

**AGREEMENT**

**Between**

**THE TOWN OF VERNON**

**and**

**AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL  
EMPLOYEES**

**LOCAL 818 OF COUNCIL #4**

**AFL-CIO**

**July 1, 2015 - June 30, 2018**



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## **PREAMBLE**

This Agreement is entered into by and between the Town of Vernon, hereinafter referred to as the "Town" and Local 818 of Council 4, American Federation of State, Country and Municipal Employees, AFL-CIO, hereinafter referred to as the "Union".

### **ARTICLE 1. RECOGNITION**

The Town recognizes the Union as the sole and exclusive bargaining representative for the purposes of collective bargaining in matters of wages, hours of employment and other conditions of employment for all Supervisory employees of the Town of Vernon who work in the Department of Public Works, excluding the Director of Public Works and all others excluded by the Act. This recognition is granted pursuant to the certification issued by the Connecticut State Board of Labor Relations as Decision #3472, Case No. ME-18,564 issued on March 7, 1997.

### **ARTICLE 2. UNION SECURITY**

The Town agrees to deduct dues from each paycheck as specified by the Secretary of the Union from the wages of all Town employees covered by this Agreement. The deduction shall be made by the Finance Officer at his/her convenience. A signed card authorizing the deduction will be provided to the Finance Officer on behalf of each employee for whom deductions are to be made.

#### **Section 2.1**

All employees in the bargaining unit shall, from their date of hire and thereafter as condition of employment, pay dues or service fees as specified by the Secretary of the Union.

#### **Section 2.2**

The monthly dues remittance to the Union will be accompanied by a list of names of employees from whose wages dues deductions have been made.



**Section 2.3**

The Union agrees to hold the Town harmless from any and all damages arising from the making of authorized deductions or from compliance by the Town with the Union security provisions of Section 2.1.

**Section 2.4**

At least one (1) bulletin board shall be reserved at an accessible place in the Department for the exclusive use of the Union for the posting of **official** Union notices or announcements. The bulletin board shall be maintained by the Union and shall not contain any material that is derogatory of the Town Administration.

**Section 2.5**

The Town shall provide the Council 4 representatives with five (5) signed copies of this Agreement at the time of signing. The Town agrees to provide one (1) copy of the Agreement to individual employees upon request. New employees shall be supplied with a copy of the Agreement at the time of hire. Any additional copies of this Agreement must be furnished at the expense of the party desiring them.

**ARTICLE 3. MANAGEMENT RIGHTS**

**Section 3.1**

The direction of the working forces, including the right to hire, promote, demote, discipline and terminate employees for just cause and to determine and make changes in job content, frequency and standards of inspections, size of the workforce, number of days and hours in the work day and work week for all employees, to establish, distribute, modify and enforce reasonable rules of employee conduct and employee manuals of operating procedures and safety regulations and to investigate all matters relating to Town operations, citizen relations, employee conduct and the right to layoff employees because of lack of work or other legitimate reasons are rights exclusively vested in the Town.



### **Section 3.2**

The Town retains the right to control, determine and change the manner and extent to which the Town's facilities and properties shall be located, operated, increased, decreased or discontinued and to introduce and change and operate new or improved methods and procedures; to vary the work load due to better methods; to set the standards of quality and quantity of work and to subcontract work as it has in the past.

### **Section 3.3**

The Town has the right to enforce rules and regulations now in effect, including safety rules, and can issue new rules and regulations, provided such rules and regulations are not arbitrary and capricious, and a copy of such rules and regulations will be given to the Union and the employees.

### **Section 3.4**

It is agreed that except as specifically delegated, abridged, granted or modified by this Agreement, all the rights, powers and authorities the Town had prior to signing this Agreement are retained by the Town and remain the exclusive right of management.

## **ARTICLE 4. PROBATIONARY PERIOD**

All new bargaining unit employees shall be considered probationary during the first six (6) calendar months of employment. *During this probationary period, the employee shall not obtain seniority rights to this Agreement and such probationary employee will be subject to discipline/discharge by the Town without recourse or access to the grievance/arbitration provisions of this Agreement. Upon successful completion of the probationary period an individual employee's seniority shall be retroactive as of the commencement of his/her employment.*

- a. **Interruption of the Probationary Period:** No leave from service during the probationary period, with or without pay, shall be counted as part of the total probationary service required, unless otherwise recommended by the appointing authority and approved by the Town Administrator.
- b. **Dismissal During Probationary Period for New Hires:** During this probationary period, the employee shall not obtain seniority rights, but shall



be subject to all other provisions of this Agreement, except as specifically stated herein, and such probationary period employee will be subject to discipline/discharge by the Town without recourse or access to the grievance/arbitration process of this Agreement, as long as the discipline/discharge is not done in an arbitrary or capricious manner. Upon successful completion of their probationary period an individual employee's seniority shall be retroactive as of the commencement of his/her employment.

- c. **Re-instatement to Former Bargaining Unit for Promoted Employees from 1471**: An employee promoted or transferred who does not successfully complete his/her probationary period shall be transferred to a vacancy in their former bargaining unit for which they are qualified.

## **ARTICLE 5. SENIORITY**

### **Section 5.1**

The Town shall prepare a list of employees showing their seniority in length of service with the Town in position covered by this Agreement and deliver the same to the Union President at a mutually agreed upon date. Unless the Union files a grievance concerning the list within thirty (30) days of receipt of same the list will be presumed to be correct for all purposes of this Contract. Upon completion of their probationary period, new employees shall be added to the list.

### **Section 5.2**

When a vacancy exists or a new position is created and the Town decides to fill the position or vacancy, the employee with the highest departmental seniority who applies for the position or vacancy will be given an opportunity to fill the position or vacancy provided the employee is qualified to do the job as determined by the Director of Public Works. If the employee is unable to perform the job as determined by the Director of Public Works within forty-five (45) working days of assuming the position, the employee will return to his/her previous position.



If the most senior employee who applies for the position does not get the job or does not complete his/her probationary period, the Director of Public Works may look to applicants outside of the bargaining unit to fill the position.

In the event of a layoff the following procedure will be followed:

- a. temporary employees will be laid-off first followed by,
- b. part-time employees followed by,
- c. probationary employees followed by;
- d. employees with the least bargaining unit seniority within classification. An employee who is laid-off or whose position is eliminated shall bump the least senior employee in the same classification. If there is no such employee, the employee may bump an employee in a lower classification previously held by the employee within the bargaining unit provided he can perform the job.

#### **Section 5.4**

Employees will lose their seniority for the following reasons

- a. discharged for just cause;
- b. resignation;
- c. retirement;
- d. voluntarily quit;
- e. layoff for more than three hundred sixty-five (365) days;
- f. failure to return to work from an authorized leave of absence;
- g. failure to return to work within ten (10) days from recall; and
- h. holding another job while on an authorized leave of absence.

### **ARTICLE 6. HOURS OF WORK AND OVERTIME**

#### **Section 6.1**

The basic work week/work day for employees in the bargaining unit shall be eight and one half (8 ½) hours a day, five (5) days a week with one half (½) hour off for unpaid lunch.



**Section 6.2**

The present schedule is Monday through Friday, 7:00 a.m. to 3.30 p.m. The Refuse/Recycling Supervisor is scheduled to work from April 1 to November 1, 6:00 a.m. to 2:30 p.m.

These schedules shall not be deemed a guarantee by the Town nor in anyway restrict the Town from scheduling or making changes in the schedule or starting time.

**Section 6.3 - Overtime**

Employees will be required to work overtime when requested. Non-exempt employees (Road Foreman) will be paid time and one half (1 ½) for those hours worked in excess of eight (8) hours in any one day or forty (40) hours in any one (1) work week. In addition, these employees will be paid time and one half (1 ½) for all worked performed on Saturday.

All overtime shall be divided equally by hours among employees in this section. Overtime shall be equalized within thirty-five (35) hours during a fiscal year. Any employee not equalized within thirty-five (35) hours shall be compensated at his/her hourly rate for the number of hours required to be equalized.

Overtime hours of all employees in this section shall be posted on a suitable bulletin board by the number of overtime hours worked weekly. A copy of the posting shall be given to the Union President.

Non-exempt employees (Road Foreman) will receive double time for all work performed on Sunday and all work performed on holidays plus their regular holiday pay.

**Section 6.4 - Overtime-Buildings and Grounds Supervisor,**

**Refuse/Recycling Supervisor, Vehicle Maintenance  
Supervisor**

All employee positions in this Section are exempt and exempt employees will be required to work overtime when required. Exempt employees will receive one (1) hour off for each hour worked beyond the normal schedule provided such work is authorized by the Town Administrator. Compensatory time shall be taken at the mutual convenience of the employee and the Director of Public Works. In case of conflict, the



Director of Public Works shall have final authority. Compensatory time off shall not accumulate to more than five (5) working days. Employees will not be paid for unused compensatory time.

**Section 6.5**

When a non-exempt employee is called in for work outside his/her regularly scheduled working hours, he/she shall be paid a minimum of four (4) hours at the applicable overtime rate. In addition, for snowplowing such employees will receive a one (1) hour call in time. Up to but not exceeding 5 bargaining unit employees, who may be exempt or non-exempt, as part of their job duties, shall be reachable by phone thus requiring them to be “on call.” Effective July 1, 2009, those “on call” employees will receive a bi-weekly stipend of \$57.70, to be paid monthly, for their on call responsibilities. Effective July 1, 2011, this bi-weekly stipend for those “on call” employees will be increased to \$73.60, to be paid monthly.

**ARTICLE 7. HOLIDAYS**

**Section 7.1**

The following holidays will be observed with a day off with pay for the employees who have completed their probationary period.

New Years Day	Labor Day
Martin Luther King Day	Columbus Day
President’s Day	Veteran’s Day
Good Friday	Thanksgiving Day
Memorial Day	Friday Following Thanksgiving
Independence Day	Christmas Day

**Section 7.2**

One (1) floating holiday to be individually observed by the employee, and mutually agreed upon by the Town and the employee in advance of the holiday.



**Section 7.3**

When the holiday falls on a Saturday, it will be observed on the preceding Friday.  
When the holiday falls on a Sunday, it will be observed on the following Monday.  
The parties may mutually agree in writing to a different schedule.

**Section 7.4**

In order to be eligible for holiday pay, an employee must work his/her last scheduled shift preceding the holiday and his/her first scheduled shift following the holiday. Failure to meet this requirement will result in the forfeiture of the holiday pay.

**Section 7.5**

When a holiday occurs during an employee’s regular vacation, the holiday shall not be charged against an employee’s vacation time.

**ARTICLE 8. VACATION**

**Section 8.1**

Each full-time employee, who has completed his/her probationary period covered by this Agreement, shall be entitled to the following vacation pay at their base rate of pay determined by the length of his/her continuous employment with the Town on the following basis:

**Length of Continuous Service**

1 year up to but not including 5 years	10 days
5 years up to but not including 12 years	15 days
12 years up to but not including 20 years	20 days
20 years and over	25 days*

\* Only applies to employee hired before July 1, 2009

July 1st will be used to determine the amount of vacation due to an employee. Vacation earned in one fiscal year must be used by the end of the next fiscal year. Employees may not accumulate or carry over unused vacation days except as set forth in Section 8.2. In addition, an employee may not exchange unused vacation time for equivalent payment.



**Section 8.2 - Vacation Leave Accumulation**

Subject to the recommendation of the Department Head and approval of the Town Administrator, employees may carry over a maximum of five (5) vacation days. Such vacation days may be used as sick days. Employees will never have more than five (5) vacation days carried over. Such days may not be used to enhance the value of the employee's pension.

Notwithstanding any language to the contrary in this Section 8.2, employees hired prior to July 1, 2009 and in the bargaining unit or who transfer to the bargaining unit may keep all vacation days they have accumulated to date. These days must be used before the employee's retirement from employment with the Town of Vernon.

As of the date of this contract, new employees who do not successfully complete their probationary period are ineligible to receive accrued vacation time in their final pay.

