of one year. Application for such a leave of absence must be made in writing to the employee's immediate supervisor. During the period of leave without pay, except for military leave, the employee shall not be credited for length of service and shall not be credited with the time for the purpose of accruing sick leave or vacation time.

9.11 RETURN AFTER LEAVE OF ABSENCE:

a. Employees who have been granted a leave of absence in excess of ninety (90) days shall notify the Superintendent of Schools in writing of their intention to return to work at least two months prior to the end of such granted leave.

b. All employees returning from leave of absence under this provision shall be restored to the same or comparable position they held at the time the leave was granted and at the same step held prior to the leave. The employee's accumulation of sick leave shall be retained to their credit when they return.

ARTICLE X - INSURANCE AND PENSION

10.0 The Enfield Board of Education agrees to provide coverage for employees and their eligible dependents participating in the CIGNA Health Plan at the following cost share:

7/1/20-6/30/21: The parties agree that no changes with respect to the health insurance be retroactive.

7/1/21-6/30/22: Effective upon the signing of the agreement all employees shall be eligible for individual and dependent coverage. The employee shall be responsible for 16%.

7/1/22-6/30/23: The employee shall be responsible for 16.5%.

7/1/23-6/30/24: The employee shall be responsible for 17.5%

The Board shall provide a Section 125 Plan which permits employees to elect a salary reduction to pay for their premium cost share on a pre-tax basis subject to federal and state law and IRS rules and regulations.

The Plan Design is attached at Appendix A.

10.1 Life Insurance and Dental Plan

a. Group Life Insurance: $40,000 for each employee

b. Dental Plan: See attached at Appendix A-1.

The Board will provide to all 12-month and 10-month personnel and their dependents the CIGNA Dental PPO Benefit including all dental services described in Class I, II, III as described in Appendix A-1

10.2 The Board may at any time or from time to time, change the carriers of any of the foregoing insurance, provided the benefits shall be the equivalent or better than those provided in the above-referenced coverages.

10.3 The parties have agreed that for the duration of this Agreement, should the State of Connecticut health insurance plans be made available to municipal employees at lower costs, the parties will meet to discuss possible implementation of these plans. These discussions shall be held within thirty (30) days' notice by either party, and these discussions will not affect the premium cost share percentage which has previously been established.

10.4 HEALTH INSURANCE· RETIRED EMPLOYEES:

While in retirement and upon the written request to the Superintendent, a clerical, library or cafeteria employee who has worked for Enfield Public Schools for a period of at least five (5) years consecutively shall have the opportunity to continue at the group rate the cost of maintaining any or all health benefit insurance provided:

a. The retired employee pays the cost of said insurance in accordance with the provisions determined by the Superintendent of Schools.

b. Upon death of the retired employee, his/her spouse may continue such coverage by paying cost of said insurance.

c. The Board of Education incurs no additional expense.

d. The arrangement is agreeable to the carrier of the insurance program.

e. This program will be administered by the Enfield Board of Education.

10.5 RETIREMENT:

Normal retirement will be at the age of sixty-five (65) years. All employees shall be entitled to participate in the Retirement Plan of the Town of Enfield as arranged by the Board after one full year of employment and the attainment of age twenty-five (25). All employee contributions toward the pension plan will be treated as I.R.S. Section #414 (h) contributions.

ARTICLE XI· SEVERANCE PAY

11.0 Upon termination, a clerical or library employee with twenty (20) or more years of full-time continuous service from date of hire shall receive a payment of $500.00. An employee with twenty-five (25) or more years of full-time continuous service from date of hire shall receive a payment of $750.00.

Clerical and library employees hired after October 6, 1996 shall no longer be eligible for the payment.

11.1 Upon termination, a cafeteria employee with twenty (20) or more years of full-time continuous service from date of hire shall receive a payment of $250.00. An employee with twenty-five (25) or more years of full-time continuous service from date of hire shall receive a payment of $500.00.

Employees hired after July 1, 2001 shall no longer be eligible for the payment.

ARTICLE XII - SALARIES

12.0 Salary schedules and classification of position negotiated and in force on-are hereby incorporated and included as Appendices B – F

12.1 COMPUTATION:

a. 10-month employees shall be paid for 190 working days and eleven (11) holidays per school year. Working days refer to days when school is in session and ten (10) additional days per year to be worked as determined by the school principal or immediate supervisor. The Board shall have the option to extend the work year beyond 190 days with appropriate compensation. Should the work year extend into the next fiscal year, wages for that period will be at the new rate effective July 1st. Payment will be made in biweekly installments between September and June.

