COLLECTIVE BARGAINING AGREEMENT

between

EAST HAMPTON BOARD OF EDUCATION

and

MUNICIPAL EMPLOYEES UNION INDEPENDENT LOCAL 506, SEIU, AFL-CIO

for

SCHOOL NURSES

JULY 1, 2024– JUNE 30, 2027

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Preamble

The agreement is entered into by and between the Board of Education of the Town of East Hampton (hereinafter referred to as the "Board") and the Municipal Employees Union Independent, Inc. (hereinafter referred to as the "Union").

Article 1
Recognition

1. The Board recognizes the Union as the exclusive bargaining agent for the purposes of bargaining over hours, wages and all other conditions of employment for all full-time building, registered nurses employed by the Board who are in charge of the general school population.

2. It is recognized that the Board has and continues to retain, whether exercised or not, the sole unquestioned right, responsibility and prerogative to direct the operation of the East Hampton school system in all aspects. Such operation shall include the right to establish policies, practices and procedures for the conduct of Board business, and from time to time, to change and abolish such policies, practices or procedures.

3. The Board's right, responsibility and prerogative are not subject to delegation in whole or in part, except that the same shall not be exercised in a manner inconsistent with or in violation of the specific terms and provisions of this agreement. All past practices and understandings between the parties are void and of no force and effect unless specifically incorporated herein.

Article 2
Union Security

1. During the terms of this contract or extension thereof, all employees in the collective bargaining unit may elect either to become or remain members of the Union. The Board shall provide the Union with electronic notification of the name, job title, home or cell phone numbers, home address, and personal and work e-mail addresses of any newly hired employee within seven work (7) days of the date of hire.

2. The deduction of Union dues for any month shall be made during the applicable month and shall be remitted to the Financial Officer of the Union not later than the third Thursday of the following month. The monthly dues remittances to the Union will be accompanied by a list of names of employees from whose wages dues deductions have been made. Employees may express authorization for payroll deduction of membership dues and/or COPE contributions by submitting

to the Union a written membership form, or by any other means of indicating agreement allowable under state and federal law. The Union will submit to the Board a list of members who have authorized payroll deduction and shall provide the Board with verification that payroll deduction and/or COPE contributions have been authorized by the employee only in the event a question arises about an employee's membership status. An employee who is paying dues may withdraw from membership in the Union and stop making those payments by giving written notice to the Union and the Board which notice must be received or postmarked during the period not less than thirty (30) and not more than forty-five (45) days before the annual anniversary date of the employee's authorization or the date of termination of the applicable contract between the Board and the Union, whichever occurs sooner. The Board will honor employee checkoff authorizations unless they are revoked in writing during the window period, regardless of whether the employee is a member of the Union

3. No dues will be deducted from an employee on sick leave who has exhausted her/his accumulated sick leave or while collecting Workers' Compensation.

4. The Union agrees to indemnify and to hold and save the Board harmless against any and all claims, damages suits, judgments or other forms of liability, including attorney fees, that shall or may arise out of or by reason of any action taken by the Board for the purpose of complying with the provisions of this Article.

5. The Board shall post a copy of the contract by making it available on the Board's website within thirty (30) days after the signing of this Agreement.

6. Union representatives and stewards shall be permitted to enter any of the schools with approval of the building principal for the purpose of discussing, processing, or investigating grievances or fulfilling the Union's role as bargaining agent as long as school operations, including the flow of work with the building, are not disrupted.

7. The Board shall provide space on a bulletin board in each building under its supervision in which a member of the bargaining unit works.

9. Upon request through the principal in a timely manner, the Union will have the right to use school buildings at reasonable times at no cost as long as school operations are not disrupted and the health and safety of the students and staff are not placed at risk.

Article 3
Hours of Work and Overtime

1. The work schedule for nurses shall be Monday through Friday, seven (7) hours and twenty (20) minutes per day, one hundred and eighty-five (185) days per year.

2. Employees shall be notified of schedule changes or transfer between work sites at least two (2) weeks in advance, subject to unexpected events.

