

AGREEMENT

between the

WEST HARTFORD BOARD OF EDUCATION

And

LOCAL 818, AFSCME, COUNCIL 4, AFL-CIO

CAFETERIA MANAGERS

July 1, 2026 – June 30, 2030



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AGREEMENT

This Agreement has been entered into between the West Hartford Board of Education hereinafter referred to as the "Board" and Local 818 of Council 14 of the American Federation of State, County, and Municipal Employees, AFL-CIO, hereinafter referred to as the "Union".

ARTICLE I **RECOGNITION**

Section 1.0

The Board of Education recognizes the Union as the sole and exclusive bargaining agent for the purposes of collective bargaining on matters of wages, hours of employment, and other conditions of employment for all supervisory employees of the West Hartford Public Schools Nutrition Services, excluding the Nutrition Services Operations Manager.

ARTICLE II **UNION SECURITY**

Section 2.0

During the term of this Agreement, all employees in the bargaining unit, who are members of the Union, shall tender periodic dues to the Union.

The Union shall certify in writing to the Board the annual rate of membership dues within ten (10) days following any change in said annual rates.

Section 2.1

As specifically stated in Public Act No. 21-25, 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 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. 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.

Section 2.2

A listing of the names and addresses of employees from whose wages dues have been deducted will be sent to the Financial Officer of the Union no later than the last day of the month.

Section 2.3

The dues deduction for each month will be made from each payroll check during the first payroll period of each month and will be remitted to the Financial Officer of the Union not later than the last day of each month.

Section 2.4

The Union shall hold the Board harmless against any and all claims, demands, liabilities, lawsuits, attorneys' fees or other costs which may arise out of, or by reason of, actions taken against the Board as a result of the enforcement or administration of this Article

Section 2.5

The Board agrees that there will be no lockout of any employee or employees during the life of this Agreement or any extension thereof.

Section 2.6

All new hires which are represented by the bargaining unit, within fifteen (15) days of their start date, shall be released from work, for one (1) hour without loss of pay, to attend a Union orientation, Management shall not be present during the Union's orientation.

Section 2.7

Every 120 days the Employer will submit information on employees represented by the bargaining unit in the format of an excel spreadsheet to the Union via a secure upload site to be provided by the Union. The spreadsheet will contain the following information for all employees represented by bargaining unit: last name, first name, middle initial, hire date, rate of pay, total hours worked in the reporting period, dues paid, employment status, job hours, Employee ID, job title, shift, worksite, home address, home phone, cell phone, work email, and home email.

Section 2.8

The employer agrees to deduct from the wages of any employee who is a member of the Union a PEOPLE deduction provided for in a written authorization. Such an authorization must be executed by the employee and may be revoked by the employee at any time by giving written notice to both the employer and the Union. The employer agrees to remit any deduction made pursuant to this provision promptly to the Union together with an itemized statement showing the name of each employee from whose pay such deductions have been made and the amount deducted during the period covered by the remittance. The Union agrees to hold the employer harmless from any claims arising as a result of any deduction made pursuant to this subsection.

ARTICLE III **SENIORITY**

Section 3.0

The Employer shall prepare a list of all employees in the bargaining unit showing their seniority, date of hire and length of service with the Board and shall deliver the same in duplicate to the Council 4 office on or before October 1, of each year.

Section 3.1

New employees shall serve a probationary period of sixty (60) working days, which can be extended an additional thirty (30) working days if management determines additional time is needed to evaluate the probationary employee. Employees shall have no seniority rights during their probationary period, but shall be subject to all other provisions of this Agreement. All employees who have completed their probationary period shall be regular employees and shall acquire length of service records, included as those used for accrual of benefits, as of the date of their initial employment.

Section 3.2

If vacancies occur within the unit, the Board shall post the vacancies in all schools for a period of ten (10) days on a bulletin board made accessible to each employee and notify the Union of such posting. Qualified applicants within the bargaining unit shall be given first consideration for such vacancy in order of seniority.

If no Bargaining Unit employees apply for the vacancy, the Board can then fill the position from outside the bargaining unit. The filling of job vacancies, which are included within the scope of this contract, is subject to arbitration.

Vacancies shall be filled within a reasonable time after a particular Position has been vacated, and/or within a reasonable time from the date that a new position has been created.

When an employee fills a vacancy which is considered a lateral transfer, he/she shall serve a thirty (30) calendar day probationary period in the new position. When an employee fills a vacancy which is considered a promotional transfer, he/she shall serve a ninety (90) calendar day probationary period in the new promoted position. When an employee is retained in a vacancy or new position for the period of probation, he/she shall be considered as qualified to hold the position to which he/she has been assigned. In any event, the employee filling the vacancy shall have the right to return to their former position.

Section 3.3

The term "layoff" shall mean termination of employment due to the reduction in the number of positions. In the case of layoff, Employees shall be laid off in inverse order of seniority within classification, last hired, first fired.

For the purposes of this Article there shall be two (2) classifications:

Classification I	Conard High School Manager and;
Classification II	Hall High School Manager
	Middle School Manager
	Area Manager

Seniority for purposes layoff and recall under this Article shall be defined as length of service within the bargaining unit.

Section 3.4

The order of layoff within classification, first to last, shall be:

- 1st - New hire probationary full time employees
- 2nd - Regular full time employees

Section 3.5

When a position is eliminated and the number of employees within the bargaining unit exceeds the number of positions in the bargaining unit, the employee directly affected shall bump the employee with least seniority within their classification, if any.

Section 3.6

For a period of two (2) years following layoff, laid off employees with the most seniority shall be recalled first and no new employees shall be hired into the bargaining unit until all laid off employees in the bargaining unit have been given the opportunity to return to work via certified mail sent to the employee's last known address. A laid off employee shall have recall rights to their former position or any other position in their classification.

Section 3.7

Individuals who are recalled must contact the West Hartford Board of Education with their decision to accept or decline the recall position being offered via certified mail. If the employee accepts the position, then the employee shall assume their duties within fourteen (14) working days following the certified written notice of recall or it shall be considered that they have declined the recall. The Nutrition Services Operations Manager may grant an extension to the time for reporting back to work. The recalled individual will return to work at the appropriate contractual pay rate.

Section 3.8

All bargaining unit work will be performed by bargaining unit employees

ARTICLE IV **HOURS OF WORK**

Section 4.0

The normal working hours for the bargaining unit shall be as follows:

- | | | |
|----|--|--|
| a. | Conard High School Manager | Eight (8) hours per day with
one-half (1/2) hour unpaid lunch |
| b. | Hall High School Manager
Middle School Managers | Seven and one-half (7.5)
hours per day with one-half (1/2) |

Area Managers

hour unpaid lunch

In general, the schedule and/or number of hours may be changed prior to the beginning of a new school year with up to four (4) weeks prior notice to the Union. Under emergency circumstances, the Board may alter the schedule and/or number of hours during the school year with four (4) weeks notice to the Union.

Section 4.1

Any hours worked in excess of forty (40) hours per week shall be paid at time and one-half the employee's regular hourly rate.

Any hours worked for "catering" in excess of the employee's regular working hours, shall be paid at time and one-half the employee's regular hourly rate.

Any employee called in to work after regular working hours, who works two (2) or more hours after being called in, shall be paid for four (4) hours, or the actual number of hours worked, whichever is greater, at the applicable rate.

Section 4.2

Subject to the Board's right to change the school year for students and subject to the union or local right to negotiate over the impact of any such change, the work year shall be 186 days (182 shall be student days, 2 prior to the start of the school year, 1 day after the school year ends, and 1 day of professional development).

ARTICLE V **HOLIDAYS**

Section 5.0

Employees shall be granted a total of eleven (11) paid holidays during each year as follows:

New Year's Day	Labor Day
Martin Luther King Day	Indigenous People's Day
President's Day	Thanksgiving Day
Good Friday	Day After Thanksgiving
Memorial Day	Christmas Day
Juneteenth	

When Juneteenth occurs on a day when school is in session, employees shall receive Juneteenth as a paid holiday.

Should any employee work during the summer, said employee shall receive the July 4th holiday as a paid holiday.

Section 5.1

Holidays occurring on Saturday will be observed on the preceding Friday if there is no school on said Friday.

Holidays occurring on Sunday will be observed on the following day if there is no school on said Monday.

Section 5.2

Whenever any of these holidays shall occur while an employee is out on sick leave, the employee shall receive said holiday pay and will not have leave charged to sick leave.

Section 5.3

In order to be eligible for a holiday off with pay (holiday pay), an employee must be at work or on approved sick leave per the sick leave call in practice, or other leave with pay on the days immediately preceding and following the day on which the holiday is observed.