In the event that employment begins or terminates during the contract year, total compensation will be adjusted to reflect the per diem rate for each day worked and holidays accrued.

b. 12-month employees shall be paid in 26 biweekly installments. In the event that employment begins or terminates during the contract year, total compensation will be adjusted to reflect the per diem rate for each day worked, accrued holidays and vacation time.

c. Deductions – Provisions shall be made for payroll deductions for: Credit Union, U.S. Savings Bonds, United Way, Tax Sheltered Annuity and Pension Plan.

d. Payment for payroll for all employees covered under this agreement shall be made via direct deposit.

ARTICLE XIII-GRIEVANCE PROCEDURE

13.0 Grievances arising out of matters covered by this Agreement will be processed in the following manner:

13.1 Employee and Immediate Supervisor:

a. The employee and/or his/her representative shall, within fifteen (15) working days of the occurrence of the conditions causing the grievance or within fifteen (15) working days of their knowledge of its occurrence, whichever comes later, present to their supervisor in writing the fact(s) pertaining to the problem or incident.

b. The immediate supervisor shall have a meeting to discuss the issue and adjust the problem at once or notify the employee and/or their representative of the decision within three (3) working days from the day the problem is presented.

13.2 Employee and Department Head:

a. If the Union representative feels that further review is justified, all the facts pertaining to the problem shall be presented in writing to the department head within five (5) working days.

b. The department head shall have a meeting to discuss the issue and notify the employee and their representative of the decision in writing within five (5) working days from the day the problem was submitted to the department head.

13.3 Employee and Human Resources Director:

a. In the case of an adverse decision, the Union representative may request further review by the Human Resources Director providing the request for review is made to the Human Resources Director within ten (10) working days from the time the decision was rendered by the Department Head.

b. The Human Resources Director shall, within five (5) working days, review the facts with all those concerned present, at a special meeting to be called by the Human Resources Director for

that purpose. Within ten (10) working days thereafter, the employee and their representative and the supervisors concerned shall be notified in writing of the decision reached.

13.4 Arbitration:

In the event the Union feels that further review is justified, the Union may, within thirty (30) days, submit the grievance to arbitration by the Connecticut State Board of Mediation and Arbitration. Prior to submittal to Arbitration, the Union may request mediation through the State Board of Mediation and Arbitration. Such request shall be made ten (10) working days from the receipt of the written decision noted in Section 13.3b above. If further review is justified, the Union shall request arbitration ten (10) working days after mediation.

a. The Union will advise the Human Resources Director in writing, of their submission of the grievance to arbitration at the time of filing.

b. The decision of the Arbitrator(s) shall be final and binding on both parties. The cost of such arbitration, if any, shall be borne equally by the Union and the Board.

c. The time limits provided for in the article may be extended by mutual agreement of the parties.

d. The Arbitrator shall have no power to add to, delete from, or modify, in any way, any of the provisions of this agreement.

13.5 The total number of employees to be paid for each grievance hearing held at the State Board of Mediation and Arbitration shall be four, three of which shall be Union officers. The Union shall have the right to substitute other employees for Union officers provided the total number of paid employees does not exceed four (4) per- hearing.

ARTICLE XIV DISCIPLINARY PROCEDURE

14.0 All disciplinary actions shall be applied in a fair manner and shall be consistent with the infraction for which disciplinary action is being applied.

14.1 All discipline must be for just cause and must be stated in writing with reason given and a copy given to the employee.

14.2 Probationary employees may be terminated at any time during the probation period and do not have recourse to the grievance and arbitration provisions of this Agreement.

14.3 The Union President shall receive copies of all discipline.

14.4 A verbal or written warning or reprimand on the service record of an employee which takes place more than eighteen (18) months regarding a verbal warning or two (2) years for a written

warning before a subsequent infraction will not be used in any subsequent disciplinary action by the Board against an employee. A suspension without pay on the service record of any employee which takes place more than four (4) years before a subsequent infraction will not be used in any subsequent disciplinary action by the Board against an employee.

ARTICLE XV – NEGOTIATION

15.0 The Board agrees to begin negotiations in good faith with the bargaining representative in accordance with the procedure set forth herein to secure a successor Agreement.

15.1 During the negotiations the Board and the Union shall confer at reasonable times appropriately scheduled with regard to the budgetary calendar and exchange relevant data, points of view and proposals and counterproposals.

ARTICLE XVI - SAVINGS CLAUSE

16.0 If any portion of this Agreement is ruled invalid for any reason, the remainder of the agreement shall remain in full force and effect.

ARTICLE XVII - NO STRIKE PROVISION

17.0 During the life of this agreement, there shall be no strike, slowdown, suspension or stoppage of work in any part of the Board's operation authorized by the Union, nor shall there be any lockout by the Board in any part of the Board's operation.