**Section 8.3 - Schedule of Vacation**

On or before March 15th, employees shall submit a vacation schedule request to their Department Head. An employee may not take vacation leave of less than one-half (1/2) his/her normal work day.

The Department Head will determine the annual vacation schedule, taking into consideration the desire of the employee, the needs of the department, and the best interests of the Town. Wherever possible, the request of the employee shall be granted. A conflict in scheduling vacation leave among employees will be resolved by the Department Head on the basis of seniority in Town service. Any employee who does not submit a vacation schedule request by March 15 shall forfeit any seniority claim for vacation priority.

**ARTICLE 9. LEAVE PROVISIONS**

**Section 9.1**

Sick leave allowance will be earned by each regular, full-time employee at the rate of one and a quarter (1.25) days for each full calendar month of service.



### Section 9.2

Sick leave earned in any month of service shall be available at any time during the subsequent month. Further, sick leave shall continue to accumulate during leaves of absence with pay and during the time employees are on authorized sick leave or on vacation.

### Section 9.3

The Department Head may request a doctor's note with regard to any request for sick leave and an employee may use up to three (3) days of his/her fifteen (15) sick days per year for illness for a member in the immediate family.

### Section 9.4

Any employee who is employed in the bargaining unit **as of July 1, 1997** shall maintain the following benefits for sick days:

- a. Such an employee who retires from the Town service shall be paid for one hundred percent (100%) of accumulated sick leave, to a maximum of one hundred eighty (180) days. All days to be paid at the fixed pay rate of **\$161.44 per day** as of June 30, 1997 as specified in the Town Administrator's memorandum dated August 14, 1997 and attached to this Agreement as Appendix F.
- b. In the event of his/her death, the employee's unused accumulated sick pay, up to a maximum one hundred eighty (180) days, shall be paid at the employee's rate of pay as of June 30, 1997 (See Appendix F) to the beneficiary designated by said employee in writing and retained in his/her personnel file. In the event said employee file does not have a beneficiary in writing prior to his/her death, the Town shall pay said money to the spouse, if any, if said spouse is not alive, to the child(ren) of said deceased employee. In the event no designation in writing is made and the employee has neither spouse nor child(ren), the pay shall be given to the estate of the deceased employee.
- c. An employee who terminates employment in the Town services in good standing shall be paid fifty (50%) percent of accumulated sick days, not to exceed ninety (90) days, at the employee's rate pay as of June 30, 1997 (See Appendix F).
- d. Nothing herein shall be construed so as to prohibit an employee from requesting additional paid sick leave from the Town Administrator in



exceptional cases. The refusal to grant such request shall not be subject to the grievance and arbitration provisions of this agreement.

Any employee who is hired into the bargaining **after July 1, 1997 and before July 1, 2009** shall maintain the following benefits for sick days:

- a. Such an employee who retires from the Town service shall be paid for one hundred percent (100%) of accumulated sick leave, to a maximum of ninety (90) days. All days to be paid for at the fixed rate of \$228.00 per day. In the event of the death of the employee, his/her spouse and/or minor children shall be paid for one hundred percent (100%) of accumulated sick leave to a maximum of ninety (90) days at the fixed rate of \$228.00 per day.
- b. Such an employee who terminates employment with the Town in good standing shall be paid for one hundred percent (100%) of accumulated sick leave to a maximum of ninety (90) days at the fixed rate of \$228.00 per day.
- c. All unused sick leave may be accumulated up to one hundred and eighty (180) days. Sick days accumulated beyond ninety (90) days may be used by the employee for his or her own illness but will not be paid for or become the basis for compensation when the employee leaves the employ of the Town of Vernon.
- d. Nothing herein shall be construed so as to prohibit an employee from requesting additional paid sick leave from the Town Administrator in exceptional cases. The refusal to grant such request shall not be subject to the grievance and arbitration provisions of this agreement.

Any employee hired **after July 1, 2009** into the bargaining unit shall maintain the following benefits for sick days:

- a. All unused sick leave may be accumulated up to ninety (90) days.
- b. Such an employee who retires from the Town service shall be paid for one hundred percent (100%) of accumulated sick leave, to a maximum of thirty (30) days. Sick days will be paid out at the fixed rate of \$228.00 per day. In the event of the death of the employee, his/her spouse and/or minor children shall be paid for one hundred percent (100%) of accumulated sick leave to a maximum of thirty (30) days at the fixed rate of \$228.00 per day.
- c. Accumulated sick leave paid at the time of retirement or death will not be added to the employee's pension calculation when the employee leaves his/her employment with the Town.



- d. If an employee is terminated from his/her employment with the Town, or does not successfully complete his or her probationary period, he/she will forfeit any and all accumulated sick leave.
- e. Nothing herein shall be construed so as to prohibit an employee from requesting additional paid sick leave from the Town Administrator in exceptional cases. The refusal to grant such request shall not be subject to the grievance and arbitration provisions of this agreement.

#### **Section 9.5**

Any employee receiving workers' compensation will not receive any additional payment from the Town. An employee may, at their discretion, use some or all of his/her annual fifteen (15) sick days to supplement their workers' compensation benefits, but in no event will the workers' compensation payment and sick days exceed the employee's regular weekly earnings.

#### **Section 9.6 Military Leave**

The Town shall comply with applicable federal and state law with regard to military leave.

#### **Section 9.7 Union Leave**

One (1) member of the bargaining unit shall be allowed to attend official Union convention or conference without loss of pay for up to three (3) days per year. Permission to attend such conferences or conventions will not be unreasonably withheld. In all cases, requests to use such Union leave must be given to the Director of Public Works at least thirty (30) days in advance of the convention and/or conference.

#### **Section 9.8 Personal Leave**

The Town may, at its discretion, grant an employee a personal leave of absence, without pay, for legitimate reasons, provided, however, no such leave shall be granted for the purpose of engaging in other employment. Personal leave shall generally not exceed thirty (30) days.

The Town Administrator, after consultation with the employee's supervisor, shall make the decision on whether or not to grant the requested leave of absence. Such decision will not be subject to the grievance/arbitration provisions of this Agreement.



### **Section 9.9 Bereavement Leave**

Any regular, full-time employee who has completed his/her probationary period shall be granted up to three (3) days of leave, with pay by the Town Administrator for death in the immediate family. The immediate family includes; father, mother, sister, brother, wife, husband, child, grandchild, grandparent, mother-in-law, father-in-law or other relative living in the immediate household. Any regular, full-time employee who has completed his/her probationary period shall be granted one (1) day of leave, with pay by the Town Administrator for death of the following relatives of the employee: aunt, uncle, niece, nephew or cousin.

### **Section 9.10 Personal Days**

Employees whose normal work week is twenty (20) hours or more are entitled to three (3) personal days with pay each year to attend to personal business which cannot be conducted outside the normal work week. Requests for a personal day shall be made in writing, approved by the Department Head and submitted to the Town Administrator at least twenty-four (24) hours in advance of the scheduled day of leave. Approval of personal days shall be granted unless such approval would jeopardize necessary staff requirements. Personal days may not be accrued.

## **ARTICLE 10. GRIEVANCE PROCEDURE**

### **Section 10.1**

A grievance is a dispute which arises under this Agreement between an employee and the Employer.

Step1: Within ten (10) days after the employee knew or should have known of the cause of the grievance an employee having a grievance and/or his Union steward shall take it up with the Director of Public Works. The Director of Public Works shall provide a written answer to the employee and/or his Union steward within ten (10) days after the presentation of the grievance in Step 1.



**Section 10.2**

Step 2: If the grievance is not settled in Step 1, the grievant and/or his/her Union steward may within ten (10) days after receipt of the answer in Step 1 be presented to Step 2 by the employee. The grievance will be presented at this Step to the Town Administrator and/or his designee and he/she shall render his decision in writing within ten (10) days after the presentation of the grievance in this Step 2.

**Section 10.3**

Anything to the contrary herein notwithstanding, a grievance regarding a discharge, must be presented at Step 2 in the first instance within ten (10) days of the discharge.

**Section 10.4**

All time limits refer to work days in this Article. Any disposition of a grievance from which no appeal is taken within the time limits specified herein, will be deemed resolved and shall not thereafter be considered subject to the grievance and arbitration provisions of this Agreement. All time limits in this Article may be extended by written mutual agreement of the parties.

**Section 10.5**

A grievance not timely appealed to the next Step shall be deemed resolved in favor of the opposing side.

**Section 10.6**

No more than one (1) steward of the Union shall be designated by the Union for the purpose of adjusting grievances and shall be afforded no more than one (1) hour a week without loss of pay to conduct such business. No more than a maximum of two (2) employees, including a steward or Union official, will be permitted to attend meetings to adjust grievances and such employees shall be afforded a reasonable amount of time to discuss grievances. No more than two (2) members of the bargaining unit will be paid to attend contract negotiations without loss of pay.



## **ARTICLE 11. ARBITRATION**

### **Section 11.1**

In the event any grievance has not been settled through the foregoing grievance procedure, the Union and/or Town shall have the right to submit the grievance to the State Board of Mediation and Arbitration. Such request for arbitration must be received by the State Board of Mediation and Arbitration within twenty (20) calendar days from receipt of the decision from Step 2 of the grievance procedure. A copy of such request for arbitration shall be sent by certified mail to the Town and/or the Union as the case may be.

### **Section 11.2**

In any arbitration involving a discharge, the Town, at its discretion, may require that the grievance be submitted to the American Arbitration Association and an arbitrator chosen in accordance with the procedures of the American Arbitration Association. If a discharge case is submitted to the American Arbitration Association, the Town agrees to pay all arbitration fees and its own representation fees. The Union will pay for its representation fees.

### **Section 11.3**

The arbitration shall have no power to modify, add to, amend or delete any of the terms or provision of this Agreement. The arbitrator shall not be entitled to substitute his/her judgement for that of the Town and shall be limited to the expressed terms of this Agreement.

### **Section 11.4**

The arbitrator shall be limited to deciding the specific issue placed before him/her and the specific language alleged to be misapplied or misinterpreted and shall have no authority to establish wage rates.



The decision of the arbitrator shall be binding on the Town, Union and aggrieved employee or employees. Expenses for arbitration shall be borne equally by the Employer and the Union.

## **ARTICLE 12. DISCHARGE AND DISCIPLINE**

### **Section 12.1**

Discipline, including discharge, shall be for cause only.

Any employee who is being questioned concerning an incident or action which the employee reasonably believes may subject him/her to disciplinary action has the right upon his/her request to have a member of the Union present.

### **Section 12.2**

When the Town deems it appropriate, it will follow a progressive disciplinary procedure. Such procedure to include four (4) steps: verbal warning, written warning, suspension and discharge. The parties, however, recognize that not all discipline can be progressive in nature and whether or not progressive discipline is followed by the Town depends upon the nature of the events for which discipline is being imposed.

## **ARTICLE 13. JURY DUTY**

Any regular employee who works twenty (20) or more hours per week shall be granted a leave of absence with pay for required jury duty. The employee shall continue to receive his/her regular pay, but shall submit to the Town any jury fees, except travel or meal allowance. The employee shall give to the Town Administrator a certified record of jury attendance from the Clerk of Court.

## **ARTICLE 14. NO DISCRIMINATION**

The parties agree that they will not discriminate against any employee because of his/her race, color, religion, sex, national origin, disability or age. The parties further



agree that there will be no discrimination because of an employee's membership in the Union.

#### **ARTICLE 15. PAST PRACTICE**

This Agreement, upon ratification, supersedes and cancels all prior practices and agreements, whether written or oral, unless expressly stated to the contrary herein and constitutes a complete and entire agreement between the parties.

#### **ARTICLE 16. TOWN VEHICLES**

If an employee is supplied with a Town vehicle, such vehicle may be taken home at night, on weekends, holidays and other such appropriate occasions. This vehicle is to be used for non-personal use including transportation to and from work and for other job related duties outside the employee's normal working hours. The Town will comply with all applicable Internal Revenue Service Rules and Regulations.

