AGREEMENT

Between

THE TOWN OF VERNON

and

AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES

LOCAL 818 OF COUNCIL #4

AFL-CIO

July 1, 2018 - June 30, 2021

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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, in accordance with all applicable State and Federal laws, as authorized by the employee, and 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 deduction authorization card, signed by the employee, will be provided to the Finance Officer.

Section 2.1

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. The remittance of dues shall not constitute a condition of employment.

Section 2.2

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 2.3

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 2.4

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. Current bargaining unit members are subject to a forty-five (45) working day probationary period outlined in Section 5.2.

d. **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 6:00 a.m. to 2:30 p.m. These schedules shall not be deemed a guarantee by the Town nor in any way 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 Director of Public Works. 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 8.1A – Effective July 1, 2018, new employees entering the bargaining unit will receive their vacation leave on a monthly basis, using the following schedule:

Length of Continuous Service	**Day Per Full Month of Continuous Service**	**Maximum Earned Days Per Year of Continuous Service**
Date of hire through 4th full year	.83 day	10 days
More than 4 years through the 11th full year	1.25 days	15 days
More than 11 years through the 19th year	1.67 days	20 days

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 not withstanding, 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:

Year	Town HMO* see 19.4 F	Town HSA
July 1, 2018-June 30, 2019	13%	13%
July 1, 2019-June 30, 2020	14%	14%
July 1, 2020-June 30, 2021	15%	15%

Section 19.2

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

Section 19.3

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/$4,000 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: 13%

b. Second year: 14%

c. Third year: 15%

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 19.4

An employee who separates from service and meets the requirements for retirement as defined by the provisions of the Town of Vernon Pension Plan may continue to participate in the group insurance coverages, specified in this section of the contract, for himself/herself and his/her eligible dependents provided:

1. No other medical insurance is available through another employer or spouse.

2. The employee shall pay the full cost of such coverages at applicable group rates in conformance with Federal law;

3. Upon attaining eligibility for Medicare, the separated employee shall no longer be eligible for such coverages, except that his/her spouse may continue coverage until he/she has attained eligibility for Medicare;

4. Spouses of deceased employees or deceased separated employees previously participating in the continuation program shall be eligible to continue to participate in the continuation program until he/she attains eligibility for Medicare; and

5. Payment of premiums must be made by the twentieth (20th) day of the month for the succeeding month's coverage; payments not received by the thirtieth (30th) day of the month shall result in termination of coverage without right to reinstatement.

Section 19.5

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 and 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

In year one (July 1, 2018 – June 30, 2019), of the contract dated July 1, 2018 to June 30, 2020, the Town will increase each bargaining unit employees' base salary by $200.00. There will be no such increases in years two or three. This clause sunsets at the conclusion of said contract, and will not carry over to any successor agreements.

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

Year 1	July 1, 2018 – 6/30/2019	1.00%
Year 2	July 1, 2019 – 6/30/2020	1.25%

Year 3	July 1, 2020 – 6/30/2021	1.50%

See Appendix A

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 three hundred ($300) 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 three hundred ($300) 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, 2021 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

10/24/2018

Michael J. Purcaro
Town Administrator

FOR LOCAL 818 OF COUNCIL 4
AFSCME, AFL-CIO

Jeff Schambach
President, Local 818

Laurie J. Webster

Laurie Webster
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

10/04/2018 18:57
dmaselek

TOWN OF VERNON
SALARY TABLES

EFF. DATE	GROUP/BU	GRADE/ RANK	DESCRIPTION	PAY BASIS	FREQUENCY	CALC	PERIODS	HRS/ DAY	HRS/ PERIOD	DAYS/ PERIOD	HRS/ YEAR	DAYS/ YEAR	USE PCT
07/01/2018	SPRV SUPERVISOR 01		DPW-FOREMAN	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N

$200 added to base, change was made by 1.0000% to hrly rate
based on 40 hours per week, or 2080 hours per year

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00
01	0.0000	35.5933	284.7460	1,423.73	74,033.96
02	0.0000	35.8140	286.5120	1,432.56	74,493.12

07/01/2018	SPRV SUPERVISOR 02		DPW SUPERVISORS	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N

$200 added to base, change was made by 1.0000% to hrly rate
based on 40 hours per week, or 2080 hours per year

