APPENDIX C
Health Insurance

Change in Carrier

The Board of Education may provide insurance under a different policy or policies, for all or some of the health insurance benefits set forth herein provided that the different insurance provides substantially the same level of benefits or better as the then current insurance plan when viewed on an overall plan benefit basis. Prior to implementing any change in carrier, the Board will notify RETA of its intention to change, and RETA shall have thirty (30) calendar days to review the proposed change in carrier(s). If RETA does not agree that the different insurance desired by the Board is substantially the same level of benefits or better as the then current insurance plan when viewed on an overall plan benefit basis within twenty (20) calendar days after the end of the review period, RETA may file a grievance directly at Level 5 under the contract grievance procedure (arbitration). The *status quo* shall be maintained during the pendency of any such grievance/arbitration proceeding.

Voluntary Waiver of Insurance Coverage

Members of the bargaining unit who are eligible for insurance coverage under this section may voluntarily elect in writing to waive such coverage, in whole, provided that such waiver does not conflict with the rules regulations or other requirements of the appropriate insurance carriers. Teachers electing such a waiver shall receive periodic cash payments from the Board in the amount of $2,500.00 per year, while the waiver is in effect. Life Insurance and Disability Insurance shall not be terminated by a waiver, and shall remain in effect. The provisions set forth herein regarding an employee's ability to waive insurance coverage shall not apply when the employee's spouse is enrolled in an insurance plan offered by the Board.

In order to exercise this waiver option, teachers must apply in writing to the Superintendent not later than June 30th in any year, with such waiver to be effective the following September 1st. All waiver applications must be completely voluntary on the part of the staff member and must be accompanied by a signed waiver of coverage document acceptable to the Board and the carrier(s). If the waiver is acceptable to the Board and the applicable insurance carrier(s) it shall be effective as of September 1 and shall remain in effect until revoked as provided below. Teachers whose waiver applications are acceptable to the applicable insurance carrier(s) shall receive periodic payments of the waiver amount as determined by the Board.

There shall be an annual open enrollment window of June 1st - June 30th, at which time an employee may choose to reinstate or waive his/her insurance for the fiscal year commencing September 1st. All such reinstatements shall be subject to all the rules of the applicable insurance carrier(s), including but not limited to, any mandatory waiting periods.

High Deductible Health Plan (HDHP)

Effective during the term of this Agreement, the Board will provide a High Deductible Health Plan (HDHP) to full-time employees that elect to participate. The program shall be offered on a contract year basis with open enrollment to be available in May.

The HDHP shall have a $2,250.00 single and $4,500.00 two-person/family deductible for in network services. Prescription drugs are covered as part of the program and are subject to the deductible.

Once the deductible is met there shall be no coinsurance in network for covered services, except for prescriptions. Upon satisfaction of the HDHP deductible, prescriptions are subject to a managed three tier drug rider with co-pays of $5 Generic/ $25 Brand Name/ $40 Non Formulary Brand Name co-pay (unlimited maximum) (2x retail co-payment for 90-day supply).

Out of network services will be subject to a 70% plan/30% member coinsurance to a combined in-and-out-of-network coinsurance maximum of two thousand two hundred fifty dollars ($2,250.00) for the individual and four thousand five hundred dollars ($4,500.00) for the family, for a combined in-and-out-of-network out-of-pocket maximum of four thousand dollar ($4,000.00) for the individual and six thousand eight hundred fifty ($6,850.00) for the family.

Enrollees in the HDHP shall have a Health Savings Account (HSA) to defray deductible expenses.

In year one of the contract (July 1, 2019 through June 30, 2020) the Board agrees to contribute forty-five percent (45%) of the deductible.

In year two of the contract (July 1, 2020 through June 30, 2021) the Board agrees to contribute forty-five percent (45%) of the deductible.

In year three of the contract (July 1, 2021 through June 30, 2022) the Board agrees to contribute forty-five percent (45%) of the deductible.

In each year of the contract one-half (1/2) of the Board's contribution toward the deductible shall be deposited in the HSA bank account of the employee on or about July 1st and the remaining one-half (1/2) of the Board's contribution shall be deposited in the HSA bank account of the employee on or about January 1st.

The employee's contribution toward the deductible shall either be, at the employee's option, via payroll deduction or contributed directly by the employee in his/her Health Savings Account (HSA) bank account.

A HSA is not health insurance, it is a bank account. The parties acknowledge that the Board's contribution toward funding the deductible is not an element of the underlying plan, but rather relates to the manner in which the deductible shall be funded for active employees.

Additionally, the Board will provide Vision Care in accordance with the Vision Care Plan set forth below and full service dental Insurance with Rider A (with the employee being responsible for the premium share contribution set forth below).

EMPLOYEE PREMIUM SHARE CONTRIBUTIONS

For the HDHP insurance, the employee will pay the following percent of the premium costs: for coverage via payroll deduction, regardless of the coverage level (single, single plus one or family) selected:

2019-2020	2020-2021	2021-2022
18.5%	19%	19.5%

A health reimbursement account ("HRA") will be offered to any teacher eligible for health insurance who is not eligible for a HSA. The Board's annual contribution toward the HRA shall be equal to the annual contribution toward the HSA (based upon the teacher's level of insurance (single, single + 1 or family)).

