

**MANCHESTER**  
**BOARD OF SCHOOL COMMITTEE**  
**AND**  
**MANCHESTER**  
**CERTIFIED INSTRUCTORS NEA-NH**  
**ASSOCIATION**  
**2015-2017**

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## **APPENDICES**

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**ARTICLE ONE**  
**PURPOSE**

The purpose and intent of this document is to set forth the agreement reached between the Board of School Committee (hereinafter referred to as the "Board") and the Manchester Certified Instructor Association, NEA-New Hampshire (hereinafter referred to as the "Association") with respect to wages, hours and other terms and conditions of employment for the bargaining unit described in Article Two, Recognition.

**ARTICLE TWO**  
**RECOGNITION**

1. The Board of School Committee hereby recognizes the Association as the exclusive representative for all public employees in the bargaining unit.
2. The bargaining unit is limited to all full-time and regular part-time employees as certified by the N.H. PELRB on 8/19/14, including the following positions:
  - Certified Instructor: Title I
  - DHH & Visual Interpreters
  - Certified Instructor: Credit Recovery
3. All other employees of the Board are excluded from the bargaining unit.
4. Whenever the Board establishes a new position, the Board shall provide to the Association President, prior to the posting of the position, a copy of the job description.

**ARTICLE THREE**  
**NEGOTIATIONS PROCEDURE**

1. Either party desiring to bargain a successor Agreement may serve written notice to the other of its intentions within the deadlines set forth in RSA 273-A. Thereafter, the parties shall schedule a meeting at a mutually agreed upon time and place to commence negotiations and establish ground rules.
2. Either party may utilize the services of outside consultants and may call upon professional and lay representatives to assist in negotiations.

**ARTICLE FOUR**  
**GRIEVANCE PROCEDURE**

1. Definitions

A "grievance" is an alleged violation, misinterpretation, or misapplication of any of the provisions of this Agreement with respect to a public employee.

The term "days" when used in this Article shall mean Monday through Friday, excluding holidays or other days when the Central Administration office is closed.

2. Purpose

The purpose of the procedure is to secure, at the lowest possible administrative level, solutions to grievances. Both parties agree that the proceedings at any level will be kept appropriately informal and confidential.

Nothing herein contained will be construed as limiting the right of any bargaining unit member having a grievance to discuss the matter informally with any appropriate supervisor and to have the grievance adjusted without the intervention of the Association, provided that such adjustment is not inconsistent with the terms of the Agreement. The Association shall have the right to communicate its concerns to the appropriate administrator, relative to any interested party; however, this right shall not extend to being present at any meeting, unless the grievant wants the Association to be there. Any adjustment reached without the presence of a designated representative of the Association shall not be precedential in any way.

3. Procedures

Since it is anticipated that nearly all grievances can be resolved informally at level one, it is important that the complaint be processed as rapidly as possible. The timelines contained herein should be considered a maximum. The time limits may be extended by written mutual agreement.

Bargaining unit members shall, notwithstanding the pendency of any grievance, continue to observe all assignments and applicable rules and regulations until their grievance(s) is resolved, provided that such assignments, rules and/or regulations do not jeopardize that bargaining unit member's personal safety and/or integrity.

A. Level One Discussion

If the grievance is not brought to the attention of a bargaining unit member's immediate supervisor within twenty (20) days after the grievant knew or should have known of the act or condition upon which the grievance is based, then the grievance shall be considered waived. An

aggrieved person shall give written notice to the immediate supervisor and a brief explanation of the alleged grievance. Such aggrieved person will informally discuss the complaint with his/her immediate supervisor either directly or through the Association's representative with the object of seeking resolution. The immediate supervisor shall hold a discussion with the grievant and his/her Association representative, if the representative is requested by the grievant, within five (5) days after receiving the written grievance notice. The immediate supervisor shall give an answer within five (5) days from the date that the complaint is informally discussed.

**B. Level Two Formal Grievance**

If the grievant is not satisfied with the disposition of the grievance at Level one, or if no decision has been rendered within ten (10) days after the informal meeting at Level one, the grievant may file the grievance, in writing, with the Association's Grievance Committee within five (5) days after the decision at Level one or fifteen (15) days after the grievance was presented, whichever is sooner. Within five (5) days of the receipt of the grievance the Chair of the Association Grievance Committee may refer the grievance in writing to the Superintendent or his/her designee. The grievance and its specifics shall be submitted on the form contained in Appendix A of this Agreement.

Within ten (10) days of the receipt of the written grievance, the Superintendent or his/her designee shall meet with the aggrieved person in an effort to resolve it. The Superintendent or his/her designee shall render his/her decision within five (5) days after the meeting.

**C. Level Three Pre-arbitration**

If the grievant is not satisfied with the disposition of the grievance at Level Two or if no decision has been rendered within the time frames specified in Level Two, the grievant may refer the matter, in writing, to the Chair of the Association Grievance Committee within five (5) days after the decision at Level Two, or twenty-five (25) days after the complaint was referred to Level Two, whichever is sooner. Within five (5) days after receiving the written appeal, the Association may refer the matter, in writing, to the Superintendent's Office who shall schedule a pre-arbitration meeting within fifteen (15) days after receiving the request.

Representatives of the School District, the Association, and the grievant will attend the pre-arbitration meeting. Representative of the Human Resources Department and/or the District's legal representative shall attend as necessary.

The purpose of this meeting is to determine if the grievance can be resolved without arbitration. Failing resolution, the parties will attempt to

frame the issue for the arbitrator and to stipulate joint exhibits. The parties will also attempt to agree on an arbitrator.

If no satisfactory resolution is reached as a result of the meeting, the Association may submit a written demand for arbitration, with a copy to the Superintendent's office, to a mutually agreed upon neutral dispute resolution agency under its rules or to the American Arbitration Association under its rules, which rules shall govern the Arbitration hearing.

D. Level Four Arbitration

The arbitrator shall schedule the arbitration hearing at a time and place mutually agreeable to the parties. The Arbitrator shall have no authority to hold a hearing on more than one grievance at any hearing unless the parties mutually agree to the submission of multiple grievances to one arbitrator.

The arbitrator shall not have the power to alter, add to, or subtract from the terms of the Agreement. The arbitrator shall have no authority to render a decision which requires the payment for retroactive wages or adjustments which extend prior to the date when an aggrieved employee knew or should have known of the act or condition upon which the grievance was based, as specified in Section A of this Article.

The decision of the arbitrator shall be final and binding on the parties as to the matter in dispute, except either party may appeal the decision in accordance with RSA Chapter 542.

The costs for the services of the Arbitrator, including reasonable expenses, shall be born equally by the parties. The parties agree that the party who requests a postponement of any arbitration hearing shall be obligated to pay any related postponement costs or fees.

E. Miscellaneous

1. Failure at any level of the grievance procedure of "management" to render a decision within the specified time limits shall permit the grievance to proceed to the next level.

2. Failure of the grievant and/or the Association to abide by the time limits set forth in this article shall result in the grievance being dismissed without further action being taken with respect to such grievance.

3. All documents, communications and records dealing with the processing of a grievance will be filed separately from the personnel files

of the participants.

4. If, in the judgment of the Association, a grievance affects a group or class of bargaining unit members, the Association's Grievance Committee may file such a grievance in writing at Level Two. In the event of such a grievance, said Committee must specify the names of all bargaining unit members who claim there has been a violation or misapplication of a provision of the Agreement as to them, the specific provision(s) involved and the date(s) of the alleged violation(s) or misapplication(s). The signature of the bargaining unit members who claim the violation, etc., must be provided within ten (10) days of the filing or the grievance will not be processed, except if any bargaining unit member is unavailable and a reasonable attempt has been made to secure his/her signature.

#### **ARTICLE FIVE** **STRIKES, SANCTIONS, RESIGNATIONS AND LOCKOUTS**

The Board and the Association desire uninterrupted services, and, therefore, it is agreed that the Board shall not invoke any lockout, and the Association shall not cause, sponsor, encourage or condone any strikes, including "wildcat" strikes, sanctions, wholesale resignations, job actions or any curtailment or interruption of the operations of the Manchester School District. The term "wholesale resignations" shall not include any bargaining unit members who have quit in order to accept job offers, or who have decided to retire. In the event any such activity occurs, the parties shall promptly and publicly notify the participants to cease and desist and a participant's failure to cease and desist constitutes cause for discipline.

#### **ARTICLE SIX** **MANAGEMENT CLAUSE**

1. The Association agrees that, except as specifically abridged or limited by the provisions of this Agreement or any agreement that hereafter be duly made, all the rights, powers and authority of the Board and its agents to manage, direct or supervise all of the operations of the Manchester School District and its employees in all its phases and details shall be retained by the Board and its agents and the exercise of any such right as set forth in this Article shall not be subject to the grievance or arbitration provisions of this Agreement.

**ARTICLE SEVEN  
DUES DEDUCTIONS**

1. The Board agrees to deduct from the wages of Bargaining Unit Members, who occupy positions included in the bargaining unit dues for the Association as such employees individually and voluntarily authorize the Board to deduct and to transmit the monies promptly to the Association. Authorizations shall be in writing in the form set forth below, or in the form used by the Association to enroll its members. The employees and the Association shall indemnify and hold the Board and its employees harmless from any and all claims arising out of the deduction from wages.