#### **ARTICLE 17. EVALUATIONS**

##### **Section 17.1**

Employees in the bargaining unit will be evaluated annually by the Director of Public Works or by his designee and such evaluation will not be used as a sole basis for any disciplinary action toward the employee.

##### **Section 17.2**

Members, due to their supervisory status, would be eligible for additional compensation under a merit pay plan. The following are the guidelines for the plan:

- a. The maximum amount that each individual may be eligible for annually is \$600.
- b. There would be two levels of the awards: the first level for the category of being overall "very good," for \$300; and the next level, overall "outstanding" for \$600.
- c. In each category, the department head would recommend the awarding of such merit pay annually and the Town Administrator would have the authority to approve or reject said recommendation.
- d. The program would begin upon the establishment of mutual expectations with the performance evaluations and annually thereafter. The awards



would actually be determined based on the period of performance from the previous year.

- e. If an individual is not satisfied with the department head's evaluation, the individual may appeal that evaluation to the Town Administrator. The Town Administrator or his/her designee will meet with the employee and the department head. The Town Administrator's decision, based upon the information gathered at this meeting, will be final.
- f. The Town will provide the Union with the criteria which will be utilized in recommending and awarding merit pay.
- g. Announcement of the Merit Pay Award(s) shall be done once annually by the Town Administrator.
- h. The Union agrees not to grieve an alleged violation of this section.

**ARTICLE 18. NO STRIKE**

The Union agrees that all employees included in this Agreement will not collectively, concertedly or individually engage in or participate, directly or indirectly, in any strike, sympathy strike, slowdown or work stoppage during the term of this Agreement. The Union further agrees that it shall make every effort to prevent such activities on the part of any employees covered by this Agreement and if any employee engages in such conduct they shall be subject to immediate discipline up to and including discharge.

**ARTICLE 19. INSURANCE**

**Section 19.1**

Employees shall contribute to a Section 125 IRS plan the following share amounts in accordance with Section 19.4 of this contract:

<b>Year</b>	<b>Town HMO* see 19.4 F</b>	<b>Town HSA</b>
July 1, 2015-June 30, 2016	11%	11%
July 1, 2016-June 30, 2017	12%	12%
July 1, 2017-June 30, 2018	13%	13%

**Section 19.2**

If the employee waives his/her right to health insurance the Town will give back twenty-five (25%) percent of the premium cost to the employee. Twelve and one half (12



½%) percent in December and twelve and one half (12 ½ %) percent in June. This waiver will not be available for employees who have health insurance paid by the Town of Vernon through their spouse or any other family member.

**Section 19.3**

The Town shall provide and pay for life insurance in the amount of \$40,000.00 and \$80,000 accidental death and dismemberment.

**Section 19.4**

In order for an employee to be eligible to participate in the insurance plan, employees must work thirty (30) hours per week.

- A. Employees may choose medical coverage through a Town sponsored Health Savings Account (“HSA”). Plan details are set forth in Appendix B (prescription plan) attached hereto. The annual deductible shall be \$2,000 individual account/\$4000 two-person and family accounts. The deductible contribution to the HSA shall be as follows:

- First Year: Town 50% / Employee 50%
- Second Year: Town 50% / Employee 50%
- Third Year: Town 50% / Employee 50%

- B. On July 1 of each year the Town shall make the requisite contribution into each employee’s account regardless of the balance in said account.
- C. The Town shall provide Anthem Blue Cross and Blue Shield Full Service Dental Care. Dental riders shall be available in accordance with Appendix E attached hereto. Dependents may remain on the Town’s dental plan until age 26.
- D. Employees shall contribute the following premium cost of the HSA and Anthem Blue Cross Blue Shield Full Service Dental Care:
  - a. First year: 11%
  - b. Second year: 12%
  - c. Third year: 13%

Any medical or dental premium contributions, and any deductible contributions, shall be made on a pre-tax basis. The Town shall pay any group administrative



costs charged by the carrier in connection with integrated HSA account management. Any fees associated with an HSA bank deposit account will be the responsibility of each employee.

- E. The Town shall contribute the additional deductible contribution made upon notification that an employee is changing status from an individual account to a two person or family account. An employee shall reimburse the Town for any excess deductible contribution made during any fiscal year when the employee's status changes from two person or family account to an individual account.
- F. \*Employees who are age 65 or older have the option of remaining on the Town's current HMO plan:

The Town HMO plan will have the following payments:

- G. Office visits preventative \$10
- H. Office visits \$10
- I. Inpatient \$200
- J. Emergency \$50
- K. Outpatient \$50
- L. Dependent rider 19/23
- M. Prescriptions - Retail up to 34 days and Mail Order up to 100 days: \$5 generic, \$25 Listed Brand Name, \$40 Non-Listed Brand Name, with no cap, in accordance with Appendix B-1, entitled Managed Prescription Program 3-Tier.

The Town may change carriers, provided the level of benefits and administration of the plan is no lesser than the current insurance benefits. Prior to making any change the Town shall notify the Union so the changes can be reviewed prior to implementation. In the event that the insurance carrier providing the benefits is no longer in business or has been merged or been acquired by another carrier, the parties will meet to discuss alternative coverage. Such cost shall not exceed the cost of the previous insurance plan provided to the employees. If a change in insurance is to take place, an insurance committee shall be established and will include one (1) member of the bargaining unit.

#### **Section 19.6**

The Town will establish an Employee Assistance Program (EAP).



## ARTICLE 20. PENSION

### Section 20.1

The Town will continue in effect the existing pension plan presently covering bargaining unit members **as of July 1, 1997** with the following changes:

1. Effective January 1, 2006, five (5) years cliff vesting.
2. Effective July 1, 2009, the monthly benefit rate becomes two and twenty hundredths percent (2.20%) of average monthly earnings times credited service to a maximum of thirty-five (35) years and a maximum of seventy percent (70%).
3. Average monthly earnings based on highest three (3) consecutive years.
4. Effective January 1, 2006, the employee contribution rate becomes seven (7.0) percent pre-tax Section 414 h2.
5. Normal retirement age will follow rule 85 for all employees in the bargaining unit as of July 1, 2009.
6. Employees hired after July 1, 2009 must meet the requirements of rule 85 plus be at least fifty-eight (58) years of age.
7. Three (3) year cap on annuitant spouse option.
8. Employees who become members of the bargaining unit subsequent to **January 1, 2010** are not eligible for the defined benefit pension plan set forth herein. Such employees will be eligible for a Town 457(b) plan, and will be automatically enrolled in the plan. The Town will contribute 2% of the employee's base wages of all employees who elect to participate in the 457(b) plan upon their hire and do not elect to opt out of the plan. If an employee contributes 7.5% or more of his or her base wages to a 457(b) plan, the Town will contribute an additional 2% for a total contribution of 4% of the employee's annual base wages to the plan. Vesting schedule same as defined benefit pension plan.
9. Employees hired prior to January 1, 2010 are not eligible to participate in the 457(b) plan to which the Town makes any contribution.

## ARTICLE 21. WAGES

Upon ratification of this contract, the Town will increase the base salary for the Road Foremen, Lead Road Foreman and the Refuse Supervisor by \$1,250.00. Upon



ratification of this contract, the Town will increase the Fleet Supervisor's base salary by \$2,500.00.

The Town will increase all bargaining unit employees' wages in the following amounts on the following dates:

Year 1	July 1, 2015 – 6/30/2016	0.00%
Year 2	July 1, 2016 – 6/30/2017	2.00%
Year 3	July 1, 2017 – 6/30/2018	2.00%

Additionally, in year one (July 1, 2015 – June 30, 2016), the Town will increase each bargaining unit employees' base salary by \$1.00. There will be no additional such increases in years two or three.

See Appendix A

The Town reserves the right to set wages for new employees hired after July 1, 2001 within the following pay range in the respective classification:

	<b>Per hour</b>	<b>Per hour</b>
Foreman:	\$18.11	\$20.79
Supervisors:	\$41,984.00	\$53,046.00

NOTE: Current employees salaries may not be within these ranges per Dan Sullivan 1/7/99.

#### **ARTICLE 22. LONGEVITY**

In recognition for continuous employment with the Town, employees shall be paid in the second paycheck in December the following amounts:

10 years of service:	\$250.00 annually
15 years of service:	\$325.00 annually
20 years of service:	\$400.00 annually
30 years of service:	\$475.00 annually

Longevity continues for existing employees but will be removed for all new employees to the bargaining unit hired after 7/1/97.



## **ARTICLE 23. PAYROLL**

The Town reserves the right to change the payroll period to bi-weekly. If the Town goes to a bi-weekly payroll period the Union will be given thirty (30) days notice by the Town.

## **ARTICLE 24. SAFETY AND HEALTH**

### **Section 24.1**

Road Foreman will be required to wear a uniform in accordance with the existing policy.

### **Section 24.2**

A credit of two hundred (\$200.00) dollars will be provided by the Town for all bargaining unit employees towards the purchase of safety shoes and similar equipment authorized by the Town as soon as possible during the first quarter of each fiscal year.

### **Section 24.3**

All employees will receive two hundred-fifty (\$250.00) dollars annual meal allowance payable the second week of November.

### **Section 24.4**

The Town will provide free of charge to the employees, medical injections for the prevention and treatment of certain diseases including poison ivy, flu, and diphtheria. Hepatitis-B and tetanus.

### **Section 24.5**

Safety helmets shall be supplied and must be worn by any employee working in hazardous location in accordance with applicable safety regulations.



**Section 24.6**

The Town will pay for physicals required for a CDL, when said physical is not covered or paid for by insurance. This shall also include any co-pays, if applicable. All physicals shall be conducted through the Town's contracted health care service provider.

**ARTICLE 25. TRAINING**

In its discretion, the Town may provide release time and reimbursement for employees for course/seminars which are job related. In order to receive release time and/or reimbursement under this Section, an employee must receive prior written approval from the Director of Public Works or his/her designee. Any decision made by the Director of Public Works or his/her designee under this Section shall not be subject to the grievance and/or arbitration procedure of this Agreement.

**ARTICLE 26. ENTIRE AGREEMENT**

**Section 26.1**

The agreement expressed herein in writing, constitutes the entire agreement between the parties and no practice or oral statement shall add to or supersede any of its provisions.

**Section 26.2**

The parties acknowledge that during the bargaining for this Agreement, each had unlimited right and opportunity to make demands and proposals with respect to any subject or matter not removed by law from the area of collective bargaining and that the parties after the exercise of that right and opportunity, are set forth in this Agreement.

**ARTICLE 27. SAVINGS CLAUSE**

If any Section, sentence, Clause or phrase of this Agreement shall be held for any reason to be inoperative, void or invalid by a court of final jurisdiction, the validity of the



remaining portions of this Agreement shall not be affected thereby, it being the intention of the parties in adopting this Agreement that no portion thereof or provisions therein shall become inoperative or fail by reason of the invalidity of any other portion or provision, and the parties do hereby declare that they would have severally approved of and adopted the provisions contained herein separately and apart from the other. The parties agree to immediately negotiate a substitute for the invalidated Article, Section sentence, clause or phrase.

**ARTICLE 28. DURATION**

This Agreement will become effective upon its signing and shall remain in effect through June 30, 2018 and from fiscal year to fiscal year thereafter unless said party notifies the other by registered or certified mail, return receipt requested no later one hundred twenty (120) days before the expiration of the Agreement they wish to negotiate a new Agreement. Upon receipt of such notice, the parties shall meet as soon as possible to negotiate such changes.

**IN WITNESS WHEREOF**, the Town and the Union have caused this Agreement to be signed by their duly authorized representative on the day and year noted below.

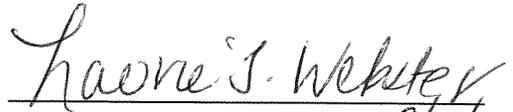
**FOR THE TOWN OF VERNON**

  
\_\_\_\_\_  
**John D. Ward**  
Town Administrator

  
\_\_\_\_\_  
**Ryan O'Donnell**  
Labor Attorney

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

  
\_\_\_\_\_  
**Jeff Schambach** 9/28/15  
President, Local 818

  
\_\_\_\_\_  
**Laurie Webster** 9/3/15  
Staff Representative  
AFSCME, Council 4, AFL-CIO

In order for the Town's signatories to give full effect and force to the Agreement, this Agreement must be ratified by the Vernon Town Council.



