AGREEMENT

BETWEEN

THE DARIEN BOARD OF EDUCATION

- AND -

THE DARIEN REGISTERED NURSES' ASSOCIATION
LOCAL 1303 CHAPTER 141
OF COUNCIL #4 AFSCME,AFL-CIO

EXPIRES JUNE 30, 2029

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ARTICLE I
AGREEMENT

THIS AGREEMENT, entered into by and between the Darien Board of Education, hereinafter referred to as the "**Board**," and the Darien Registered School Nurses Association, Local 1303-141, affiliated with the American Federation of State, County and Municipal Employees, AFL-CIO, hereinafter referred to as the "**Union.**"

ARTICLE II
PREAMBLE

The purpose of this Agreement is to establish fair and equitable employment conditions for the Nurses covered herein and an orderly system of mutually respectful and cooperative employer-employee relationships, in order that more efficient, effective and progressive health care services may be rendered.

ARTICLE III
RECOGNITION

Pursuant to Certification of Representative issued by the Connecticut State Board of Labor Relations in Case No. ME-3347 and in accordance with *Conn. Gen. Stat.* Section 7-467, as amended by Public Act 85-503 and Section 7-471, the Board hereby recognizes the Union as the representative of regular full-time and regular part-time registered nurses employed by the Board as school nurses; excluding the Director of Nurses and other supervisory employees, administrators, teachers and all other employees of the Board not specifically included in the unit, for the purposes of collective bargaining with respect to wages, hours, and other conditions of employment. As used throughout this Agreement, the term "Nurses" will refer only to those nurses who are included in the bargaining unit represented by the Union.

ARTICLE IV
BOARD'S RIGHTS

The Board shall have the exclusive right, power and authority to exercise all the rights and privileges of management of the schools and direction of its Nurses, except to the extent that such rights, powers and authority are specifically limited by the express provisions of this Agreement.

ARTICLE V
THE NURSES' ROLE AS RESOURCE PERSONS

Upon request, Nurses will act as resource persons when questions related to their area of expertise are raised in the classroom. Nurses will be expected to cooperate with teachers and may be asked to work with them in the classroom. However, Nurses will not be expected to have primary responsibility for planning and/or teaching health classes. This provision is not meant to describe the Nurses' duties in their entirety, but only to clarify the Nurses'

function in the classroom.

ARTICLE VI
HOURS OF WORK

Section 1. The normal work year for regular full-time Nurses shall be the normal school calendar plus a maximum of five (5) additional normal workdays for a total of 185 for the school year. The additional five (5) days shall be scheduled by the Director of Nursing Services in consultation with the Nurse to perform such duties as may be assigned.

Section 2. A normal workday for regular full-time Nurses shall be a seven (7) hour day, exclusive of a thirty (30) minute unpaid lunch and Nurses shall stay at work as long thereafter as necessary to complete their work in a professional manner. Nurses shall work a normal workday when students are dismissed early or there is a delayed opening for students (e.g., PLC delayed openings and elementary parent conferences). This provision shall not apply to weather-related delayed openings or early dismissals.

Section 3. Each regular full-time Nurse shall have a one-half hour duty free lunch period on each full normal workday (i.e., one that is not shortened by early dismissal), except for emergencies.

Section 4. Nurses may be required to attend a maximum of four (4) meetings a year if such meetings take place before or after the regularly scheduled workday. Should the required attendance at these meetings exceed one(1)) hour for any individual meeting or four (4) hours in any school year, the Nurse will be compensated at his/her hourly rate. Meetings may be held via Zoom or other electronic means and may include asynchronous learning.

Section 5. "Overtime work" shall be defined as any approved hours worked in excess of thirty-five (35) hours in a payroll week or for approved hours worked on Saturdays, Sundays and/or holidays recognized by this Agreement, except that pay for approved hours worked on recognized holidays shall be paid in addition to regular holiday pay

Section 6. No overtime work shall be performed unless authorized in advance by the Director of Finance. When attending to the emergency medical needs of a child requires the Nurse to work overtime, the overtime may be authorized subsequent to the event, rather than in advance, by the Director of Finance or, in his or her absence, by the Principal of the school at which the emergency arose.

Section 7. In scheduling compensatory time off, the Administrator will make a reasonable effort to accommodate the desires of the Nurse, subject to the needs of the system as determined by the Administrator and the requirements of the Wage-Hour laws. Disagreements between the Nurse and the Administrator will be resolved by the Director of Human Resources.

ARTICLE VII
SALARIES

Section 1. (a) Appendix A reflects an annual general wage increase of 3.75% to each classification retroactive to July 1 2026; an annual general wage increase of 3.75% to each classification effective July 1, 2027 and an annual general wage increase of 3.75% to each classification effective July 1, 2028. Annual degree stipends for Nurses who have a Masters Degree or Bachelors Degree will be calculated and added to Nurses' annualized salary.

(b) Any Nurse newly hired may, at the discretion of the Director of Human Resources, be paid at a rate of compensation that is ten percent (10%) less than the rate then in effect for the position for which the Nurse is hired, as set forth on Appendix A hereof, provided that upon successful completion of the Nurse's first six (6) months of employment, such Nurse will be paid 5% less than the regular Nurse's rate, and upon successful completion of one (1) year of employment, the Nurse's rate of compensation shall be increased to the then-applicable rate, as set forth on Appendix A hereof.

Section 2. A Nurse's *per diem* shall be established by dividing her regular annualized salary by 185 normal workdays. A regular full-time Nurse's regular straight-time hourly rate shall be established by dividing her *per diem* by seven (7) hours. A regular part-time Nurse regularly assigned to work a regular schedule consisting of at least twenty (20) hours of work per week will be paid at the regular straight-time hourly rate for a regular full-time Nurse for the time she works.