**“Dues Authorization Card”**

**MANCHESTER CERTIFIED INSTRUCTORS ASSOCIATION**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

I hereby request and authorize the Board to deduct from my earnings in accordance with the procedure set forth in Article Seven (7) between the Board and the Association and to transmit to the treasurer of the Association/NEA-New Hampshire an amount sufficient to provide for the regular payment of the membership dues, as certified by the Association for the present school year and for succeeding years. I understand that if I wish to discontinue such deductions for any school year, I must notify the School District Finance office and the Association in writing to do so no later than sixty (60) days prior to the commencement of the school year. I hereby waive all right and claim for said monies so deducted and transmitted in accordance with this authorization, and relieve the Board and all its officers from any liability therefore.

\_\_\_\_\_  
Bargaining Unit Member's Signature

Dated: \_\_\_\_\_

2. The Association will certify to the School District Finance office the current rate of its membership dues and will give the district thirty (30) days written notice prior to any change.

3. Dues shall be deducted in equal installments with the exception of the (1<sup>st</sup>) payday in January, and the (1<sup>st</sup>) payday after the so-called February and April school vacations.

The Board will not be required to honor any authorizations that are delivered to it later than October 15.

The October 15<sup>th</sup> cut-off date shall not apply to probationary employees who satisfactorily complete their probationary period after September 30. If such employees submit a Dues Authorization Card within thirty (30) work days of the successful completion of their probationary period, they shall have all such dues deducted in equal amounts for the remainder of the twenty (20) pay deduction schedule.

4. No later than October 15, the Association will provide the District Finance office with a list of new employees who have voluntarily authorized the Board to deduct dues for the Association along with copies of their dues authorization cards and the amount of the deduction for each pay period. Any employee desiring to have the Board discontinue deductions that the employee has previously authorized must notify the District Finance officer and the Association sixty (60) days prior to the commencement of the new school year.

## **ARTICLE EIGHT** **ASSOCIATION AND EMPLOYEE RIGHTS**

1. The Association shall have the right to place notices, circulars and other materials in employee mailboxes and on bulletin boards, provided that such written material is not disruptive. A courtesy copy of such material will be given to the Superintendent and the administrator in charge of the worksite. The Association shall also have the right to use the intra-school distribution system to circulate Association materials.

2. If the Board or the School District intends to change its method of operations which involves contracting out, for more than thirty (30) consecutive days, the work being performed by bargaining unit members, the Board will give thirty (30) days notice to the Association and the employees covered by this Agreement of its intention. Further the Board will make every effort to absorb affected employees into other District positions. In those cases where employees are not absorbed into other District positions, the Board provides as much notice as possible. The decision to contract out shall not be grievable or subject to arbitration.

3. The parties recognize that the contents of and access to employee personnel files is governed by RSA 275:56. With reasonable notice a bargaining unit member can request copies of the materials contained in his/her personnel file. Bargaining unit members may also attach a written statement to any document for the purposes of clarification or refutation. Employees will be given a copy of any written evaluation or appraisal of performance, which is to be placed in that employee's personnel file. The employee will sign the evaluation or appraisal prior to being filed. The signature requirement is only to show that the employee had an opportunity to review the material before it was filed.

**ARTICLE NINE**  
**EMPLOYEE DISCIPLINARY PROCEDURES**

1. Disciplinary actions shall normally be progressive in accordance with the following order; however, disciplinary action may be taken out of order depending on the severity of the infraction as determined solely by the administration:

- (a) Verbal warning
- (b) Written reprimand
- (c) Suspension without pay
- (d) Discharge

2. Disciplinary action shall be proportionate to the severity of the infraction. All reprimands, suspensions and discharges must be in writing. The employee may request reasons.

3. A bargaining unit member, upon his/her request, may have a representative of the Association present during any investigation meeting which may lead to a written reprimand, suspension or discharge.

4. No bargaining unit member may be reprimanded, suspended or discharged without proper cause, which means that the evidence supports the disciplinary action.

**ARTICLE TEN**  
**OCCUPATIONAL AND PROFESSIONAL IMPROVEMENT**

1. **Delegates:** Official Delegates and official members elected to the NEA-New Hampshire Delegate Assembly shall be granted one (1) paid leave of absence day to attend the annual meeting. In addition, Association members, designated by the President, shall be granted one (1) paid leave of absence in order to conduct pre-planned official Association business, such as attending meetings, workshops and conferences. The total number of days under this section shall not exceed five (5) in a calendar year. Such time may be used in blocks of one-half day.

2. **Tuition Reimbursement:** Full time employees may receive reimbursement at accredited colleges, universities or training schools or at related seminars, workshops or conferences, must submit a request for reimbursement at least five (5) days in advance of the start of the education program to the Human Resources Department, which shall determine eligibility. In order to be eligible for reimbursement, the education program must:

- a. Relate to the current duties and classification of the employee; or be approved as relating to a future work assignment.
- b. Be approved by the Superintendent or his/her designee.

- c. Be in accordance with the policies and procedures for educational incentive reimbursement as established by the Human Resources Department.
- d. Effective upon ratification by the parties, the Board shall pay not more than seventy-five percent (75%) of the costs of tuition, course fees, required textbooks, and materials for any education program(s) for qualified individuals not to exceed a maximum of \$825.00 per person. The total amount for Education Incentive Reimbursement shall not exceed Five Thousand Dollars (\$5,000.00) per fiscal year.
- e. Once an education program is approved as meeting the requirements and paid receipts are submitted, an advance will be made to the qualified Bargaining Unit Member of one-half (½) of the authorized amount. The remainder of the reimbursement will be paid upon the presentation of a certificate of satisfactory completion of the education program, which must be submitted within ninety (90) days of the completion of the course. Failure to satisfactorily complete the course shall result in repayment of the advance through equal payroll deduction over the remaining pay periods. Receipt of the advance shall be deemed consent to the payrolls deductions set forth above.
- f. Workshops: When attendance at a workshop is mandated by the administration, unit members shall receive pay for the time as may be required by law.

## **ARTICLE ELEVEN** **WORK SCHEDULE**

The parties recognize that the length of the work day and year is contingent upon the number of pupil days, length of the school day, availability of funding, and shall not interfere with the Board's rights to extend or shorten the length of the school year or the length of the school day. The parties also recognize that this Agreement is not a guarantee of work, which may be adjusted subject to the operational needs of the District, the educational needs of students, and available financial resources, including but not limited to "Title I" funding ("limitations"). To this end, each employee shall receive a yearly contract which may or may not be renewed in successive years. In the event the contract is not renewed, the employee shall have no right of recall.

The normal workweek for bargaining unit members shall be Monday through Friday. The length of the normal work day for such employees shall be determined at the time of hire and as set forth in the employee's written contract. Nothing herein shall be construed to prevent the District from establishing a schedule that is comprised of a portion of a normal work week.

All bargaining unit members will be entitled each day to a ten (10) minute respite for each four (4) hours worked. All bargaining unit members, working more than five (5) hours each day, shall be entitled to a lunch break as provided for by law.

For the purposes of this contract and benefits eligibility, there shall be three classifications of employees. Those classifications are full time employees, regular part time employees and part time employees. Full time employees are defined as any bargaining unit member who is regularly scheduled to work thirty (30) hours or more per week as averaged over the entire school year. Regular part time are employees that have been employed by the District in a unit position for five (5) or more consecutive years. All employees that are neither full time or regular part time shall be deemed part time employees.

All full time and regular part time employees shall receive notice of the District's intent to rehire, subject to receipt of anticipated funding, no later than June 30<sup>th</sup> of the prior school year. Full time and regular part time employees shall notify the District of their intent to return to employment in the next school year no later than July 15<sup>th</sup> following notification by the District. Whenever possible, employees shall provide two (2) weeks notice of intent to resign from a position with the District.

## **ARTICLE TWELVE** **SAFETY AND HEALTH**

The School District shall have the right to make reasonable regulations for the safety and health of its employees during their working hours of employment. Representatives of the District and the Association will meet once in ninety (90) days at the request of either party to discuss such regulations. Members of the bargaining unit will comply with the reasonable rules and regulations to safety and health promulgated by the District. In addition, employees will receive appropriate training as determined by the Superintendent.

## **ARTICLE THIRTEEN** **OTHER WORKING CONDITIONS**

All full time bargaining unit members will be entitled to one (1) personal day, which shall be taken only on a scheduled work day, provided, however, it cannot be used on a work day, prior to or after, a school vacation period without the supervising administrator's written approval. Except in the case of an emergency, the bargaining unit member must notify in writing his/her supervising administrator at least twenty-four (24) hours prior to use. Personal days shall expire if unused at the end of the year.

**ARTICLE FOURTEEN**  
**PROBATIONARY PERIOD**

The normal probationary period shall be four (4) working months. In an unusual circumstance, the probationary period may be extended for an additional four (4) months. In such a case, the probationary full time employee shall be eligible for all contract benefits except for vacation leave. Such employees may be terminated with or without cause during said initial or extended probationary period. Employees that completed their probationary period prior to the effective date of this contract shall not be required to complete an additional probationary period.

**ARTICLE FIFTEEN**  
**SICK LEAVE**

1. A. All full time and regular part time employees within the bargaining unit shall be entitled to accrue paid sick leave as of his/her first day of actual work but no accrued sick leave may be used until an employee's initial probationary period has been completed. Sick leave shall accrue at the rate of one and one quarter (1.25) workdays per month with pay after each completed of six months of service (not to exceed 12 days per school year).

B. Sick leave may be used only for an employee's personal illness or injury that prevents him/her from doing the job. Sick leave shall be prorated for regular part time employees.

2. Any unused sick leave credit may be accumulated up to a maximum of one hundred and twenty (120) workdays. Employees shall be grandfathered as to any sick leave that has accumulated prior to the effective date of this initial contract.