ARTICLE XVIII – LONGEVITY

18.0 The Board of Education shall provide a longevity remuneration to any employee of the bargaining unit who is actively employed by the Enfield Public Schools, and on the payroll which includes November 30th of each respective contract year. The stipend will be paid in the paycheck prior to the Christmas Holiday, in accordance with the following schedule:

Years Completed in the Enfield Public Schools As of November 30th,	Amount of Stipend
20 years (but less than 25)	$250.00
25 years (but less than 29)	$300.00
30 years or more	$350.00

ARTICLE XIX- MISCELLANEOUS

19.0 The Board agrees that when, for any reason technological changes take place that require additional knowledge and/or skills on the part of its employees, such employees will be given the opportunity to acquire such knowledge and skills through training. The Board shall establish at its own expense during regularly scheduled working hours an adequate training program for effected employees.

19.1 The Board shall establish a course reimbursement account of a total of $2,000 maximum per year for the Union for the reimbursement of prior approved job related courses. Clerical personnel and Enfield Schools Library Assistants must receive approval from their immediate supervisor and the Human Resources Director.

19.2 The Board agrees to allow employees to participate in a flexible spending account, dependent care and AFLAC (or comparable) voluntary supplementary insurance plans at their own expense.

19.3 Effective July 1, 2021 cafeteria employees will be reimbursed $150 annually for appropriate shoe and approved uniform purchases. Employees must purchase one pair of shoes before using the remaining annual allowance to purchase tops and pants. Shoe and apparel purchases may be made at any time during the school year. Receipts must be submitted for reimbursement in September and January only.

ARTICLE XX-DURATION

20.0 This Agreement shall be effective as of the 1st day of July 2020 and shall remain in full force and effect through the 30th day of June, 2024.

Negotiations for a successor agreement shall commence at least one hundred twenty (120) days prior to the expiration date of this Agreement subject to the provisions of C.G.S.A., sections 7-467 to 7-477, inclusive.

Either party may request to begin negotiations earlier commencing on a mutually agreed upon date.

This Agreement shall remain in full force and be effective until a successor agreement is reached.

IN WITNESS WHEREOF, the parties hereto have set their hands this____ day of _____, 2021

Christopher Drezek, Superintendent
Board of Education

Date: 12/22/21

Tricia Johnson, Staff Attorney Representative
AFSCME, Council 4

Date: 12/22/2021

Ellen Smith, President
Local 1303-046

Date: 12/22/2021

APPENDIX A

NEED TO ADD INSURANCE SUMMARY CHARTS

BENEFIT SUMMARY

Cigna Health and Life Insurance Co.
For - Enfield & Board of Education, Town of
Open Access Plus IN Plan
INB4
Effective - 07/01/2021

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

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

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated
Plan Coinsurance	Plan pays 100%
Maximum Reimbursable Charge	Not Applicable
Plan Deductible	Individual: None Family: None
Plan Out-of-Pocket Maximum	Individual: $2,000 Family: $4,000

- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.

Benefit	In-Network
Physician Services - Office Visits	
Primary Care Physician (PCP) Services/Office Visit	$10 copay, and plan pays 100%
Specialty Care Physician Services/Office Visit	$10 copay, and plan pays 100%

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).

Benefit	In-Network
Surgery Performed in Physician's Office	Plan pays 100%
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office	Plan pays 100%
Cigna Telehealth Connection Services (Virtual Care)	$10 copay, and plan pays 100%
• Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies • Virtual Wellness Screenings are available for individuals 18 and older and are covered same as Preventive Care (see Preventive Care Section).	
Preventive Care	
Preventive Care	Plan pays 100%
• 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. • Annual Limit: Unlimited	
Immunizations	Plan pays 100%
Mammogram, PAP, and PSA Tests	Plan pays 100%
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.	
Inpatient	
Inpatient Hospital Facility Services	Plan pays 100%
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%
Inpatient Professional Services	Plan pays 100%
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Outpatient	
Outpatient Facility Services	Plan pays 100%
Outpatient Professional Services	Plan pays 100%
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Emergency Services	
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. • Per visit copay is waived if admitted.	$50 copay, and plan pays 100%
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	$10 copay, and plan pays 100%
Ambulance	Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	

Benefit	In-Network
Inpatient Services at Other Health Care Facilities	
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 90 days	Plan pays 100%
Laboratory Services	
Physician's Services/Office Visit	Plan pays 100%
Independent Lab	Plan pays 100%
Outpatient Facility	Plan pays 100%
Radiology Services	
Physician's Services/Office Visit	Plan pays 100%
Outpatient Facility	Plan pays 100%
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.
Outpatient Facility	Plan pays 100%
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Outpatient Therapy Services	
Outpatient Therapy Services	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 40 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 therapy services maximum.	
Chiropractic Services	Covered same as Physician Services - Office Visit
Annual Limit: • Chiropractic Care - 20 days	
Cardiac Rehabilitation Services	Covered same as Physician Services - Office Visit
Annual Limit: • Cardiac Rehabilitation - Unlimited days	
Hospice	
Inpatient Facilities	Plan pays 100%
Outpatient Services	Plan pays 100%
Note: Includes Bereavement counseling provided as part of a hospice program.	
Bereavement Counseling (for services not provided as part of a hospice program)	
Services Provided by a Mental Health Professional	Covered under Mental Health benefit