Section 3. Compensation for overtime work shall be as follows:

(a) Pay at the Nurse's regular straight-time hourly rate of pay for time she worked in excess thirty-five (35) hours in a payroll week but not in excess of forty (40) hours;

(b) Pay at one and one-half (1-1/2) times the Nurse's regular straight-time hourly rate of pay for time she worked in excess of forty (40) hours in a payroll week; or

Section 4. Degree Stipends. Regular full-time Nurses with the following degrees in nursing or a nursing-related field approved in advance by the Superintendent will have the following non-cumulative amounts added to their base annualized salaries, as set forth on Appendix A:

The BA stipend is $2,200
The MA stipend is $2,700

Section 5. Direct Deposit Effective July 1, 2011 all salaries will be paid via Direct Deposit.
Nurses may choose to be paid in either twenty-two (22) or twenty-six (26) consecutive normal bi-weekly pay dates of the Board. Such pa dates will occur in accordance with the Board's approved payroll calendar.

Section 6. Bus Stipend Nurses who ride the bus to and from school to support students shall receive a stipend of $2,000 per year for the term of this contract. Such stipend shall be payable in equal installments in December and June. Such stipend shall be prorated if the nurse rides the bus only one way or for any part of a school year.

Section 7. Time Documentation. Nurses shall use the electronic time documentation system provided by the Board, and in the manner prescribed by the Board, to record the hours they actually perform work for the Board. Employees shall record all absences from work in the electronic absence management system provided by the Board, and in the manner prescribed by the Board, to record any absence from work and the reason for such absence.

Section 8. School Nurse Certification. Nurses who become nationally certified School Nurses shall be reimbursed for all test materials and exams ($750) if the Nurses passes the test. Nurses who possess the School Nurse certification shall receive a yearly stipend of $1600, which shall be prorated for any partial year of such certification and will be paid in June of each year.

Section 9. License Renewal. The Board shall reimburse each Nurse for his/her annual license renewal fee, provided that the Nurse must submit proof of payment of such fee to the Director of Nursing Services.

ARTICLE VIII
LEAVES

Section 1. Sick Leave. Nurses who are ill or otherwise similarly incapacitated shall be eligible for a maximum of fifteen (15) days sick leave per year without loss of pay. Unused sick leave days from past years shall be cumulative up to a maximum of 165 days. A Nurse who has 165 sick leave days accumulated at the end of a normal work year will be credited with the aforesaid fifteen (15) sick leave days during the ensuing normal work year, provided that the maximum number of unused accumulated sick leave days which a Nurse may carry over to any subsequent normal work year will not exceed 165, and the maximum number of sick leave days available to a Nurse in any normal work year will not exceed 180. Sick leave shall not be used for routine medical appointments. Each sick day for regular part-time Nurses regularly assigned to work a regular schedule consisting of at least twenty (20) hours of work per week will be prorated based on each such part-time Nurse's normal work schedule. Two days of sick leave per year may also be used for the sickness of member of immediate family [spouse, child or stepchild or member of Nurses' household for whom the Nurse is responsible]; Such absences must be documented in the Board's absence management system; In the event that Nurses are covered by Connecticut's Paid Sick Leave Law, Connecticut General Statutes §§ 31-57r et seq. (as it may be amended from time to time), the Board shall permit Nurses to use their first forty (40) hours of contractual paid sick leave in each fiscal year for the same purposes and under the same conditions as the conditions described in Connecticut's Paid Sick Leave Law ("Statutory Sick Leave) notwithstanding the provisions of this section to the contrary. Statutory Sick Leave may be taken in one-half or full day increments. Any contractual paid sick leave accrued and used in excess of the Statutory Sick Leave shall be subject to the requirements of this section above and applicable Board policy requirements. In requesting leave for reasons other than personal illness Nurses shall specify the reason for which the Nurse is taking such leave.

Section 2. Personal Leave. (a) Regular full-time Nurses shall be eligible for leaves for personal reasons not to exceed four (4) days per year for the following reasons:

(1) Legal obligations which cannot be handled outside regular working hours.

(2) Marriage of staff member or immediate family

(3) Graduation, college drop-off, college pick up.

(4) Recognized religious holidays;

(5) Family/house/car emergencies (Does not include daycare issues)

(6) Other justifiable reasons

Requests for such purposes must be made through the district's absence management software. The Nurse will be required to state the reason for each request for days that are either (a) a Monday or Friday during May and June, or (b) a day immediately before or after a holiday or vacation period.

Section 3. Bereavement Leave. (a) Eligibility for bereavement leave:

(1) Employees are entitled to five (5) consecutive work days funeral leave with pay in the event of the death of their parent, stepparent, child, stepchild, spouse, mother-in-law, or father-in-law.

(2) Employees are entitled to three (3) consecutive work days funeral leave with pay in the event of the death of their grandparent, grandchild, sibling, brother-in-law, sister-in-law, daughter-in-law or son-in-law.

(3) An employee may use a total of five (5) days per contract year for bereavement leave.

(b) The Superintendent will have the discretion to grant additional leave without loss of pay beyond the aforesaid five (5) days in case of death in the immediate family which the Superintendent considers to present extreme circumstances.

Section 4. Attendance Incentive. Any Nurse who is absent from work for any reason other than bereavement days and district approved professional development for not more than two(2) days between the first workday of the school year and January 30 shall receive a one-time lump sum payment of $500. Any Nurse who is absent from work for any reason other than bereavement days for not more than two (2) days between January 31 and June 30 shall receive a one-time lump sum payment of $500. This attendance incentive program may be terminated unilaterally of, in the Boards judgement, it is not effective.

Section 5. Sabbatical Leave. (a) Up to six (6) weeks leave without loss of pay may be granted to a Nurse who has completed seven (7) years of consecutive and continuous full-time service provided the Nurse uses the sabbatical leave to improve his/her professional competence through educational pursuits. The Nurse will notify the Board in writing three (3) months prior to such leave, specifying the time required and how it will be used.

(b) The Board will have the right of approval or denial based on the potential benefit of the leave to the school system, availability of funds and the recommendation of the school administration.

Section 6. General. (a) A Nurse may apply for a one (1)-year leave of absence without pay or other contractual benefits but with no loss of seniority. A position shall be available to the Nurse upon return. It shall be within the sole discretion of the Board as to whether or not to grant the request of the Nurse.