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00
01	0.0000	37.2641	298.1120	1,490.56	77,509.12
02	0.0000	40.3113	322.4900	1,612.45	83,847.40

07/01/2018	SPRV SUPERVISOR 03		DPW-LEADRDSFRMN	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N

$200 added to base, change was made by 1.0000% to hrly rate
based on 40 hours per week, or 2080 hours per year

STEP/LEVEL	PERCENT	HOURLY RATE	DAILY RATE	PERIOD SALARY	ANNUAL SALARY
00	0.0000	.0000	0.0000	0.00	0.00
01	0.0000	37.2641	298.1120	1,490.56	77,509.12

07/01/2019	SPRV SUPERVISOR 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 1.2500%
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	36.0382	288.3060	1,441.53	74,959.56
02	0.0000	36.2617	290.0940	1,450.47	75,424.44

07/01/2019	SPRV SUPERVISOR 02		DPW SUPERVISORS	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N

Change was made by 1.2500%
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	37.7299	301.8400	1,509.20	78,478.40
02	0.0000	40.8152	326.5220	1,632.61	84,895.72

10/04/2018 18:57
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TOWN OF VERNON
SALARY TABLES

EFF. DATE	GROUP/BU	GRADE/ RANK	DESCRIPTION	PAY BASIS	FREQUENCY	CALC	PERIODS	HRS/ DAY	HRS/ PERIOD	DAYS/ PERIOD	HRS/ YEAR	DAYS/ YEAR	USE PCT
07/01/2019	SPRV SUPERVISOR	03	DPW-LEADRDSFRMN	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N

Change was made by 1.2500%
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	37.7299	301.8400	1,509.20	78,478.40

07/01/2020	SPRV SUPERVISOR	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 1.5000%
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	36.5788	292.6300	1,463.15	76,083.80
02	0.0000	36.8056	294.4440	1,472.22	76,555.44

07/01/2020	SPRV SUPERVISOR	02	DPW SUPERVISORS	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N

Change was made by 1.5000%
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	38.2958	306.3660	1,531.83	79,655.16
02	0.0000	41.4274	331.4200	1,657.10	86,169.20

07/01/2020	SPRV SUPERVISOR	03	DPW-LEADRDSFRMN	H HOURLY	W WEEKLY	02	52.0000	8.00	40.00	5.00	2080.00	260.00	N

Change was made by 1.5000%
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	38.2958	306.3660	1,531.83	79,655.16

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

ConnectiCare

FlexPOS-CNT-HSA-2000I/4000F-99-Combined Open Access Contract Year Benefit Summary (A)

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself and not for any dependents. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. In addition, if you have family coverage, any applicable copayments or coinsurance will not apply to services until the total deductible is met for the family, without regard to how much any one family member has met.

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your certificate of coverage on connecticare.com for a complete list of benefits.

Personalized for: Town of Vernon - Union Employees

In-Network Preventive Services

These services are no cost to you when you use an **in-network** doctor or facility. Frequency is based on age and gender. For a complete list of preventive services and to find a doctor, refer to connecticare.com.

Getting care within ConnectiCare's network typically costs you less. You may also get care outside of our network; however, your share of the costs will be higher. Out-of-network doctors and facilities do not appear in the "Find a doctor directory on connecticare.com

- **Physical**
- **Well woman visit and pap test**
- **More than 25 screenings, including mammograms and colonoscopies**
- **Flu shot**
- **Vaccinations**
- **Certain birth control and other prevention medications**

	In-network member pays	Out-of-network member pays
Your deductible Deductible is combined for medical services and prescription drugs Deductible is combined for in and out-of-network	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$2,500 Individual $5,000 Family	$4,000 Individual $8,000 Family
Out-of-network reimbursement	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount

After you have spent the out-of-pocket maximum amount in deductibles, copayments and coinsurance, ConnectiCare will pay 100% of your covered health care expenses for the remainder of the year.