## **Appendix A**

### Salary Tables

2015

2016

2017



07/01/2015 11:08 dmaselek

TRAINING DATABASE Jun 27 2015 SALARY TABLES

P 1 pmgrstep

EFF. DATE	GROUP/BU	GRADE/RANK	DESCRIPTION	PAY BASIS	FREQUENCY	CALC	PERIODS DAY	HRS/ DAY	HRS/ PERIOD	DAYS/ YEAR	USE PCT		
07/01/2015	SPRV SUPERVISOR 01		DPW-FOREMAN	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N
			\$1250 increase to base plus \$1.00 per hour										
			No Dollar amount used.										

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00
01	0.0000	33.7800	270.2400	1,351.20	70,262.40
02	0.0000	33.9900	271.9200	1,359.60	70,699.20

EFF. DATE	GROUP/BU	GRADE/RANK	DESCRIPTION	PAY BASIS	FREQUENCY	CALC	PERIODS DAY	HRS/ DAY	HRS/ PERIOD	DAYS/ YEAR	USE PCT		
07/01/2015	SPRV SUPERVISOR 02		DPW SUPERVISORS H HOURLY	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N
			\$1250 add to base for Step 1, Step 2 \$2500 plus \$1.00 er hr										
			No Dollar amount used.										

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00
01	0.0000	35.3700	282.9600	1,414.80	73,569.60
02	0.0000	38.2700	306.1600	1,530.80	79,601.60

EFF. DATE	GROUP/BU	GRADE/RANK	DESCRIPTION	PAY BASIS	FREQUENCY	CALC	PERIODS DAY	HRS/ DAY	HRS/ PERIOD	DAYS/ YEAR	USE PCT		
07/01/2015	SPRV SUPERVISOR 03		DPW-LEADRSPRNM H HOURLY	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N
			Change was made by 2.0000%										
			No Dollar amount used.										

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00
01	0.0000	35.3700	282.9600	1,414.80	73,569.60
02	0.0000	38.2700	306.1600	1,530.80	79,601.60

\*\* END OF REPORT - Generated by Dawn Maselek \*\*



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TRAINING DATABASE Jun 27 2015 SALARY TABLES

P 1 pmgrstep

EFF. DATE	GROUP/BU	GRADE/RANK	DESCRIPTION	PAY BASIS	FREQUENCY	CALC	PERIODS DAY	HRS/ DAY	HRS/ PERIOD	DAYS/ PERIOD	DAYS/ YEAR	USE PCT	
07/01/2016	SPRV SUPERVISOR 01	01	DPW-FOREMAN	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N
Change was made by 2.0000%													
No Dollar amount used.													

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00
01	0.0000	34.4556	275.6440	1,378.22	71,667.44
02	0.0000	34.6698	277.3580	1,386.79	72,113.08

EFF. DATE	GROUP/BU	GRADE/RANK	DESCRIPTION	PAY BASIS	FREQUENCY	CALC	PERIODS DAY	HRS/ DAY	HRS/ PERIOD	DAYS/ PERIOD	DAYS/ YEAR	USE PCT	
07/01/2016	SPRV SUPERVISOR 02	02	DPW SUPERVISORS H HOURLY	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N
Change was made by 2.0000%													
No Dollar amount used.													

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00
01	0.0000	36.0774	288.6200	1,443.10	75,041.20
02	0.0000	39.0354	312.2840	1,561.42	81,193.84

EFF. DATE	GROUP/BU	GRADE/RANK	DESCRIPTION	PAY BASIS	FREQUENCY	CALC	PERIODS DAY	HRS/ DAY	HRS/ PERIOD	DAYS/ PERIOD	DAYS/ YEAR	USE PCT	
07/01/2016	SPRV SUPERVISOR 03	03	DPW-LEADRSFRMN	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N
Change was made by 2.0000%													
No Dollar amount used.													

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00
01	0.0000	36.0774	288.6200	1,443.10	75,041.20
02	0.0000	39.0354	312.2840	1,561.42	81,193.84

\*\* END OF REPORT - Generated by Dawn Maselek \*\*



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TRAINING DATABASE Jun 27 2015

P 1 pmgrstep

EFF. DATE	GROUP/BU	GRADE/RANK	DESCRIPTION	PAY BASIS	FREQUENCY	CALC	PERIODS DAY	HRS/PERIOD	DAYS/PERIOD	HRS/ YEAR	DAYS/ YEAR	USE PCT	
07/01/2017	SPRV SUPERVISOR 01	01	DPW-FOREMAN	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N

Change was made by 2.0000%  
No Dollar amount used.

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	WEEKLY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.0000	0.00	0.00
01	0.0000	35.1447	281.1580	1,405.79	73,101.08	73,555.56
02	0.0000	35.3632	282.9060	1,414.53	73,555.56	73,555.56

07/01/2017	SPRV SUPERVISOR 02	02	DPW SUPERVISORS H HOURLY	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N
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Change was made by 2.0000%  
No Dollar amount used.

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	WEEKLY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00	0.00
01	0.0000	36.7989	294.3920	1,471.96	76,541.92	76,541.92
02	0.0000	39.8161	318.5280	1,592.64	82,817.28	82,817.28

07/01/2017	SPRV SUPERVISOR 03	03	DPW-LEADRDSFRMN	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N
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Change was made by 2.0000%  
No Dollar amount used.

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	WEEKLY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00	0.00
01	0.0000	36.7989	294.3920	1,471.96	76,541.92	76,541.92
02	0.0000	39.8161	318.5280	1,592.64	82,817.28	82,817.28

**Appendix B & B-1**  
Health Insurance  
Summary Plan Descriptions  
For  
HDHP/HSA  
HMO\*  
(B-1) Prescription Plan\*

\*available for employees Medicare eligible only



## FlexPOS-CAL-10-10-0-200A-04 Open Access Calendar Year Benefit Summary

This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per Member per Calendar year. A referral from your primary care provider is not required.

**Personalized for: Vernon Town - \$10**

	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Calendar Year Plan Deductible</b>	None	\$5,000 Employee \$10,000 Employee + 1 \$15,000 per Family
<b>Out-of-Pocket Maximum</b> <i>(Includes a combination of deductible, copayments and coinsurance for health and pharmacy services)</i>	\$6,350 Employee \$12,700 Employee + 1 \$12,700 per Family	\$15,000 Employee \$30,000 Employee + 1 \$45,000 per Family
<b>Out-of-Network Reimbursement</b>	None	<b>Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.</b>
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited
<b>PREVENTIVE SERVICES</b> <i>(Refer to "Prevention and Wellness" section found at the end of this summary)</i>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Physical Exam</b>	No Member cost	50% after Plan Deductible
<b>Gynecological Preventive Exam</b>	No Member cost	50% after Plan Deductible
<b>Preventive Laboratory Services</b> <i>(Complete blood count and urinalysis)</i>	No Member cost	50% after Plan Deductible
<b>Baseline Routine Mammography</b>	No Member cost	50% after Plan Deductible
<b>Routine Mammography</b>	No Member cost	50% after Plan Deductible
<b>Breast Ultrasound Screening</b>	No Member cost	50% after Plan Deductible
<b>Routine Vision Exam</b> <i>(one exam every 12 months when provided by an Optometrist or Ophthalmologist)</i>	\$10 Copayment per visit	50% after Plan Deductible
<b>Hearing Screening</b> <i>(one exam every 24 months)</i>	\$10 Copayment per visit	50% after Plan Deductible
<b>OUTPATIENT SERVICES</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Primary Care Services</b> <i>(includes services for illness, injury, sickness, follow-up care and consultations)</i>	\$10 Copayment per visit	50% after Plan Deductible

<b>OUTPATIENT SERVICES</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Specialist Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	\$10 Copayment per visit	50% after Plan Deductible
<b>Gynecological Office Services</b>	\$10 Copayment per visit	50% after Plan Deductible
<b>Maternity Care Office Visits</b> (Prenatal Care)	No Member cost	50% after Plan Deductible
<b>Allergy Testing</b> (Unlimited)	No Member cost	50% after Plan Deductible
<b>Allergy Injections</b> (Unlimited)	No Member cost	50% after Plan Deductible
<b>Laboratory Services</b> (includes services performed in a Hospital or laboratory facility) (Please refer to the provider directory for facility type)	No Member cost	50% after Plan Deductible
<b>Non-Advanced Radiology</b> (includes services performed in a Hospital or radiology facility)	No Member cost	50% after Plan Deductible
<b>Advanced Radiology</b> (includes services for MRI, PET and CAT scan and nuclear cardiology performed in a Hospital or radiology facility) (Please refer to the provider directory for facility type)	No Member cost	50% after Plan Deductible
<b>Outpatient Rehabilitative Therapy</b> combined with chiropractic (includes services combined for physical, speech, and occupational therapy and chiropractic services) (Unlimited)	No Member cost	50% after Plan Deductible
<b>Retail Clinic</b>	\$10 Copayment per visit	50% after Plan Deductible
<b>EMERGENCY / URGENT CARE</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Walk-In Centers</b>	\$10 Copayment per visit	\$10 Copayment per visit
<b>Urgent Care Centers</b>	\$25 Copayment per visit	\$25 Copayment per visit
<b>Emergency Room</b> (Copayments waived if admitted)	\$50 Copayment per visit	\$50 Copayment per visit
<b>Ambulance Services</b>	No Member cost	No Member cost
<b>HOSPITAL SERVICES</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Inpatient Hospital Services, Including Room &amp; Board</b>	\$200 Copayment per admission	50% after Plan Deductible

<b>HOSPITAL SERVICES</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Hospital Outpatient Surgical Facilities</b> (includes services performed in a Hospital facility) <i>(Please refer to the provider directory for facility type)</i>	No Member cost	50% after Plan Deductible
<b>Ambulatory Surgical Center</b> (includes services performed in a stand-alone ambulatory facility) <i>(Please refer to the provider directory for facility type)</i>	No Member cost	50% after Plan Deductible
<b>Skilled Nursing and Rehabilitation Facilities</b> up to 120 days per year	No Member cost	50% after Plan Deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Inpatient Mental Health Services</b> (including inpatient acute and residential programs)	\$200 Copayment per admission	50% after Plan Deductible
<b>Inpatient Alcohol and Substance Abuse Treatment</b> (including inpatient acute and residential programs)	\$200 Copayment per admission	50% after Plan Deductible
<b>Outpatient Mental Health, Alcohol and Substance Abuse Treatment</b> (including office visits and professional services provided in the home)	\$10 Copayment per visit	50% after Plan Deductible
<b>Outpatient Mental Health, Alcohol and Substance Abuse Treatment</b> (intensive outpatient treatment and partial hospitalization programs)	No Member cost	50% after Plan Deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Durable Medical Equipment Including Prosthetics and Disposable Medical Supplies</b> (No Member cost for wigs prescribed by an oncologist for a Member suffering hair loss as a result of chemotherapy or radiation therapy up to one wig per year)	No Member cost	50% after Plan Deductible
<b>Diabetic Equipment and Supplies</b>	No Member cost	50% after Plan Deductible

OTHER SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
<b>Infertility</b> (Infertility benefits outlined in the Certificate Of Coverage are unlimited, with no age or cycle restrictions)	\$10 Copayment per visit (Office visit)  No Member cost (Ambulatory Services Outpatient)  \$200 Copayment per admission (Inpatient Hospital)	50% after Plan Deductible
<b>Nutritional Counseling</b> (Limit 3 visits per year)	No Member cost	50% after Plan Deductible
<b>Home Health Services</b> up to 200 visits per year	No Member cost	25% after \$50 Benefit Deductible

## PREVENTION AND WELLNESS

In-Network prevention and wellness services as defined by the United States Preventive Service Task Force (listed below) are exempt from all member cost share (deductible, copayment and coinsurance) under the Patient Protection and Affordable Care Act (PPACA). Services that are exempt from cost share must be identified by the specific codes. The codes your health care provider submits must match ConnectiCare's coding list to be exempt from all cost share. Please note that not all preventive services are listed below and that some diagnostic services provided in relation to preventive and wellness services require member cost share. Go to [www.connecticare.com/preventive](http://www.connecticare.com/preventive) for more information on coverage of preventive care or services.