(b) Any leave, with or without loss of regular pay, granted under this

Agreement that satisfies the requirements for a leave under the state or federal Family and Medical Leave Act or any other statutorily mandated leave provision will be counted and considered as a leave taken under the applicable statute, and any Nurse taking such leave shall comply fully with the application, notice and other requirements set forth in the applicable statute for taking such a leave. Nurses must substitute their unused sick and personal leave for the first part of any leave taken under the FMLA. Any FMLA leave time remaining after such paid time is exhausted will be unpaid. Substitution of such paid leave time will not increase the amount of the FMLA leave available.

Section 7. For purposes of applying the provisions of this Article, the word "day(s)" shall be construed as the Nurse's normal workday.

ARTICLE IX
VACANCIES

Section 1. The filling of vacancies in the Nurse staff and the determination of whether any given vacancy shall be filled is solely the responsibility of the Board.

Section 2. The procedure for filling vacancies, provided that the Board decides to fill the vacancy, is as follows:

(a) All Nurses currently employed by the Board will receive an electronic notification of vacant positions, and may thereby be notified of a vacancy at least five (5) days prior to filling the vacancy.

(b) Currently employed Nurses who wish to be considered for such vacancy will so notify the Director of Health Services and Director of Human Resources in writing within two (2) days of receipt of the notice of vacancy.

(c) When in the judgment of the Board, acting through its Administration, the qualification, attainments and professional backgrounds of candidates are equal, first consideration in filling such vacancies on a regular basis shall be given to candidates already employed within the Darien School System. Seniority will be the criterion, everything else being equal.

(d) The Board will hire replacements for regular positions that it has decided to fill within three (3) months of the time that the regular position has become available, provided that within that period the Board may fill the vacancy on a temporary basis.

(e) The Board may fill temporary vacancies with temporary replacements.

ARTICLE X
ASSIGNMENTS

Section 1. The parties recognize that reassignment of Nurses from one school to another is sometimes unavoidable. However, when the Board determines that a transfer is necessary, qualified volunteers shall be first considered.

Section 2. The following general rules will apply to assignments:

(a) When the Nurse's assignment includes more than one school, travel time will be kept to a reasonable level.

(b) Nurses will not be assigned more than two schools.

(c) Notice of change of assignment for the next school year shall be given to the Nurse not later than May 15, except under unusual circumstances which the Board could not foresee.

(d) With the prior approval of the Director of Health Services, Nurses may volunteer to mentor nursing students. Nurses who are assigned to mentor student nurses will be paid a stipend of $250 in the payroll following the end of such assignment.

ARTICLE XI
SENIORITY

Section 1. Seniority means length of continuous employment in the Darien School System in a position covered by this Agreement.

Section 2. Seniority shall be lost and continuous employment terminated by:

(a) Resignation;

(b) Discharge for just cause or other involuntary termination of employment;

(c) Disability which is not job-related and continuous for more than one (1) year;

(d) Failure to return to work upon the expiration of an authorized leave without satisfactory reason for failure to return; or

(e) Layoff which exceeds two (2) years.

Section 3. Seniority of Nurses will be shown on the seniority list to be retained in the personnel office.

Section 4. Nurses hired to begin work on or after the effective date of this Agreement shall be on probation for their first ninety (90) days actually worked, during which time they may be discharged or disciplined without recourse to the grievance and arbitration procedure set forth in Article XXI hereof.

ARTICLE XII
LAYOFF AND RECALL

Section 1. Layoff Procedures. In the event the Board decides to reduce the number of Nurses by layoff, those Nurses scheduled to remain will be the most qualified in the judgment of the Board to perform the assignments remaining after the layoff. In exercising its judgment, the Board will not act arbitrarily or capriciously, but will act in an effort to keep the most qualified Nurses irrespective of their salaries. In determining the relative qualification between two Nurses, the Board will take into account their respective lengths of continuous service in the system, professional training and prior evaluations. When two or more Nurses are equally qualified in the Board's judgment to fill an assignment remaining after the layoff, the Nurses with the greater length of continuous service in the Darien School System will be given the option to remain.

Section 2. Recall Procedures. To be eligible for recall, a Nurse, within thirty (30) days after layoff, must submit his/her name in writing by certified mail to the Superintendent to be placed on the recall list. A Nurse whose name appears on the recall list will be eligible for recall only until the second September 1 after the effective date of her/his layoff and only in accordance with the following:

(a) Notice of recall will be effective if sent to the address on the Board's records;

(b) The order of recall will be in reverse order of layoff;

(c) The Superintendent must receive acceptance of recall within two (2) weeks after notification of recall is sent unless there are extreme circumstances that prevent the Nurse from accepting recall within such a period; and

(d) Unless otherwise provided, all notices provided for in this Section 2 must be in writing and transmitted by Certified Mail, U.S. Postage Prepaid.

Section 3. (a) Nurses on layoff and still eligible for recall pursuant to Section 2 hereof will be given first opportunity to serve as substitutes in bargaining unit positions for which they are qualified in the judgment of the Board.

(b) If such Nurse works as a substitute for more than five (5) consecutive normal workdays, pay for the first five (5) such days will be at the substitutes' rate, and, for each consecutive day worked thereafter, will be at the *per diem* rate paid to the substituting Nurse prior to her/his layoff.

(c) In the event that a Nurse on layoff fails to accept a substitute position, the position may be filled from any other source, provided, however, that if the substitute position continues for more than five (5) consecutive normal workdays, it shall be re-offered once to the Nurse on layoff who had earlier failed to accept it.

ARTICLE XIII
EVALUATIONS AND SUPERVISORY CONFERENCES

Section 1. The Director of Health Services and the respective principal(s) shall evaluate the performance of each Nurse at least once a year. Evaluation results shall be reduced to writing, prepared by the Director of Health Services who will incorporate into her/his evaluation input from the school principal. A copy will be given to the Nurse as soon as practicable after the evaluation has been completed. At the time of evaluation the Nurse shall also evaluate herself using the same format and criteria as are being used by the Director of Health Services and the principal(s).

Section 2. All formal monitoring or observation of the Nurse's work performance shall be conducted with the full knowledge of the Nurse.

Section 3. All personnel records shall be made available for the Nurse's inspection. She/he may be accompanied by her/his designated representative. Each Nurse shall be entitled to a copy of her/his personnel records upon request.