Benefit	In-Network
Medical Specialty Drugs	
Outpatient Facility	Plan pays 100%
Physician's Office	Plan pays 100%
Home	Plan pays 100%
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.	
Maternity	
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100%
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit
Abortion	
Abortion Services	Coverage varies based on Place of Service
Note: Elective and non-elective procedures	
Family Planning	
Women's Services	Plan pays 100%
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)	
Men's Services	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)	
Infertility	
Infertility Treatment	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. • Lifetime Maximum: Unlimited	

Benefit	In-Network
Other Health Care Facilities/Services	
Home Health Care • Annual Limit: 100 days (The limit is not applicable to mental health and substance use disorder conditions.) **Note:** Includes outpatient private duty nursing when approved as medically necessary	Plan pays 100%
Organ Transplants	
Inpatient Hospital Facility Services	
LifeSOURCE Facility	Plan pays 100%
Non-LifeSOURCE Facility	Plan pays 100%
Inpatient Professional Services	
LifeSOURCE Facility	Plan pays 100%
Non-LifeSOURCE Facility	Plan pays 100%
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant	
Durable Medical Equipment • $100 DME annual deductible • Annual Limit: Unlimited	Plan pays 100%
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	Plan pays 100%
External Prosthetic Appliances (EPA) • $100 EPA annual deductible • Annual Limit: Unlimited	Plan pays 100%
Temporomandibular Joint Disorder (TMJ) • Unlimited lifetime maximum **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service
Routine Foot Care **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered
Hearing Aids • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share • Coverage through age 12	Plan pays 100%
Early Intervention Services • Birth to Age 3	Plan pays 100%
Routine Hearing Exam • Annual Limit: One exam	Plan pays 100%
Wigs • Annual Limit: Unlimited	Plan pays 100%

Benefit	In-Network
Mental Health and Substance Use Disorder	
Inpatient mental health	Plan pays 100%
Outpatient mental health – Physician's Office	Plan pays 100%
Outpatient mental health – all other services	Plan pays 100%
Inpatient substance use disorder	Plan pays 100%
Outpatient substance use disorder – Physician's Office	Plan pays 100%
Outpatient substance use disorder – all other services	Plan pays 100%

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

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

Cigna Total Behavioral Health - Inpatient and Outpatient Management

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

Pharmacy

Benefits not provided by Cigna.

Additional Information

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

Additional Information

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

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; or (ii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

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.

Pre-Certification - Continued Stay Review - Basic Care Low Management Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician

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

Additional Information

Your Health First - 200 - St. Louis Care Center
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 - 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.

Exclusions

- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- 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 or Pharmacy 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 any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- 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; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to 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

Exclusions

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 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 (except for custom molds and diabetic shoes), elastic stockings, garter belts, corsets and dentures.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded 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 (unless coverage is specifically provided under this plan), 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.
- Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- 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 Covered Expenses.

Exclusions

- Massage therapy.

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, service agreement 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.

EHB State: CT

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711) まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

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BENEFIT SUMMARY

Cigna Health and Life Insurance Co.
For - Enfield & Board of Education, Town of
Open Access Plus Plan
OAPB5
Effective - 07/01/2021

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

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

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.	
Plan Coinsurance	Plan pays 100%	Plan pays 80%
Maximum Reimbursable Charge	Not Applicable	200%
Plan Deductible	Individual: None Family: None	Individual: $200 Individual +1: $400 Family: $500

- The amount you pay for out-of-network covered expenses counts towards your out-of-network deductibles.
- Benefit copays always apply before plan deductible and coinsurance.
- Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

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

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: $1,000 Individual +1: $2,000 Family: $2,500	Individual: $1,000 Individual +1: $2,000 Family: $2,500