Screenings	In-network member pays	Out-of-network member pays
Baseline routine mammography	No charge	20% coinsurance after plan deductible
Routine mammography including tomosynthesis screening	No charge	20% coinsurance after plan deductible

Screenings	In-network member pays	Out-of-network member pays
Breast ultrasound	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Annual routine vision exam one exam per year	No charge	20% coinsurance after plan deductible
Allergy testing Unlimited	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Hearing Screenings one exam every 24 months	No charge	20% coinsurance after plan deductible
Ongoing Care and Sick Visits	**In-network member pays**	**Out-of-network member pays**
Primary care services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Specialist services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Gynecologist services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Maternity and prenatal care visits	No charge	20% coinsurance after plan deductible
Allergy injections Unlimited	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Telemedicine visit	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Retail clinic	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Nutritional Counseling Limit 3 visits per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Infertility Infertility benefits outlined in the Certificate of Coverage are unlimited, with no age or cycles restrictions	0% coinsurance (Office visit) after plan deductible 0% coinsurance (Ambulatory Services Outpatient) after plan deductible 0% coinsurance (Inpatient Hospital) after plan deductible	20% coinsurance after plan deductible
Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network member pays**	**Out-of-network member pays**
Laboratory services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Non-advanced radiology X-ray, diagnostic	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network member pays**	**Out-of-network member pays**
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Advanced radiology **Stand-alone facility** MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Sudden and Unexpected Care	**In-network member pays**	**Out-of-network member pays**
Urgent care or other walk-in clinic	0% coinsurance after plan deductible	Same as In-network benefit
Emergency room	0% coinsurance after plan deductible	Same as In-network benefit
Ambulance	0% coinsurance after plan deductible	Same as In-network benefit
Inpatient Hospital Services	**In-network member pays**	**Out-of-network member pays**
Inpatient hospital services, including room and board	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Skilled nursing and rehabilitation facilities up to 120 days per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient Hospital Services and Home Care	**In-network member pays**	**Out-of-network member pays**
Hospital outpatient facilities	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Ambulatory surgical center	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Home health services up to 200 visits per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient Rehabilitative Services	**In-network member pays**	**Out-of-network member pays**
Rehabilitative services Unlimited (includes services combined for physical, speech and occupational therapy and chiropractic services)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Mental Health and Substance Abuse	**In-network member pays**	**Out-of-network member pays**
Inpatient mental health services	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Mental Health and Substance Abuse	In-network member pays	Out-of-network member pays
Inpatient alcohol and substance abuse treatment	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Supplies	**In-network member pays**	**Out-of-network member pays**
Durable medical equipment including prosthetics and disposable medical supplies Includes 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	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Diabetic equipment and supplies	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Modified food products and specialized formula pharmacy tier	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Important Information

- 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 are per member per Contract year.
- If you have questions regarding your plan, visit our website at **www.connecticare.com** or call us at (860) 674-5757 or 1-800-251-7722.
- Out-of-Network reimbursement is based on 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 benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2018.

ConnectiCare

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

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.		
	In-network member pays	**Out-of-network member pays**
Your deductible (Deductible is combined for medical services and prescription drugs) (Deductible is combined for In and out-of-network)	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Your out-of-pocket maximum (Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services)	$2,500 Individual $5,000 Family	$4,000 Individual $8,000 Family
Retail Pharmacy (up to a 34 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$5 copayment/prescription after plan deductible	20% coinsurance after plan deductible
Preferred brand drugs (Tier 2)	$15 copayment/prescription after plan deductible	20% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	$35 copayment/prescription after plan deductible	20% coinsurance after plan deductible
Mail Order Pharmacy (up to a 100 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$10 copayment/prescription after plan deductible	Not covered
Preferred brand drugs (Tier 2)	$30 copayment/prescription after plan deductible	Not covered
Non-preferred brand drugs (Tier 3)	$70 copayment/prescription after plan deductible	Not covered

Additional Information

- 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 & 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.
- 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.
- Most Specialty drugs are dispensed through specialty pharmacies by mail, up to 30 day supply. Specialty pharmacies have the same member cost share as all other participating pharmacies and are not part of ConnectiCare's voluntary mail order program. The member cost share for specialty pharmacy is different from the cost share for ConnectiCare's mail order program.
- If you are a Massachusetts resident, please refer to your amendatory rider for Massachusetts mandated benefits for additional details of your benefits.