Section 4. Persons who are found to have deficiencies will be given special help to overcome them at the time they are discovered. If the deficiency is worthy of note in the evaluation report, the Nurse's response to the help will be noted in the report as well.

Section 5. It shall be acceptable for Nurses to be accompanied to conferences with their supervisors and/or their principals by a Union Representative. The purpose of the meeting shall be made known to the Nurse prior to the meeting.

ARTICLE XIV
DISCHARGE

Nurses who have successfully completed their probationary periods of employment shall not have their increases withheld or be discharged without just cause.

ARTICLE XV
PROFESSIONAL DEVELOPMENT

Section 1. The in-service education program will continue, with programs planned and coordinated by the Director of Health Services, taking into consideration the suggestions of Nurses. These programs will be scheduled so as to avoid the need for substitutes.

Section 2. Time for participation in professional and educational institutes, workshops or meetings, in-service programs which will, in the sole judgment of the Superintendent, improve the individual's on-the-job performance and professional growth may he granted by the Superintendent on a rotating basis, subject to the necessity for maintaining the efficient operation of the department. Requests for such time must be made two (2) weeks prior to the meeting whenever possible. A response to this request will be made within three (3) working days of the time that the Superintendent receives the request.

Section 3. Nurses may submit documentation of their participation in professional and educational institutes, workshops, meetings, in-service programs or other professional

development activities that will be kept in their personnel file. This information will be available to the Nurse upon request.

ARTICLE XVI
EDUCATION ASSISTANCE

Nurses shall be reimbursed for costs they incur by attendance at seminars or conferences, payment of tuition and purchase of books required for course work relevant to their work assignment in Darien, subject to approval by the Director of Human Resources. Requests for such reimbursement shall be made promptly and shall be supported by relevant information.

ARTICLE XVII
INSURANCE PROGRAM

Section 1. Medical Plan. The Board will make comprehensive group hospitalization and medical coverage, as described herein, available during the term of this Agreement to each eligible Nurse who applies for it and to his or her eligible dependents. Covered services will be made available at a level that is substantially equivalent to the level of covered services available under the medical plan in effect as of the date on which this Agreement is signed (the "Medical Plan"), subject to the terms and conditions set forth below:

(a) The primary medical plan will be the HSA as outlined in Appendix B.

(b) The Board will pay 50% of the HSA deductible. The payment shall be made during the first week in September.

(c) Plan Deductibles:

Single	$3,000
Two Person/Family	$6,000

(d) Prescription Drug Coverage. Prescription drug coverage shall be subject to full prior authorization requirements. Nurses must use generic medication if available. If a Nurse has a clinical need for a specific brand the provider will submit a clinical exemption request through the prior authorization process. If a Nurse requests medication other than the generic brand the nurse will pay the difference in cost between that drug and the generic equivalent The following co-pay program for covered prescription drugs after the deductible is met:

At retail for dosages up to thirty-four (34) days:

- Generic $10.00
- Formulary: $35.00
- Non-formulary $40.00

Via Mail Order for dosages up to ninety (90) days:

- Generic $20.00
- Formulary $70.00
- Non-Formulary $80.00

(e) Those employees 65 years of age will be able to access an HRA account with the same deductibles and co-pays as the HSA.

Section 2. Dental Plan. The Board will make comprehensive group dental insurance coverage available during the term of this Agreement to each eligible Nurse who applies for it and to his or her eligible dependents. Covered services will be made available at a level that is substantially equivalent to the level of covered services available under the dental plan in effect as of the date on which this Agreement is signed (the "Dental Plan"), subject to the terms and conditions set forth in the Dental Plan and in this Article. : The Dental Plan will be 100% Board paid coverage for the full service portion plus additional services with a $2,000 per calendar year maximum and $1,000 lifetime max on orthodontics.

Section 3. Vision Plan. The Board will make the Vision Service Plan available during the term of this Agreement to each eligible Employee who applies for it

Section 4. (a) Means Of Providing Covered Service And Terms. The Board may self-insure the Medical, Dental, Long Term Disability and/or other Plans described herein in whole or in part or, upon termination of an insurance contract with any carrier, may enter into an insurance contract with the same or a different carrier to provide covered services at a level substantially equivalent to the level of covered services in effect on the date on which this Agreement is signed. The Board will provide the Union with as much advance notice as practicable of its plan to change the means by which it provides such covered service or to self-insure, which, under normal circumstances, shall be not less than sixty (60) days in advance.

(b). Deductible, Coinsurance, Co-pay Requirements. Covered individuals must meet any and all deductible, coinsurance and/or co-pay requirements set forth in the Medical and/or Dental Plans, whether established by the Board's primary carrier, in an available alternate plan to which the Nurse subscribes and/or by the care/service provider.

(c) Cost Containment. Covered individuals must comply with any and all of the requirements set forth in the Medical and/or Dental Plans, an available alternate plan to which the Nurse subscribes and/or by the care/service provider concerning pre-certification, pre-admission testing, utilization review, second opinions and other such cost control and utilization monitoring provisions.

Section 5. Long Term Disability Coverage. Long Term Disability coverage for each Nurse (i.e. one who is regularly assigned to a normal work schedule of at least five (5) full normal work days in each normal work week as defined in this Agreement) who has successfully completed at least five (5) consecutive years' of accredited service as a Nurse in

the Darien School System and who becomes totally and permanently disabled under the terms and conditions normally found in policies providing such coverage, as follows:

(a) The monthly maximum benefit payable under the coverage shall be 60% of the Nurse's salary as of the last day worked, up to a maximum monthly disability payment of $2,000.

(b) Monthly disability payments will begin with the seventh (7) month following the month in which the disability occurs and will continue to be made each month thereafter during the period of disability until the Nurse ceases to be totally and permanently disabled, dies, reached age 65, or becomes eligible for full retirement benefits under the Town of Darien Retirement Plan, whichever occurs first.

(c) Monthly benefit payments will be reduced by any amount paid the Nurse through workers' compensation, social security and any other offset normally found in long-term disability policies.