3. All assigned work for field trips, flu clinics, Board-sponsored vaccination clinics, and other activities beyond normal school functions in excess of eight (8) hours in one day will be paid at time and one half.

Article 4
Payment for Services

1. All employees shall be paid on a biweekly basis on the same day of every other week. In the event the scheduled payday falls on a holiday or other non-work day, paychecks shall be distributed on the workday immediately preceding the scheduled payday.

2. Employees (10-month) shall have the option of receiving their paychecks in the following manner:

    a. yearly salary divided by twenty-two (22) pay dates
    b. balloon check - yearly salary divided by 26 with last 4 checks paid in one balloon check, separate from the last paycheck.

    All employees shall be paid through direct deposit at a participating bank or qualified financial institution of the employee's choice, on a biweekly basis on the same day of every other week.

Article 5
Payroll Deductions

1. In addition to those payroll deductions required by law, the following agencies are eligible for payroll deductions:

    a. Insurance premium (if any),
    b. Union dues or fees,
    c. Disability insurance,
    d. Tax Sheltered Annuity plans,
    e. Credit Union,

f. Town Pension plan,
g. United Way, and
h. Health Savings Account

Article 6
Seniority

1. Seniority shall be defined as status for specific purposes based on an employee's uninterrupted service with the Board, from date of last hire including all authorized paid leave providing the employee returns to work immediately at the conclusion of such leave.

2. The Board shall prepare a list of all employees covered by this Agreement showing their seniority and length of service with the Board and deliver the same to the Union office on October 1 of each year.

3. Seniority shall not be broken by any authorized leave, but seniority will not accrue during an unpaid leave. Seniority shall be held in abeyance during a period of layoff. Seniority will accrue while an employee is receiving Worker's Compensation benefits.

Article 7
Probationary Period

1. All newly hired employees shall serve a ninety (90) school-day probationary period. During such probationary period, newly hired employees may be discharged without recourse to the grievance procedure.

2. Seniority shall accrue from the date of hire if the probationary period is successfully completed.

Article 8
Vacancy

1. Job vacancy is defined as an opening brought about by death, retirement, resignation, dismissal or the creation of a new position that the Board intends to fill on a permanent basis.

2. All job openings covered by this Agreement shall be posted within five (5) working days of the vacancy so created. Postings shall be in each school and at the office of the Board for five (5) working days and the Union shall be notified of the vacancy by e-mail.

3. Employees desiring to transfer to a vacancy shall file a desire to transfer in writing within the posted time limit.

4. Vacancies shall be filled in one of the following ways:

    a. by transfer of employees within the bargaining unit;
    b. by qualified new applicants.

5. In filling vacancies, consideration shall first be given to the present staff on the basis of seniority.

    An employee with a transfer request on file may be considered first to fill a vacancy.

6. When an employee is temporarily retained in a vacancy or new position for a period of thirty (30) calendar days, she/he will be considered during the selection process for permanent retention in the position.

Article 9
Layoff, Recall & Reduction of Hours

1. No employee shall be laid off as a result of contracting out bargaining unit work.

2. In the event of a layoff or reduction of work hours, the employee affected shall be allowed to bump the least senior employee in the bargaining unit provided the replacing employee has more overall seniority than the employee she/he replaces.

3. A laid off individual's name shall be placed on a recall list for a period of two (2) calendar years, subject to recall in order of seniority (from highest to lowest).

4. All laid off employees shall be given four (4) weeks notice prior to layoff. Prior to any layoff taking place, the Superintendent shall meet with the Union to discuss any possible alternatives to the layoffs being implemented.

Article 10
Leave Provisions

1. All active employees shall receive sick leave with full pay for fifteen (15) working days per year with an accumulation of one hundred sixty-five (165) days of unused sick leave. Each employee shall be notified in writing of her/his accumulated sick leave by November of each year. Sick leave may be used in increments of half or full days. Employees on an approved unpaid leave of

absence at the start of any work year shall be entitled to a prorated award of sick leave upon return to active work.