- Routine physical exam and appropriate screening and counseling for adults (including but not limited to cardiovascular disease, depression, obesity and sexually transmitted infections)
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration (including but not limited to depression, obesity and sexually transmitted infections)
- Preventive care and screenings for women supported by the Health Resources and Services Administration:
  - At least one well-woman preventive care visit annually to obtain the recommended preventive services
  - Screening for diabetes during pregnancy, two per pregnancy
  - Human Papillomavirus (HPV) testing, age 30 or older, one per year
  - Counseling on sexually transmitted infections for all sexually active women, two per year
  - Counseling and screening for human immune-deficiency virus (HIV) for all sexually active women
  - Contraceptive methods approved by the Food and Drug Administration, sterilization procedures and contraceptive patient education and counseling
  - Comprehensive lactation support, counseling, a breast pump, (either manual or non-hospital grade electric), and breastfeeding supplies
  - Screening and counseling for interpersonal and domestic violence for all women and adolescents
- Bone density screenings, age 60 or older
- Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, age 50 or older
- Routine mammography screening
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Outpatient Laboratory Services:
  - Cervical cancer and cervical dysplasia screening – pap smear
  - Lipid cholesterol screening for adults and children at risk
  - Fasting plasma glucose or hemoglobin A1c
  - Hematocrit and Hemoglobin for children up to age 21
  - Lead screening for children
  - Tuberculin testing for children
  - Chlamydia, syphilis and gonorrhea screening for females all ages
  - Human immunodeficiency virus screening – HIV testing
  - Hypothyroidism screening in newborns, under 3 months of age
  - Screening for phenylketonuria (PKU) in newborns, 3 months of age
  - Screening for sickle cell disease in newborns, 3 months of age
  - Hepatitis B screening for adolescents and adults at risk
  - Hepatitis C screening for adults at risk
  - Lung Cancer Screening for adults ages 55 -80 who have smoked
- Routine vision screening up to age 21, one per year when services are rendered by a primary care provider.
- Routine hearing screening up to age 21 when rendered by a primary care provider
- Dental caries prevention up to age 5 when rendered by a primary care provider
- Developmental, autism, and psychosocial/behavioral assessments when rendered by a primary care provider
- Dietary counseling for adults with cardiovascular disease, hyperlipidemia or obesity
- Alcohol misuse screening and counseling
- Tobacco cessation interventions
- Screening for hepatitis B, iron deficient anemia, Rh (D) blood typing and asymptomatic Bacteriuria in women who are pregnant.
- Screening for abdominal aortic aneurysm in men age 65 - 75 who have ever smoked
- BRCA counseling and genetic screening for women at risk
- Physical therapy to prevent falls in adults age 65 and older

### Important Information

- If you have questions regarding your plan, visit our website at [www.connecticare.com](http://www.connecticare.com) or call us at (860) 674-5757 or 1-800-251-7722.
- Many services require that you obtain our pre-certification or pre-authorization prior to obtaining care prescribed or rendered by network providers or non-participating providers. A reduction will apply if you do not obtain pre-authorization for these specified services. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for more information.
- For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain pre-authorization.
- Out-of-Network cost shares are reimbursed at the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for more information.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your mandated benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2015.
- Your plan is Insured by ConnectiCare Insurance Company, Inc.

### Benefits are Subject to Department of Insurance Approval

**ConnectiCare** : FlexPOS-CAL-10-10-0-200A-04  
 Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2015 to 06/30/2016  
**Coverage for: Family | Plan Type: POS**

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.ConnectiCare.com](http://www.ConnectiCare.com) or by calling 1-800-251-7722.



Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: \$0; Out-of-Network: \$5,000 member / \$15,000 family	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers \$6,350 member / \$12,700 family. For non-participating providers \$15,000 member / \$45,000 family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the insurer pays?	No.	The chart starting on page 2 describes any limits on what the insurer will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See <a href="http://www.ConnectiCare.com">www.ConnectiCare.com</a> or call 1-800-251-7722 for a list of participating providers and hospitals.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).  
 If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-800-251-7722 to request a copy



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**)
- The plan may encourage you to use **In-network providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need		Your cost if you use an		Limitations & Exceptions
	In-network Provider	Out-of-network Provider	In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 Copayment per visit	\$10 Copayment per visit	50% after Plan Deductible	-----none-----
	Specialist visit		\$10 Copayment per visit	50% after Plan Deductible	-----none-----
	Other practitioner office visit		for chiropractor	50% after Plan Deductible for chiropractor	combined with Rehabilitation
	Preventive care / screening / immunization		No Member cost	50% after Plan Deductible	Frequency limits apply
If you have a test	Diagnostic test (x-ray, blood work)		Xray: No Member cost, Lab: No Member cost	50% after Plan Deductible	-----none-----
	Imaging (CT / PET scans, MRIs)		No Member cost	50% after Plan Deductible	-----none-----
If you need drugs to treat your illness or condition More information about <b>prescription drug coverage</b> is available at <a href="http://www.ConnectiCare.com">www.ConnectiCare.com</a>	Generic drugs		Not covered	Not covered	Not Covered
	Preferred brand drugs		Not covered	Not covered	Not Covered
	Non-preferred brand drugs		Not covered	Not covered	Not Covered
	Specialty drugs		Not covered	Not covered	Not Covered

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Member cost	50% after Plan Deductible	-----none-----
	Physician/surgeon fees	No Member cost	50% after Plan Deductible	-----none-----
	Emergency room services	\$50 Copayment per visit	\$50 Copayment per visit	-----none-----
	Emergency medical transportation	No Member cost	No Member cost	-----none-----
	Urgent care	\$10 Copayment per visit	\$10 Copayment per visit	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$200 Copayment per admission	50% after Plan Deductible	-----none-----
	Physician/surgeon fee	No Member cost	50% after Plan Deductible	-----none-----
	Mental/Behavioral health outpatient services	\$10 Copayment per visit	50% after Plan Deductible	-----none-----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health inpatient services	\$200 Copayment per admission	50% after Plan Deductible	-----none-----
	Substance use disorder outpatient services	\$10 Copayment per visit	50% after Plan Deductible	-----none-----
	Substance use disorder inpatient services	\$200 Copayment per admission	50% after Plan Deductible	-----none-----
<b>If you become pregnant</b>	Prenatal and postnatal care	No Member cost	50% after Plan Deductible	-----none-----
	Delivery and all inpatient services	\$200 Copayment per admission	50% after Plan Deductible	-----none-----

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Common Medical Event	Services You May Need		Your cost if you use an		Limitations & Exceptions
	In-network Provider	Out-of-network Provider	In-network Provider	Out-of-network Provider	
If you need help recovering or have other special health needs	Home health care	No Member cost	No Member cost	25% after \$50 Benefit Deductible	up to 200 visits per year
	Rehabilitation services	No Member cost	No Member cost	50% after Plan Deductible	combined with chiropractic
	Habilitation services	Not covered	Not covered	Not covered	Not covered
	Skilled nursing care	No Member cost	No Member cost	50% after Plan Deductible	up to 120 days per year
	Durable medical equipment	No Member cost	No Member cost	50% after Plan Deductible	-----none-----
If your child needs dental or eye care	Hospice service	No Member cost	No Member cost	50% after Plan Deductible	Pre-authorization is required
	Eye exam	\$10 Copayment per visit	\$10 Copayment per visit	50% after Plan Deductible	up to one visit every year
	Glasses	25% Discount	25% Discount	Not covered	25% Discount
	Dental check-up	Not Applicable	Not Applicable	Not covered	-----none-----

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation Services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs (discounted rate)

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic care
- Hearing aids (may be covered with limitations)
- Routine eye care
- Infertility treatment
- Routine hearing tests

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).

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For more information on your rights to continue coverage, contact the plan at 1-800-251-7722. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### **Your Grievance Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ConnectiCare Member Appeals, PO Box 4061, Farmington, CT 06034-4061 or 1-800-251-7722 or Facsimile 1-800-319-0089  
Connecticut Residents: CT State Department of Insurance at 1-800-203-3447 or [www.ct.gov/cid/site/default.asp](http://www.ct.gov/cid/site/default.asp)  
Massachusetts Residents: MA Division of Insurance at 1-877-563-4467 or [www.mass.gov/ocabr/government/oca-agencies/doi-lp/](http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/)

### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

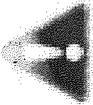
-----To see examples of how this plan might cover costs for a sample medical situation, see the next page.-----

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).

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## About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

 **This is not a cost estimator.**

Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$7,170
- Patient pays: \$370

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Co-pays	\$200
Co-insurance	\$0
Limits or exclusions	\$170
<b>Total</b>	<b>\$370</b>

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-390-3522.

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$2,370
- Patient pays: \$3,030

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Co-pays	\$100
Co-insurance	\$0
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$3,030</b>

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).

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## Questions and answers about Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and are not specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).

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### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles** and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summaries of Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.



## FlexPOS-CNT-HSA-2000I/4000F-05-Combined Open Access Contract Year Benefit Summary

Open Access High Deductible Health Plan (HDHP) for use with a Health Savings Account (HSA)

This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc Certificate of Coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per Contract year. A referral from your primary care provider is not required.

The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. In addition, if you have family coverage, any applicable copayment, coinsurance or cost share maximums will apply until the total is met for the family, without regard to how much any one family member has met.

**Personalized for: Town of Vernon - Union Employees**

	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Contract Year Plan Deductible</b> <i>(Deductible is combined for In- and out-of-network health services and prescription drugs)</i>	\$2,000 per Individual \$4,000 per Family	\$2,000 per Member \$4,000 per Family
<b>Out-of-Pocket Maximum</b> <i>(Includes a combination of deductible, copayments and coinsurance for health services and pharmacy services)</i>  <i>(Out-of-Pocket Maximum is combined for In- and out-of-network health services and prescription drugs)</i>	\$2,500 per Individual \$5,000 per Family	\$4,000 per Member \$8,000 per Family
<b>Out-of-Network Reimbursement</b>	Not Applicable	<b>Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.</b>
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited
<b>PREVENTIVE SERVICES</b> <i>(Refer to "Prevention and Wellness" section found at the end of this summary)</i>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Physical Exam</b>	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible
<b>Gynecological Preventive Exam</b>	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible
<b>Preventive Laboratory Services</b> <i>(Complete blood count and urinalysis)</i>	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible
<b>Baseline Routine Mammography</b>	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible
<b>Routine Mammography</b>	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible
<b>Breast Ultrasound Screening</b>	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Routine Vision Exam</b> <i>(one exam per year when provided by an Optometrist or Ophthalmologist)</i>	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible

<b>PREVENTIVE SERVICES</b> (Refer to "Prevention and Wellness" section found at the end of this summary)	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Hearing Screenings</b> (one exam every 24 months)	No Member cost ( <i>Plan Deductible waived</i> )	20% after Plan Deductible
<b>OUTPATIENT SERVICES</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Primary Care Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Specialist Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Gynecological Office Services</b>	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Maternity Care Office Visits</b> ( <i>Prenatal Care</i> )	No Member cost	20% after Plan Deductible
<b>Allergy Testing</b> (Unlimited)	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Allergy Injections</b> (Unlimited)	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Laboratory Services</b> (includes services performed in a Hospital or laboratory facility) ( <i>Please refer to the provider directory for facility type</i> )	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Non-Advanced Radiology</b> (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Advanced Radiology</b> (includes services for MRI, PET and CAT scan and nuclear cardiology performed in a Hospital or radiology facility) ( <i>Please refer to the provider directory for facility type</i> )	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Outpatient Rehabilitative Therapy</b> (includes services combined for physical, speech, and occupational therapy and chiropractic services) (Unlimited)	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Retail Clinic</b>	No Member cost after Plan Deductible	20% after Plan Deductible
<b>EMERGENCY / URGENT CARE</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Walk-In Centers</b>	No Member cost after Plan Deductible	Same as In-Network Benefit
<b>Emergency Room</b>	No Member cost after Plan Deductible	Same as In-Network Benefit