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$15 copay, and plan pays 100%	Plan pays 80% ^
Specialty Care Physician Services/Office Visit	$15 copay, and plan pays 100%	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	Plan pays 100%	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office	Plan pays 100%	Covered same as Physician Services - Office Visit
Cigna Telehealth Connection Services (Virtual Care)	$15 copay, and plan pays 100%	Not Covered
• Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies • Virtual Wellness Screenings are available for individuals 18 and older and are covered same as Preventive Care (see Preventive Care Section).		
Preventive Care		
Preventive Care	Plan pays 100%	Plan pays 80% ^
• 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. • Annual Limit: Unlimited		
Immunizations	Plan pays 100%	Plan pays 80% ^
Mammogram, PAP, and PSA Tests	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
• 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.		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.		
Inpatient		
Inpatient Hospital Facility Services	$200 per admission copay, and plan pays 100%	Plan pays 80% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%	Plan pays 80% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%	Plan pays 80% ^
Outpatient		
Outpatient Facility Services	Plan pays 100%	Plan pays 80% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%	Plan pays 80% ^
Emergency Services		
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. • Per visit copay is waived if admitted.	$25 copay, and plan pays 100%	$25 copay, and plan pays 100%
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	$25 copay, and plan pays 100%	$25 copay, and plan pays 100%
Ambulance	Plan pays 100%	Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 180 days	Plan pays 100%	Plan pays 80% ^
Laboratory Services		
Physician's Services/Office Visit	Plan pays 100%	Plan pays 80% ^
Independent Lab	Plan pays 100%	Plan pays 80% ^
Outpatient Facility	Plan pays 100%	Plan pays 80% ^
Radiology Services		
Physician's Services/Office Visit	Plan pays 100%	Plan pays 80% ^
Outpatient Facility	Plan pays 100%	Plan pays 80% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.		
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 100%	Plan pays 80% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Therapy Services		
Outpatient Therapy and Chiropractic Services	Plan pays 100%	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Chiropractic Care, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - Unlimited days **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Cardiac Rehabilitation Services	Plan pays 100%	Covered same as Physician Services - Office Visit
Annual Limit: • Cardiac Rehabilitation - 36 days		
Hospice		
Inpatient Facilities	Plan pays 100%	Plan pays 80% ^
Outpatient Services	Plan pays 100%	Plan pays 80% ^
Note: Includes Bereavement counseling provided as part of a hospice program.		
Bereavement Counseling (for services not provided as part of a hospice program)		
Services Provided by a Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Medical Specialty Drugs		
Outpatient Facility	Plan pays 100%	Plan pays 80% ^
Physician's Office	Plan pays 100%	Plan pays 80% ^
Home	Plan pays 100%	Plan pays 80%
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.		
Maternity		
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100%	Plan pays 80% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Plan pays 100%	Covered same as plan's Inpatient Hospital benefit
Abortion		
Abortion Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Elective and non-elective procedures		
Family Planning		
Women's Services	Plan pays 100%	Coverage varies based on Place of Service
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
Infertility		
Infertility Treatment	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. • Lifetime Maximum: Unlimited		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.		
Other Health Care Facilities/Services		
Home Health Care • Annual Limit: Unlimited **Note:** Includes outpatient private duty nursing when approved as medically necessary	Plan pays 100%	Plan pays 80%
Organ Transplants		
Inpatient Hospital Facility Services		
LifeSOURCE Facility	$200 per admission copay, and plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	$200 per admission copay, and plan pays 100%	Plan pays 80% ^
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Plan pays 100%	Plan pays 80% ^
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant		
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 100%	Plan pays 80% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%	Plan pays 80% ^
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 100%	Plan pays 80% ^
Temporomandibular Joint Disorder (TMJ) • Unlimited lifetime maximum **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Routine Foot Care **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered	Not Covered
Hearing Aids • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share • Coverage through age 12	Plan pays 100%	Plan pays 80% ^
Early Intervention Services • Birth to Age 3	Plan pays 100%	Plan pays 100%
Routine Hearing Exam • One exam per 24 months	Plan pays 100%	Plan pays 80% ^
Wigs • Annual Limit: Unlimited	Plan pays 100%	Plan pays 100%

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.		
Mental Health and Substance Use Disorder		
Inpatient mental health	$200 per admission copay, and plan pays 100%	Plan pays 80% ^
Outpatient mental health – Physician's Office	$15 copay, and plan pays 100%	Plan pays 80% ^
Outpatient mental health – all other services	Plan pays 100%	Plan pays 80% ^
Inpatient substance use disorder	$200 per admission copay, and plan pays 100%	Plan pays 80% ^
Outpatient substance use disorder – Physician's Office	$15 copay, and plan pays 100%	Plan pays 80% ^
Outpatient substance use disorder – all other services	Plan pays 100%	Plan pays 80% ^

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

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

Cigna Total Behavioral Health - Inpatient and Outpatient Management

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

Pharmacy

Benefits not provided by Cigna.

Additional Information

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

Additional Information	
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
The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (200%) 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 will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

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 - Basic Care Low Management 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.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

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

Your Health First - 200 - St. Louis Care Center
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 out-of-network 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.
- 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 or Pharmacy 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 any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- 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;

and rolfing.

- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to 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 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, elastic stockings, garter belts, corsets and dentures.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded 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 (unless coverage is specifically provided under this plan), 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

Exclusions

utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- 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 Covered Expenses.
- Massage therapy.

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, service agreement 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.