A new employee shall be eligible for coverage under the health and dental insurance plans offered by the Board effective on the first day of the month subsequent to the date that he/she commences work for the Board.

Additionally, an employee shall receive a prorated contribution toward his/her HSA, if the employee: (a) is hired by the Board after the commencement of the applicable plan year; or (b) he/she elects health insurance after the commencement of the plan year due to a change in status.

The prorated amount of the contribution shall be based on the first day that the employee is covered under the plan through June 30th of the applicable contract year.

The Board of Education will provide the following insurances at no costs to teachers:

Full Term Life and Accidental Death and Dismemberment Insurance $50,000.00 for the individual teacher.

Retiring Teachers

Retiring Teachers employed by Regional School District Eighteen who have qualified for retirement with the Connecticut State Retirement Board, may fully participate in one or more group health insurance plans maintained by Regional School District Eighteen. Premiums for membership cost, up to one hundred percent (100%) of the premium, will be paid by the retired teacher. The Board shall not be responsible for any portion of the deductible under the HDHP for retiring or retired teachers.

Premium payments due by the teacher shall be submitted to the Office of the Superintendent of Schools no later than the fifteenth of each month.

Health Insurance "Age Out" Provision

Eligible dependents of insured teachers may be covered as dependents as provided by state statute.

Explanatory Summary of Benefits

An explanation/description of insurance benefits is attached to this Agreement. It is understood and agreed that this explanation document is not an insurance policy and is intended only as a Description or summary of insurance coverage. Should there be any variance between the summary descriptions contained on the attached and the provisions of the insurance policies, the policies shall prevail.

Insurance Coverage Reopener Negotiations in Event of National or State Health Care Legislation

If at any time prior to or during the term of this contract, Congress or the State of Connecticut enacts national and/or state health coverage care or similar legislation applicable to teachers, either or both parties shall have the right to reopen contract negotiations limited to medical and related dental and vision insurance coverage provided employees in this Agreement. Such negotiations shall be conducted in accord with provisions of the Teacher Negotiating Act relating to reopener negotiations occurring during the term of an existing contract.

VISION CARE PLAN

CIGNA VISION RIDER OFFERS:

- **Yearly eye examinations for vision corrections**
- **Coverage for prescription lenses (single-vision, bifocals, trifocals), frames, and contact lenses with fitting, adjustment and aftercare for maintenance of comfort and efficiency.**
- **In-plan and out-of-plan coverage.**

VISION EXAM COVERAGE:

Exam with dilation of pupils (cycloplegia) and post cycloplegic visit if required	**Up to $50 per calendar year**
Exam without cycloplegia	**Up to $50 per calendar year**

OPTICAL SERVICES:

Frames for prescription lenses	**Up to $28 per calendar year**
Single vision lenses	**Up to $33.50 per calendar year**
Bifocal lenses	**Up to $52 per calendar year**
Trifocal lenses	**Up to $84 per calendar year**
Contact lenses when used to correct visual acuity to 20/70 or when medically necessary	**Up to $225 per calendar year**
Contact lenses when used for any other reason, equivalent to amount payable for single vision	**Up to $33.50 per calendar year**

PRINCIPAL LIMITATIONS & EXCLUSIONS

Services, frames, and lenses required by the employer as a condition of employment. Sunglasses, tinted glasses or industrial glasses unless they are prescription lenses. Contact lenses for cosmetic, convenience or any purpose other than correction of visual acuity to 20/70 or medical necessity as determined by CIGNA will be covered in an amount up to the single prescription lenses indemnity amount subject to the annual maximum.

THIS IS NOT A CONTRACT. It is an overview of your benefits and exclusions. If there are discrepancies between this Summary of Benefits and the coverage document, the coverage document will govern.

****NO CHANGES**

The **Full Dental Plan** is designed to cover diagnostic, preventive and restorative procedures necessary for adequate dental health.

Covered services include:

- Oral Examinations
- Periapical and bitewing x-rays
- Topical fluoride applications for those under age 19
- Prophylaxis, including cleaning, scaling and polishing
- Repair of 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 the 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 Dental Amendatory Rider A.

ACCESSING BENEFITS:

Participating Dentists Benefits
When receiving care from one of over 1,800 Participating Dentists, the member simply presents an identification card showing dental coverage. The dentist bills us directly for all covered services.

For dental care provided by a participating Dentist, we pay the lesser of the dentist's usual charge or the Usual, Customary and Reasonable Charges 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 an amount equal to the dentist's usual charge or the applicable allowance for the procedure, as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.
This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal of the Anthem Blue Cross & Blue Shield Full Dental Plan. Refer to your Master Group Policy or Description of Benefits on file with your employer for a complete listing of benefits, maximums, exclusions and limitations.

DENTAL AMENDATORY RIDER A

ADDITIONAL BASIC BENEFITS

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

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

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

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

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

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

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

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 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 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.