ConnectiCare : FlexPOS-CNT-HSA-2000I/4000F-99-Combined

Coverage for: Individual + Family | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.connecticare.com or call 1-800-251-7722. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-251-7722 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $2,000 individual / $4,000 family. Doesn't apply to preventive care. Out-of-Network: $2,000 individual / $4,000 family	Generally, you must pay all the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the policy, the overall family **deductible** must be met before the **plan** begins to pay.
Are there services covered before you meet your deductible?	Yes. **Preventive care** is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive** services without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Yes. For participating providers $2,500 individual / $5,000 family. For non-participating providers $4,000 individual / $8,000 family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family **out-of-pocket limit** must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a participating provider?	Yes. See www.ConnectiCare.com or call 1-800-251-7722 for a list of participating **providers**.	This **plan** uses a **provider** network. You will pay less if you use a **provider** in the plan's network. You will pay the most if you use a non-participating **provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays (balance billing).
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral**.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None
	Specialist visit	0% coinsurance after plan deductible	20% coinsurance after plan deductible	
	Preventive care / screening / immunization	No charge	20% coinsurance after plan deductible	---none---
If you have a test	Diagnostic test (x-ray, blood work)	Xray: 0% coinsurance after plan deductible, Lab: 0% coinsurance after plan deductible	20% coinsurance after plan deductible	Preauthorization is required for certain services (ie: genetic testing)
	Imaging (CT / PET scans, MRIs)	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.ConnectiCare.com**	Generic drugs (Tier 1)	$5 copayment/prescription after plan deductible (retail); $10 copayment/prescription after plan deductible (mail order)	20% coinsurance after plan deductible (retail); Not covered (mail order)	Certain drugs will require preauthorization Covers up to 34 day supply per prescription (retail); 100 day supply per prescription (mail order) **Specialty Drugs** are available from specialty retail pharmacies only and cover up to a 30-day supply limit.
	Preferred brand drugs (Tier 2)	$15 copayment/prescription after plan deductible (retail); $30 copayment/prescription after plan deductible (mail order)	20% coinsurance after plan deductible (retail); Not covered (mail order)	
	Non-preferred brand drugs (Tier 3)	$35 copayment/prescription after plan deductible (retail); $70 copayment/prescription after plan deductible (mail order)	20% coinsurance after plan deductible (retail); Not covered (mail order)	
	Specialty drugs (Tier 4)	Varies based on above drug categories	20% coinsurance after plan deductible (specialty retail only); Not covered (mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after plan deductible	20% coinsurance after plan deductible	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%.
	Physician/surgeon fees	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	0% coinsurance after plan deductible	Same as In-network benefit	None
	Emergency medical transportation	0% coinsurance after plan deductible	Same as In-network benefit	
	Urgent care	0% coinsurance after plan deductible	Same as In-network benefit	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after plan deductible	20% coinsurance after plan deductible	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%.
	Physician/surgeon fee	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None
	Inpatient services	0% coinsurance after plan deductible	20% coinsurance after plan deductible	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you become pregnant	Office visits	No charge for prenatal and postnatal care	20% coinsurance after plan deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or copayments may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None
	Childbirth/delivery facility services	0% coinsurance after plan deductible	20% coinsurance after plan deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after plan deductible	20% coinsurance after plan deductible	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. up to 200 visits per year
	Rehabilitation services	0% coinsurance after plan deductible	20% coinsurance after plan deductible	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. Unlimited (includes services combined for physical, speech and occupational therapy and chiropractic services)
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	0% coinsurance after plan deductible	20% coinsurance after plan deductible	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. up to 120 days per year
	Durable medical equipment	0% coinsurance after plan deductible	20% coinsurance after plan deductible	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. Includes wigs prescribed by an

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				oncologist for a member suffering hair loss as a result of chemotherapy or radiation therapy up to one wig per year
	Hospice service	Applicable inpatient hospital facility or home health care cost share	Applicable inpatient hospital facilty or home health care cost share	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%.
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance after plan deductible	one exam per year
	Children's glasses	25% Discount	Not covered	25% Discount
	Children's 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
- 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)
- Infertility treatment
- Routine eye care
- Routine hearing tests

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 X61565 or www.cciio.cms.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information on your rights to continue coverage, you may also contact the plan at 1-800-251-7722.

Your Grievance Appeals Rights:

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

ConnectiCare Member Appeals: PO Box 4061, Farmington, CT 06034-4061 or 1-800-251-7722
Connecticut Residents: CT State Department of Insurance at 1-800-203-3447 or 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
Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this Coverage Provide Minimum Essential Coverage? Yes.