EHB State: CT

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711) まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

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BENEFIT SUMMARY

Cigna Health and Life Insurance Co.
For - Enfield & Board of Education, Town of
Open Access Plus IN Plan
INB4
Effective - 07/01/2021

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

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

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated
Plan Coinsurance	Plan pays 100%
Maximum Reimbursable Charge	Not Applicable
Plan Deductible	Individual: None Family: None
Plan Out-of-Pocket Maximum	Individual: $2,000 Family: $4,000

- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.

Benefit	In-Network
Physician Services - Office Visits	
Primary Care Physician (PCP) Services/Office Visit	$10 copay, and plan pays 100%
Specialty Care Physician Services/Office Visit	$10 copay, and plan pays 100%

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).

Benefit	In-Network
Surgery Performed in Physician's Office	Plan pays 100%
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office	Plan pays 100%
Cigna Telehealth Connection Services (Virtual Care)	$10 copay, and plan pays 100%
• Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies • Virtual Wellness Screenings are available for individuals 18 and older and are covered same as Preventive Care (see Preventive Care Section).	
Preventive Care	
Preventive Care	Plan pays 100%
• 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. • Annual Limit: Unlimited	
Immunizations	Plan pays 100%
Mammogram, PAP, and PSA Tests	Plan pays 100%
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.	
Inpatient	
Inpatient Hospital Facility Services	Plan pays 100%
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%
Inpatient Professional Services	Plan pays 100%
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Outpatient	
Outpatient Facility Services	Plan pays 100%
Outpatient Professional Services	Plan pays 100%
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Emergency Services	
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. • Per visit copay is waived if admitted.	$50 copay, and plan pays 100%
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	$10 copay, and plan pays 100%
Ambulance	Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	

Benefit	In-Network
Inpatient Services at Other Health Care Facilities	
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 90 days	Plan pays 100%
Laboratory Services	
Physician's Services/Office Visit	Plan pays 100%
Independent Lab	Plan pays 100%
Outpatient Facility	Plan pays 100%
Radiology Services	
Physician's Services/Office Visit	Plan pays 100%
Outpatient Facility	Plan pays 100%
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.
Outpatient Facility	Plan pays 100%
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Outpatient Therapy Services	
Outpatient Therapy Services Annual Limits: • All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 40 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 therapy services maximum.	Covered same as Physician Services - Office Visit
Chiropractic Services Annual Limit: • Chiropractic Care - 20 days	Covered same as Physician Services - Office Visit
Cardiac Rehabilitation Services Annual Limit: • Cardiac Rehabilitation - Unlimited days	Covered same as Physician Services - Office Visit
Hospice	
Inpatient Facilities	Plan pays 100%
Outpatient Services **Note:** Includes Bereavement counseling provided as part of a hospice program.	Plan pays 100%
Bereavement Counseling (for services not provided as part of a hospice program)	
Services Provided by a Mental Health Professional	Covered under Mental Health benefit

Benefit	In-Network
Medical Specialty Drugs	
Outpatient Facility	Plan pays 100%
Physician's Office	Plan pays 100%
Home	Plan pays 100%
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.	
Maternity	
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100%
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit
Abortion	
Abortion Services	Coverage varies based on Place of Service
Note: Elective and non-elective procedures	
Family Planning	
Women's Services	Plan pays 100%
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)	
Men's Services	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)	
Infertility	
Infertility Treatment	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. • Lifetime Maximum: Unlimited	

Benefit	In-Network
Other Health Care Facilities/Services	
Home Health Care • Annual Limit: 100 days (The limit is not applicable to mental health and substance use disorder conditions.) **Note:** Includes outpatient private duty nursing when approved as medically necessary	Plan pays 100%
Organ Transplants	
Inpatient Hospital Facility Services	
LifeSOURCE Facility	Plan pays 100%
Non-LifeSOURCE Facility	Plan pays 100%
Inpatient Professional Services	
LifeSOURCE Facility	Plan pays 100%
Non-LifeSOURCE Facility	Plan pays 100%
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant	
Durable Medical Equipment • $100 DME annual deductible • Annual Limit: Unlimited	Plan pays 100%
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	Plan pays 100%
External Prosthetic Appliances (EPA) • $100 EPA annual deductible • Annual Limit: Unlimited	Plan pays 100%
Temporomandibular Joint Disorder (TMJ) • Unlimited lifetime maximum **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service
Routine Foot Care **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered
Hearing Aids • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share • Coverage through age 12	Plan pays 100%
Early Intervention Services • Birth to Age 3	Plan pays 100%
Routine Hearing Exam • Annual Limit: One exam	Plan pays 100%
Wigs • Annual Limit: Unlimited	Plan pays 100%

Benefit	In-Network
Mental Health and Substance Use Disorder	
Inpatient mental health	Plan pays 100%
Outpatient mental health – Physician's Office	Plan pays 100%
Outpatient mental health – all other services	Plan pays 100%
Inpatient substance use disorder	Plan pays 100%
Outpatient substance use disorder – Physician's Office	Plan pays 100%
Outpatient substance use disorder – all other services	Plan pays 100%

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

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

Cigna Total Behavioral Health - Inpatient and Outpatient Management

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

Pharmacy

Benefits not provided by Cigna.