3. An employee on sick leave shall inform his/her immediate supervisor of the fact and the reasons therefore, as soon as possible and failure to do so within a reasonable time may be cause for denial of pay for the period of absence. The Superintendent or his designee may require a doctor's certificate before approving sick leave with pay for a period of more than three (3) days on any one period of absence.

4. Sick Leave may be used in blocks of two (2) hours for medical appointments.

5. Absences for a fraction or part of a day that are chargeable to sick leave in accordance with these provisions shall be charged in the amount not smaller than two (2) hours.

6. The Superintendent or his/her designee reserves the right to have an independent physician examine any employee at the District's expense, who claims sick leave and who, in the opinion of the Superintendent or his/her designee, is not entitled to sick leave.

7. Full time and regular part time employees who use six (6) or less paid sick days during a fiscal year (July 1 through June 30) will receive two (2) incentive leave days with pay during the following fiscal year (July 1 through June 30). An employee must give notice for use of any unused incentive leave days on or before June 1 that are to be used during the month of June. If an employee's elected use of the incentive leave days in June is denied, the employee shall be paid for said day. Incentive days shall not extend vacation days unless approved by the Superintendent.

## **ARTICLE SIXTEEN** **MATERNITY LEAVE**

1. Upon application of a bargaining unit member at least sixty (60) days in advance of the commencement of a maternity leave, a maternity leave of absence without pay or other benefits shall be granted. A maternity leave of absence will commence at the time recommended by the employee's attending physician and to extend for a period not to exceed six (6) months after the birth of the child. If an employee who has been granted a maternity leave of absence in accordance with this provision and shall fail to return to work upon the expiration of such leave of absence, that employee shall be deemed to have voluntarily terminated her employment, unless the employee has been certified by a physician as being physically unable to perform the employee's duties.

2. Full time bargaining unit members shall be entitled to draw accumulated sick leave benefits with pay for a period not to exceed sixty (60) work days from the date of confinement or the birth of a child, during which time the employee is certified as being unable to perform regular duties, as certified by a medical certificate from a physician. Requests for such sick leave benefits must be submitted in writing to the Superintendent or designee no later than thirty (30) days after the date of confinement in order to be eligible for paid sick leave benefits.

3. Extensions of the thirty (30) day paid sick leave benefits may be granted by the Superintendent or his/her designee if circumstances so warrant.

4. All child rearing/bonding leave shall be governed by the District's FMLA policy. Such FMLA leave shall run concurrent with any maternity leave provided hereunder.

## **ARTICLE SEVENTEEN** **JURY DUTY**

1. Any bargaining unit member who is called for jury duty shall notify the Superintendent or his/her designee within five (5) work days after being summoned to appear for jury duty. Notification to the Superintendent or his/her designee must be made in advance of the jury duty assignment with supporting documentation. Upon proper notification of full time employees being called for jury duty, such full time employees will be paid the difference between the fee received for jury duty and the amount of straight time earning lost by reason of the jury duty. Satisfactory evidence of

actual jury duty must be submitted to the Superintendent or his/her designee.

2. Bargaining unit members who are excused from jury duty for a day or days shall be responsible to report to their assignment as set forth herein. Employees, serving as jurors in the courts of Rockingham, Merrimack or Hillsborough Counties shall, if there are more than two (2) hours remaining in the normal work day, be responsible to report to their work site as soon as possible after being released. Failure of full time employees to report to work will disqualify the employee from the District's Jury Duty Leave payment. In this case, the full time employee will retain the daily stipend paid by the Court in which the employee serves as a juror.

3. Regular part-time and part time employees shall be entitled to the same jury duty leave benefit as the full time employees but without pay.

### **ARTICLE EIGHTEEN** **BEREAVEMENT LEAVE**

1. Full time and regular part time employees shall be entitled to paid Bereavement Leave of five (5) working days because of a death in his/her immediate family shall be granted to a permanent member of the bargaining unit, provided however that two (2) of these days may be reserved for dealing with matters arising out of settling the decedent's estate to be used at any time with at least five (5) days notice. Immediate family shall be defined as:

Spouse	Sister
Father	Brother
Mother	Child
Father-in-law	Mother-in-law
Son-in-law	Daughter-in-law
Stepmother	Stepfather
Stepchild	

or, a blood relative or ward residing in the same household.

2. Special leave of one (1) working day with pay, for the purpose of attending the funeral, shall be granted to a full time employee and regular part time in the event of death of his/her:

Grandmother	Sister-in-law
Grandfather	Aunt
Grandchild	Uncle
Brother-in-law	

In addition to the family members named in this Section 2, a full time and regular part time bargaining unit member is entitled to one (1) day of paid leave to attend the funeral of a relative not listed above.

3. Under extenuating circumstances, two (2) additional days with pay may be granted under Section 1 to full time employees, with the written approval of the Superintendent or his/her designee. Such days shall be charged to the employee's accrued sick leave.

4. Under no circumstances shall Bereavement Leave be paid on an overtime basis. Pay shall be prorated for regular part time employees.

5. Part-time employees shall be entitled to the same bereavement leave as the full time and regular part time employees but without pay.

### **ARTICLE NINETEEN** **INSURANCE**

1. Effective upon implementation, the Board agrees to provide full time employees with the following health insurance plans and will pay eighty-five (85%) percent of the following District HSA health plans:

Lumenos Regional High deductible Health Saving Account (HSA) Plan  
\$2,000/\$4,000 plan year deductible; or

Lumenos National High deductible Health Saving Account (HSA) Plan  
\$2,000/\$4,000 plan year deductible.

Effective July 1, 2016, the District shall pay eighty percent (80%) of the monthly the Lumenos HSA plan premium. For those employees electing to take either plan specified in Section 1 above, they shall receive from the School District annually \$1,500 for those on the single plan and \$3,000 for those on the two-person or family plan that shall be deposited into a Health Savings Account (HSA). Said contributions and funds shall be governed by the applicable federal law. Half of the School District's annual contribution amount shall be deposited in the HSA at the beginning of the plan year with the second half being deposited over the course of the remaining plan year. Provided however, if the employee experiences a catastrophic illness during the plan year that results in the employee incurring medical bills that exceed the amount of the funds then in the HSA, upon presentation of an explanation of benefits form, the School District shall contribute additional funds up to the maximum annual contribution by the School District as may be permitted by law. The above referenced contributions to the HSA shall be prorated based upon the effective dates of coverage.

2. Effective upon implementation, the District shall pay eighty five percent (85%) of the monthly premium of the following HMO/POS plans or eighty five percent (85%) of the Lumenos HSA plan premium, whichever is less. Effective July 1, 2016, the District shall pay eighty percent (80%) of the monthly premium of the following HMO/POS plans or eighty percent (80%) of the Lumenos HSA plan premium, whichever is less.

- a. BC/BS POS with \$1,500.00 deductible as set forth in the attached Appendix B.
- b. BC/BS HMO with \$1,500.00 deductible as set forth in the attached Appendix B.
- c. Blue Cross/Blue Shield HMO Access Blue New England (Higher Copay Plan) as set forth in the attached Appendix B.
- d. Blue Cross/Blue Shield POS Blue Choice New England (Higher Copay Plan) as set forth in the attached Appendix B.

The Parties agree that the Board may discontinue any of the above-referenced health plans in the event that the plan will incur an excise tax or other penalty under the requirements of the Affordable Care Act. In such case, notice of discontinuance shall be provided during open enrollment or under such other circumstances as necessitated to avoid the excise tax or penalty. Employees shall receive no less than thirty (30) days prior notice of discontinuance.

3. The District agrees to establish a fund to provide for a payment, equal to the base salary, to the named beneficiary or estate of any full time member of the bargaining unit who dies from any cause while employed by the District of Manchester or who dies within sixty (60) calendar days of separation from service with the District because of paid retirement, disability retirement or resignation due to health reasons. There shall be no right to the benefit under this provision beyond the sixty (60) calendar day period referred to in the preceding sentence. It is agreed by the parties that the Board and/or the District shall have the sole right to determine whether the District will make the payment referred to above from the fund established by the District or contract with an insurance carrier or another company of the District's choosing to provide this benefit.

4. The Board shall provide coverage under Delta Dental Insurance Plan Coverage A, B, and C to all full time employees with the District paying eighty percent (80%) for the coverage selected.

The annual maximum dental allowance shall be \$1,500.00.

5. All members of the bargaining unit shall be entitled to full participation in the District's Employee Assistance Program (EAP). The parties agree that if the EAP is terminated by the District that this benefit will lapse.

6. Notwithstanding the foregoing, non-full time employees who are eligible to receive health and/or dental insurance as of the effective date of this contract (grandfathered employees) shall continue to remain eligible so long as they continue their employment with the District. Eligibility is lost upon separation. Notwithstanding the foregoing, grandfathered employee's who have committed to employment in the succeeding school year shall make contributions to health/dental insurance for the months of July, August and September equal to their normal monthly contribution plus

50% of the Board's normal monthly contribution. Such grandfathered employee contributions can be made in monthly deductions or by lump sum so long as full payment is received by July 15<sup>th</sup> in the applicable calendar year. Employees may opt out of health/dental insurance coverage for the months of July, August and September.

**ARTICLE TWENTY**  
**RETIREMENT**

All bargaining unit members shall be covered under the City of Manchester Contributory Retirement System if they are eligible under applicable state law and the rules of the retirement system, as they may be changed from time to time.

Retirement Supplement: Effective on the date of ratification, full time bargaining unit members with twenty (20) years of service with the school district shall receive a three thousand dollar (\$3,000.00) lump sum and up to 90 days of unused accumulated sick leave at their per diem rate upon retirement as a retirement supplement, provided that the employee gives at least two (2) months notice of their retirement.