ARTICLE VI **INSURANCE**

All "employees" who are paid at least fifty percent of the rate of any category shown in Appendix A shall be eligible for any of the insurance programs listed within this Article. Dependent coverage may include bona fide domestic partners, provided that such status is established by affidavit as shown in Appendix D.

Section 6.0 Benefits

Effective July 1, 2026, the Board shall pay for all full-time employees seventy eight and three quarter percent (78.75%) of the premium cost and the employee shall pay twenty one and one quarter percent (21.25%) of such cost. Effective July 1, 2027 the Board shall pay for all full-time employees seventy eight and one half percent (78.5%) of the premium cost and the employee shall pay twenty one and one half percent (21.5%) of such cost. Effective July 1, 2028 the Board shall pay for the all full-time employees seventy eight and one quarter percent (78.25%) of the premium cost and the employee shall pay twenty one and three quarter percent (21.75%) of such cost. Effective July 1, 2029 the Board shall pay for the all full-time employees seventy eight percent (78%) of the premium cost and the employee shall pay twenty two percent (22%) of such cost.

The SPP contains a Health Enhancement Plan (HEP) component. All employees participating in the SPP are subject to the terms and provisions of the HEP. In the event SPP administrators impose the HEP non-participation or non-compliance \$100 per month premium cost increase or the \$350 per participant to a maximum of \$1400 family annual deductible, those sums shall be paid 100% in their entirety by the non-participating or non-compliant employee. No portion or

percentage shall be paid by the Board. The \$100 per month premium cost increase shall be implemented through payroll deduction, and the \$350/\$1400 annual deductible shall be implemented through claims administration.

In the event any of the following occur, the Board or the Federation may reopen negotiations in accordance with the Municipal Employee Relations Act as to the sole issue of medical benefits, including plan design and plan funding, premium cost share and/or introduction of a replacement medical benefits plan in whole or in part.

i) If the SPP in its current form is no longer available; or if the benefit plan design of the SPP is modified as a result of a change in the State's collective bargaining agreement with SEBAC, if such modifications would substantially increase the cost of the medical benefits plan offered herein. Reopener negotiations shall be limited to medical benefits plan design and funding, premium cost share and/or introduction of an additional optional medical benefits plan; and/or

ii) If Conn. Gen. Stat. Section 3-123rrr et seq. is amended, or if there are any changes to the administration of the SPP, or if additional fees and/or charges for the SPP are imposed so as to affect the Board, any of which amendments, changes, fees or charges (individually or collectively) would substantially increase the cost of the medical benefits plan offered herein. Reopener negotiations shall be limited to medical benefits plan design and funding, premium cost share and/or introduction of an additional optional medical benefits plan; and/or

iii) If the cost of medical benefits plan offered herein is expected to result in the triggering of an excise tax under The Patient Protection and Affordable Care Act ([ACA; P.L. 111-148], as amended, inter alia, by the Consolidated Appropriations Act of 2016 [P.L. 114-113]) and/or if there is any material amendment to the ACA that would substantially increase the cost of the medical benefits plan offered herein. Reopener negotiations shall be limited to medical benefits plan design and funding, premium cost share and/or introduction of an additional optional medical benefits plan.

In any negotiations triggered under the conditions above as well as negotiations for a successor to the current collective bargaining agreement, the parties shall consider the plan options in place as of June 30, 2018 (as well as the premium cost-sharing amounts as set forth above, as may be subsequently negotiated between the parties) to be the baseline for such negotiations, and the parties shall consider the following additional factors:

- Trends in medical insurance plan design outside of the SPP;
- The costs of different plan designs, including a high deductible health plan structure and a PPO plan structure.

Should such negotiations be submitted to arbitration for resolution, the arbitration panel shall consider the foregoing in applying the statutory criteria in making its ruling

3. Dental

a. CIGNAPremier Dental Plan

The Board shall make available for the duration of this Agreement and at a level of service no-less-than that in effect June 30, 1998 the CIGNAPremier plan as described in Appendix C.

b. CIGNAPreferred Dental Plan

The Board shall make available as a second dental option the CIGNAPreferred Dental Plan. Described in Appendix C.

The Board may substitute a comparable plan if agreed to by the Union. Such consent shall not be withheld except for just cause. The issue of just cause shall be subject to review through the grievance arbitration provision of this Agreement. No change shall be implemented prior to the completion of arbitration, if required.

c. Vision Plan

The Board shall make the State Partnership Vision Rider available to all employees at 100% employee cost for enrolled level (single, two person, or family).

4. Other

Long term disability and group life insurances shall be provided. The maximum monthly long term disability benefit shall be \$4,000 and the maximum life insurance benefit shall be \$70,000.

There is a twenty-four month limitation for disabilities due to mental illness unless the employee is confined to a hospital or institution. The Board may substitute a comparable plan if agreed to by the Union. Such consent shall not be withheld except for just cause. The issue of just cause shall be subject to review through the grievance arbitration provision of this Agreement. No change shall be implemented prior to the completion of arbitration, if required.

Section 6.1 Premium Cost Sharing

1. Long Term Disability

The employee shall pay ten percent (10%) of the premium cost for the coverage for which he/she is eligible and which he/she selects. The Board shall pay the balance of the cost.

2. Group Life

For coverage up to two times (2X) the annual salary, not to exceed \$50,000, the employee shall pay ten percent (10%) of the premium cost. The Board shall pay the balance of the cost.

For any coverage available to the employee and that he/she chooses to purchase beyond the maximum coverage applicable for him/her, the employee shall pay one hundred percent (100%) of the premium cost.

3. Dental

The employee shall pay twenty percent (20%) of premium costs for the DeltaPremier plan or the DeltaPreferred Dental Plan. The Board shall pay the balance of the cost.

Section 6.3

The Board shall make an IRS Section 125 plan available to the employee making premium contributions for insurance benefits under Section 6.2 of the Agreement.

The Board shall make available on an optional basis a Section 125 Flexible Spending Account for Accident and Health Insurance (IRC Sections 105 and 106) and Dependent Care Assistance (IRC Section 129). Those employees who utilize this option will assume the actual administrative costs for these Accounts.

Section 6.4

Employee shall be permitted to change their participation in insurance programs only once annually during the open enrollment period in June, to be effective in September, unless there is a change in status ~ marriage, birth, divorce, death).

Section 6.5

The Board shall provide prompt notification to the Union of any change(s) or intended change(s) in existing conditions of employment under this Article after the Board or the Administration have become aware of such change(s) or intended change(s).

This section shall not be construed to waive the Union's right to negotiate changes the Board proposes concerning mandatory subjects of negotiation.

Section 6.6

Upon retirement or resignation at age fifty-five (55) or greater with at least ten (10) years of service, the employee may continue medical coverage in the Board of Education sponsored plan for self and dependents.

The Board of Education will pay 100% of individual medical coverage for each enrolled retired or resigned employee who is under age 65. The Board of Education will pay for each enrolled retired or resigned employee under age 65, 100% of the cost of the employee's enrolled dependents who are under age 65, and shall provide the same medical insurance coverage that would be provided by the Board of Education if the member were a regularly employed and active employee. This benefit section shall be for current employees as of 01.01.2010.

ARTICLE VII **LEAVE PROVISIONS**

Section 7.0 Sick Leave

Sick leave of twelve (12) days annually, not including absence covered by Workers' Compensation, cumulative to one hundred fifty (150) days, shall be granted to the members of the bargaining unit. Each employee shall be notified of his/her accumulated sick leave by letter annually.

Section 7.1

As outlined in the Connecticut Paid Sick Leave Policy, the first 40 hours of sick leave can be taken in one-hour increments. Sick leave may be used in the following cases.

- a. Personal illness or physical incapacity.
- b. Enforced quarantine of the employee in accordance with community health regulations.
- c. To meet dental or medical appointments or other sickness prevention measures, provided that it is not possible to arrange for a dental or medical appointment at a time other than when the employee is to be on duty. Except in emergency situations, the employee shall inform the Department Head in advance of the date and time of such appointment.
- d. Up to three (3) days per year for illness of physical incapacity of a member of the employee's household, after personal leave has been exhausted.
- e. For reasons outlines in the Connecticut Paid Sick Leave 31-57.

Section 7.2

A medical certificate acceptable to the Board may be required for any absence of five (5) consecutive working days or more or in the event of frequent or habitual absences as determined by the Executive Director of Human Resources.