Section 6. Costs of Coverage. The Board and each covered Nurse will share the cost of the Medical Plan and Dental Plan coverage that the Nurse elects for him- or herself and his or her dependents from among the coverage that the Board makes available and for the Long-Term Disability coverage the Board provides Nurses, as described below.
The Nurse will pay the balance through payroll deductions. The Board's share of the premium cost will continue to be pro-rated for coverage elected by regular part-time Nurses eligible for coverage.

a) Medical and Dental Plan. For coverage of regular full-time Nurses under any of the Board's Medical and Dental Plans, the Board will contribute an amount equal to the following percentages of the premium cost (or fully insured equivalent cost) of such coverage under the Board's primary Medical and Dental Plans (including any and all increases in such costs that may arise during the term of this Agreement) and the covered Nurse will pay the balance, provided that the Board will not be required to pay more for the coverage supplied by a more expensive alternate provider selected by the Employee than it would have to pay for coverage supplied by its primary carrier for the coverage provide

July 1, 2026	23%	77%
July 1, 2027	23%	77%
July 1, 2028	23%	77%

b) Long-Term Disability Plan. Effective July 1, 2004, The Board's share of the premium coverage under the Long-Term Disability Plan that the Board makes available to each eligible Nurse will be equal to Eighty percent (80%) of the premium cost.

Section 7. Life Insurance. The Board will provide group term life insurance coverage for each Nurse in an amount equal to one and one-half (1 ½) times the Nurse's annual salary rate from the schedules set forth in Article VII, Section 1 hereof, which is then applicable, rounded to the next highest thousand, provided such coverage will not be less than $10,000

or more than $35,000 per Nurse. Nurses will not be required to contribute to the premium for such coverage.

Section 8. General Provisions. Plan Year. (a) "Plan Year", as used in this Article, is hereby defined as the Board's fiscal year (July 1 - June 30). The Board will notify the Union President of any change in Plan Year.

(b)(1) Eligibility for Coverage. Eligibility for coverage under the Medical Plan (including prescription drug coverage), Dental Plan and Long-Term Disability Plan will continue to be determined in accordance with and subject to eligibility criteria in effect on May 1, 2004.

The Board will not be required to extend coverage under the Medical Plan (including but not limited to, prescription drug coverage), Dental Plan or Long-Term Disability Plan to any Nurse who is not regularly assigned to a regular full-time work schedule (i.e., one who is regularly assigned to a normal work week schedule consisting of five full normal workdays or 90% of a normal workweek as defined in this Agreement).

(b)(2) Eligibility Dependents. No Nurse may extend his or her dependents coverage under any of the Plans provided by this Agreement unless the Nurse is covered by such plans.

(c) Change of Insurance Carrier. The Board shall have the sole discretion to choose its primary carrier, to change carriers and/or to self-insure in whole or in part, provided that the level of covered services are not significantly diminished.

(d) Disputes Relating to Benefits. Eligibility for benefits shall be determined exclusively in accordance with the provisions of the respective insurance contracts acquired by the Board to provide covered services, and any dispute relating to eligibility for or the amount of covered services or benefits in any individual case shall be processed by the Nurse directly with the respective insurance carrier and shall not subject the Board to any claim in any forum. In no event shall the Board be considered to be an insurer or a guarantor of any covered services or benefits.

Section 9. Professional Liability Coverage. The Board will continue in effect the professional liability insurance coverage that it provided as of the effective date of this Agreement.

Section 10. Reimbursement Account Plan. As of the effective date of this Agreement, the Board will make available to covered Nurses a Reimbursement Account Plan ("RA Plan") in accordance with and subject to the provisions of Internal Revenue Service Section 125 whereby covered Nurses may divert a portion of their gross pay, prior to reduction for federal income or social security taxes, into an account from which, during the course of the RA Plan Year, they can be reimbursed for their share of Group Insurance Premiums (Premium Conversion), Health Care costs which are not covered by the Medical or Dental Plans described in this Article (Health Care Reimbursement) and Dependent Care costs (Dependent Care Reimbursement). Under the RA Plan, each Nurse will be permitted to divert a maximum of $5,000 per Twelve-Month RA Plan Year for Dependent Care and $3,000 per Twelve-Month

RA Plan Year for Health Care Reimbursement. There is no specific maximum limit for Premium Conversion, but all diversions of income in the RA Plan are subject to applicable provisions of the Internal Revenue Code.

ARTICLE XVIII
RETIREMENT BENEFIT

Section 1. All full-time registered Nurses employed by the Board shall be covered by the Darien Municipal Employees Retirement Plan or any other plan adopted by the Town of Darien in *lieu* thereof, as well as the Social Security retirement plan. Eligibility shall be determined under the regulations the Darien Retirement Board and disputes concerning eligibility for benefits and other matters relating to retirement shall not be subject to the grievance procedure.

Section 2. Retirees. Upon retirement, a full-time Nurse employed before the approval of the 2017-2020 collective bargaining agreement with at least ten (10) years of continuous service who is between the age of 62 and normal Social Security retirement age, or eligible for the "Rule of 80", shall receive a one-time payment of $15,000.

ARTICLE XIX
GRIEVANCE PROCEDURE

Section 1. Purpose. The purpose of this procedure is to secure, at the lowest possible administrative level, equitable solutions to problems that may arise affecting the welfare or working conditions of Nurses.

Section 2. Definitions.

(a) As used in this Agreement, the word "Grievance" is hereby defined to mean any complaint that a specific provision of this Agreement has been misapplied or misinterpreted by the Board or the Superintendent (or Superintendent's agent), or by an administrator acting in a supervisory capacity.

(b) As used in this Agreement, the word "Grievant" is hereby defined to mean any person who files a Grievance.

(c) "Days," as used in this Article will mean days when the Nurse is scheduled to be at work.

Section 3. Time Limits. The time limits specified herein are of the essence and may only be extended by mutual written Agreement of the Director of Human Resources and the Union. Failure to process a Grievance within the time limits provided herein shall be deemed a waiver of such Grievance, and the Grievance shall be considered resolved in accordance with the position of the Board. Failure by the Board representatives to meet or respond to the Grievance within the time limits provided herein shall permit the Grievant or the Union, as appropriate, to process the Grievance to the next Step provided they do so within the time limits set forth herein.