**ARTICLE TWENTY-ONE**  
**HOLIDAYS**

1. All full time and regular employees shall be paid for the following named holidays:

- |                           |                        |
|---------------------------|------------------------|
| New Year's Day            | Memorial Day           |
| President's Day           | Election Day           |
| Veteran's Day             | Thanksgiving Day       |
| Christmas Day             | Day after Thanksgiving |
| Labor Day (if school day) |                        |

2. Eligible employees shall be granted the above holidays in accordance with the school calendar. When a holiday falls on a day when schools are open (floating holidays), eligible employees shall work such holidays and will be granted an equal amount of paid time off on a date which will not disrupt school operations.

3. Any employee shall forfeit his/her right to payment for any holiday if he/she has an unexcused absence on the last day preceding such holiday or the next regular workday following such holiday.

**ARTICLE TWENTY-TWO**  
**COMPENSATION**

1. Effective upon ratification, employees will receive an increase in pay equal to the percentage of the District's allocated tax cap (as calculated by the City of Manchester's Finance Director) for the then current fiscal year, not to exceed three (3.0) percent or less than one half (.5) percent in any year of the contract. The new starting rate of pay shall be \$15.50 per hour. Employees hired between 11/26/13 and 5/13/14 shall receive \$15.60 per hour, with no additional tax cap increase. During the 2016-2017 school year, increases shall be implemented in the first full pay period in September. This increase will be considered granted upon attaining a rating of "effective" on their immediately preceding performance evaluation. This process may be changed at any time by mutual agreement. Evaluation increases will stop when an employee reaches the top of their respective pay range.
2. All full time bargaining unit members hired to work beyond their normal contracted work year, shall be paid at their then hourly rate and shall receive applicable fringe benefits on a pro rata basis.
3. Bargaining unit members shall be paid at one and one-half (1½) times their regular rate for any hours worked beyond forty (40) hours per week. Overtime must be authorized by the Superintendent or his/her designee.
4. Bargaining unit members required to use their own vehicles for District business shall be reimbursed at the IRS approved mileage rate in effect at the time.

**ARTICLE TWENTY-THREE**  
**GENERAL PROVISIONS**

1. The parties do hereby recognize that in an effort to complete an agreement many issues were withdrawn by each of them. Accordingly, it is and hereby is agreed that said issues were withdrawn without prejudice whatsoever during the term of this Agreement.
2. This instrument constitutes the entire agreement between the parties hereto and may not be modified in whole or in part except in writing duly executed by the parties.
3. If any provision of this Agreement or application thereof is found contrary to law by a court of competent jurisdiction, then such provision or application shall not be deemed valid and subsisting except to the extent permitted by law, but all other provisions or applications will continue in full force and effect.
4. Copies of this Agreement shall be made available to the unit members either electronically or in print.

**ARTICLE TWENTY-FOUR**  
**DURATION**

The provisions of this Agreement shall be effective upon ratification, unless otherwise agreed by the parties, and shall continue in full force and effect through June 30, 2017. Each year thereafter, the Agreement shall automatically renew itself unless by December 1 of any succeeding year, either party gives written notice to the other party of its desire to modify or terminate the Agreement.

The persons whose signatures appear below certify that they are authorized representatives of the parties for the purpose of executing this Agreement.

For the Board of School Committee:

By: Theodore Gatson,

Date: 12/11/15

For the Manchester Certified Instructors Association:

By: Deborah P. Meisser

Date: 12/14/15

**APPENDIX A  
GRIEVANCE FORM**

Manchester Certified Instructor's Association

**Grievance Form**

Name of Complainant \_\_\_\_\_ Date of Filing \_\_\_\_\_

Home Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ No. of years as a  
school employee \_\_\_\_\_

Position Held \_\_\_\_\_

Name of Work Location  
and Address \_\_\_\_\_

Immediate Supervisor \_\_\_\_\_

Grievance Representative \_\_\_\_\_

Meeting with Immediate Supervisor: \_\_\_\_\_

Held on: \_\_\_\_\_

Result: \_\_\_\_\_

Provision(s) of Master Agreement Allegedly Violated: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Known: Statement of Grievance: (Explain what happened. The statement should include if when it occurred, who caused it, and where it happened. Also, explain your loss and injury.)

Action Requested (Set forth the remedy sought.)

\_\_\_\_\_  
Signature of the Complainant





BlueChoice™ New England Regional HSA  
(NH, VT, MA, ME, CT and RI)  
Lumenos Plan Summary

### Earn Rewards

You can earn reward dollars to redeem for gift cards at select retailers. See below for details:

**Future Moms:** Individualized obstetric support for expectant high-risk and non-high-risk mothers. Members can earn up to a \$200 Future Mom's incentive. This includes three milestones: \$100 initial enrollment, \$50 interim, and \$50 postpartum; timing and rules apply.

**Healthy Lifestyles Online:** Each adult family member can earn up to \$150 each year. Members earn a \$50 incentive at each 3,000, 5,000 and 10,000 point milestone. Members can quickly achieve their first milestone of 3,000 points by completing the Well-Being Assessment and setting up their Well-Being Plan.

**Enroll in ConditionCare:** (Incentive \$100) Disease management for prevalent, high-cost conditions (asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease and heart failure). Each family member can get one incentive per year. In the first year and later years, members must stay qualified to enroll and earn incentives. Members who have more than one health problem will enroll in one combined program — not separate ones for each condition.

**Graduate from ConditionCare:** (Incentive \$200) There's no limit to the number of family members that can graduate and earn the incentive. Each family member can earn one credit per year. In the first year and later years, members must stay qualified to enroll, graduate and earn incentives. Members who have more than one health problem will graduate from one combined program — not separate ones for each condition.

### Summary of Covered Services

#### Preventive Care

Anthem's Lumenos with HSA plan covers preventive services<sup>1</sup> recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The Preventive Care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to help prevent avoidable premature injury, illness and death.

All preventive services received from a network provider are covered at 100%, are not deducted from your HSA and do not apply to your deductible. If you see an out-of-network provider, then your deductible or out-of-network coinsurance responsibility will apply. If you receive any of these services for diagnostic purposes — for example, a colonoscopy when symptoms are present — the appropriate plan deductible and coinsurance will apply and available account dollars may be used to cover costs.

The following is an overview of the types of preventive services covered:

#### Child Preventive Care

Office Visits for preventive services  
Screening Tests for vision, hearing, and lead exposure.  
Also includes pelvic exam and Pap test for females who are age 18, or have been sexually active.  
Immunizations:  
Hepatitis A  
Hepatitis B  
Diphtheria, Tetanus, Pertussis (DtaP)  
Varicella (chicken pox)  
Influenza – flu shot  
Pneumococcal Conjugate (pneumonia)  
Human Papilloma Virus (HPV) – cervical cancer  
H. Influenza type b  
Polio  
Measles, Mumps, Rubella (MMR)

#### Adult Preventive Care

Office Visits for preventive services  
Screening Tests for coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams and Pap test.  
Immunizations:  
Hepatitis A  
Hepatitis B  
Diphtheria, Tetanus, Pertussis (DtaP)  
Varicella (chicken pox)  
Influenza – flu shot  
Pneumococcal Conjugate (pneumonia)  
Human Papilloma Virus (HPV) – cervical cancer

<sup>1</sup>Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

**Summary of Covered Services (Continued)**

**Medical Care**

Anthem's Lumenos with HSA plan covers a wide range of medical services to treat an illness or injury. You can use your available HSA funds to pay for these covered services. Once you spend up to your deductible amount shown on Page 1 for covered services, you will have traditional health coverage with the coinsurance listed on Page 1 to help pay for additional covered services.

The following is a summary of covered medical services under Anthem's Lumenos with HSA plan:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Physician Office Visits</li> <li>• Inpatient Hospital Services</li> <li>• Outpatient Surgery Services</li> <li>• Diagnostic X-rays/Lab Tests</li> <li>• Emergency Hospital Services<br/>(network coinsurance applies to both network and out-of-network)</li> <li>• Inpatient and Outpatient Mental Health and Substance Abuse Services</li> </ul> | <ul style="list-style-type: none"> <li>• Maternity Care</li> <li>• Chiropractic Care</li> <li>• Prescription Drugs</li> <li>• Home Health Care and Hospice Care</li> <li>• Physical, Speech, and Occupational Therapy Services</li> <li>• Durable Medical Equipment</li> </ul> |
|---|--|

Some covered services may have limitations or other restrictions.<sup>2</sup> With Anthem's Lumenos with HSA plan, the following services are limited:

- Skilled nursing facility services limited to 100 days per member per calendar year.
- Home health care services are limited to 100 visits per member per calendar year.
- Durable Medical Equipment: unlimited per member per contract year.
- Chiropractic Visits: Unlimited visits per member per contract year.
- Physical Therapy, Occupational Therapy, and Speech Therapy, up to a combined maximum of 60 visits per member per contract year.
- Nutritional Counseling: Unlimited visits per member per contract year (in-network benefit only).
- Inpatient hospitalizations require authorizations
- Routine Vision: Limited to one per member per calendar year
- Fitness Club Reimbursement \$200 maximum (limited to one member per enrolled household per plan year).
- Vision Hardware (per member every 2 plan years) \$100 maximum reimbursement for frames and lenses.
- Your Lumenos HSA plan includes a lifetime maximum of unlimited.

<sup>2</sup> Additional limitations and exclusions may apply. For a complete list of exclusions and limitations, please refer to your Certificate of Coverage. Some covered services may require pre-approval.