Section 7.3 - Payment for Unused Sick Leave

- a. Upon retirement under the Town pension and retirement plan, an employee shall receive, on the basis of his /her current regular-time wage rate, payment for up to sixty (60) days of accrued sick leave. This provision shall not apply to employees hired by the Board after 01.01.2011.
- b. In the event of an employee's death, his/her spouse and/or minor children or estate shall receive, on the basis of the employee's current regular-time wage rate, payment for up to sixty (60) days of accrued sick leave.
- c. If an employee is at the maximum permitted accumulation of sick leave and does not use any sick leave in the calendar year (January through December), then the employee shall receive, in January of the year following the qualifying time period, an incentive payment of three hundred fifty dollars (\$350).

Section 7.4 - Union Leave

- a. The Union Executive Board members shall be allowed time off without loss of pay to conduct Union business up to a maximum of three (3) days per year. No more than two (2) employees may be on Union Leave at any one time.
- b. A maximum of one (1) Officer and/or Steward of the Union, designated by the Union, shall be afforded the necessary amount of time without loss of wages to adjust grievances actually filed.

Section 7.5 - Other Leave with Pay

Employees shall be granted leave with pay for the following reasons:

- a. Jury duty. Fees realized from jury service, however, must be turned over to the Board of Education.
- b. Any other appearance of the employee before a court or other public body to which the employee is legally summoned. Proof of required appearance will be provided as a condition of payment for the date(s) of absence.
- c. Participation in short term military training in Federal Reserve or National Guard. The difference between military pay, plus allowances and the employee's scheduled pay, shall be paid to the employee upon submission by the latter of a form certifying the amount of money which he/she has been paid during his/her period of absence, upon approval of the Superintendent or his/her designee, in his/her sole discretion.
- d. Participation in conferences or official meetings as approved by the Superintendent or his/her designee or the Operations Manager.
- e. Participation in education or training courses as approved by the Superintendent or his/her designee, which enhance the employee's value to the school system. In the event that the employee receives a scholarship or fellowship, his/her normal salary shall be reduced by that amount for the duration of the leave.

Section 7.6 - Personal Leave

Employees shall be granted five (5) personal days per year, non-cumulative. Personal Leave shall be granted for reasons such as, but not limited to;

1. Non-illness emergencies
2. Events which are beyond the employee's control
3. Graduations
4. Weddings
5. Business that cannot be conducted during non-work hours
6. Legal business

7. Holy Days
8. Bereavement
9. Illness of a family member

Generally, employees shall not be required to provide any additional information for personal leave other than the reason, or related to reason, listed above, but employees may be required to produce documentation when it is requested by the Superintendent or his/her designee.

ARTICLE VIII **GRIEVANCE PROCEDURE**

Section 8.0

Grievances arising out of matters covered by this Agreement and past practice will be processed in the following manner.

GRIEVANCE PROCEDURE

Section 8.1 - Purpose The purpose of the grievance procedure shall be to settle employee grievances on as low an administrative level as possible to insure efficiency and employee morale.

Section 8.2 - Definition A grievance for purposes of this procedure shall be considered to be an employee or Union complaint concerned with:

- A. Disciplinary action.
- B. Matters relating to the interpretation and application of the Articles and Sections in this Agreement.
- C. Interpretation and application of rules and regulations and policies of the Employer.

Section 8.3 -Procedure

- A. Any employee may use this grievance procedure with or without Union assistance, although the Union shall have the right to be present. Should an employee process a grievance through one or more of the steps provided herein prior to seeking Union aid, the Union may, at its discretion, process the grievance anew from the first step or from the next succeeding step following that which the employee has utilized.
- B. No grievance settlement made as a result of an individually processed grievance shall be in conflict With the Union.

STEP ONE - Any employee who has a grievance shall reduce the grievance to writing and submit it within thirty (30) calendar days to the Budget and Business Administrator, who shall use his/her best efforts to settle the dispute. The Budget and Business Administrator's decision

shall be submitted in writing to the aggrieved employee and the Union, within seven (7) calendar days of receipt of the grievance.

STEP TWO - If the complainant or the Union, are not satisfied with the decision rendered by the Budget and Business Administrator, the complainant or the Union shall submit the grievance in writing to the Deputy Superintendent within fifteen (15) working days. The Deputy Superintendent shall, within seven (7) working days of receipt of the grievance, submit their decision to the complainant and the Union.

STEP THREE - If the complainant or the Union are not satisfied with the decision rendered by the Deputy Superintendent, the Union shall submit the grievance, in writing, to the Connecticut State Board of Mediation & Arbitration (CSBMA) within thirty (30) calendar days with notice to the Board. If mutually agreed, the parties may submit the grievance to AAA in lieu of the CSBMA, unless the Board elects to have the grievance heard before AAA, in which case the Board shall assume all costs associated with AAA arbitration except for the Union's cost for their representative. Only the Union, not the individual grievant, can take a grievance to arbitration. For the purposes of this article, section 8.2.c. can only be processed to the step two level and can not be processed to arbitration.

The decision rendered by the arbitrator(s) shall be final and binding upon the parties. The arbitrator(s) shall not add to, delete from or modify this Agreement in any way. The arbitrator's decision shall be in writing and in accordance with the rules and regulations of the State Board of Mediation & Arbitration. The arbitrator(s) shall arbitrate only one grievance at a time unless grievances arise directly out of the same incident.

Section 8.4 - Meetings If either party related to the grievance process desires to meet for the purpose of an informal discussion, a meeting shall be requested and scheduled not later than ten (10) days after receipt of the request.

Section 8.5 - Union as a Complainant The Union shall be entitled to submit grievances in the name of the Union in the same manner as is provided herein for employees.

Section 8.6 - Time Extensions Time extensions beyond those stipulated in this grievance procedure may be arrived at by mutual agreement of the parties concerned.

Section 8.7- Representation Employees and the Union shall have the right and choice of Union representation whenever Union representation is desired by either individual employees or the Union. The Board shall not be allowed representation from within the bargaining unit.

Section 8.8 A grievance which arises as a result of disciplinary action taken by the Board may be filed in accordance with this Agreement at the step next above where such action was taken.

Section 8.9 Any disciplinary action or discharge may be grieved.

Section 8.10 Failure of the employer to respond within the required time frames will result in the grievance being resolved in favor of the grievant. If a grievance is not processed by the Union in accordance with the required time frames, it shall be deemed settled on the basis of the answer provided at the last step to which the grievance was processed.

ARTICLE IX
DISCIPLINE AND PERSONNEL FILE

Section 9.0

- a. No employee shall be disciplined, without just cause.
- b. All discipline must be in writing with reason given, and a copy of the discipline shall be given or mailed to the Employee and the Union within five (5) days of the discipline.
- c. Employees shall have the right to see and review their personnel file by prior appointment with the appropriate office. Employees may request that the Employer correct or amend material in the file. Failing mutual agreement, the employees shall have the right to respond in writing to all items in their personnel file. Such responses shall be made part of the file.

ARTICLE X
WAGES

Section 10.0

Employee wages shall be included in Appendix A.

Section 10.1

- Retroactive to July 1, 2026 step movement and steps 1-6 will receive a general wage increase of 3% and step 7 will receive a 3% general wage increase.
- Effective July 1, 2027 step movement and steps 1-6 will receive a general wage increase of 2.75% and step 7 will receive a 2.75% general wage increase.
- Effective July 1, 2028 step movement and steps 1-6 will receive a general wage increase of 3% and step 7 will receive a 3% general wage increase.
- Effective July 1, 2029 step movement and steps 1-6 will receive a general wage increase of 2.75% and step 7 will receive a 2.75% general wage increase.

The Conard manager will receive a \$9,000 stipend.

Employees not at top step, shall advance one (1) step on the wage scale on July 1 of each year.

Section 10.2 - Longevity Program

Employees shall receive the following longevity payments for their years of service with the West Hartford Public Schools;

5 to 9 years of service	\$625
10 to 14 years of service	\$825
15 to 19 years of service	\$1,000

20 to 24 years of service	\$1,075
25 or more years of service	\$1,175

Longevity payments shall be made by June 30th.

Section 10.3

When an employee takes normal retirement under the pension plan between anniversary dates, an employee who is eligible for longevity shall receive a pro-rated payment as follows:

- a. Less than three (3) months of service following the anniversary date -no payment.
- b. Three (3) months service but less than six (6) months service following the anniversary date - one quarter (1/4) payment.
- c. Six (6) months service but less than nine (9) months service following the anniversary date one half (1/2) payment.
- d. Nine (9) month's service but less than twelve (12) months' service following the anniversary date - three quarters (3/4) payment.

ARTICLE XI **PENSION**

Section 11.0

Employees who are eligible to participate in the Pension Plan and do participate in the Pension Plan shall contribute a percentage of their gross income as outlined in Section 11.2.