Additional Information

Case Management

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

Additional Information	
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

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; or (ii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

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.

Pre-Certification - Continued Stay Review - Basic Care Low Management Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician

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

Additional Information

Your Health First - 200 - St. Louis Care Center
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 - 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.

Exclusions

- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- 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 or Pharmacy 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 any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- 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; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to 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

Exclusions

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 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 (except for custom molds and diabetic shoes), elastic stockings, garter belts, corsets and dentures..
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded 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 (unless coverage is specifically provided under this plan), 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.
- Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- 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 Covered Expenses.

Exclusions

- Massage therapy.

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, service agreement 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.

EHB State: CT

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Cigna®

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

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French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711) まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

Cigna Dental Benefit Summary
Enfield Town & Board of Education - DENB
Plan Renewal Date: 07/01/2021

Administered by: Cigna Health and Life Insurance Company

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

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

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Billed Charge. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Late Entrant Limitation Provision	No coverage until next open enrollment period. This provision does not apply to new hires.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.

Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. This provision does not apply to fillings.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 1 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation. 1 per 36 months.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.

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

- Procedures and services not included in the list of covered dental expenses;
- Occlusal guard and Occlusal Adjustments; Anesthesia: general and IV sedation; Periodontics: minor and major;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: ceramic, resin, or acrylic materials on crowns or bridges on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Implants: implants or implant related services;
- Orthodontics: orthodontic treatment;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Billed Charge.

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

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

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

APPENDIX A-1 DENTAL

MOVED FROM INSURANCE ARTICLE - **ADD ADDITIONAL CHARTS/INFORMATION**

Class I	**100% of reasonable & customary**
Oral Examinations	Yes (2/12 months)
Radiographs (x-rays)	
Intra-oral-complete series	Yes (1/36 months)
Periapical	Yes
Bitewing	Yes (1/6 months)
Prophylaxis (cleaning)	Yes (2/12 months)
Topical Fluoride Application	Yes (1/12 months)
Emergency Treatment	Yes
Space Maintainers	
Topical Application of Sealants	
for children under 14	Yes (1/36 months)
Class II	**100% of reasonable & customary**
Restoration (fillings)	Yes
Root Canal Therapy	Yes
Oral Surgery	Yes
Simple Extractions	Yes
Surgical Extractions	Yes
Repair of Dentures	Yes
Apicoectomy	Yes
Class III	**50% of reasonable & customary**
Inlays	Yes
Crowns	Yes
Bridges	Yes
Dentures	Yes

APPENDIX B 2020-2021

Clerical and Library

2.0% GWI for Grades 3&4, GWI of 2.5% for Grade 5

	10 Month
	Grade 3
Step	Library Assistant
1	$26,217
2	$28,499
3	$29,921
4	$31,413
5	$33,851

	Grade 4	
	Athletics Secretary, Guidance Secretary, Office Assistant, Office Secretary, Pupil Services Secretary, Receptionist	Guidance Secretary, Medicare Clerk, Office Secretary
Step	12 Month	Step 10 Month
1	$35,599	1 $27,521
2	$38,697	2 $29,916
3	$40,627	3 $31,408
4	$42,665	4 $32,982
5	$45,960	5 $35,531

	Grade 5	
	Benefits Specialist, Personnel Assistant, Pupil Services Secretary, SR Administrative Secretary, Curriculum Secretary Accounting Assistant	Admin Secretary, SR Admin Secretary
Step	12 Month	Step 10 Month
1	$37,561	1 $29,037
2	$40,830	2 $31,564
3	$42,873	3 $33,139
4	$45,013	4 $34,799
5	$48,499	5 $37,494

NOTE: 12 Month salaries based on 260 days, 26 bi-weekly pays

10 Month salaries based on 201 days, 21 bi-weekly pays

APPENDIX C 2021-2022

GWI of 2.5%

	10 Month
	Grade 3
Step	Library Assistant
1	$26,872
2	$29,211
3	$30,669
4	$32,198
5	$34,697

	Grade 4		
	Athletics Secretary, Guidance Sec., Office Assistant, Office Secretary, Pupil Services Secretary, Receptionist		Guidance Secretary, Medicare Clerk, Office Secretary
Step	12 Month	Step	10 Month
1	$36,489	1	$28,209
2	$39,664	2	$30,664
3	$41,643	3	$32,193
4	$43,732	4	$33,807
5	$47,109	5	$36,419

	Grade 5		
	Benefits Specialist, Personnel Asst., Pupil Services Secretary, SR Admin Secretary, Curriculum Secretary, Accounting Assistant		Admin Secretary, SR Admin Secretary
Step	12 Month	Step	10 Month
1	$38,500	1	$29,763
2	$41,851	2	$32,353
3	$43,945	3	$33,967
4	$46,138	4	$35,669
5	$49,711	5	$38,431

There will be step advancement for employees in the 2021-22 work year.