BlueChoice™ New England Regional HSA  
(NH, VT, MA, ME, CT and RI)  
Lumenos Plan Summary

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Additional limitations and exclusions may apply. For a complete list of exclusions and limitations, please refer to your Certificate of Coverage. Some covered services may require pre-approval.

Please note: This summary is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Group Master Contract, Certificate and Cost Sharing Schedule. In the event of a conflict between the Group Master Contract and this description, the terms of the Certificate will prevail. This summary is for a full year in the Lumenos plan. If you join the plan mid-year or have a qualified change of status, your actual benefits levels may vary.

Additional limitations and exclusions may apply.

The information included does not constitute legal, tax, or benefit plan design advice. Anthem strongly encourages consultation with a tax advisor before establishing a Health Savings Account. Any Health Savings Account will be established between the individual account holder and the HSA custodian or trustee. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.

Anthem Blue Cross and Blue Shield is the trade name for the following: In Connecticut: Anthem Health Plans, Inc. In Maine: Anthem Health Plans of Maine, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ® Anthem and Lumenos are registered trademarks. ® Blue Cross and Blue Shield names and symbols are registered trademarks of the Blue Cross and Blue Shield Association.

SISA1137P3 (Core SISA1137P2) Manchester School District  
7/1/15

4 of 4

If you have questions, please call toll-free 1-800-870-3122.



# Lumenos National HDHP Plan Summary

## Plan Year

Manchester School District 7/1/15 SISA258PN9 (core SISA258PN7)

The Lumenos® with HSA plan is designed to empower you to take control of your health, as well as the dollars you spend on your health care. This plan gives you the benefits you would receive from a typical health plan, plus health care dollars to spend your way.

### Your Lumenos HDHP Plan

**First -** Use your HSA to pay for covered services:

#### Health Savings Account

With a Health Savings Account (HSA), you can contribute pre-tax dollars to your HSA. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

#### Contributions to Your HSA

The annual contribution maximum set by the U.S. Treasury and IRS:

2015

\$3,350 Individual coverage

\$6,650 family coverage

Note: Rollover funds are not subject to these limits.

**Plus -** To help you stay healthy, use:

#### Preventive Care

100% coverage for nationally recommended services.

#### Preventive Care

No out-of-pocket costs for you as long as you receive your preventive care from a network provider. If you choose to go to an out-of-network provider, your deductible or traditional health coverage benefits will apply.

**Then -**

#### Your Deductible

The deductible is the amount you pay – using your HSA dollars or out of your pocket – before you reach the traditional health coverage portion of the plan.

#### Annual Deductible Responsibility

\$2,000 individual coverage

\$4,000 family coverage\*

\* This plan includes a family deductible, which means that the medical expenses of all family members count toward the deductible. Once the full deductible has been satisfied, all family members are covered under the Traditional Health Coverage portion of the plan.

**If needed -**

#### Traditional Health Coverage

Similar to a PPO, once the deductible has been met, you pay coinsurance (a percentage of the provider's charges) when visiting an out-of-network provider. When visiting network providers, you and your family members are covered at 100% once your deductible and coinsurance have been satisfied.

#### Traditional Health Coverage

After your deductible, the plan pays:

100% for network providers

70% for out-of-network providers

After your deductible, your coinsurance responsibility is:

0% for network providers

30% for out-of-network providers

#### Additional protection:

For your protection, the total amount you spend out of your pocket is limited. Once you spend that amount, the plan pays 100% of the cost for covered services for the remainder of the plan year.

#### Annual Out-of-Pocket Maximum

Network Providers

Out-of-Network Providers

\$2,000 individual coverage

\$4,000 individual coverage

\$4,000 family coverage

\$8,000 family coverage

Your annual out-of-pocket maximum consists of your annual deductible responsibility and your coinsurance amounts.

If you have questions, please call toll-free 1-888-224-4896

## Earn Rewards

You can earn reward dollars to redeem for gift cards at select retailers. See below for details:

**Future Moms:** Individualized obstetric support for expectant high-risk and non-high-risk mothers. Members can earn up to a \$200 Future Mom's incentive. This includes three milestones: \$100 initial enrollment, \$50 interim, and \$50 postpartum; timing and rules apply.

**Healthy Lifestyles Online:** Each adult family member can earn up to \$150 each year. Members earn a \$50 incentive at each 3,000, 5,000 and 10,000 point milestone. Members can quickly achieve their first milestone of 3,000 points by completing the Well-Being Assessment and setting up their Well-Being Plan.

**Enroll in ConditionCare:** (Incentive \$100) Disease management for prevalent, high-cost conditions (asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease and heart failure). Each family member can get one incentive per year. In the first year and later years, members must stay qualified to enroll and earn incentives. Members who have more than one health problem will enroll in one combined program — not separate ones for each condition.

**Graduate from ConditionCare:** (Incentive \$200) There's no limit to the number of family members that can graduate and earn the incentive. Each family member can earn one credit per year. In the first year and later years, members must stay qualified to enroll, graduate and earn incentives. Members who have more than one health problem will graduate from one combined program — not separate ones for each condition.

## Summary of Covered Services

### Preventive Care

Anthem's Lumenos with HSA plan covers preventive services recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The Preventive Care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to help prevent avoidable premature injury, illness and death.

All preventive services received from a network provider are covered at 100%, are not deducted from your HSA and do not apply to your deductible. If you see an out-of-network provider, then your deductible or out-of-network coinsurance responsibility will apply. If you receive any of these services for diagnostic purposes — for example, a colonoscopy when symptoms are present — the appropriate plan deductible and coinsurance will apply and available account dollars may be used to cover costs.

The following is an overview of the types of preventive services covered:

#### Child Preventive Care

**Office Visits** for preventive services

**Screening Tests** for vision, hearing, and lead exposure. Also includes pelvic exam and Pap test for females who are age 18, or have been sexually active.

**Immunizations:**

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer
- H. Influenza type b
- Polio
- Measles, Mumps, Rubella (MMR)

#### Adult Preventive Care

**Office Visits** for preventive services

**Screening Tests** for coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams and Pap test.

**Immunizations:**

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer

## Summary of Covered Services (Continued)

### Medical Care

Anthem's Lumenos with HSA plan covers a wide range of medical services to treat an illness or injury. You can use your available HSA funds to pay for these covered services. Once you spend up to your deductible amount shown on Page 1 for covered services, you will have traditional health coverage with the coinsurance listed on Page 1 to help pay for additional covered services.

The following is a summary of covered medical services under Anthem's Lumenos with HSA plan:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Physician Office Visits</li> <li>• Inpatient Hospital Services</li> <li>• Outpatient Surgery Services</li> <li>• Diagnostic X-rays/Lab Tests</li> <li>• Emergency Hospital Services<br/>(network coinsurance applies to both network and out-of-network)</li> <li>• Inpatient and Outpatient Mental Health and Substance Abuse Services</li> </ul> | <ul style="list-style-type: none"> <li>• Maternity Care</li> <li>• Chiropractic Care</li> <li>• Prescription Drugs</li> <li>• Home Health Care and Hospice Care</li> <li>• Physical, Speech, and Occupational Therapy Services</li> <li>• Durable Medical Equipment</li> </ul> |
|---|--|

Some covered services may have limitations or other restrictions.\* With Anthem's Lumenos with HSA plan, the following services are limited:

- Skilled nursing facility services limited to 100 days per calendar year.
- Home health care services are limited to 100 visits per calendar year.
- Durable Medical Equipment: unlimited per member per contract year.
- Chiropractic Visits: unlimited per member per contract year.
- Physical Therapy, Occupational Therapy, and Speech Therapy, up to a combined maximum of 60 visits per member per contract year.
- Nutritional Counseling: Unlimited visits per member per contract year (in-network benefit only).
- Inpatient hospitalizations require authorizations.
- Routine Vision: Limited to one per member per calendar year.
- Fitness Club Reimbursement \$200 maximum (limited to one member per enrolled household per plan year).
- Vision Hardware (per member every two plan years) \$100 maximum reimbursement for frames and lenses.

Your Lumenos HSA plan includes a lifetime maximum of unlimited.

Specific state mandates regarding limitations may apply.

\*For a complete list of exclusions and limitations, please refer to your Certificate of Coverage.



# Lumenos HDHP Plan Summary

Manchester School District 7/1/14 SISA258PN9 (core SISA258PN7)

**Please note:** This summary is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail. This summary is for a full year in the Lumenos plan. If you join the plan mid-year or have a qualified change of status, your actual benefit levels may vary.

Additional limitations and exclusions may apply.