<b>EMERGENCY / URGENT CARE</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Ambulance Services</b>	No Member cost after Plan Deductible	Same as In-Network Benefit
<b>HOSPITAL SERVICES</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Inpatient Hospital Services, Including Room &amp; Board</b>	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Hospital Outpatient Surgical Facilities</b> (includes services performed in a Hospital facility) <i>(Please refer to the provider directory for facility type)</i>	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Ambulatory Surgical Center</b> (includes services performed in a stand-alone ambulatory facility) <i>(Please refer to the provider directory for facility type)</i>	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Skilled Nursing and Rehabilitation Facilities</b> up to 120 days per year	No Member cost after Plan Deductible	20% after Plan Deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Inpatient Mental Health Services</b> (including inpatient acute and residential programs)	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Inpatient Alcohol and Substance Abuse Treatment</b> (including inpatient acute and residential programs)	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Outpatient Mental Health, Alcohol and Substance Abuse Treatment</b> (including office visits and professional services provided in the home)	No Member cost after Plan Deductible	20% after Plan Deductible
<b>Outpatient Mental Health, Alcohol and Substance Abuse Treatment</b> (intensive outpatient treatment and partial hospitalization programs)	No Member cost after Plan Deductible	20% after Plan Deductible

OTHER SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
<p><b>Durable Medical Equipment Including Prosthetics and Disposable Medical Supplies</b></p> <p>(No Member cost for wigs prescribed by an oncologist for a Member suffering hair loss as a result of chemotherapy or radiation therapy up to one wig per year)</p>	No Member cost after Plan Deductible	20% after Plan Deductible
<p><b>Diabetic Equipment and Supplies</b></p>	No Member cost after Plan Deductible	20% after Plan Deductible
<p><b>Infertility</b> (Infertility benefits outlined in the Certificate Of Coverage are unlimited, with no age or cycle restrictions)</p>	<p>No Member cost after Plan Deductible (Office visit)</p> <p>No Member cost after Plan Deductible (Ambulatory Services Outpatient)</p> <p>No Member cost after Plan Deductible (Inpatient Hospital)</p>	20% after Plan Deductible
<p><b>Nutritional Counseling</b> (Limit 3 visits per year)</p>	No Member cost after Plan Deductible	20% after Plan Deductible
<p><b>Home Health Services</b> up to 200 visits per year</p>	No Member cost after Plan Deductible	20% after Plan Deductible

## PREVENTION AND WELLNESS

In-Network prevention and wellness services as defined by the United States Preventive Service Task Force (listed below) are exempt from all member cost share (deductible, copayment and coinsurance) under the Patient Protection and Affordable Care Act (PPACA). Services that are exempt from cost share must be identified by the specific codes. The codes your health care provider submits must match ConnectiCare's coding list to be exempt from all cost share. Please note that not all preventive services are listed below and that some diagnostic services provided in relation to preventive and wellness services require member cost share. Go to [www.connecticare.com/preventive](http://www.connecticare.com/preventive) for more information on coverage of preventive care or services.

- Routine physical exam and appropriate screening and counseling for adults (including but not limited to cardiovascular disease, depression, obesity and sexually transmitted infections)
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration (including but not limited to depression, obesity and sexually transmitted infections)
- Preventive care and screenings for women supported by the Health Resources and Services Administration:
  - At least one well-woman preventive care visit annually to obtain the recommended preventive services
  - Screening for diabetes during pregnancy, two per pregnancy
  - Human Papillomavirus (HPV) testing, age 30 or older, one per year
  - Counseling on sexually transmitted infections for all sexually active women, two per year
  - Counseling and screening for human immune-deficiency virus (HIV) for all sexually active women
  - Contraceptive methods approved by the Food and Drug administration, sterilization procedures and contraceptive patient education and counseling
  - Comprehensive lactation support, counseling, a breast pump, (either manual or non-hospital grade electric), and breastfeeding supplies
  - Screening and counseling for interpersonal and domestic violence for all women and adolescents
- Bone density screenings, age 60 or older
- Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, age 50 or older
- Routine mammography screening
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Outpatient laboratory services:
  - Cervical cancer and cervical dysplasia screening – pap smear
  - Lipid cholesterol screening for adults and children at risk
  - Fasting plasma glucose or hemoglobin A1c
  - Hematocrit and Hemoglobin for children up to age 21
  - Lead screening for children
  - Tuberculin testing for children
  - Chlamydia, syphilis and gonorrhea screening for females all ages
  - Human immunodeficiency virus screening – HIV testing
  - Hypothyroidism screening in newborns, under 3 months of age
  - Screening for phenylketonuria (PKU) in newborns, 3 months of age
  - Screening for sickle cell disease in newborns, 3 months of age
  - Hepatitis B screening for adolescents and adults at risk
  - Hepatitis C screening for adults at risk
  - Lung Cancer Screening for adults ages 55 - 80 who have smoked
- Routine vision screening up to age 21, one per year when services are rendered by a primary care provider
- Routine hearing screening up to age 21 when rendered by a primary care provider
- Dental caries prevention up to age 5 when rendered by a primary care provider
- Developmental, autism, and psychosocial/behavioral assessments when rendered by a primary care provider
- Dietary counseling for adults with cardiovascular disease, hyperlipidemia or obesity
- Alcohol misuse screening and counseling
- Tobacco cessation interventions
- Screening for hepatitis B, iron deficient anemia, Rh (D) blood typing and asymptomatic Bacteriuria in women who are pregnant
- Screening for abdominal aortic aneurysm in men age 65 - 75 who have ever smoked
- BRCA counseling and genetic screening for women at risk
- Physical therapy to prevent falls in adults age 65 and older

### Important Information

- If you have questions regarding your plan, visit our website at [www.connecticare.com](http://www.connecticare.com) or call us at (860) 674-5757 or 1-800-251-7722.
- Many services require that you obtain our pre-certification or pre-authorization prior to obtaining care prescribed or rendered by network providers or non-participating providers. A reduction will apply if you do not obtain pre-authorization for these specified services. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for more information.
- For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain pre-authorization.
- Out-of-Network cost shares are reimbursed at the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for more information.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your mandated benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2015.
- Your plan is Insured by ConnectiCare Insurance Company, Inc.

## **Benefits are Subject to Department of Insurance Approval**



## FlexPOS Copayment Prescription Drug Plan for Use with Health Savings Account (HSA) Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your prescription drug rider for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per Contract year.

**Personalized for: Town of Vernon - Union Employees**

<b>PRESCRIPTION DRUGS</b>		
Covered prescription drugs through retail Participating Pharmacies or our mail order service. Your Plan includes the following: Mandatory Drug Substitution, Tiered Cost-Share Program, and Voluntary Mail Order Program.		
	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Contract Year Plan Deductible</b> (Deductible is combined for In- and Out-Of-Network prescription drug benefits)	\$2,000 Individual \$4,000 Family  The Contract Year Deductible can be reached by any combination of covered Health Services or covered prescription drug services.  If you have Family coverage, then covered Health Services and covered prescription drugs will be applied to the Family Plan Deductible until the total amount is met without regard to which family member uses the benefits.	\$2,000 Individual \$4,000 Family  The Contract Year Deductible can be reached by any combination of covered Health Services or covered prescription drug services.  If you have Family coverage, then covered Health Services and covered prescription drugs will be applied to the Family Plan Deductible until the total amount is met without regard to which family member uses the benefits.
<b>Out-of-Pocket Deductible</b> (Includes a combination of deductible, copayments and coinsurance for health and pharmacy services) (The Out-of-Pocket Maximum is combined for In- and Out-of-Network prescription drug benefits)	\$2,500 Individual \$5,000 Family	\$4,000 Individual \$8,000 Family
<b>Out-of-Network Reimbursement</b>	Not Applicable	<b>Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.</b>
<b>RETAIL PHARMACY (up to a 34 day supply per prescription)</b>	<b>IN-NETWORK MEMBER PAYS</b>	<b>OUT-OF-NETWORK MEMBER PAYS</b>
<b>Tier 1 drugs</b> (Generic Drugs)	\$5 Copayment after Plan Deductible up to Out-of-Pocket Maximum	20% after Plan Deductible up to Out-of-Pocket Maximum
<b>Tier 2 drugs</b> (Preferred Brand Drugs)	\$15 Copayment after Plan Deductible up to Out-of-Pocket Maximum	20% after Plan Deductible up to Out-of-Pocket Maximum
<b>Tier 3 drugs</b> (Non-Preferred Brand Drugs)	\$35 Copayment after Plan Deductible up to Out-of-Pocket Maximum	20% after Plan Deductible up to Out-of-Pocket Maximum

MAIL ORDER PHARMACY (up to a 100 day supply per prescription)	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
<b>Tier 1 drugs</b> (Generic Drugs)	\$10 Copayment after Plan Deductible up to Out-of-Pocket Maximum	100%
<b>Tier 2 drugs</b> (Preferred Brand Drugs)	\$30 Copayment after Plan Deductible up to Out-of-Pocket Maximum	100%
<b>Tier 3 drugs</b> (Non-Preferred Brand Drugs)	\$70 Copayment after Plan Deductible up to Out-of-Pocket Maximum	100%
<b>Additional Information</b>		
<ul style="list-style-type: none"> <li>• Under this program covered prescription drugs and supplies are put into categories (i.e., tiers) to designate how they are to be covered and the member's cost-share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy &amp; Therapeutics Committee based on the drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.</li> <li>• Generic drugs can reduce your out-of-pocket prescription costs. Generics have the same active ingredients as brand name drugs, but usually cost much less. So, ask your doctor or pharmacist if a generic alternative is available for your prescription. Also, remember to use a participating pharmacy. Most pharmacies in the United States participate in our network. To find one, visit our Web site at <a href="http://www.connecticare.com">www.connecticare.com</a> or call our Member Services Department at 1-800-251-7722.</li> <li>• Amounts paid by members because they must pay a price difference for a brand name drug do not count towards meeting any deductible, coinsurance, copayment, or cost share maximum.</li> <li>• Certain prescription drugs and supplies require pre-authorization from us before they will be covered under the prescription drug rider. You should visit our Web site at <a href="http://www.connecticare.com">www.connecticare.com</a> or call our Member Services Department at 1-800-251-7722 to find out if a prescription drug or supply requires pre-authorization.</li> <li>• Most Specialty drugs are dispensed through Specialty Pharmacies by mail, up to a 30 day supply. Specialty Pharmacies have the same Member Cost Share as all other participating pharmacies and <u>are not part</u> of ConnectiCare's Voluntary Mail Order program. The Member Cost Share for Specialty Pharmacy <u>is different</u> from the Cost Share for ConnectiCare's Mail Order program.</li> <li>• Always remember to carry your ConnectiCare ID Card.</li> <li>• If you are a Massachusetts resident, please refer to your amendatory rider for Massachusetts mandated benefits for additional details of your benefits.</li> </ul>		

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.ConnectiCare.com](http://www.ConnectiCare.com) or by calling 1-800-251-7722.



Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	In-Network: \$2,000 member / \$4,000 family. Doesn't apply to preventive care. Out-of-Network: \$2,000 member / \$4,000 family	You must pay all the costs up to the <b>deductible</b> amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	There are no other specific deductibles.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes. For participating providers \$2,500 member / \$5,000 family. For non-participating providers \$4,000 member / \$8,000 family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the insurer pays?</b>	No.	The chart starting on page 2 describes any limits on what the insurer will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. See <a href="http://www.ConnectiCare.com">www.ConnectiCare.com</a> or call 1-800-251-7722 for a list of participating providers and hospitals.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**)
- The plan may encourage you to use **In-network providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need		Your cost if you use an		Limitations & Exceptions
	In-network Provider	Out-of-network Provider	In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Member cost after Plan Deductible	20% after Plan Deductible	20% after Plan Deductible	-----none-----
	Specialist visit	No Member cost after Plan Deductible	20% after Plan Deductible	20% after Plan Deductible	-----none-----
	Other practitioner office visit	No Member cost after Plan Deductible for chiropractor	20% after Plan Deductible for chiropractor	20% after Plan Deductible for chiropractor	combined with Rehabilitation
If you have a test	Preventive care / screening / immunization	No Member cost ( <i>Plan Deductible waived</i> )	20% after Plan Deductible	20% after Plan Deductible	Frequency limits apply
	Diagnostic test (x-ray, blood work)	Xray: No Member cost after Plan Deductible, Lab: No Member cost after Plan Deductible	20% after Plan Deductible	20% after Plan Deductible	-----none-----
	Imaging (CT / PET scans, MRIs)	No Member cost after Plan Deductible	20% after Plan Deductible	20% after Plan Deductible	-----none-----

**ConnectiCare** : **FlexPOS-CNT-HSA-2000I/4000F-05-Combined** Coverage Period: 07/01/2015 to 06/30/2016  
**Summary of Benefits and Coverage: What this Plan Covers & What it Costs** Coverage for: **Family** | **Plan Type: POS**

Common Medical Event	Services You May Need	In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.ConnectiCare.com">www.ConnectiCare.com</a></p>	Generic drugs	\$5 Copayment after Plan Deductible up to Out-of-Pocket Maximum (retail); \$10 Copayment after Plan Deductible up to Out-of-Pocket Maximum (mail order)	20% after Plan Deductible up to Out-of-Pocket Maximum (retail); 100% (mail order)	Covers up to a 34 day supply (retail prescription); 100 day supply (mail order prescription)
	Preferred brand drugs	\$15 Copayment after Plan Deductible up to Out-of-Pocket Maximum (retail); \$30 Copayment after Plan Deductible up to Out-of-Pocket Maximum (mail order)	20% after Plan Deductible up to Out-of-Pocket Maximum (retail); 100% (mail order)	Covers up to a 34 day supply (retail prescription); 100 day supply (mail order prescription)
	Non-preferred brand drugs	\$35 Copayment after Plan Deductible up to Out-of-Pocket Maximum (retail); \$70 Copayment after Plan Deductible up to Out-of-Pocket Maximum (mail order)	20% after Plan Deductible up to Out-of-Pocket Maximum (retail); 100% (mail order)	Covers up to a 34 day supply (retail prescription); 100 day supply (mail order prescription)
<p>If you have outpatient surgery</p>	Specialty drugs	Varies based on above drug categories	20% after Plan Deductible up to Out-of-Pocket Maximum (retail); 100% (mail order)	Covers up to a 34 day supply (retail prescription); 100 day supply (mail order prescription);
	Facility fee (e.g., ambulatory surgery center)	No Member cost after Plan Deductible	20% after Plan Deductible	-----none-----
	Physician/surgeon fees	No Member cost after Plan Deductible	20% after Plan Deductible	-----none-----

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).

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**ConnectiCare** : FlexPOS-CNT-HSA-2000I/4000F-05-Combined Coverage Period: 07/01/2015 to 06/30/2016  
**Summary of Benefits and Coverage: What this Plan Covers & What it Costs** Coverage for: Family | Plan Type: POS

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<b>If you need immediate medical attention</b>	Emergency room services	No Member cost after Plan Deductible	Same as In-Network Benefit	-----none-----
	Emergency medical transportation	No Member cost after Plan Deductible	Same as In-Network Benefit	-----none-----
	Urgent care	No Member cost after Plan Deductible	Same as In-Network Benefit	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No Member cost after Plan Deductible	20% after Plan Deductible	-----none-----
	Physician/surgeon fee	No Member cost after Plan Deductible	20% after Plan Deductible	-----none-----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	No Member cost after Plan Deductible	20% after Plan Deductible	-----none-----
	Mental/Behavioral health inpatient services	No Member cost after Plan Deductible	20% after Plan Deductible	-----none-----
	Substance use disorder outpatient services	No Member cost after Plan Deductible	20% after Plan Deductible	-----none-----
	Substance use disorder inpatient services	No Member cost after Plan Deductible	20% after Plan Deductible	-----none-----
	Prenatal and postnatal care	No Member cost	20% after Plan Deductible	-----none-----
<b>If you become pregnant</b>	Delivery and all inpatient services	No Member cost after Plan Deductible	20% after Plan Deductible	-----none-----

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).  
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Common Medical Event	Services You May Need	In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Member cost after Plan Deductible	20% after Plan Deductible	up to 200 visits per year
	Rehabilitation services	No Member cost after Plan Deductible	20% after Plan Deductible	combined with chiropractic
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	No Member cost after Plan Deductible	20% after Plan Deductible	up to 120 days per year
	Durable medical equipment	No Member cost after Plan Deductible	20% after Plan Deductible	-----none-----
If your child needs dental or eye care	Hospice service	No Member cost after Plan Deductible	20% after Plan Deductible	Pre-authorization is required
	Eye exam	No Member cost ( <i>Plan Deductible waived</i> )	20% after Plan Deductible	(one exam per year)
	Glasses	25% Discount	Not covered	25% Discount
	Dental check-up	Not Applicable	Not covered	-----none-----

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Habilitation Services
- Cosmetic Surgery
- Long-term care
- Dental Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs (discounted rate)

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Hearing aids (may be covered with limitations)
- Chiropractic care
- Infertility treatment
- Routine eye care
- Routine hearing tests

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).

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[www.ctio.cms.gov](http://www.ctio.cms.gov) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-800-251-7722 to request a copy

### **Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-251-7722. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.ccoio.cms.gov](http://www.ccoio.cms.gov).

### **Your Grievance Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ConnectiCare Member Appeals, PO Box 4061, Farmington, CT 06034-4061 or 1-800-251-7722 or Facsimile 1-800-319-0089

Connecticut Residents: CT State Department of Insurance at 1-800-203-3447 or [www.ct.gov/cid/site/default.asp](http://www.ct.gov/cid/site/default.asp)

Massachusetts Residents: MA Division of Insurance at 1-877-563-4467 or [www.mass.gov/ocabr/government/oca-agencies/doi-lp/](http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/)

### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

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

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).

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## About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

### This is not a cost estimator.

Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

#### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$3,390
- Patient pays: \$4,150

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$4,000
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$4,150</b>

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-390-3522.

#### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$1,320
- Patient pays: \$4,080

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$4,000
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$4,080</b>

Questions: Call 1-800-251-7722 or visit us at [www.ConnectiCare.com](http://www.ConnectiCare.com).

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## Questions and answers about Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and are not specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summaries of Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles** and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**APPENDIX B-1**

Town of Vernon

Managed Prescription Program, 3-Tier

*Benefits at a Glance*

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**How to Use the 3-Tier Managed Prescription Program**

The 3-Tier Managed Prescription Program (“Program”) has three (3) different levels (or “tiers”) of copayments, depending on the type of prescription drug you purchase (*see the chart below for details*). Your copayments will be lower when you use generic or brand-name medications that are on our list of preferred prescription drugs. The medications on this list are selected for their quality, safety and cost-effectiveness. You will still have coverage for brand-name drugs that are not on the list, but your copayment will be higher.

**Talk to your provider** about using generic drugs or listed brand-name drugs. It is a simple way to save out-of-pocket expenses.

**Copayments and Day Supplies**

- You will be responsible for **one (1) copayment** when purchasing up to **34 days supply** of any prescription drugs from a retail pharmacy.
- You’ll be responsible for **one (1) copayment** when purchasing up to **100 days supply** of maintenance prescription drugs through the mail-service program.

*Generic Drugs Have the Lowest Copayment*

*Your HMO or PPO Copayment:*

Type of Prescription Drug Covered		Any	Maintenance
Number of Allowed Refill Supply <small>(subject to state and federal restrictions)</small>		Retail	Mail
		< 34 Days	> 31 Days < 100 Days
Tier 1: <b>Generic drugs</b>	The term “generic” refers to a prescription drug that is not protected by a trademark. It is required to meet the same bioequivalency test as the original brand-name drug.	<b>\$ 5</b>	<b>\$ 5</b>
Tier 2: <b>Listed brand-name drugs</b>	The term “listed brand-name” refers to a brand-name prescription drug that is on the Program list of preferred prescription drugs.	<b>\$ 25</b>	<b>\$ 25</b>
Tier 3: <b>Non-listed brand-name drugs</b>	The term “non-listed brand-name” refers to a brand-name prescription drug that is not on the Program list of preferred prescription drugs.	<b>\$ 40</b>	<b>\$ 40</b>
<b>Annual Maximum – HMO</b>	Per member per calendar year-	Unlimited	
<b>Annual Maximum – PPO</b>	Per member per calendar year-	\$5,000	

## APPENDIX B-1

Town of Vernon

Managed Prescription Program, 3-Tier

*Benefits at a Glance*

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### **Generic Substitution**

Prescriptions will be filled with the generic equivalent when there is one available. Generic equivalents contain the same active ingredients and subject to the same, rigid FDA standards for quality, strength and purity as their brand-name counterparts. The brand name of a medication is the product name under which it is advertised and sold. Using generic, “preferred” drugs helps control costs for you and your plan while still providing you with the medications you need to stay healthy.

Exception: If your doctor indicates “Dispense as Written,” you will receive the brand-name drug, and you will be responsible for the applicable listed brand or non-listed brand copayment.

Note: If your doctor does *not* indicate “Dispense as Written,” and you choose the brand drug, you will be responsible for the applicable listed brand or non-listed brand-name copayment as well as the difference in cost between the generic and listed brand or non-listed brand name drug.

### **Preferred Drug Step Therapy**

The Program will offer and the employees will make every effort to use clinically interchangeable, generic drug alternatives in certain categories as a first line therapy before non-preferred drugs are used. Such categories of maintenance drugs include: ace inhibitors, beta blockers, NSAIDS, gastrointestinal, osteoporosis, sleep medication and intranasal steroids, etc.; with the antidepressants expressly excluded from the preferred drug step therapy. A Coverage Review Request by members, comprising trial and failure of preferred drug therapy, will be offered to be covered for non-preferred drugs.

### **Retail Refill Allowance**

Members can use retail for non-maintenance drugs with no restrictions, subject to copayments specified in the Program. Non-maintenance drugs are defined as those taken on a short-term basis, i.e. usually fewer than 34 days – e.g. an antibiotic used to treat a strep throat.

Members may use retail for maintenance prescription drugs only two (2) times before the penalty will apply. Maintenance medications are defined as those taken regularly for an ongoing condition – e.g. medications used to treat high blood pressure. Members will be contacted by the Program at each retail refill to utilize the mail order service. At and following the third (3<sup>rd</sup>) time of retail use for such drugs, a penalty will be charged, equal to five per cent (5%) of the retail cost of such prescription drug and two (2) times the retail copayment for the respective Tier, i.e. \$10 / \$50 / \$80. No penalty will apply if the member utilizes the mail order.

When using the mail order, any medications that are temperature-sensitive for reasons of their sustained potency and effectiveness are shipped in special insulated packages designed to keep the contents at the correct temperature through the delivery process.

## APPENDIX B-1

Town of Vernon

Managed Prescription Program, 3-Tier

*Benefits at a Glance*

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The low copayments for the mail order refill supplies provide an added incentive for the members to use the mail order over retail purchases for maintenance medications.

### **National Pharmacy Network**

Members also have access to a network (currently more than 53,000) retail pharmacies throughout the country.

### **Non-Participating Pharmacies**

Members who fill prescriptions at a non-participating pharmacy are responsible for payment at the time the prescription is filled. Members must submit claims for reimbursement, and payment will be sent to the member. Members who use non-participating pharmacies will pay 20% of the in-network allowance, plus the difference between the Program payment and the pharmacist's actual charge.