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.**

Does this Coverage Meet the Minimum Value Standard? Yes.

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 (TTY: 1-800-833-8134).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 (TTY: 1-800-833-8134).

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

About these Coverage Examples

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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ **The plan's overall deductible**	**$2,000**
■ Specialist coinsurance	**0%**
■ **Hospital (facility)** coinsurance	**0%**
■ **Other** coinsurance	**0%**

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,080

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$2,000**
■ Specialist coinsurance	**0%**
■ **Hospital (facility)** coinsurance	**0%**
■ **Other** coinsurance	**0%**

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,460

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$2,000**
■ Specialist coinsurance	**0%**
■ **Hospital (facility)** coinsurance	**0%**
■ **Other** coinsurance	**0%**

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

Total Example Cost	**$1,900**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-390-3522.
*Note: This plan may have other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

Accessibility and Nondiscrimination Notice

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

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06032, 1-800-251-7722, and TTY number 1-800-833-8134. You can file a grievance in person at 175 Scott Swamp Road, Farmington, CT, or by mail, or fax (860) 674-2232. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S, Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

Language Access Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 (TTY: 1-800-833-8134).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 (TTY: 1-800-833-8134).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 (TTY: 1-800-833-8134).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-251-7722 (TTY: 1-800-833-8134)。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 (TTY: 1-800-833-8134).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 (ATS: 1-800-833-8134).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 (TTY: 1-800-833-8134).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-251-7722 (телетайп: 1-800-833-8134).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-251-7722 (TTY: 1-800-833-8134).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 1-800-833-8134).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-7722 (TTY: 1-800-833-8134)번으로 전화해 주십시오.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-224-2273 (TTY: 1-800-842-9710).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-224-2273 (TTY: 1-800-842-9710) पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-224-2273 (TTY: 1-800-842-9710).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-224-2273 (TTY: 1-800-842-9710).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បម្រើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-224-2273 (TTY: 1-800-842-9710)

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-224-2273 (TTY: 1-800-842-9710).

ConnectiCare

FlexPOS-CAL-10-10-0-200A-06 Open Access Calendar Year Benefit Summary

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your certificate of coverage on connecticare.com for a complete list of benefits.

Personalized for: Town of Vernon - $10

In-Network Preventive Services
These services are no cost to you when you use an **in-network** doctor or facility. Frequency is based on age and gender. For a complete list of preventive services and to find a doctor, refer to connecticare.com.

Getting care within ConnectiCare's network typically costs you less. You may also get care outside of our network; however, your share of the costs will be higher. Out-of-network doctors and facilities do not appear in the "Find a doctor on connecticare.com.

- **Physical**
- **Well woman visit and pap test**
- **More than 25 screenings, including mammograms and colonoscopies**
- **Flu shot**
- **Vaccinations**
- **Certain birth control and other prevention medications**

	In-network member pays	Out-of-network member pays
Your deductible	$0 Individual $0 Employee +1 $0 Family	$5,000 Individual $10,000 Employee +1 $15,000 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$6,850 Individual $13,700 Employee +1 $13,700 Family	$15,000 Individual $30,000 Employee +1 $45,000 Family
Out-of-network reimbursement	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount

After you have spent the out-of-pocket maximum amount in deductibles, copayments and coinsurance, ConnectiCare will pay 100% of your covered health care expenses for the remainder of the year.

Screenings	In-network member pays	Out-of-network member pays
Baseline routine mammography (age 35-40)	No charge	50% coinsurance after plan deductible
Routine mammography including tomosynthesis screening (over age 40)	No charge	50% coinsurance after plan deductible
Breast ultrasound	No charge	50% coinsurance after plan deductible
Routine vision exam one exam every 12 months	$10 copayment/visit	50% coinsurance after plan deductible
Allergy testing Unlimited	No charge	50% coinsurance after plan deductible