The information included does not constitute legal, tax, or benefit plan design advice. Anthem strongly encourages consultation with a tax advisor before establishing a Health Savings Account. Any Health Savings Account will be established between the individual account holder and the HSA custodian or trustee. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In most of Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In most of Virginia (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123): Anthem Health Plans of Virginia, Inc. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSW") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSW collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross Blue Shield Association. © ANTHEM and Lumenos are registered trademarks of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

**Summary of Benefits – Plan Year**

*This is only a brief summary of your coverage. Benefits apply when care is medically necessary. Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. However, if you receive services from a non-network provider, under Self Referred benefits, it is your responsibility to pay the difference between the MAB and the provider's charge.*

Service Received	Your Share of the Cost	
<b>You do not need a referral from your Primary Care Provider. Your benefit is determined by whether you choose a provider in your designated network or an out-of-network provider.</b>		
<b>Preventive Care</b>	<b>In Network Benefits</b>	<b>Out of Network Benefits<sup>⊗</sup></b>
<ul style="list-style-type: none"> <li>Immunization, lead screening, PSA (prostate screening), mammograms and PAP smears</li> <li>Routine physical exam for babies, children and adults including family planning visits</li> <li>Routine hearing exam</li> <li>Routine vision exam (<i>one exam per calendar year under age 19, one exam every two calendar years for age 19 and over</i>)</li> </ul>	Covered in full	Covered up to MAB  Subject to:  \$1,500 deductible per member, no more than \$3,000 per family per plan year
<b>Other Outpatient Care</b> <ul style="list-style-type: none"> <li>Medical exam, office surgery, and anesthesia</li> <li>Early Childhood Intervention therapy services for children up to age 3</li> </ul>	\$25 per visit to your PCP \$35 per visit to any specialist	and
<ul style="list-style-type: none"> <li>Lab, X-ray, ultrasound, injections</li> <li>Short term rehabilitative therapy - physical, occupational, or speech (<i>unlimited, per member, per plan year</i>)<sup>⊙</sup></li> <li>CT scan, MRI, PET scan, MRA outpatient facility fees</li> </ul>	Covered in full	20% coinsurance up to \$400 per member, no more than \$1,200 per family per plan year
<ul style="list-style-type: none"> <li>Surgery in hospital outpatient department or ambulatory surgery center</li> </ul>	\$1500 copayment per surgery	Out-of-pocket maximum \$1,900 per member, no more than \$4,200 per family per plan year
<b>Inpatient Care</b> (as a bed patient in an acute care hospital) <ul style="list-style-type: none"> <li>Semi-private room and board</li> <li>Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy.</li> </ul>	\$1500 copayment per admission  Covered in full	Some benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details. Call 1-800-531-4450 to precertify.
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> ( <i>limited to 100 days for each per member, per calendar year</i> ) <sup>⊙</sup>	\$1500 copayment per admission	
<b>Durable Medical Equipment (DME)</b> ( <i>Unlimited</i> ) <sup>⊙</sup>	Covered in full	
<b>Other Services</b> <ul style="list-style-type: none"> <li>Chiropractic visit (<i>12 visits per member per plan year</i>)</li> <li>Chiropractic X-ray</li> <li>OB/GYN care (performed by an OB/GYN provider) <ul style="list-style-type: none"> <li>Exam</li> <li>Maternity care (routine prenatal, delivery and postpartum)</li> </ul> </li> </ul>	\$35 per visit Covered in full  \$25 per visit \$1500 copayment per admission	
<b>Emergency Room or Urgent Care Visit</b> <ul style="list-style-type: none"> <li>ER facility charge (<i>copayment waived if admitted</i>)</li> <li>Urgent Care facility charge</li> <li>ER/Urgent Care physician fee, CT Scan, MRI, medical supplies, etc.</li> </ul>	\$150 per visit \$75 per visit Covered in full	Same as Network Benefits
<b>Ambulance</b> (medically necessary emergency transport only)	Covered in full	Covered in full up to MAB

⊙ Any combination of benefits from either column count toward this maximum.

⊗ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the MAB.

† BlueChoice New England is administered by Anthem Blue Cross and Blue Shield and underwritten by Matthew Thornton Health Plan

Service Received	Your Share of the Cost	
	In Network Benefits	Out of Network Benefits <sup>®</sup>
<b>Mental Health and Substance Abuse</b> <ul style="list-style-type: none"> <li>Outpatient services <ul style="list-style-type: none"> <li>Visit/consultation</li> </ul> </li> <li>Inpatient services <ul style="list-style-type: none"> <li>Semi-private room &amp; board</li> <li>Physician visit</li> </ul> </li> </ul>	\$25 copayment per visit  \$1500 copayment per admission Covered in full	Subject to deductible and coinsurance
<b>Prescription Drugs</b>		
Covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy <ul style="list-style-type: none"> <li>Copayment applies to each fill, up to a 30-day supply for retail</li> <li>Includes maintenance drugs at a retail or mail order pharmacy</li> <li>Only certain drugs are considered "maintenance" and are available for a supply greater than 30 days.</li> <li>Important notes: <ul style="list-style-type: none"> <li>If you choose to buy a brand drug, you pay the brand copay</li> </ul> </li> </ul> Refer to your prescription drug program flyer for details.	<b>Network Benefits</b>  <b>Retail (30 day supply):</b> \$10 copay / tier 1 \$30 copay / tier 2 \$50 copay / tier 3  90 day supply available at retail for 3 copays  <b>Mail Order (90 day supply):</b> \$20 copay / tier 1 \$60 copay / tier 2 \$100 copay / tier 3	<b>Out-of-Network Benefits<sup>®</sup></b> Same as network benefits
<b>Maximums for Services Subject to \$1500 Copayment</b>		
Individual Maximum Family Maximum	\$1500 per member per plan year \$3000 per family per plan year	Not applicable. All services subject to out of network deductible and coinsurance.
<b>Out of Pocket Limitations</b>		
<b>Medical Out-of-Pocket Limitation</b> The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Calendar Year. It does not include your Premium, amounts over the Maximum Allowable Benefit, or charges for non-covered services.	Once the Out-of-Pocket Limit is satisfied, you will not have to pay additional Deductibles, Coinsurance or Copayments for the rest of the Plan Year. \$6,350 per Member, per Plan Year \$12,700 per family, per Plan Year	Not applicable. All services subject to out of network deductible and coinsurance.
<b>Other</b>		
Fitness Club Reimbursement  Vision Hardware (per member every two plan years)	\$200 maximum reimbursement (limited to one member per enrolled household per plan year)  \$100 maximum reimbursement for frames and lenses	

## Exclusions and Limitations

The services listed below are not covered by this plan. Please review your Subscriber Certificate for complete details on exclusions and limitations.

### Services Not Covered

• Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Claims for services received more than 12 months ago • Complementary and Alternative Therapies/ Medicine • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the Subscriber Certificate as covered benefits • Mental health services which do not usually result in favorable modification through short-term therapy • Miscellaneous devices, materials, and supplies, including, but not limited to, hearing aids (except for children under 19), eyeglasses, contact lenses (except after cataract surgery), dentures and support devices for the feet and corrective shoes • Permanent dental restoration, orthognathic and most oral surgery • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Sex changes • Sterilization reversal

### Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:

• Injuries which are the responsibility of other parties • Services for which another insurance carrier or Medicare is primary • Services related to illegal conduct

### This is only a brief summary of your coverage.

This summary of benefits is not a contract. It is a general description of the benefits and exclusions of this plan. Complete information about all benefits, limitations and exclusions is in the Subscriber Certificate, which will be mailed to you after you enroll. If you need further information, call Customer Service at 1-800-870-3122.

## Summary of Benefits – Plan Year

*This is only a brief summary of your coverage. Benefits apply when care is medically necessary. Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full.*

Service Received	Your Share of the Cost
<b>You do not need a referral from your Primary Care Provider, however you must receive covered services in the Access Blue Network.</b>	
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>Immunization, lead screening, PSA (prostate screening), mammograms, and PAP smears</li> <li>Routine physical exam for babies, children and adults including family planning visits</li> <li>Routine hearing exam</li> <li>Routine vision exam (<i>one exam per calendar year under age 19, one exam every two calendar years for age 19 and over</i>)</li> </ul>	Covered in full
<b>Other Outpatient Care</b> <ul style="list-style-type: none"> <li>Medical exam, office surgery and anesthesia</li> <li>Early Childhood Intervention therapy services for children up to age 3</li> </ul>	\$20 per visit to your PCP \$30 per visit to any Specialist
<ul style="list-style-type: none"> <li>Lab, X-ray, ultrasound, injections</li> <li>Short term rehabilitative therapy- physical, <i>occupational, or speech (up to 60 visits, any combination, per member, per plan year)</i></li> <li>CT scan, MRI, PET Scan, MRA, outpatient facility fees</li> </ul>	Covered in full
<ul style="list-style-type: none"> <li>Surgery in hospital outpatient department or ambulatory surgery center</li> </ul>	\$1,500 copayment per surgery
<b>Inpatient Care</b> (as a bed patient in an acute care hospital) <ul style="list-style-type: none"> <li>Semi-private room and board</li> </ul>	\$1,500 copayment per admission
<ul style="list-style-type: none"> <li>Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy</li> </ul>	Covered in full
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> <i>(limited to 100 days for each per member, per calendar year)</i>	\$1,500 copayment per admission
<b>Durable Medical Equipment (DME)</b> <i>Unlimited</i>	Covered in full
<b>Other Services</b> <ul style="list-style-type: none"> <li>OB/GYN care (<i>performed by an OB/GYN provider</i>)                             <ul style="list-style-type: none"> <li>Exam</li> <li>Maternity care (routine prenatal, delivery and postpartum)</li> </ul> </li> <li>Chiropractic visit (<i>unlimited visits</i>)</li> <li>Chiropractic X-ray</li> </ul>	\$20 per visit \$1,500 copayment per admission \$30 per visit Covered in full
<b>Emergency Room or Urgent Care Center Visit</b> <ul style="list-style-type: none"> <li>ER facility charge (<i>copayment waived if admitted</i>)</li> <li>Urgent Care facility charge</li> <li>ER/Urgent Care physician fee, CT Scan, MRI, medical supplies, etc.</li> </ul>	\$100 per visit \$50 per visit Covered in full
<b>Ambulance</b> ( <i>medically necessary emergency transport only</i> )	Covered in full

† Access Blue New England is administered by Anthem Blue Cross and Blue Shield and underwritten by Matthew Thornton Health Plan