Section 11.1

The Board shall establish and maintain a 457k retirement savings plan for the members of the bargaining unit.

Section 11.2

For bargaining unit employees who are Part B members of the Pension Plan, Section 3012 of the Pension Ordinance shall be modified, effective July 1, 2004, to reflect the following:

Any member who is hired by the Board of Education on or after July 1, 2004 and shall have attained the age of 65 years and completed 15 years of credited service or attained the age of 62 years and completed 35 years of credited service shall be eligible for retirement from active service and for a normal unreduced retirement allowance.

Any member who is hired by the Board before July 1, 2004 and who retires on or after July 1, 2004 and who becomes eligible for a normal retirement attaining at least the age of 55 and having at least 25 years of credited service or by attaining at least the age of 60 and having at least 10 years of credited service, and does not retire shall earn the following annual pension supplement of reach full year beyond their normal retirement date:

<u>Years after Normal Retirement</u>	<u>Supplement Amount</u>
1	\$ 600
2	\$1,200
3	\$1,800
4	\$2,400
5	\$3,000
Each full year over 5	\$3,600

The above supplement will not be a survivor benefit. The supplement shall be made annually in a single payment during the month of July, starting the first of July after the employee's retirement date.

Effective July 1, 2026, employees who are eligible to participate in the Pension Plan (Part B) and do participate in the Pension Plan shall contribute 7 % of gross income. Effective July 1, 2027 employees who are eligible to participate in the Pension Plan (Part B) and do participate in the Pension Plan (Part B) shall contribute 7% of gross income. Effective July 1, 2028 employees who are eligible to participate in the Pension Plan (Part B) and do participate in the Pension Plan (Part B) shall contribute 7.25% of gross income. Effective July 1, 2029 employees who are eligible to participate in the Pension Plan (Part B) and do participate in the Pension Plan (Part B) shall contribute 7.25% of gross income.

Employees hired after July 1, 2014 will become members of a Hybrid Plan which will become part of the Town of West Hartford Pension Ordinance (Part E of amended Pension Ordinance). Summary of the plan is as follows:

Defined Benefit Pension Plan Design:

1. Member contributes 3% of base wages
2. Member is eligible for a retirement allowance payable during the member's lifetime of an annual amount equal to one percent (1%) of the member's final average compensation multiplied by the member's years of credited service up to a maximum of 35 years.

Defined Contribution Plan Design:

- Adopt a Defined Contribution Plan proposed by the Town with the matching employer contribution being 2.25% of base salary and employee contribution being 2.25%.

ARTICLE XII **MANAGEMENT RIGHTS**

Except where such rights, powers and authority are specifically relinquished, abridged or limited by the provisions of this Agreement, the Board has and will continue to retain, whether exercised or not, all of the rights, powers and authority heretofore had by it and except where such rights,

powers and authority are specifically relinquished, abridged or limited by the provisions of this Agreement, it shall have the sole and unquestioned right, responsibility and prerogative of management of the affairs of the Board and direction of the working forces, including but not limited to the following:

- a. To determine the care, maintenance and operation of equipment and property used for and on behalf of the purposes of the Board;
- b. To establish or continue policies, practices and procedures for the conduct of Board business and, from time to time, to change or abolish such policies, practices or procedures;
- c. To select and to determine the number of types of employees required to perform the Board's operations;

To employ, transfer, promote or demote employees, or to layoff, discipline, suspend, terminate, or otherwise relieve employees from duty for lack of work or other legitimate reasons;

- d. To prescribe and enforce reasonable rules and regulations provided such rules and regulations are made known to employees affected by them, including but not limited to prescribing rules for the maintenance of discipline and for the performance of work in accordance with the requirements of the Board;
- e. To create job specifications and revise existing job specifications as deemed necessary and to ensure that related duties connected with departmental operations, whether enumerated in job descriptions or not, shall be performed by employees provided that, upon request, the Board agrees to negotiate with the Union regarding any significant impact which any such change may have on employee's wages, hours or other terms of employment;
- f. To take any action which the Board reasonably believes is necessary to comply with any legal requirement.

ARTICLE XIII

GENERAL PROVISIONS

Section 13.0 The Board shall distribute signed copies of the Agreement as follows:

- a. Six (6) copies to the Union upon the signing of the Agreement.
- b. A copy to each employee within thirty (30) days after the signing of this contract.
- c. A copy to each new employee within thirty (30) days after the date on which he/she has been hired.

Section 13.1

Any employee required to use his/her personal vehicle in connection with his/her work assignment will be reimbursed for the mileage involved at the prevailing IRS rate.

Section 13.2

The Union and the Employer agree not to violate any Federal and State Laws or Statutes. The provisions of this section shall not be the subject to the grievance procedure.

Section 13.3

The Employer and the Union shall continue their practice of non-discrimination with respect to race, religion, sex, sexual orientation, age, national origin, marital status, disability, or membership in or participation in the activities of any employee organization. The provisions of this section shall not be the subject to the grievance procedure.

Section 13.4

Upon request, the employee shall receive an updated list of all leave (Vacation, Personal, Sick, Holiday) which the employee has available including leave which as been accrued or earned and not yet utilized. This list shall include the previous anniversary dates numbers, leave used throughout the year and the updated, current year leave availability.

Section 13.5

The Union shall establish a committee which shall meet with the Operations Manager quarterly to review and recommend safety and health conditions in all Nutrition Services departments and work areas.

Section 13.6

The Board agrees to hold harmless and indemnify all employees acting in official capacity of the Board or the Food Service.

Section 13.7

The annual shoe allowance shall be two hundred dollars (\$200) per employee. Appropriate shoes must be purchased by the employee and worn at all times at work.

ARTICLE XIV
DURATION

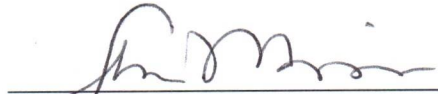
Section 14.0

This Agreement shall be effective July 1, 2026, and shall remain in effect until June 30, 2030.

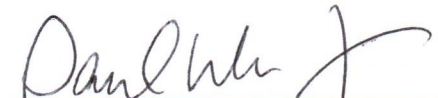
This contract shall be automatically renewed and be in full force and effect from year to year after July 1, 2030 unless either party shall notify the other in writing no later than March 1, 2030 of its intent for renewal or modification with the objective of completing negotiations by July 1, 2030, insofar as that may be practicable.

IN WITNESS WHEREOF the parties have set their hands this 23rd day of ~~June~~^{September}, 2026.

FOR THE EMPLOYER

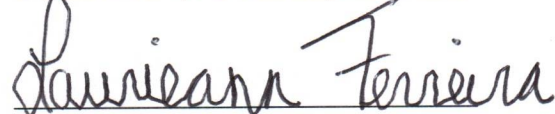


SIGNED: Chairman
Board of Education

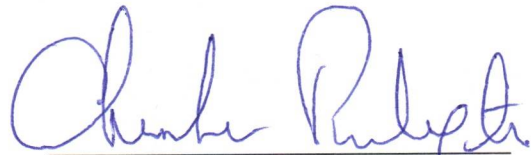


SIGNED: Superintendent

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



SIGNED: Laurieann Ferreira
President Local 818

 9/23/26

SIGNED: Staff Representative
Council 4, AFSCME

Appendix A (Wages)

Cafeteria Managers 2026 - 2030

B/Caft Mgr - Conard		1552 Hours worked per year				Position # 8009		
Effective	%	CF2						
Date	Increase	1	2	3	4	5	6	7
07/01/26	3.0%	26.92	27.73	28.57	29.42	30.28	31.25	32.69
		41,783.62	43,036.43	44,342.16	45,665.55	46,988.93	48,506.41	50,737.25
07/01/27	2.75%	27.66	28.49	29.36	30.23	31.11	32.11	33.59
		42,932.67	44,219.93	45,561.57	46,921.35	48,281.13	49,840.34	52,132.53
07/01/28	3.00%	28.49	29.35	30.24	31.14	32.04	33.08	34.60
		44,220.65	45,546.53	46,928.42	48,328.99	49,729.56	51,335.55	53,696.5
07/01/29	2.75%	29.28	30.15	31.07	32.00	32.92	33.99	35.55
		45,436.72	46,799.06	48,218.95	49,658.04	51,097.12	52,747.28	55,173.16