Section 4. Steps of the Grievance Procedure.

(a) First Step - Grievant and Director of Nursing Services/Principal - Informal. The Grievant and, at her/his option, the Union President, will discuss the matter with the Director of Nursing Services and the principal at the school to which she/he is regularly assigned with the objective of resolving the matter informally.

(b) Second Step - Director of Nursing Services/Principal - Formal. If the Grievant is not satisfied with the outcome of the informal procedure and she/he desires to proceed further, she/he will present her/his claim as a written grievance to the Director of Nursing Services within twenty (20) days of the event or 20 days from when the grievant knew or should have known of the event giving rise to the Grievance. The Director of Nursing Services will, within five (5) days, answer the Grievance in writing. If the Grievant so requests, the Director of Nursing Services will discuss the answer with her/him. The Union President may be included in this conference at the Grievant's option.

(c) Third Step – Director of Human Resources. If the Grievance has not been adjusted satisfactorily in the Second Step and the Grievant desires to proceed further, such Grievance will be submitted to the Director of Human Resources within five (5) days of the receipt of the Second Step answer. The Director of Human Resources will discuss the Grievance with Grievant at a mutually convenient time within five (5) days after receipt the Grievance by the Director of Human Resources. The Union President and the AFSCME Service Representative may be included in this conference at the Grievant's option, and the Director of Human Resources may include other supervisors at his/her option. The Director of Human Resources will, within ten (10) days of the meeting with the Grievant, answer the Grievance in writing.

(d) Fourth Step - Arbitration: If the Grievance is not resolved at the Third Step, and the Union wishes to proceed further, the Union must file a Demand for Arbitration with the American Arbitration Association (AAA) in accordance with its Voluntary Rules for Labor Arbitration then subsisting, subject to the following terms and conditions:

(1) The Grievance must arise out of and involve the interpretation or application of a specific provision expressed in this Agreement and will not be arbitrable if it claims a right, benefit or obligation not expressly set forth in a specific provision of this Agreement.

(2) The Demand for Arbitration must be made in writing by certified mail, return receipt requested, with a copy to the Assistant Superintendent, postmarked within the twenty (20) calendar days immediately following the Grievant's receipt of the Director's response at Step Two, or absent such response, within twenty (20) calendar days following the expiration of the time for providing such response.

(3) The Arbitration must be in accordance with the American Arbitration Association's Voluntary Rules for Labor Arbitration in existence at the time the Demand for Arbitration is filed.

(4) The Demand for Arbitration must be limited to the same Grievance submitted to the Assistant Superintendent Step 2.

(5) The Arbitrator's authority will be limited to determining whether, by the allegations contained in the Grievance, the Board violated or misapplied the specific provision expressed in this Agreement as alleged in the Grievance. The Arbitrator will have authority to render appropriate "make whole" awards consistent with the provisions of this Agreement and other applicable rules governing the arbitrator's conduct and authority.

(6) The decision of the Arbitrator will be final and binding, subject to the right of either party to have the award confirmed, vacated or modified according to law.

(7) The cost of the Arbitrator's fees and hearing room rental, if any, will be shared equally by the Board and the Union, but each party will bear the cost of its own representatives, transcripts and other items.

(8) Grievances must be filed for arbitration separately, and an Arbitrator may not hear multiple Grievances unless the Assistant Superintendent and the Union agree in writing to allow the Arbitrator to do so.

(9) Only the Union will have the authority to submit a Grievance to Arbitration.

Section 5. Representation. Grievant will be permitted to be accompanied by the Union's steward and/or the Union's Business Representative at all grievance meetings and arbitration hearings except at Step 1, where only the Steward will be permitted. Grievances shall not be processed and Grievance meetings or discussions shall not be held during work time without the express prior approval of the Director of Human Resources, although arbitration hearings may be held during work time according to a schedule mutually acceptable to the Board, the Union and the arbitrator.

Section 6. Confidentiality. The Grievance and the Grievance process, including arbitration, shall be kept confidential.

Section 7. Sole Procedure. The Grievance procedure contained herein, including arbitration, shall be the exclusive method of resolving Grievances.

Section 8. Union Authority. Nothing contained herein shall require the Union to process any Grievance which in its opinion is without merit, and no Nurse shall have the right to process a Grievance to arbitration, as such right is reserved exclusively to the Union.

Section 9. Settlements. Grievance settlements reached at Step 1 shall not be used as evidence or precedent in any other Grievance, at arbitration or in any other forum.

ARTICLE XX
COPY OF THIS AGREEMENT

A copy of this Agreement shall be posted online by the Board.

ARTICLE XXI
SEPARABILITY

This Agreement is intended to preserve the legal rights and benefits of the parties and the individual Nurse. Should any provision of this Agreement be found to be inoperative, void, or invalid by a court of competent jurisdiction or to be in conflict with any applicable Federal or State law, said provision shall no longer be operative or binding on the parties, but the remainder of this Agreement shall continue in full force and effect for the duration of this Agreement.

ARTICLE XXII
WORK CONTINUITY

The Union agrees that for the duration of this Agreement, there will be no strike, work stoppage, slowdown, curtailment or restriction of work or refusal to cross any picket line whether lawful or unlawful. The Board agrees not to "lockout" its Nurses.

ARTICLE XXIII
AGENCY SHOP AND CHECK-OFF

Section 1.

All employees will be offered an opportunity to join the Union. Employees who elect to join the Union shall sign and deliver to the Union an authorization for the payroll deduction of membership dues/fees of the Union. Such authorization shall be delivered to the Board. Upon receipt of a signed authorization card, the Board agrees to deduct from the wages of the employee such Union dues/fees. Such deductions shall continue in effect until revoked by the employee by written notice to the Union and the Union has notified the Board by written notice that the employee no longer desires to be a member of the Union. The Union reserves the right to modify and or replace any such authorization form. The Union agrees to indemnify and to hold the Board harmless against any and all claims, demands, suits or other forms of liability that shall, or may arise out of, or by reason of, action taken by the Board for the purpose of complying with the provisions of this Article.