2. Each active nurse shall receive a total of five (5) personal leave days per year. Personal leave days may be used in increments of half or full days. These days may be taken only for business that cannot otherwise be transacted or scheduled outside school hours but is necessary to be performed on a work day. Advance notice of the personal leave day shall be given to the immediate supervisor as soon as possible. Employees on an approved unpaid leave of absence at the start of any work year shall be entitled to a prorated award of personal leave upon return to active work.

3. Personal days may not be taken just prior to or the day after a paid school holiday. In the case of extenuating circumstances, personal leave time may be used in conjunction with other leave with the approval of the Superintendent of Schools.

4. The Superintendent of Schools may grant additional personal days and extend the maximum allowance of personal days per year after all days have been used or are about to be used.

5. Military Leave shall be granted in accordance with Connecticut State Statute and the Federal Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA).

6. Active employees shall be entitled to full pay at their base rate for absence because of jury duty, less the fee paid with respect to such jury duty. Employees who are dismissed from jury duty during the first half of their workday shall return to work. Employees are encouraged to exercise their option to initially postpone jury duty to the summer non-school months.

7. Prior to the exhaustion of sick leave, an employee may request, in writing, an unpaid leave of absence with position held with the approval of the Superintendent. An employee may also request a leave of absence with position held for other reasons subject to the Superintendent's approval. Upon written request by an employee for continuation of paid insurance coverage, the Board will consider and act upon such request based on the reasons given for the request or leave of absence.

8. Workers' Compensation leave, as distinguished from sick leave, shall mean leave given to an employee due to absence from duty caused by an accident or injury that occurred while the employee was engaged in the performance of her/his duties. The Board shall cover all employees with Workers' Compensation insurance that pays an eligible employee a percentage of her/his earnings during the period of absence.

The difference between her/his Workers' Compensation and her/his current wages shall be provided by the Board for a total period not to exceed ninety (90) days. Said amount shall be payable at the time benefits are paid by the compensation carrier and in accordance with the procedures, rules and regulations of the Board and carrier.

In exceptional cases the Board may grant additional injury leave beyond the original ninety (90) days, upon request of the employee and analysis of the individual case. If the Board refuses to grant additional injury leave beyond the original ninety (90) days, an employee may elect to use a portion of sick leave.

An employee may request the use of her/his sick leave pay while awaiting Workers' Compensation payments. When the Compensation check is paid, it will be sent to the Board who will audit the time and make the necessary adjustments.

Article 11
Pregnancy Leave

Pregnancy disability leave shall be granted in accordance with law.

Article 12
Insurance and Pension Benefits

1. Bargaining unit employees may participate in health and dental insurance plans provided by the Board of Education as set forth in this Article.

2. Subject to law, including the rules and regulations of the Internal Revenue Service, the Board shall maintain a "Section 125" salary reduction agreement which shall be designed to permit exclusion from taxable income of the employee's share of health insurance premiums.

3. Employees shall receive life insurance with accidental death and dismemberment benefits totaling to the nearest $500 of each employee's wage at the Board's expense. Upon retirement, an employee may elect to participate in a life insurance program if permitted to do so by the existing life insurance agency.

4. For budgetary purposes, the Board has discretion to change insurance carriers, managed care providers or health care administrators at any time, in whole or in part, in order to provide insurance coverage as set forth in this Article, provided that the plans which result from change in carriers or third-party administrators are substantially equivalent to the HDHP/HSA plan set forth in the parties' 2018-2021 collective bargaining agreement in terms of coverage, benefits, and

administration . The Board will make efforts to consult with the union when changing carriers. The Board will arrange for information sessions with the employees covered by such insurance in order to provide for the smooth transition in the practices and procedural changes that may occur because of the change to new insurance carriers.

5. Employees hired on or before June 30, 2018 and presently enrolled in such plan shall continue to be eligible to participate in the Master Pension Plan of the Town of East Hampton.