B/Caft Mgr - Hall		1455 Hours worked per year				Position # 8009		
Effective Date	%	CM1			CM2		CM3	
	Increase	1	2	3	4	5	6	7
07/01/26	3.00%	26.92	27.73	28.57	29.42	30.28	31.25	32.69
		39,172.15	40,346.65	41,570.78	42,811.45	44,052.12	45,474.76	47,566.17
07/01/27	2.75%	27.66	28.49	29.36	30.23	31.11	32.11	33.59
		40,249.38	41,456.18	42,713.98	43,988.77	45,263.56	46,725.32	48,874.24
07/01/28	3.00%	28.49	29.35	30.24	31.14	32.04	33.08	34.60
		41,456.86	42,699.87	43,995.4	45,308.43	46,621.46	48,127.08	50,340.47
07/01/29	2.75%	29.28	30.15	31.07	32.00	32.92	33.99	35.55
		42,596.93	43,874.11	45,205.27	46,554.41	47,903.55	49,450.57	51,724.83

B/Caft Mgr -ES/MS		1462.5 Hours worked per year				Position # 8008		
Effective Date	%	CM4		CM8		CM5		CM6
	Increase	1	2	3	4	5	6	7
07/01/26	3.00%	26.92	27.73	28.57	29.42	30.28	31.25	32.69
		39,374.07	40,554.63	41,785.07	43,032.13	44,279.20	45,709.17	47,811.36
07/01/27	2.75%	27.66	28.49	29.36	30.23	31.11	32.11	33.59
		40,456.85	41,669.88	42,934.16	44,215.51	45,496.88	46,966.17	49,126.17
07/01/28	3.00%	28.49	29.35	30.24	31.14	32.04	33.08	34.60
		41,670.56	42,919.98	44,222.18	45,541.98	46,861.79	48,375.16	50,599.96
07/01/29	2.75%	29.28	30.15	31.07	32.00	32.92	33.99	35.55
		42,816.5	44,100.28	45,438.29	46,794.38	48,150.49	49,705.48	51,991.46

*Work year does not reflect any additional hours required for additional professional training on days school is not in session (excludes days immediately before or after school days, which are included in standard year), or Juneteenth, when applicable per Article V, Section 5. In those scenarios additional pay would be remitted consistent with employee's rate.

CONNECTICUT PARTNERSHIP PLAN



A Great Opportunity for Very Valuable Healthcare Coverage

Welcome to the Connecticut (CT) Partnership Plan—a low-/no-deductible Point of Service (POS) plan now available to you (and your eligible dependents up to age 26) and other non-state public employees who work for municipalities, boards of education, quasi-public agencies, and public libraries.

The CT Partnership Plan is the same Expanded Access plan currently offered to State of Connecticut employees. You get the same great healthcare benefits that state employees get, including \$15 in-network office visits (average actual cost in CT: \$150*), free preventive care, and \$5 or \$10 generic drug copays for your maintenance drugs. You can see any provider (e.g., doctors, hospitals, other medical facilities) you want—in- or out-of network. But, when you see in-network providers, you pay less. That's because they contract with Anthem Blue Cross and Blue Shield (Anthem)—the plan's administrator—to charge lower rates for their services. You have access to Anthem's State Bluecare POS network in Connecticut, and access to doctors and hospitals across the country through the BlueCard® program.

When you join the CT Partnership Plan, the state's Health Enhancement Program (HEP) is included. HEP encourages you to get preventive care screenings, routine wellness visits, and chronic disease education and counseling. When you remain compliant with the specific HEP requirements on page 6, you get to keep the financial incentives of the HEP program!

Look inside for a summary of medical benefits, and or visit carecompass.ct.gov/ctpartner.

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
Preventive Care (including adult and well-child exams and immunizations, routine gynecologist visits, mammograms, colonoscopy)	\$0	20% of allowable UCR* charges
Annual Deductible (amount you pay before the Plan starts paying benefits)	Individual: \$350 Family: \$350 per member (\$1,400 maximum) <i>Waived for HEP-compliant members</i>	Individual: \$300 Family: \$900
Coinsurance (the percentage of a covered expense you pay after you meet the Plan's annual deductible)	Not applicable	20% of allowable UCR* charges
Annual Out-of-Pocket Maximum (amount you pay before the Plan pays 100% of allowable/UCR* charges)	Individual: \$2,000 Family: 4,000	Individual: \$2,300 (includes deductible) Family: \$4,900 (includes deductible)
Primary Care Office Visits	\$15 copay (\$0 copay for Preferred Providers)	20% of allowable UCR* charges
Specialist Office Visits	\$15 copay (\$0 copay for Preferred Providers)	20% of allowable UCR* charges
Urgent Care & Walk-In Center Visits	\$15 copay	20% of allowable UCR* charges
Acupuncture (20 visits per year)	\$15 copay	20% of allowable UCR* charges
Chiropractic Care	\$0 copay	20% of allowable UCR* charges
Diagnostic Labs	\$0 copay (your doctor will need to get prior authorization for high-cost testing)	20% of allowable UCR* charges (you will need to get prior authorization for high-cost testing)
Durable Medical Equipment	\$0 (your doctor may need to get prior authorization)	20% of allowable UCR* charges (you may need to get prior authorization)

¹ IN NETWORK: Within your carrier's immediate service area, no co-pay for preferred facility. 20% cost share at non-preferred facility.
Outside your carrier's immediate service area: no co-pay.

¹ OUT OF NETWORK: Within your carrier's immediate service area, deductible plus 40% coinsurance.
Outside of carrier's immediate service area: deductible plus 20% coinsurance.

(continued on next page)

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Care	\$250 copay (waived if admitted)	\$250 copay (waived if admitted)
Eye Exam (one per year)	\$15 copay	50% of allowable UCR* charges
**Infertility (based on medical necessity)		
Office Visit	\$15 copay	20% of allowable UCR* charges
Outpatient or Inpatient Hospital Care	\$0	20% of allowable UCR* charges
**Inpatient Hospital Stay	\$0	20% of allowable UCR* charges
Mental Healthcare/Substance Abuse Treatment	\$0	20% of allowable UCR* charges (you may need to get prior authorization)
**Inpatient		
Outpatient	\$15 copay	20% of allowable UCR* charges
Nutritional Counseling (Maximum of 3 visits per Covered Person per Calendar Year)	\$0	20% of allowable UCR* charges
**Outpatient Surgery	\$0	20% of allowable UCR* charges
**Physical/Occupational Therapy	\$0	20% of allowable UCR* charges, up to 60 inpatient days and 30 outpatient days per condition per year
Foot Orthotics	\$0 (your doctor may need to get prior authorization)	20% of allowable UCR* charges (you may need to get prior authorization)
Speech therapy: Covered for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx	\$0	Deductible plus Coinsurance (30 visits per Calendar Year)
Medically necessary treatment resulting from other causes is subject to Prior Authorization	\$0 (30 visits per Covered Person per Calendar Year)	Deductible plus Coinsurance (30 visits per Calendar Year)

*Usual, Customary and Reasonable. You pay 20% coinsurance based on UCR, plus you pay 100% of amount provider bills you over UCR.

** Prior authorization required: If you use in-network providers, your provider is responsible for obtaining prior authorization from Anthem. If you use out-of-network providers, you are responsible for obtaining prior authorization from Anthem.

When you need information about your benefits...

CareCompass.CT.gov is your one-stop shop for benefits and general information on your coverage. Click Partnership to view medical, dental, pharmacy and vision benefit information.

- Access your personalized benefits portal at **carecompass.quantum-health.com**, or by clicking Sign In on the Care Compass home page
- To view forms, visit **CareCompass.CT.gov/forms**, or click the Forms button at the bottom of the Care Compass home page.

When you need benefits support...

You and any enrolled dependents can speak with a personal **Care Coordinator** (833-740-3258) for help understanding your benefits, finding a doctor, and dealing with the complexities of health care. Quantum Health makes it easier for you to navigate your benefits and access the right care for you by coordinating with your medical, pharmacy, and dental member service teams. Chat with a Care Coordinator 8:30 a.m. – 10 p.m., Monday – Friday, at 833-740-3258, or send a message through your secure portal.

When Seeking Mental Health Support...

It's important to care for your mental and emotional health and your plan makes it easy to find providers and resources. Your benefits include coverage for mental health coaching, therapy, substance use treatment, and addiction recovery. Learn more at

CareCompass.ct.gov/mental-health.

When you need to find the best provider or to find a location for a routine lab test...

Visit your Quantum Health benefits portal, select **Provider Search**. You pay nothing—\$0 copay—for lab tests, if you visit a preferred Site of Service provider. To find a Site of Service provider, visit your personalized benefits portal at **CareCompass.quantum-health.com**.