NOTE: 12 Month salaries based on 260 days, 26 bi-weekly pays

10 Month salaries based on 201 days, 21 bi-weekly pays

APPENDIX D 2022-2023
GWI 2.5%

	10 Month
	Grade 3
Step	Library Assistant
1	$27,554
2	$29,941
3	$31,436
4	$33,003
5	$35,564

	Grade 4		
	Athletics Secretary, Guidance Secretary, Office Assistant, Office Secretary, Pupil Services Secretary, Receptionist		Guidance Secretary, Medicare Clerk, Office Secretary
Step	12 Month	Step	10 Month
1	$37,401	1	$28,914
2	$40,656	2	$31,431
3	$42,684	3	$32,998
4	$44,825	4	$34,652
5	$48,287	5	$37,329

	Grade 5		
	Benefits Specialist, Personnel Assistant, Pupil Services Secretary, SR Administrative Secretary, Curriculum Secretary Accounting Assistant		Administrative Secretary SR Administrative Secretary
Step	12 Month	Step	10 Month
1	$39,463	1	$30,507
2	$42,897	2	$33,162
3	$45,044	3	$34,816
4	$47,291	4	$36,561
5	$50,954	5	$39,392

There will be step advancement for employees in the 2022-23 work year.

NOTE: 12 Month salaries based on 260 days, 26 bi-weekly pays

10 Month salaries based on 201 days, 21 bi-weekly pays

APPENDIX E 2023-2024

GWI 2.5%

10 Month

Grade 3

Step	Library Assistant
1	$28,243
2	$30,690
3	$32,222
4	$33,828
5	$36,453

Grade 4

Athletics Secretary, Guidance Secretary, Office Assistant, Office Secretary, Pupil Services Secretary, Receptionist

Step	12 Month
1	$38,336
2	$41,672
3	$43,751
4	$45,946
5	$49,494

Guidance Secretary, Medicare Clerk Office Secretary

Step	10 Month
1	$29,637
2	$32,217
3	$33,823
4	$35,518
5	$38,262

Grade 5

Benefits Specialist, Personnel Assistant Pupil Services Secretary, SR Admin Secretary Curriculum Secretary Accounting Assistant

Step	12 Month
1	$40,450
2	$43,969
3	$46,170
4	$48,473
5	$52,228

Administrative Secretary, SR Administrative Secretary

Step	10 Month
1	$31,270
2	$33,991
3	$35,686
4	$37,475
5	$40,377

There will be step advancement for employees in the 2023-24 work year.

NOTE: 12 Month salaries based on 260 days–, 26 bi-weekly pays;
10 Month salaries based on 201 days–, 21 bi-weekly pays

APPENDIX F
CAFETERIA POSITIONS
2020-21 THROUGH 2023-24

		2020-21	2021-22	2022-23	2023-24
Food Service Technician	Step 1	$14.43	$14.79	$15.16	$15.54
	Step 2	$15.79	$16.18	$16.59	$17.00
Bookkeeper	Step 1	$14.68	$15.05	$15.42	$15.81
Assistant Salad Person*	Step 2	$16.06	$16.46	$16.87	$17.29
Head Salad Person, 2nd Cook,	Step 1	$15.17	$15.55	$15.94	$16.34
Assistant Truck Driver**,	Step 2	$17.43	$17.87	$18.31	$18.77
Baker**					
Truck Drivers**, Head	Step 1	$16.26	$16.67	$17.08	$17.51
Cashiers, Lead Truck	Step 2	$17.99	$18.44	$18.90	$19.37
Driver**					
1st Cook, Head Bakers**	Step 1	$16.79	$17.21	$17.64	$18.08
	Step 2	$18.42	$18.88	$19.35	$19.84

Note: The parties agreed to eliminate A, B, C of Food Service Technician step 1.

* When position becomes vacant and if no current bargaining unit member applies, position will be reclassified to Food Service Technician.

** For employees hired before July 1, 2010, they shall be grandfathered into these positions and shall have promotional opportunities into these positions should vacancies occur. For employees hired after July 1, 2010 into these positions shall be assigned as either Baker, Lead Truck Driver or Assistant Truck Driver.

There will be step movement for eligible employees each year of the contract.