Service Received	Your Share of the Cost
<b>You do not need a referral from your Primary Care Provider, however you must receive covered services in the Access Blue Network.</b>	
<b>Mental Health and Substance Abuse</b> <ul style="list-style-type: none"> <li>• Outpatient services <ul style="list-style-type: none"> <li>- Visit/consultation</li> </ul> </li> </ul>	\$20 copayment per visit
<ul style="list-style-type: none"> <li>• Inpatient services <ul style="list-style-type: none"> <li>- Semi-private room &amp; board</li> <li>- Physician visit</li> </ul> </li> </ul>	\$1,500 copayment per admission Covered in full
<b>Prescription Drugs</b>	
<p>Covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy</p> <ul style="list-style-type: none"> <li>• Copayment applies to each fill, up to a 30-day supply for retail</li> <li>• Includes maintenance drugs at a retail or mail order pharmacy</li> <li>• Only certain drugs are considered “maintenance” and are available for a supply greater than 30 days.</li> </ul> <p>Important notes:</p> <ul style="list-style-type: none"> <li>• Whenever available, your prescription will be filled generically. If you <b>choose</b> to buy a brand drug, you pay the generic copay, plus the difference in cost between the brand and generic drug.</li> <li>• If, <b>due to medical necessity</b>, your physician must prescribe a brand drug, you pay the brand copay.</li> </ul> <p>Refer to your prescription drug program flyer for details.</p>	<p><b>Retail (30 day supply):</b>  \$10 copay /tier 1  \$30 copay / tier 2  \$50 copay / tier 3</p> <p>90 day supply at retail for 3 copayments</p> <p><b>Mail Order (90 day supply):</b>  \$20 copay /tier 1  \$60 copay / tier 2  \$100 copay / tier 3</p>
<b>Maximum for Services Subject to \$1,500 Copayment</b>	
Individual Maximum Family Maximum	\$1,500 per member per plan year \$3,000 per family per plan year
<b>Out of Pocket Limitations</b>	
<b>Medical Out-of-Pocket Limitation</b> The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Calendar Year. It does not include your Premium, amounts over the Maximum Allowable Benefit, or charges for non-covered services.	Once the Out-of-Pocket Limit is satisfied, you will not have to pay additional Deductibles, Coinsurance or Copayments for the rest of the Plan Year. \$6,350 per Member, per Plan Year \$12,700 per family, per Plan Year
<b>Other</b>	
Fitness Club Reimbursement  Vision Hardware (per member every two plan years)	\$200 maximum reimbursement (limited to one member per enrolled household per plan year) \$100 maximum reimbursement for frames and lenses.

## Exclusions and Limitations

The services listed below are not covered by this plan. Please review your Subscriber Certificate for complete details on exclusions and limitations.

### Services Not Covered

• Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Claims for services received more than 12 months ago • Complementary and Alternative Therapies/Medicine • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the subscriber certificate as covered benefits • Mental health services which do not usually result in favorable modification through short-term therapy • Miscellaneous devices, materials, and supplies, including, but not limited to, hearing aids, eyeglasses, contact lenses (except after cataract surgery), dentures and support devices for the feet and corrective shoes • Permanent dental restoration, orthognathic and most oral surgery • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Sex changes • Sterilization reversal

### Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:

• Injuries which are the responsibility of other parties • Services for which another insurance carrier or Medicare is primary • Services related to illegal conduct

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This summary of benefits is not a contract. It is a general description of the benefits and exclusions of this plan. Complete information about all benefits, limitations and exclusions is in the Subscriber Certificate, which will be mailed to you after you enroll. If you need further information, call Customer Service at 1-800-870-3122

**Summary of Benefits – Plan Year**

*This is only a brief summary of your coverage. Benefits apply when care is medically necessary. Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. However, if you receive services from a non-network provider, under Self Referred benefits, it is your responsibility to pay the difference between the MAB and the provider's charge.*

Service Received	Your Share of the Cost	
<b>You do not need a referral from your Primary Care Provider. Your benefit is determined by whether you choose a provider in your designated network or an out-of-network provider.</b>		
<b>Preventive Care</b>	<b>In Network Benefits</b>	<b>Out of Network Benefits<sup>Ⓢ</sup></b>
<ul style="list-style-type: none"> <li>Immunization, lead screening, PSA (prostate screening), mammograms and PAP smears</li> <li>Routine physical exam for babies, children and adults including family planning visits</li> <li>Routine hearing exam</li> <li>Routine vision exam (<i>one exam per calendar year under age 19, one exam every two calendar years for age 19 and over</i>)</li> </ul>	Covered in full	Covered up to MAB
<b>Other Outpatient Care</b> <ul style="list-style-type: none"> <li>Medical exam, office surgery, and anesthesia</li> <li>Early Childhood Intervention therapy services for children up to age 3</li> </ul>	\$25 per visit to your PCP \$35 per visit to any specialist	Subject to:  \$100 deductible per member, no more than \$300 per family per plan year
<ul style="list-style-type: none"> <li>Lab, X-ray, ultrasound, injections</li> <li>Short term rehabilitative therapy - physical, occupational, or speech (<i>unlimited, per member, per plan year</i>)<sup>Ⓢ</sup></li> <li>CT scan, MRI, PET scan, MRA outpatient facility fees</li> </ul>	Covered in full	and  20% coinsurance up to \$400 per member, no more than \$1,200 per family per plan year
<ul style="list-style-type: none"> <li>Surgery in hospital outpatient department or ambulatory surgery center</li> </ul>	\$300 copayment per surgery	Out-of-pocket maximum \$500 per member, no more than \$1,500 per family per plan year
<b>Inpatient Care</b> (as a bed patient in an acute care hospital) <ul style="list-style-type: none"> <li>Semi-private room and board</li> <li>Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy.</li> </ul>	\$300 copayment per admission  Covered in full	Some benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details. Call 1-800-531-4450 to precertify.
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> ( <i>limited to 100 days for each per member, per calendar year</i> ) <sup>Ⓢ</sup>	\$300 copayment per admission	
<b>Durable Medical Equipment (DME)</b> ( <i>Unlimited</i> ) <sup>Ⓢ</sup>	Covered in full	
<b>Other Services</b> <ul style="list-style-type: none"> <li>Chiropractic visit (<i>12 visits per member per plan year</i>)</li> <li>Chiropractic X-ray</li> <li>OB/GYN care (performed by an OB/GYN provider)               <ul style="list-style-type: none"> <li>- Exam</li> <li>- Maternity care (<i>routine prenatal, delivery and postpartum</i>)</li> </ul> </li> </ul>	\$35 per visit Covered in full  \$25 per visit \$300 copayment per admission	
<b>Emergency Room or Urgent Care Visit</b> <ul style="list-style-type: none"> <li>ER facility charge (<i>copayment waived if admitted</i>)</li> <li>Urgent Care facility charge</li> <li>ER/Urgent Care physician fee, CT Scan, MRI, medical supplies, etc.</li> </ul>	\$150 per visit \$75 per visit Covered in full	Same as Network Benefits
<b>Ambulance</b> (medically necessary emergency transport only)	Covered in full	Covered in full up to MAB

Ⓢ Any combination of benefits from either column count toward this maximum.

Ⓢ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the MAB.

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Service Received	Your Share of the Cost	
	In Network Benefits	Out of Network Benefits <sup>®</sup>
<b>Mental Health and Substance Abuse</b> <ul style="list-style-type: none"> <li>• Outpatient services <ul style="list-style-type: none"> <li>- Visit/consultation</li> </ul> </li> <li>• Inpatient services <ul style="list-style-type: none"> <li>- Semi-private room &amp; board</li> <li>- Physician visit</li> </ul> </li> </ul>	\$25 copayment per visit  \$300 copayment per admission Covered in full	Subject to deductible and coinsurance
<b>Prescription Drugs</b>		
Covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy <ul style="list-style-type: none"> <li>• Copayment applies to each fill, up to a 30-day supply for retail</li> <li>• Includes maintenance drugs at a retail or mail order pharmacy</li> <li>• Only certain drugs are considered "maintenance" and are available for a supply greater than 30 days.</li> <li>• Important notes: <ul style="list-style-type: none"> <li>- If you choose to buy a brand drug, you pay the brand copay</li> </ul> </li> </ul> Refer to your prescription drug program flyer for details.	<b>Network Benefits</b>  <b>Retail (30 day supply):</b> \$10 copay / tier 1 \$30 copay / tier 2 \$50 copay / tier 3  90 day supply available at retail for 3 copays  <b>Mail Order (90 day supply):</b> \$20 copay / tier 1 \$60 copay / tier 2 \$100 copay / tier 3	<b>Out-of-Network Benefits<sup>®</sup></b> Same as network benefits
<b>Maximums for Services Subject to \$300 Copayment</b>		
Individual Maximum Family Maximum	\$300 per member per plan year \$600 per family per plan year	Not applicable. All services subject to out of network deductible and coinsurance.
<b>Out of Pocket Limitations</b>		
<b>Medical Out-of-Pocket Limitation</b> The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Calendar Year. It does not include your Premium, amounts over the Maximum Allowable Benefit, or charges for non-covered services.	Once the Out-of-Pocket Limit is satisfied, you will not have to pay additional Deductibles, Coinsurance or Copayments for the rest of the Plan Year. \$6,350 per Member, per Plan Year \$12,700 per family, per Plan Year	Not applicable. All services subject to out of network deductible and coinsurance.
<b>Other</b>		
Fitness Club Reimbursement  Vision Hardware (per member every two plan years)	\$200 maximum reimbursement (limited to one member per enrolled household per plan year)  \$100 maximum reimbursement for frames and lenses	
<b>Exclusions and Limitations</b>		
The services listed below are not covered by this plan. Please review your Subscriber Certificate for complete details on exclusions and		

limitations.