If you select a provider designated as a “Provider of Distinction”, you will **earn a gift card**. Note: The amount of the reward varies by procedure or condition. To view a full list of procedures and incentives, visit **CareCompass.CT.gov/providersofdistinction**.

When you're injured...

Your health plan has resources to help you through orthopedic injuries, from diagnosis to minor aches and pains, to surgery and recovery.

Get help diagnosing minor or lingering injuries through a virtual visit. Your provider will help create a rehab program you can do at home.

For surgical procedures, find the best providers for the care you need. Learn more at **CareCompass. CT.gov/orthopedics**.

Need to Manage or Want to Reverse Diabetes...

Get help managing Type 1 or Type 2 Diabetes with Virta Health. Members are connected and supported with access to a diabetes health coach and receive free testing supplies and tips to manage their A1c. In the diabetes reversal program, where members with Type 2 Diabetes can learn to eat their way to better health with personalized nutrition plans and support from medical providers, professional coaches, and digital health tools.

Need Help Preventing Diabetes...

If you have prediabetes, the digital Diabetes Prevention Program can help you prevent diabetes by focusing on lifestyle changes. This is a 12-month group participation program with health coaches and nurses to help you build healthier habits to prevent the onset of diabetes.

To learn more about these programs, visit **CareCompass.CT.gov/diabetes**.

Want to Learn About Well-being...

30-minute health seminars led by health professionals include ways to manage stress, quit smoking, boost immunity, choose healthy foods, practice meditation, chair exercises, and more. You can also meet your **HEP Chronic Condition education** requirement by attending the corresponding “Basics” seminar.

To see the upcoming schedule, visit **CareCompass.CT.gov/healthy-living**, and click “Wellbeing Seminars”

Prescription Drugs	Maintenance* (31-to-90-day supply)	Non-Maintenance (up to 30-day supply)	HEP Chronic Conditions
Generic (preferred/non-preferred)**	\$5/\$10	\$5/\$10	\$0
Preferred/Listed Brand Name Drugs	\$25	\$25	\$5
Non-Preferred/Non-Listed Brand Name Drugs	\$40	\$40	\$12.50
Annual Out-of-Pocket Maximum	\$4,600 Individual/\$9,200 Family		

+ Initial 30-day supply at retail pharmacy is permitted. Thereafter, 90-day supply is required—through mail-order or at a retail pharmacy participating in the State of Connecticut Maintenance Drug Network.

++ Prescriptions are filled automatically with a generic drug if one is available, unless the prescribing physician submits a Coverage Exception Request attesting that the brand name drug is medically necessary.

Preferred and Non-Preferred Brand-Name Drugs

A drug's tier placement is determined by Caremark's Pharmacy and Therapeutics Committee, which reviews tier placement each quarter. If new generics have become available, new clinical studies have been released, new brand-name drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

If your doctor believes a non-preferred brand-name drug is medically necessary for you, they will need to complete the Coverage Exception Request form (available at www.osc.ct.gov/ctpartner) and fax it to Caremark. If approved, you will pay the preferred brand co-pay amount.

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It

is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) If you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug.

Mandatory 90-day Supply for Maintenance Medications

If you or your family member takes a maintenance medication, you are required to get your maintenance prescriptions as 90-day fills. You will be able to get your first 30-day fill of that medication at any participating pharmacy. After that your two choices are:

- Receive your medication through the Caremark mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the State's Maintenance Drug Network (see the list of participating pharmacies on www.osc.ct.gov/ctpartner) and scroll down to Pharmacy under Benefit Summaries.)

The Health Enhancement Program (HEP) is a component of the medical plan and has several important benefits. First, it helps you and your family work with your medical providers to get and stay healthy. Second, it saves you money on your healthcare. Third, it will save money for the Partnership Plan long term by focusing healthcare dollars on prevention.

Health Enhancement Program Requirements

You and your enrolled family members must get age-appropriate wellness exams, early diagnosis screenings (such as colorectal cancer screenings, Pap tests, and mammograms). **Here are the HEP Requirements:**

PREVENTIVE SCREENINGS	Dependent Requirements	Employee and Spouse Requirements				
	6-25 years	18-29 years	30-39 years	40-49 years	50-64 years	65+ years
Preventive Visit		Every 2 years				
Dental Cleaning	At least 1 per year	At least 1 per year				
Cholesterol Screening		Every 5 years (age 20+)				
Breast Cancer Screening (for women)		N/A		Mammogram every 2 years to age 75		
Cervical Cancer Screening (for women)		Pap every 3 years (age 21+)	Pap only every 3 years or Pap/HPV combo every 5 years			N/A
Colorectal Cancer Screening		N/A		Colonoscopy every 10 years (45+), Cologuard screening every 3 years, or Annual FIT/FOBT to age 75		

To check your Health Enhancement Program compliance status, visit [CareCompass.CT.gov](https://carecompass.ct.gov), then [sign in](#) or [register](#) for your Quantum Health benefits portal. To view your status, click the [My Health](#) tab in your portal.

You can also download the MyQHealth app on the App Store or Google Play.

Additional Requirements for Those With Certain Conditions

If you or any enrolled family member has 1) Diabetes (Type 1 or 2), 2) asthma or COPD, 3) heart disease/heart failure, 4) hyperlipidemia (high cholesterol), or 5) hypertension (high blood pressure), you and/or that family member will be required to participate in a disease education and counseling program for that particular condition. You will receive free office visits and reduced pharmacy copays for treatments related to your condition.

These particular conditions are targeted because they account for a large part of our total healthcare costs and have been shown to respond particularly well to education and counseling programs. By participating in these programs, affected employees and family members will be given additional resources to improve their health.

If You Do Not Comply with the requirements of HEP

If you or any enrolled dependent becomes non-compliant in HEP, your premiums will be \$100 per month higher and you will have an annual \$350 per individual (\$1,400 per family) in-network medical deductible.

Quantum Health is the administrator for the Health Enhancement Program (HEP) and gives you access to your personalized health benefits portal. The HEP participant portal features tips and tools to help you manage your health and your HEP requirements. Login to your personal benefit portal at carecompass.quantum-health.com to:

- View HEP preventive and chronic requirements and download HEP forms
- Check your HEP preventive and chronic compliance status
- Complete your chronic condition education and counseling compliance requirement
- Send a secure message to a Care Coordinator for benefits assistance
- Connect you to your medical, pharmacy, dental and other healthcare services covered in your plan- with just one login.

Quantum Health: (833)740-3258, 8:30 a.m.-10 p.m. ET, Mon.-Fri.

Care Compass is your hub for your health benefits: CareCompass.CT.gov/ctpartner

General benefit questions, Medical, and Health Enhancement Program (HEP)

Quantum Health- Care Coordinators

CareCompass.CT.gov/ctpartner or login to your benefits portal from Care Compass

833-740-3258

Prescription drug benefits

CVS Caremark

CareCompass.CT.gov/ctpartner/pharmacy or login to your benefits portal from Care Compass

1-800-318-2572

Dental and Vision Rider benefits (if applicable)

Cigna

CareCompass.CT.gov/ctpartner/dental

CareCompass.CT.gov/ctpartner/vision

or login to your benefits portal from Care Compass

1-800-244-6224

Office of the State Comptroller, Healthcare Policy & Benefit Services Division

www.osc.ct.gov/ctpartner

860-702-3560

For details about specific plan benefits and network providers, contact the insurance carrier. If you have questions about eligibility, enrolling in the plans or payroll deductions, contact your Payroll/Human Resources office.