   Employees hired or after July 1, 2018 and those employees hired on or before June 30, 2018 who are not enrolled in the Master Pension Plan of the Town of East Hampton as of June 30, 2018 shall be eligible to participate in the Town of East Hampton's Money Purchase Plan & Trust retirement plan (the "Plan"), which became effective January 1, 2013 and which may be amended from time to time. Employees hired on or after July 1, 2018 shall receive Plan information upon hire. Such employees hired on or after July 1, 2018 shall not be eligible for participation in any other pension or retirement plan.

   The Board shall notify the Union of anticipated changes to the Master Pension Plan or the Money Purchase Plan & Trust retirement plan as it becomes aware of such anticipated changes. This provision of the Agreement is included for informational purposes only and shall not be subject to the grievance procedure.

6. Subject to the provisions of Section 4 of this Article, the medical and Rx insurance plan offered by the Board shall be the United Healthcare Block Purchasing Group medical and prescription drug insurance plan (the "United Plan").

7. The premium cost share percentages for medical and Rx benefits and associated administrative fees under the SP2.0 shall be as follows:

   - Effective July 1, 2024, eligible employees shall pay 20.5%of the premium cost share for medical and Rx coverage.
   - Effective July 1, 2025, eligible employees shall pay 21% of the premium cost share for medical and Rx coverage.
   - Effective July 1, 2026, eligible employees shall pay 21.5% of the premium cost share for medical and Rx coverage.

8. The Board shall offer dental insurance with the same administration, level of benefits, services in effect at the time of execution of this Agreement. For informational purposes, a summary of the applicable Cigna Dental PPO plan is

attached hereto as Appendix A. Effective July 1, 2024, eligible employees shall pay 17% of the premium cost share for dental coverage and associated administrative fees.

9. The Board shall offer vision benefits (lenses and frames) with the same administration, level of benefits, services in effect at the time of execution of this Agreement. For informational purposes, a summary of the Anthem Blue View Vision Plan is attached hereto as Appendix B.

10. The Board shall retain its rights under Section 4 of this Article to change insurance plans or carriers (including a change in third-party administrators) in whole or in part, provided that the change in plans, carrier or third-party administrator is substantially equivalent to the HDHP/HSA plan as set forth in the parties' 2018-2021 collective bargaining agreement in terms of coverage, benefits, and administration. Such HDHP/HSA plan shall be the baseline for determining whether any change to plan, carrier or third-party administrator results in a change that is not substantially equivalent to the HDHP/HSA plan offering as set forth above in the parties' 2018-2021 collective bargaining agreement. The Board will not be required to use the United Plan as such baseline.

11. If the total cost of the insurance plans offered pursuant to this agreement triggers an excise tax under the Patient Protection and Affordable Care Act (Internal Revenue Code Section 4980I), or any local, state or federal statute or regulation, or the Board reasonably anticipates that such a tax will apply for a future coverage period, the Board shall have discretion to reopen negotiations with respect to health insurance plan design and funding, premium cost share and/or introduction of an additional optional or alternative health insurance plan.

12. For employees who are employed by the Board on a less than full-time basis, the Board's contribution towards the Board's portion of the total cost of insurance (including any HSA deductible) shall be proportionate to the amount of time the employee works on a weekly basis. For example, the Board's contribution to the cost of insurance on behalf of a .5 FTE nurse shall be 50% of the contribution it makes to the total cost of insurance for a 1.0 FTE nurse. Likewise, the Board's contribution to the cost of insurance on behalf of a .8 FTE nurse shall be 80% of the contribution it makes to the total cost of insurance for a 1.0 FTE nurse.

Article 13
Disciplinary Action

1. No nurse shall be disciplined without reasonable and just cause. This provision shall not apply to termination, transfers or assignment.

2. The Board shall send copies of notices of such disciplinary action to the Union, unless an employee objects, in writing, to the Union.

3. Written reasons for all suspensions and discharges must be given to the employee at the time of suspension or discharge, except in cases of emergency suspension or discharge, in which case written reasons will be supplied as soon as possible.