**Services Not Covered**

• Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Claims for services received more than 12 months ago • Complementary and Alternative Therapies/ Medicine • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the Subscriber Certificate as covered benefits • Mental health services which do not usually result in favorable modification through short-term therapy • Miscellaneous devices, materials, and supplies, including, but not limited to, hearing aids (except for children under 19), eyeglasses, contact lenses (except after cataract surgery), dentures and support devices for the feet and corrective shoes • Permanent dental restoration, orthognathic and most oral surgery • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Sex changes • Sterilization reversal

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## Summary of Benefits – Plan Year

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Service Received	Your Share of the Cost
<b>You do not need a referral from your Primary Care Provider, however you must receive covered services in the Access Blue Network.</b>	
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>Immunization, lead screening, PSA (prostate screening), mammograms, and PAP smears</li> <li>Routine physical exam for babies, children and adults including family planning visits</li> <li>Routine hearing exam</li> <li>Routine vision exam (<i>one exam per calendar year under age 19, one exam every two calendar years for age 19 and over</i>)</li> </ul>	Covered in full
<b>Other Outpatient Care</b> <ul style="list-style-type: none"> <li>Medical exam, office surgery and anesthesia</li> <li>Early Childhood Intervention therapy services for children up to age 3</li> </ul>	\$20 per visit to your PCP \$30 per visit to any Specialist
<ul style="list-style-type: none"> <li>Lab, X-ray, ultrasound, injections</li> <li>Short term rehabilitative therapy- physical, <i>occupational, or speech (up to 60 visits, any combination, per member, per plan year)</i></li> <li>CT scan, MRI, PET Scan, MRA, outpatient facility fees</li> </ul>	Covered in full
<ul style="list-style-type: none"> <li>Surgery in hospital outpatient department or ambulatory surgery center</li> </ul>	\$250 copayment per surgery
<b>Inpatient Care</b> (as a bed patient in an acute care hospital) <ul style="list-style-type: none"> <li>Semi-private room and board</li> </ul>	\$250 copayment per admission
<ul style="list-style-type: none"> <li>Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy</li> </ul>	Covered in full
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> <i>(limited to 100 days for each per member, per calendar year)</i>	\$250 copayment per admission
<b>Durable Medical Equipment (DME)</b> <i>Unlimited</i>	Covered in full
<b>Other Services</b> <ul style="list-style-type: none"> <li>OB/GYN care (<i>performed by an OB/GYN provider</i>) <ul style="list-style-type: none"> <li>Exam</li> <li>Maternity care (routine prenatal, delivery and postpartum)</li> </ul> </li> <li>Chiropractic visit (<i>unlimited visits</i>)</li> <li>Chiropractic X-ray</li> </ul>	\$20 per visit \$250 copayment per admission \$30 per visit Covered in full
<b>Emergency Room or Urgent Care Center Visit</b> <ul style="list-style-type: none"> <li>ER facility charge (<i>copayment waived if admitted</i>)</li> <li>Urgent Care facility charge</li> <li>ER/Urgent Care physician fee, CT Scan, MRI, medical supplies, etc.</li> </ul>	\$100 per visit \$50 per visit Covered in full
<b>Ambulance</b> ( <i>medically necessary emergency transport only</i> )	Covered in full

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# Manchester School District

Effective: 7/1/2015

Group Number: 0163

## Outline of Coverage Delta Dental PPO plus Premier Network

*Read Your Policy Carefully—This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you READ YOUR POLICY CAREFULLY! Not all time limitations and exclusions are shown herein. Benefit percentages shown are based on the actual charges submitted up to the Maximum Allowable Charge for participating dentists, or Delta Dental's allowance for non-participating dentists.*

Diagnostic / Preventive (Coverage A)	Basic Restorative (Coverage B)	Major Restorative (Coverage C)
<p><b>DIAGNOSTIC:</b> Oral evaluations once in a 6-month period X-rays (complete series or panoramic film) once in a 3-year period Bitewing x-rays once in a 12-month period X-rays of individual teeth as necessary Brush biopsy once in a 12-month period</p> <p><b>PREVENTIVE:</b> Cleanings once in a 6-month period Fluoride once in a 12-month period to age 19 Space maintainers to age 16 Sealant application to permanent molars, once in a 3-year period per tooth, for children to age 19</p>	<p><b>RESTORATIVE:</b> Amalgam (silver) fillings; Composite (white) fillings (on anterior teeth only)</p> <p><b>ORAL SURGERY:</b> Surgical and routine extractions</p> <p><b>ENDODONTICS:</b> Root canal therapy</p> <p><b>PERIODONTICS:</b> Periodontal maintenance (cleaning) <i>Note: Cleanings are limited to one in a 6-month period; these may be routine (Coverage A) or periodontal (Coverage B), or a combination of each.</i> Treatment of gum disease Clinical crown lengthening once in a lifetime per site</p> <p><b>DENTURE REPAIR:</b> Repair of a removable denture to its original condition</p> <p><b>EMERGENCY PALLIATIVE TREATMENT</b></p>	<p><b>PROSTHODONTICS:</b> Removable and fixed partial dentures (bridge); complete dentures Rebase and reline (dentures) Crowns Onlays Implants</p>
<b>Delta Dental Pays: 100%</b>	<b>Delta Dental Pays: 60%</b>	<b>Delta Dental Pays: 50%</b>
<b>Calendar Year Maximum: \$1500 per Person</b>		

## Delta Dental PPO plus Premier Network

You will get the best value from your Delta Dental Plan when you receive your dental care from one of our PPO (greatest savings) or Premier network participating dentists:

- ✓ **No Balance Billing:** Because participating dentists accept Northeast Delta Dental's allowed fees for services, you will typically pay less when you visit a participating dentist.
- ✓ **No Claims Paperwork:** Participating dentists will prepare and submit claims for you.
- ✓ **Direct Payment:** Northeast Delta Dental pays participating dentists directly, so you don't have to pay the covered amount up front and wait for a reimbursement check.

To find out if your dentist participates in our PPO or Premier network, you can: call your dentist, visit our website at [nedelta.com](http://nedelta.com), or call Customer Service at 1-800-832-5700.

## Claim Process for Participating Dentists

Your participating dentist will submit your claim to Northeast Delta Dental (claims for any of your covered dependents should be submitted under *your* Subscriber ID number). Northeast Delta Dental will produce an Explanation of Benefits (available through our Benefit Lookup site at [nedelta.com](http://nedelta.com)) detailing what has been processed under your plan's coverage. You are responsible to pay any outstanding balance directly to the dentist.

## Non-Participating Dentists

If you visit a non-participating dentist, you may be required to submit your own claim and pay for services at the time they are provided. Claim forms are available by calling Northeast Delta Dental or visiting [nedelta.com](http://nedelta.com). Payment will be made to you, the Subscriber, unless the state in which the services are rendered requires that assignments of benefits be honored and Northeast Delta Dental receives written notice of such assignment. Payment for treatment performed by a non-participating dentist will be limited to the lesser of the dentist's actual submitted charge or Delta Dental's allowance for non-participating dentists in the geographic area in which services are provided. It is your responsibility to make full payment to the dentist.

## Predetermination of Benefits

Northeast Delta Dental recommends that you ask your dentist to submit a *pre-treatment estimate* for any dental work involving costly or extensive treatment plans. Predeterminations helps avoid any potential confusion and enable us to help you estimate any out-of-pocket expenses you may incur.

## Coordination of Benefits

When an individual covered under this plan has additional group coverage, the Coordination of Benefits (COB) provision described in your Dental Plan Description booklet will determine the sequence and extent of payment. If you have any questions about COB, please contact our Customer Service Department at 1-800-832-5700.

## Identification Cards

Two identification cards will be produced and distributed shortly after your initial enrollment. Both cards are issued in your name but can be used by any family member covered under your plan. Any future cards will be issued electronically via our Benefit Lookup site accessible through [nedelta.com](http://nedelta.com). You can also use our smartphone app and enjoy access to dentist search, claims and coverage, and your ID card. Simply scan the QR code to the right.



## Dental Plan Description Booklet

A Dental Plan Description booklet will be made available shortly after your enrollment. This benefit booklet describes your dental benefits and explains how to use them. Please read it carefully to understand the benefits and provisions of your Northeast Delta Dental plan.

## Who is Eligible?

You, your spouse, your children up to age 26, regardless of student status, and any incapacitated dependent children, regardless of age. If enrolling one eligible dependent, all of your eligible dependents must be enrolled, unless they are covered under another dental program.

**MANCHESTER BOARD OF SCHOOL COMMITTEE**

**AND**

**MANCHESTER CERTIFIED INSTRUCTORS**

12/17/15

MEMORANDUM OF UNDERSTANDING

**WHEREAS**, the Manchester Board of School Committee (BOSC) and the Manchester Certified Instructors (MCI) have negotiated a contract that has been ratified by the BOSC and union membership;

**WHEREAS**, since the tentative agreement has been ratified, it has become apparent that the holidays listed in Article 21 were incomplete;

**WHEREAS**, the MCI and the BOSC agree to modify the holidays listed in the collective bargaining agreement (CBA). In addition to the holidays listed in Article twenty-one (21) of the CBA, the following will be paid holidays for all full time and regular part time employees:

Columbus Day

Martin Luther King, Jr. Day

All language related to holidays under article 21 shall also apply to these days.



For the BOSC Date 1/11/16



For the Association

Date

12/23/15