Screenings	In-network member pays	Out-of-network member pays
Hearing Screenings one exam every 24 months	$10 copayment/visit	50% coinsurance after plan deductible
Ongoing Care and Sick Visits	**In-network member pays**	**Out-of-network member pays**
Primary care services	$10 copayment/visit	50% coinsurance after plan deductible
Specialist services	$10 copayment/visit	50% coinsurance after plan deductible
Gynecologist services	$10 copayment/visit	50% coinsurance after plan deductible
Maternity and prenatal care visits	No charge	50% coinsurance after plan deductible
Allergy injections Unlimited	No charge	50% coinsurance after plan deductible
Telemedicine visit	$10 copayment/visit	50% coinsurance after plan deductible
Retail clinic	$10 copayment/visit	50% coinsurance after plan deductible
Nutritional Counseling Limit 3 visits per year	No charge	50% coinsurance after plan deductible
Infertility (Infertility benefits outlined in the Certificate of Coverage are unlimited, with no age or cycle restrictions)	$10 copayment/visit (Office visit) No charge (Ambulatory Services Outpatient) $200 copayment/admission (Inpatient Hospital)	50% coinsurance after plan deductible
Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network member pays**	**Out-of-network member pays**
Laboratory services	No charge	50% coinsurance after plan deductible
Non-advanced radiology X-ray, diagnostic	No charge	50% coinsurance after plan deductible
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	No charge	50% coinsurance after plan deductible
Advanced radiology **Stand-alone facility** MRI, PET and CAT scan and nuclear cardiology	No charge	50% coinsurance after plan deductible

Sudden and Unexpected Care	In-network member pays	Out-of-network member pays
Walk-in center	$10 copayment/visit	Same as In-network benefit
Urgent care center	$25 copayment/visit	Same as In-network benefit
Emergency room Copayment waived if admitted	$50 copayment/visit	Same as In-network benefit
Ambulance	No charge	Same as In-network benefit
Inpatient Hospital Services	**In-network member pays**	**Out-of-network member pays**
Inpatient hospital services, including room and board	$200 copayment/admission	50% coinsurance after plan deductible
Skilled nursing and rehabilitation facilities up to 120 days per year	No charge	50% coinsurance after plan deductible
Outpatient Hospital Services and Home Care	**In-network member pays**	**Out-of-network member pays**
Hospital outpatient facilities	No charge	50% coinsurance after plan deductible
Ambulatory surgical center	No charge	50% coinsurance after plan deductible
Home health services up to 200 visits per year	No charge	25% coinsurance after $50 benefit deductible
Outpatient Rehabilitative Services	**In-network member pays**	**Out-of-network member pays**
Rehabilitative Services Unlimited includes services combined for physical, speech and occupational therapy and chiropractic services	No charge	50% coinsurance after plan deductible
Mental Health and Substance Abuse	**In-network member pays**	**Out-of-network member pays**
Inpatient mental health services	$200 copayment/admission	50% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	$200 copayment/admission	50% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	$10 copayment/visit	50% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	No charge	50% coinsurance after plan deductible

Supplies	In-network member pays	Out-of-network member pays
Durable medical equipment including prosthetics and disposable medical supplies Includes 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 charge	50% coinsurance after plan deductible
Diabetic equipment and supplies	No charge	50% coinsurance after plan deductible
Modified food products and specialized formula pharmacy tier	No charge	50% coinsurance after plan deductible

Important Information

- 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 are per member per Contract year.
- If you have questions regarding your plan, visit our website at www.connecticare.com or call us at (860) 674-5757 or 1-800-251-7722.
- Out-of-Network reimbursement is based on 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 benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2018.

APPENDIX B-1

Town of Vernon

Managed Prescription Program, 3-Tier

Benefits at a Glance

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 (subject to state and federal restrictions)		Retail < 34 Days	**Mail** > 31 Days < 100 Days
Tier 1: **Generic drugs**	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.	**$ 5**	**$ 5**
Tier 2: **Listed brand-name drugs**	The term "listed brand-name" refers to a brand-name prescription drug that is on the Program list of preferred prescription drugs.	**$ 25**	**$ 25**
Tier 3: **Non-listed brand-name drugs**	The term "non-listed brand-name" refers to a brand-name prescription drug that is not on the Program list of preferred prescription drugs.	**$ 40**	**$ 40**
Annual Maximum – HMO	Per member per calendar year-	Unlimited	
Annual Maximum – PPO	Per member per calendar year-	$5,000	

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 (3rd) 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.

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.

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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.

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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.

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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.

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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 bot 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 of 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.

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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 of 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.

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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.

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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.

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:\DS Personnel Files