ARTICLE XXIV
WORKERS' COMPENSATION

Section 1. Application of Prorated Sick Leave. Nurses absent because of compensable injuries (i.e., those for which they are eligible to receive Workers' Compensation benefits) shall have their sick leave pay prorated so that the amount a Nurse receives in daily sick leave pay will equal only that amount necessary to make up the difference between his/her regular daily rate of pay at straight-time under this Agreement (for a maximum of seven [7] hours per day) and the amount he/she receives as daily workers' compensation pay. The prorated pay will be exclusive of the three (3) days waiting period required by Workers' Compensation on a per injury basis, and the sick leave policy procedure shall apply to the three (3) day waiting period.

Similarly, the amount of sick leave time off to which the Nurse is entitled at the beginning of his/her period of absence will be charged with only so much as he/she used on a daily basis, so that for example, if workers' compensation benefits account for two-thirds of the Nurse's daily pay, and sick leave benefits one-third, then one-third sick leave day shall be charged against the Nurse's accumulated sick leave for every full day of such absence.

The maximum amount of sick leave that can be charged against the Nurse's accumulated balance for a compensable injury is twenty (20) sick days.

Such supplement shall end after six (6) months or the start of long term disability payments, whichever later occurs, after which time an affected Nurse shall only receive any Workers' Compensation pay.

Section 2. a. The procedures of this Section shall be implemented when a Nurse has been absent due to long term disability (both job-related and non-job-related) for a period of twenty-six (26) weeks from the date of disability.

b. Upon notification from the Board to the Nurse pursuant to "a" above, the Nurse must within sixty (60) days present certification from his or her physician that the Nurse is able to perform or will be able to perform. his or her job within twelve (12) mouths of the date of disability. Date of disability shall be the first day the Nurse was unable to report to work due to disabling illness or injury. Successive periods of disability separated by less than three (3) calendar months are considered as the same disability when the illness or injury rendering the Nurse disabled remains the same. A return-to-work light duty on either a full-time or part- time basis shall not alter the original date of disability. If the Nurse's physician does not certify that the employee is able to perform, without limitation, the duties of his or her position or of any other available position offered by the Board or, if in the opinion of a physician selected by the Board, the Nurse is found to be unable to perform said duties, the Board, may terminate the Nurse. In such case, any disability benefits for which the Nurse may be eligible shall continue unaffected.

c. When there is a conflict between the opinion of the Nurse's physician and the opinion of the physician selected by the Board, a third medical opinion shall be obtained. For such purpose the Nurse shall select a physician from a list of three (3) physician providers (with the appropriate medical specialty) selected by the Board. Once the three (3) physicians are submitted to the Nurse, the Nurse shall have thirty (30) days to select one of the three (3). The third medical opinion shall prevail.

d. In the event the Nurse does not report for required medical evaluations and/or fails to follow any of the timelines set forth in subparagraphs a through c, the Nurse may be terminated and such termination shall be deemed to be for just cause.

In the event the Nurse returns to work within the above-referenced twelve (12) months, he/she shall suffer no loss in continuous service or seniority rights.

If any illness or injury results in a disability that has prevented the Nurse from performing the essential functions of the position with reasonable accommodations for the period of either twelve (12) consecutive months or eighteen (18) months during a twenty-four (24) month period, the Board shall have the right to retire or discharge the Nurse.

If any illness or injury results in a disability, the Board shall have the right to retire or discharge the Nurse whenever the undisputed medical prognosis indicates that the Nurse will not be able to perform the essential functions of the position with reasonable accommodations that the Nurse held prior to the injury or illness.

Section 3. Return-to-Work Program. Nothing herein shall prevent the Board from implementing a managed care system and a "light duty" requirement in connection with its Workers' Compensation coverage.

ARTICLE XXV
DURATION

This Agreement will take effect upon approval of the parties and will remain in full force and effect to and including June 30, 2029 and thereafter until a successor agreement is in effect. Negotiation for a successor agreement shall begin no later than one hundred twenty (120) days prior to the expiration of this Agreement.

Signed and entered on this 11th day of June 2026.

DARIEN REGISTERED SCHOOL NURSES ASSOCIATION

Its President 6/19/2026

Local 1303-141 Council 4, AFSCME, AFL-CIO 6-22-2026

DARIEN BOARD OF EDUCATION

Robin P. Nelson 6/23/2026
Its Chairman

Appendix A - Wages

2025-2026	2.50%			
Salaries	0-9 Years	10 Years	15 Years	20 Years
Base	$60.59	$61.40	$61.55	$61.70
With BA	$62.29	$63.10	$63.25	$63.40
With MA	$62.68	$63.49	$63.63	$63.79
BA Stipend	$1.70			
MA Stipend	$2.08			
2026-2027	3.75%			
Salaries	0-9 Years	10 Years	15 Years	20 Years
Base	62.86	$63.70	$63.86	$64.01
With BA	$64.63	$65.47	$65.62	$65.78
With MA	$65.03	$65.87	$66.02	$66.18
BA Stipend	$1.76			
MA Stipend	$2.16			
2027-2028	3.75%			
Salaries	0-9 Years	10 Years	15 Years	20 Years
Base	$65.22	$66.09	66.25	$66.42
With BA	$67.05	$67.92	$68.08	$68.25
With MA	$67.47	$68.34	$68.49	$68.67
BA Stipend	$1.83			
MA Stipend	$2.24			
2028-2029	3.75%			
Salaries	0-9 Years	10 Years	15 Years	20 Years
Base	$67.67	$68.57	$68.73	$68.91
With BA	$69.56	$70.47	$70.63	$70.81
With MA	$69.99	$70.90	$71.06	$71.24
BA Stipend	$1.90			
MA Stipend	$2.33			

Appendix B Medical Benefits

Begins on Next Page

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, https://eoc.anthem.com/eocdps/aso. 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 www.healthcare.gov/sbc-glossary/ or call (833) 899-7070 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000/person or $6,000/family for In-Network Providers. $3,000/person or $6,000/family for Out-of-Network Providers.	Generally, you must pay all of 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. Children's eye exam. For more information see below.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,000/person or $6,000/person on a family or $12,000/family for In-Network Providers. $6,000/person or $6,000/person on a family or $12,000/family for Out-of-Network Providers	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and Out-of-Network Transplants.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/find-care/?alphaprefix=AZL or call (833) 899-7070 for a list of network providers. Benefits and	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 an Out-of-Network 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). Be aware, your network provider might use an Out-of-Network

	and how the provider bills.	services.
Do you 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
		In-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	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	0% coinsurance	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Typically Generic (Tier 1)	$5/prescription (retail) and $10/prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)	For more information, refer to "National Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section.
	Typically Preferred Brand (Tier 2)	$35/prescription (retail) and $70/prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	$40/prescription (retail) and $80/prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	0% coinsurance	30% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	0% coinsurance	Covered as In-Network	--------none--------
	Emergency medical transportation	0% coinsurance	Covered as In-Network	--------none--------
	Urgent care	0% coinsurance	30% coinsurance	--------none--------

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/aso.