Cigna Dental Benefit Summary
West Hartford Public Schools - Preferred
Plan Renewal Date: 07/01/2026



Insured by: Cigna Health and Life Insurance Company

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

DPPO				
Network Options	In-Network: State of Connecticut Network		Non-Network: See Non-Network Reimbursement	
Reimbursement Levels	Based on Contracted Fees		Maximum Allowable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II & III expenses	Unlimited		\$500	
Calendar Year Deductible Individual Family	\$0 \$0		\$100 \$300	
Benefit Highlights	Plan Pays	You Pay	Plan Pays	You Pay
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Space Maintainers: non-orthodontic Emergency Care to Relieve Pain (Note: This service is administered at the in-network coinsurance level.)	100% No Deductible	No Charge	50% No Deductible	50% No Deductible
Class II: Basic Restorative Sealants: per tooth Restorative: fillings (Includes composite (white/tooth-colored) fillings on molars.) Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments	80% No Deductible	20% No Deductible	50% After Deductible	50% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures	60% No Deductible	40% No Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Employee and All Dependents Lifetime Benefits Maximum: \$3,000	50% No Deductible	50% No Deductible	Not Covered	Not Covered

Benefit Plan Provisions:	
<i>In-Network Reimbursement</i>	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
<i>Non-Network Reimbursement</i>	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Allowable Charge. The dentist may balance bill up to their usual fees.
<i>Cross Accumulation</i>	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
<i>Calendar Year Benefits Maximum</i>	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
<i>Calendar Year Deductible</i>	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
<i>Late Entrant Limitation Provision</i>	No coverage outside of the designated open enrollment period. This provision does not apply to new hires.
<i>Pretreatment Review</i>	Pretreatment review is available on a voluntary basis when dental work in excess of \$200 is proposed.
<i>Alternate Benefit Provision</i>	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. This provision does not apply to composite (white/tooth-colored) fillings on molars.
<i>Oral Health Integration Program*</i>	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
<i>Timely Filing</i>	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 16.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Crowns, Bridges, Dentures and Partial	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Benefit Exclusions:	
Covered Expenses will not include, and no payment will be made for the following:	
• Procedures and services not included in the list of covered dental expenses; • Diagnostic: cone beam imaging; • Preventive Services: instruction for plaque control, oral hygiene and diet; • Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; • Periodontics: bite registrations; splinting; • Prosthodontic: precision or semi-precision attachments; • Implants: implants or implant related services; • Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;	

- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Allowable Charge.

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

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

A copy of the NH Dental Outline of Coverage is available and can be downloaded at [Health Insurance & Medical Forms for Customers | Cigna under Dental Forms](#).

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

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Cigna Dental Benefit Summary

West Hartford Public Schools - Premier

Plan Renewal Date: 07/01/2026



Insured by: Cigna Health and Life Insurance Company

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

DPPO

<i>Network Options</i>	<i>In-Network: State of Connecticut Network</i>		<i>Non-Network: See Non-Network Reimbursement</i>	
Reimbursement Levels	Based on Contracted Fees		Based on Billed Charge	
Calendar Year Benefits Maximum Applies to: Class I, II, III & V expenses	\$1,500		\$1,500	
Calendar Year Deductible Individual Family	\$50 \$150		\$50 \$150	
Benefit Highlights	Plan Pays	You Pay	Plan Pays	You Pay
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain (Note: This service is administered at the in-network coinsurance level.)	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings (Includes composite (white/tooth-colored) fillings on molars.) Endodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments	100% After Deductible	0% After Deductible	100% After Deductible	0% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Employee and All Dependents Lifetime Benefits Maximum: \$600	60% No Deductible	40% No Deductible	60% No Deductible	40% No Deductible
Class V: TMJ Occlusal orthotic device and adjustment	60% After Deductible	40% After Deductible	60% After Deductible	40% After Deductible
Class VI: Periodontics Periodontics: minor and major Calendar Year Maximum: \$500	100% After Deductible	0% After Deductible	100% After Deductible	0% After Deductible

Benefit Plan Provisions:	
<i>In-Network Reimbursement</i>	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
<i>Non-Network Reimbursement</i>	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Billed Charge.
<i>Cross Accumulation</i>	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
<i>Calendar Year Benefits Maximum</i>	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
<i>Calendar Year Deductible</i>	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
<i>Late Entrant Limitation Provision</i>	No coverage outside of the designated open enrollment period. This provision does not apply to new hires.
<i>Pretreatment Review</i>	Pretreatment review is available on a voluntary basis when dental work in excess of \$200 is proposed.
<i>Alternate Benefit Provision</i>	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. This provision does not apply to composite (white/tooth-colored) fillings on molars.
<i>Oral Health Integration Program*</i>	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
<i>Timely Filing</i>	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 16.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Crowns, Bridges, Dentures and Partial	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
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- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Billed Charge.

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State of Connecticut Partnership Plan 2.0 - Vision

Effective Dates: July 01, 2025 – June 30, 2026

This is a summary of benefits for your vision plan.

Cigna Vision Benefits		
Benefit	In-Network	Out-of-Network
Materials Copay	\$0	N/A
Single Vision Lenses	Covered in Full	\$40 Allowance
Bifocal Lenses	Covered in Full	\$65 Allowance
Trifocal Lenses	Covered in Full	\$75 Allowance
Lenticular Lenses	Covered in Full	\$100 Allowance
Contact Lenses (Retail Allowance)		
Elective	\$360 Allowance	\$345 Allowance
Therapeutic	Covered in Full	\$345 Allowance
Frame (Retail Allowance)	\$175 Allowance	\$126 Allowance

Frequency is 12 months for lenses, contact lenses, and frames.

In-Network Benefits Include:

One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)

Lens Options:

Standard Polycarbonate: covered for under 18 years of age; min. 20% save, \$40 out-of-pocket max. for adults

Oversize lenses: covered under plan

Rose Tints: #1 and #2 - covered under plan

Solid Tints: min. 20% save, \$15 out-of-pocket max.

Gradient Tints: \$20 out-of-pocket max.

Standard photochromic: 20% save, \$78 out-of-pocket max.

Standard anti-reflective coating: min. 20% save, \$45 out-of-pocket max.

Standard scratch/UV coating: min. 20% save, \$17 out-of-pocket max.

Progressive lenses: covered up to bifocal lens amount with 20% savings on the difference;

\$81 out-of-pocket max. for standard lens

One frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance.

One pair or a single purchase supply of contact lenses - in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation), and contact lens materials.

Vision Network Savings Program:

Minimum 20% savings on additional purchases of frames and/or lenses, including lens options, with a valid prescription; offered savings does not apply to contact lens materials. Check with your Cigna Vision Network Provider for details.

To Locate a Provider:

1. www.cigna.com Online Provider Directory:

Click on “**Find a Doctor**” at the top of the page.

Choose the “**Eye Doctor**” radio button and enter your search criteria.

2. www.myCigna.com: You can search for a provider by name, specialty or location after you enroll for coverage and your plan has taken effect.



HEALTH ENHANCEMENT PROGRAM (HEP)

BY THE STATE OF CONNECTICUT. ADMINISTERED BY QUANTUM HEALTH.

FREQUENTLY ASKED QUESTIONS

Q: What is HEP?

A: The Health Enhancement Program (HEP) encourages employees and their enrolled family members to take charge of their health and their health care. The preventive care and chronic care management requirements are based on the U.S. Preventive Taskforce guidelines. When you (or your dependents) complete all HEP age-related screenings and chronic condition education (if required), your premiums remain unchanged. If you do not complete your household's HEP requirements each year, you will incur a \$1,400 in-network deductible and your premiums will increase by \$100 per month.

Q: What are the requirements?

A: There are two parts to HEP: Age/gender-appropriate preventive requirements and if applicable, chronic condition education requirements. All HEP requirements below, including those taking effect in 2025, align with the latest U.S. Preventive Services Task Force recommendations.

PREVENTIVE REQUIREMENTS

The requirements are based on your age as of January 1 each year. As Quantum Health receives your claims, your preventive care will be marked complete in your online account.

PREVENTIVE SCREENINGS	Dependent Requirements	Employee and Spouse Requirements				
	6-25 years	18-29 years	30-39 years	40-49 years	50-64 years	65+ years
Preventive Visit		Every 2 years				
Dental Cleaning	At least 1 per year	At least 1 per year				
Cholesterol Screening		Every 5 years (age 20+)				
Breast Cancer Screening (for women)		N/A		Mammogram every 2 years to age 75		
Cervical Cancer Screening (for women)		Pap every 3 years (age 21+)	Pap only every 3 years or Pap/HPV combo every 5 years			N/A
Colorectal Cancer Screening		N/A		Colonoscopy every 10 years (45+), Cologuard screening every 3 years, or Annual FIT/FOBT to age 75		

HEALTH ENHANCEMENT PROGRAM (HEP)

BY THE STATE OF CONNECTICUT. ADMINISTERED BY QUANTUM HEALTH.

CHRONIC CONDITION REQUIREMENTS

If you have one of the following chronic conditions, you must complete additional steps to stay in compliance with the program.

- Diabetes (type 1 or 2)
- Asthma or COPD
- Heart disease/heart failure
- Hyperlipidemia (high cholesterol)
- Hypertension (high blood pressure)

If you have one of the designated chronic conditions, you must **complete ONLY one of the following** requirements for each condition:

- Read a fact sheet, linked in your Quantum Health account on the **My Health** tab.
- Attend an approved [HEP Monthly Basic Seminar](#) specific to your condition and confirm completion in your Quantum Health account on the **My Health** tab.
- Speak with a Quantum Health Nurse Care Coordinator by calling (833) 740-3258.

Please note that this is an annual requirement due by December 31st along with your preventive requirements.