### **Limits and Exclusions**

Benefits are limited to no more than a **34-day supply** for covered drugs purchased at a retail pharmacy, and no more than a **100-day supply** for covered maintenance drugs purchased by mail service. All prescriptions are subject to the quantity limitations imposed by state and federal statutes.





## FULL DENTAL PLAN

The Full Dental Plan covers diagnostic, preventive and restorative procedures necessary for adequate dental health.

### COVERED SERVICES INCLUDE:

- Oral Examinations 1/36 months
- Periapical and bitewing x-rays 1/Year
- Topical fluoride applications for members under age 19- 2/Year
- Prophylaxis, including cleaning, scaling and polishing – 2/Year
- Relining of dentures
- Repairs of broken removable dentures
- Palliative emergency treatment
- Routine fillings consisting of silver amalgam and tooth color materials; including stainless steel crowns (primary teeth)\*
- Simple extractions \*\*
- Endodontics-including pulpotomy, direct pulp capping and root canal therapy (excluding restoration)

\* Payment for an inlay, onlay or crown will equal the amount payable for a three-surface amalgam filling when the member is not covered by Dental Amendatory Rider A.

\*\* Payment for a surgical extraction or a hemisection with root removal will equal the amount payable for a simple extraction when the member is not covered by the Dental Amendatory Rider A.

### ACCESSING BENEFITS:

#### Participating Dentists Benefits

When a member receives care from one of over 1,800 Participating Dentists, he or she simply presents his or her identification card showing dental coverage. The dentist bills us directly for all covered services.

For dental care provided by a Participating Dentist, we will pay the lesser of the dentist's usual charge or the Usual, Customary and Reasonable Charge as determined by us. The dentist accepts our reimbursement as full payment and may not bill the member for any additional charges.

#### Non-Participating Dentists Benefits

For covered dental services provided by a Non-Participating Dentist, in or out of Connecticut, we pay the lesser of the dentist's charge or the applicable allowance for the procedure, as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

**This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross Blue Shield Full Dental Plan. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations.**



## **DENTAL AMENDATORY RIDER A ADDITIONAL BASIC BENEFITS**

In addition to the services provided under your dental program, the following additional basic benefits are provided:

- ◆ Inlays (not part of bridge)
- ◆ Onlays (not part of bridge)
- ◆ Crown (not part of bridge)
- ◆ Space Maintainers
- ◆ Oral Surgery consisting of fracture and dislocation treatment, diagnosis and treatment of cyst and abscess, surgical extractions and impaction
- ◆ Apicoectomy

The dental services listed above are subject to the following qualifications:

We will pay for individual crowns, inlays and onlays only when amalgam or synthetic fillings would not be satisfactory for the retention of the tooth, as determined by us.

We will not pay for a replacement provided less than five (5) years following a placement or replacement which was covered under this Rider. We will not pay for individual crowns, inlays or onlays to alter vertical dimension, for the purpose of precision attachment of dentures, or when they are splinted together for any reason.

If the member is not covered by Dental Amendatory Rider C (Prosthodontics) we will pay for the following types of crowns, inlays or onlays, but only when there is clinical evidence that amalgam or synthetic fillings would not be satisfactory for the retention of the tooth:

- ◆ One tooth on either side or two teeth on one side of a replacement for missing teeth, as part of a fixed bridge.
- ◆ No benefits will be provided for the tooth replacements.
- ◆ Space maintainers – payment will be made for devices to preserve space due to premature loss of primary teeth, but not for interceptive orthodontic devices. Payment will be made for up to two devices per member per lifetime.



## DENTAL AMENDATORY RIDER A ADDITIONAL BASIC BENEFITS

### ACCESSING BENEFITS:

#### **Participating Dentists Benefits**

Anthem Blue Cross & Blue Shield will pay the lesser of fifty percent of the dentist's usual charge or fifty percent of the Usual, Customary and Reasonable Charge, as determined by us, for the dental services described in this Rider. Dentists who participate in our dental programs agree to accept our allowance as fully payment and may not bill the member for any additional charges except for the remaining coinsurance balance.

#### **Non-Participating Dentists Benefits**

In the event a non-participating dentist renders these services, we will pay to the member the lesser of fifty percent of the dentist's charge or fifty percent of the applicable allowance for the procedure as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

***This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross & Blue Shield of Connecticut Dental Amendatory Rider A. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations.***



## DENTAL AMENDATORY RIDER B PROSTHODONTICS

The following prosthetic services are provided under Dental Amendatory Rider B:

- ◆ Denture, full and partial
- ◆ Bridges, fixed and removable
- ◆ Addition of teeth to partial dentures to replace extracted teeth

The dental services listed above are subject to the following qualifications:

Anthem Blue Cross & Blue Shield of Connecticut will pay for standard procedures for prosthetic services as determined by us. For fixed bridges, we will pay for the replacement of missing teeth and for one tooth on either side or two teeth on one side of the replacement. We will not pay for a denture or bridge replacement, which is provided less than five years following a placement or replacement, which was covered under the contract. We also not pay for crowns splinted together for any reason.

### ACCESSING BENEFITS:

#### Participating Dentists Benefits

Anthem Blue Cross & Blue Shield of Connecticut will pay the lesser of fifty percent of the dentist's usual charge or fifty percent of Usual, Customary and Reasonable Charge, as determined by us, for the dental services described in this Rider. Dentists who participate in our dental programs agree to accept our allowance as full payment and may not bill the member for any additional charges except for the remaining coinsurance balance.

#### Non-Participating Dentist Benefits

In the event a non-participating dentist renders these services, we will pay to the member the lesser of fifty percent of the dentist's charge or fifty percent of the applicable allowance for the procedure as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

***This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross & Blue Shield of Connecticut Dental Amendatory Rider A. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations.***



## DENTAL AMENDATORY RIDER C PERIODONTICS

Periodontal services consisting of:

- ◆ Gingival curettage
- ◆ Gingivectomy and gingivoplasty
- ◆ Osseous surgery, including flap entry and closure
- ◆ Mucogingivoplastic surgery
- ◆ Management of acute infection and oral lesions

The maximum benefit we will provide for periodontal services per person per year is \$500.00.

### ACCESSING BENEFITS:

#### Participating Dentists Benefits

Anthem Blue Cross & Blue Shield of Connecticut will pay the lesser of fifty percent of the dentist's usual charge or fifty percent of the Usual, Customary and Reasonable Charge, as determined by us, for the dental services described in the Rider. Dentists who participate in our dental programs agree to accept our allowance as full payment and may not bill the member for any additional charges except for the remaining coinsurance balance.

#### Non-Participating Dentists Benefits

In the event a non-participating dentist renders these services, we will pay to the member the lesser of fifty percent of the dentist's charge or fifty percent of the applicable allowance for the procedure as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

***This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross & Blue Shield of Connecticut Dental Amendatory Rider C. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations.***



## DENTAL AMENDATORY RIDER D ORTHODONTICS

The following Orthodontic services are provided:

Handicapping malocclusion for a member under age 19, consisting of the installation of orthodontic appliances and orthodontic treatments concerned with the reduction or elimination of an existing malocclusion through the correction of malposed teeth.

The maximum amount payable for orthodontic services is \$1000.00 per member per lifetime.

### ACCESSING BENEFITS:

#### Participating Dentists Benefits

Anthem Blue Cross & Blue Shield of Connecticut will pay the lesser of fifty percent of the dentist's usual charge or sixty percent of the Usual, Customary and Reasonable Charge, as determined by us, for the dental services described in this Rider. Dentists who participate in our dental programs agree to accept our allowance as full payment and may not bill the member for any additional charges except for the remaining coinsurance balance.

#### Non-Participating Dentists Benefits

In the event a non-participating dentist renders these services, we will pay to the member the lesser of fifty percent of the dentist's charge or fifty percent of the applicable allowance for the procedure as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

***This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross & Blue Shield of Connecticut Dental Amendatory Rider A. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations.***

## **Appendix F**

Agreement Relative to Section 9.4





APPENDIX F

# TOWN OF VERNON

14 PARK PLACE, VERNON, CONN. 06066

Telephone (203) 872-8591

OFFICE OF TOWN ADMINISTRATOR

**To:** Terri Krawczyk, Town Clerk  
**From:** Paul R. Mazzaccaro, Town Administrator  
**Date:** August 14, 1997  
**Re:** Agreement with AFSCME Local 818 of Counsel #4 AFL-CIO

Attached please find an original copy of the agreement between the Town and AFSCME Local 818 of Counsel #4 AFL-CIO, effective July 1, 1997 through June 30, 2001, for your files.

Also, I am requesting that you keep this memo as a permanent record as it confirms agreements (section 9.4) made with members of the bargaining unit referenced above.

For Albert LaVoie, Ronald Heim, Jim Banis, Michael Taft, Ronald Levesque, and Steve Orlowski, all of these employees shall be credited with one hundred eighty (180) days of sick leave valued at their rate of pay as of June 30, 1997 (and noted below). This sick leave will be banked until such time as the employee terminates in good standing or retires.

If such employee terminates in good standing shall be paid fifty (50%) percent of the one hundred eighty (180) days will be added to the employee's W-2 wages. If such employee retires, the one hundred eighty (180) days will be added to the employee's W-2 wages.

Rates of pay at June 30, 1997 is as follows:

Jim Banis - \$51,500.80 yearly      Ron Heim - \$44,865.60 yearly  
Albert LaVoie - \$47,902.40 yearly      Ron Levesque - \$20.18 per hour/ \$41,974.40 yearly  
Steve Orlowski - \$20.18 per hour/ \$41,974.40 yearly  
Michael Taft - \$20.18 per hour/ \$41,974.40 yearly

Town of Vernon:

By: Paul R. Mazzaccaro  
Paul R. Mazzaccaro, Town Administrator

Personally appeared, Paul R. Mazzaccaro, Signer of the foregoing instrument, and acknowledged the same to be his free act and deed as Town Administrator of the Town of Vernon, before me.

T. A. Krawczyk  
Notary Public

**TERRI A. KRAWCZYK**  
NOTARY PUBLIC  
MY COMMISSION EXPIRES MAY 31, 2001

APPENDIX F

SUPERVISOR UNION LOCAL 818

NEW CONTRACT EFFECTIVE 7/1/97

EMPLOYEES AT INCEPTION OF THIS CONTRACT WILL BANK THEIR SICK TIME AND THE RATE WILL BE FROZEN AT THE JUNE 30, 1997 WAGE RATES.

AT TERMINATION: EMPLOYEE WILL RECEIVE 50% (90 SICK DAYS)  
AT RETIREMENT: EMPLOYEE WILL RECEIVE 100% (180 SICK DAYS)

EMPLOYEES WHO ARE EFFECTED ARE AS FOLLOWS:

JIMMIE BANIS	24.76 PER HR/198.08 PER DAY 180 DAYS = \$35,654.40
ALBERT LAVOIE	23.03 PER HR/184.24 PER DAY 180 DAYS = \$33,163.20
RONALD LEVESQUE	20.18 PER HR/161.44 PER DAY 180 DAYS = \$29,059.20
STEPHEN ORLOWSKI	20.18 PER HR/161.44 PER DAY 180 DAYS = \$29,059.20
MICHAEL TAFT	20.18 PER HR/161.44 PER DAY 180 DAYS = \$29,059.20

NOTE: RONALD HEIM RETIRED 1/99 WITH 180 SICK DAYS AT 21.57 PER HR AS PER CONTRACT.

REPLACEMENT WAS STEPHEN ORLOWSKI ALREADY IN THE CONTRACT.

REPLACEMENT FOR STEPHEN ORLOWSKI IS GEORGE FETKO FROM LABORERS UNION.

GEORGE FETKO RATE AS OF 2/14/99 18.9005 PER HR/151.20 PER DAY  
BANK \_\_\_\_\_ DAYS AS OF 2/14/99  
SUPERVISORS UNION NOW IN EFFECT.

2/19/99

C.D.S  
Personnel Files