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	100 days/benefit period for Inpatient rehabilitation.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	0% coinsurance	30% coinsurance	--------none--------
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	25% coinsurance	--------none--------
	Rehabilitation services	0% coinsurance	30% coinsurance	*See Therapy Services section.
	Habilitation services	0% coinsurance	30% coinsurance	
	Skilled nursing care	0% coinsurance	30% coinsurance	220 days/benefit period for skilled nursing services.
	Durable medical equipment	0% coinsurance	30% coinsurance	*See Durable Medical Equipment section.
	Hospice services	0% coinsurance	30% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	*See Vision Services section.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's dental check-up
- Glasses for a child
- Routine foot care unless you have been diagnosed with diabetes
- Cosmetic surgery
- Long-term care
- Weight loss programs
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/aso.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Hearing aids 1 unit every 24 months
- Routine eye care (Adult) 1 exam/benefit period
- Bariatric surgery
- Infertility treatment
- Chiropractic care 50 visits/benefit period combined with all other therapies
- Private-duty nursing in a Home Setting only

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: Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov, or contact Anthem at the number on the back of your ID card. 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.

Your Grievance and 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 on how 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:

ATTN: Grievances and Appeals, P.O. Box 1038, North Haven, CT 06473-4201

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

Additionally, a consumer assistance program can help you file your appeal. Contact Connecticut Office of the Health Care Advocate, P.O. BOX 1543, Hartford CT 06144, (866) 466-4446, https://portal.ct.gov/oha, healthcare.advocate@ct.gov

Does this plan provide Minimum Essential Coverage? Yes/No.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes/No.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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	$3,000
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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, https://eoc.anthem.com/eocdps/aso. 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 www.healthcare.gov/sbc-glossary/ or call (833) 899-7070 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000/person or $6,000/family for In-Network Providers. $3,000/person or $6,000/family for Out-of-Network Providers. An HRA may be available to reimburse you for certain deductible and coinsurance amounts.	Generally, you must pay all of 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. Children's eye exam. For more information see below.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,000/person or $6,000/person on a family or $12,000/family for In-Network Providers. $6,000/person or $6,000/person on a family or $12,000/family for Out-of-Network Providers.	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and Out-of-Network Transplants.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

you use a network provider?	care/?alphaprefix=AZL or call (833) 899-7070 for a list of network providers. Benefits and costs may vary by site of service and how the provider bills.	network. You will pay the most if you use an Out-of-Network 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). Be aware, your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get services.
Do you 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
		In-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	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	0% coinsurance	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Typically Generic (Tier 1)	$5/prescription (retail) and $10/prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)	For more information, refer to "National Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section.
	Typically Preferred Brand (Tier 2)	$35/prescription (retail) and $70/prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	$40/prescription (retail) and $80/prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	0% coinsurance	30% coinsurance	--------none--------

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/aso.

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	0% coinsurance	Covered as In-Network	--------none--------
	Emergency medical transportation	0% coinsurance	Covered as In-Network	--------none--------
	Urgent care	0% coinsurance	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	100 days/benefit period for Inpatient rehabilitation.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	0% coinsurance	30% coinsurance	--------none--------
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	25% coinsurance	--------none--------
	Rehabilitation services	0% coinsurance	30% coinsurance	*See Therapy Services section.
	Habilitation services	0% coinsurance	30% coinsurance	
	Skilled nursing care	0% coinsurance	30% coinsurance	220 days/benefit period for skilled nursing services.
	Durable medical equipment	0% coinsurance	30% coinsurance	*See Durable Medical Equipment section.
	Hospice services	0% coinsurance	30% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	*See Vision Services section.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's dental check-up
- Glasses for a child
- Cosmetic surgery
- Long-term care
- Dental care (Adult)

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/aso.

- Routine foot care unless you have been diagnosed with diabetes
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Hearing aids 1 unit every 24 months
- Routine eye care (Adult) 1 exam/benefit period
- Bariatric surgery
- Infertility treatment
- Chiropractic care 50 visits/benefit period combined with all other therapies
- Private-duty nursing in a Home Setting only

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: Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov, or contact Anthem at the number on the back of your ID card. 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.

Your Grievance and 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 on how 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:

ATTN: Grievances and Appeals, P.O. Box 1038, North Haven, CT 06473-4201

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

Additionally, a consumer assistance program can help you file your appeal. Contact Connecticut Office of the Health Care Advocate, P.O. BOX 1543, Hartford CT 06144, (866) 466-4446, https://portal.ct.gov/oha, healthcare.advocate@ct.gov

Does this plan provide Minimum Essential Coverage? Yes/No.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes/No.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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	$3,000
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا نجار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

SIDE LETTER OF AGREEMENT

In the recently-concluded negotiations between the Darien Board of Education and the Darien Registered Nurses' Association Local 1303 Chapter 141 of Council #4, AFSCME, AFL-CIO, the parties agree as follows:

1. A smart cell phone will be provided to nurses when they are riding the bus or accompanying students on field trips.

DARIEN REGISTERED SCHOOL NURSES ASSOCIATION

Its President — Date 6/19/2026

Local 1303-141 Council 4, AFSCME, AFL-CIO — 6-22-2026

DARIEN BOARD OF EDUCATION

Its Chairman — Date 6/23/2026