Q: When does the program start?

A: The program runs on a calendar year basis so each year on January 1 a new compliance year begins. Your requirements for the year are based on your age on that day. So, if you are 49 on January 1, you are held to the requirements for a 49-year-old, even though you turn 50 in that calendar year.

Q: How can I track my progress toward my requirements?

A: To check your status or update your compliance, go to carecompass.quantum-health.com to register or log in to your Quantum Health account and then click on the My Health tab. Anyone on your plan over the age of 18 must log in to their own Quantum Health account to view their HEP status. Your dependents may grant permission for you to view their HEP status by going to **Privacy Settings** and clicking the **Privacy Authorization** tab. Once there, scroll down to **Wellness/Prevention** to select who can view your HEP requirements.

Q: A service is required less frequently than every year – every 2,3,4,5,7 and even 10 years. Do I have that long to complete it?

A: Quantum Health looks back at the claims for the appropriate number of years to see if the requirement has been completed. Requirements are measured using the current compliance year.

HEALTH ENHANCEMENT PROGRAM (HEP)

BY THE STATE OF CONNECTICUT. ADMINISTERED BY QUANTUM HEALTH.

Q: I had a service that I needed before this insurance went into effect. Do I have to do it again?

A: No, you do not. You may log in to carecompass.quantum-health.com and complete a self-entry for the specific activity by selecting **My Health**, then clicking **HEP Requirements**, and then scrolling to find the self-entry option for the requirement you had completed before this insurance went into effect.

Q: I can't do one or more of the HEP requirements due to medical reasons.

A: Have your doctor fill out a Medical Exemption form indicating that you should be exempt from the service. The medical exemption form can be found by logging into carecompass.quantum-health.com, selecting the **My Health** tab, and then selecting **Medical Exemption Form**. Be sure they indicate whether a permanent exemption is needed. When Quantum Health receives the form, they provide credit for the requirement. Directions for form submissions may be found at the top of the Medical Exemption Form.

Q: I can't do one or more of the HEP requirements due to changes in anatomy and the way I identify.

A: Have your doctor fill out a Medical Exemption Form indicating that you should be exempt from the service. The Medical Exemption Form can be found by logging into carecompass.quantum-health.com, selecting the **My Health** tab, and then selecting **Medical Exemption Form**. Be sure they indicate whether a permanent exemption is needed. If the exemption is approved, Quantum Health will provide credit for the requirement. In addition, you may also update your preferred pronouns by logging into carecompass.quantum-health.com, selecting **Profile Settings**, and then scrolling down to **Preferred Pronouns** to select an option in the drop-down.

Q: I can't do one or more of the requirements due to non-medical reasons.

A: Complete the Non-Medical Exemption Form indicating which requirement(s) you are requesting an exemption for. The Non-Medical Exemption Form can be found by logging into carecompass.quantum-health.com, selecting the **My Health** tab, and then selecting **Non-Medical Exemption Form**. Directions for form submissions may be found at the top of the Non-Medical Exemption.

Q: I completed my HEP requirements. Why am I still showing as being non-compliant with a requirement?

A: Quantum Health receives claims after they are processed by your insurance carrier. If a couple of months have passed and the portal continues to reflect that you're non-compliant for a screening that you have already completed, you may complete the self-entry for that activity. If the self-entry feature is not yet available, please call your Care Coordinators for further assistance at (833) 740 – 3258.

Q: Do I still have to complete the self-entry activity if I am showing as compliant via a claim?

A: No, if there is a green check mark next to the activity due to a claim being received, you do not have to complete the self-entry option.

HEALTH ENHANCEMENT PROGRAM (HEP)

BY THE STATE OF CONNECTICUT. ADMINISTERED BY QUANTUM HEALTH.

Q: Does my child have to be compliant? He/she will be turning 26 and coming off my health plan before the end of the year.

A: Dependents who are aging off the plan at the end of the calendar year will no longer be evaluated for HEP compliance.

Q: My spouse is a state retiree on Medicare and doesn't have to comply with HEP. Do I still need to meet the requirements?

A: If you are under 65 and a dependent of a retiree in the Medicare Advantage plan whose retirement date was (Oct. 2, 2011, or later), you are required to meet the HEP requirements and must be compliant with the requirements to receive the financial benefits of the program.

Q: I am a new employee – do I have to be compliant with HEP this year? Or, I just added a dependent – do they have to be compliant with HEP this year?

A: HEP compliance is measured once you are in the program for a full calendar year. For example, if the effective date of your insurance is Jan. 1, 2024, you must be compliant by Dec. 31, 2024. If the effective date of your insurance is July 1, 2024, you must be compliant by Dec. 31, 2025.

Q: If I'm out of compliance and being penalized, will I automatically be reinstated once I complete the requirement?

A: Yes, once Quantum Health receives the processed claim of the missing requirement, you will be automatically reinstated. If you've completed a requirement, but Quantum Health has not yet received a claim, you may complete the self-entry for the missing requirement. You will be reinstated on the first day of the month following receipt of a claim or self-entry. Please note that self-entries are subject to random audit if a claim has not been received after 60 days of the self-entry.

Q: Can I complete a self-entry for my dependent(s) under the age of 18?

A: If you have a dependent who is under the age of 18 and wish to self-report a completed screening, please contact your Care Coordinators at (833) 740-3258 for assistance.

Q: Can I still get a physical every year and will it be covered?

A: Yes, even though HEP does not require a preventive visit every year, one preventive visit is covered 100% by the State of Connecticut health plan per calendar year. An office visit for illness is not considered a preventive visit and does require a copay.

Q: My provider's office is telling me that my insurance won't cover me if I schedule my next physical (preventive visit) under the 365-day rule. Is this True?

A: NO- this is not true. The State of Connecticut plan is unique in that you can schedule your preventive visit in less than 365 days from your previous preventive visit if they fall on different calendar years. For example, if you have your preventive visit in December of one year, then schedule a new physical in March of the next calendar year, both will be 100% covered.

HEALTH ENHANCEMENT PROGRAM (HEP)

BY THE STATE OF CONNECTICUT. ADMINISTERED BY QUANTUM HEALTH.

Q: Does my well-woman (gynecologist) exam fulfill the HEP preventive visit requirement?

A: Yes. Remember that you may also need to schedule a mammogram or cholesterol screening to fulfill your requirements.

Q: How do I enroll or opt-out of HEP?

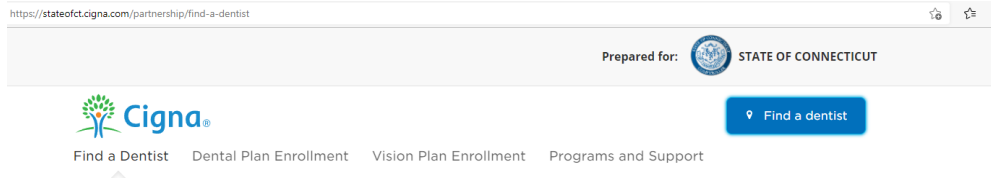
A: If you are enrolling in benefits for the first time, you will automatically be enrolled in HEP. If you wish to opt-out, then during the annual open enrollment or the first 31 days of hire, you must complete Form CO-1316 (available at [CareCompass.CT.gov/forms](https://carecompass.ct.gov/forms)) and send it to your Agency Benefits Specialist. Be sure to read this form carefully as the same financial penalties apply for opt-out as to those who are non-compliant with HEP. You can only re-enroll in HEP during the annual open enrollment by notifying your Agency Benefits Specialist. State Partnership Plan members cannot opt-out of HEP.

Cigna Dental Lookup Instructions

The following is the link to look up your dentist or to find a dentist.

<https://stateofct.cigna.com/partnership/>

On the first screen, top right click on Find a Dentist



Enter the address, city or zip code for the area you would like to search.

Find a Dentist in

West Hartford, CT


Dentist by Type


Dentist by Name


Dental Practices

Select Dental Plan – Choose West Hartford Preferred or West Hartford Premier.

Select a plan for your search

I live in West Hartford, CT

▼ Dental Plans

Selected: West Hartford Preferred

CIGNA DENTAL CARE DHMO

☐ Cigna Care DHMO

☐ Total Care DHMO

DPPO/EPO

☐ Basic

☐ Plan 1,2,5

☒ West Hartford Preferred

☐ Enhanced

☐ West Hartford Premier

Choose

Then search by type, name or practice and click search, you can continue as guest or login if registered.

Find a Dentist in

West Hartford, CT


Dentist by Type


Dentist by Name


Dental Practices

General Dentist Search

In-network providers will display a green checkmark. Providers not listed are considered out-of-network.