Article 14
Grievance Procedure

1. The purpose of this procedure is to secure, at the lowest possible administrative level, solutions to grievances regarding misapplication and misinterpretation of the contract agreement.

2. "Grievance" shall mean a complaint by a bargaining unit member, a group of bargaining unit members or the Union that his/her/its rights under this Agreement have been violated or, that there has been a misinterpretation or misapplication of this Agreement. "Grievant" shall mean the Union, any member of the bargaining unit or a group of bargaining unit members similarly affected by a grievance, seeking recourse under the terms of this Article. "Days" shall mean days when school is in session, except during summer recess when days shall be business days.

3. If a grievance is not filed, in writing at Step II, within twenty (20) working days after the grievant knows or should have known of the act or conditions on which the grievance is based, then the grievance shall be considered to have been waived.

   The time limits specified within this Article, except for the initial filing, may be extended by mutual agreement of the Union and the Board provided that if a grievance is not submitted to a higher step in the above procedure it shall be deemed settled on the basis of the answer in the last step considered.

   Failure by an administrator or the Board to hold a meeting or render his/her/its decision within the specified time limits shall be deemed to be a denial of the grievance, and the grievance shall proceed to the next level.

   In case of dismissal, suspension, and demotion, the grievance shall be submitted directly to Step III.

4. ***Step I – School Principal.*** If an employee feels that she/he may have a grievance, she/he and/or her/his Union Steward or Representative may first discuss the matter with her/his principal or other appropriate administrator in an effort to

resolve the problem informally. If unable to do so, it may be submitted to the next step by stating the grievance in writing and giving a copy to the building principal.

Step II - Director of Support Services. The Director of Support Services shall meet and answer the grievance in writing within ten (10) days of receipt.

Step III - Superintendent of Schools. If the grievant is not satisfied with the Step II answer, the grievance may be submitted within five (5) days of receipt of that answer to the Superintendent who shall meet and answer the grievance in writing within ten (10) working days.

Step IV - Board of Education. If the grievant is not satisfied with the Step III answer, the grievance may be submitted within seven (7) days of receipt of that answer to the Board which shall meet or appoint a committee to meet and answer the grievance in writing within thirty (30) days of receipt of the grievance.

Step V - Mediation. If the grievance is not resolved to the satisfaction of the Union, the Union may submit the matter to a mediator appointed by the State Board of Mediation and Arbitration for the purpose of helping to resolve the grievance within ten (10) days after receipt of the Step IV answer. A copy shall be sent to all parties. The Union may bypass this Step and process the grievance directly to Step VI within ten (10) days after receipt of the Step IV answer.

Step VI - Arbitration. If the grievance is processed to Step V and is not resolved to the Union's satisfaction, or, when Step V is bypassed, the Union may at its option submit the grievance for arbitration within fourteen (14) days after the mediation session or, when mediation is bypassed, within fourteen (14) days of receipt of the Step IV answer. The submission of the grievance shall state the provision of the contract allegedly violated and the remedy sought. Grievances shall be submitted to the American Arbitration Association (AAA) in accordance with applicable AAA rules.

The arbitrator designated shall hear and decide only one (1) grievance at a time. The arbitrator shall have no power to add to, subtract from, alter or modify this Agreement. The arbitrator shall render his/her decision in accordance with AAA rules. The decision of the arbitrator shall be final and binding. The cost of the arbitrator and court reporter shall be borne equally by the parties.

Article 15
Personnel Records

1. An employee covered hereunder shall, upon request, be permitted to examine and copy any and all materials in her/his personnel file. The Union may have access

to any employee's records upon presentation of written authorization of the said employee.

2. No new, derogatory material shall be placed in an employee's personnel file unless she/he has been provided an opportunity to review and sign the document (indicating receipt of such material) and has received a copy of such material. An employee or the Union (upon the employee's request) shall have the opportunity to explain and/or rebut materials contained in her/his file.

Article 16
Employee Expenses

Nurses who are authorized in advance to use their own vehicle for school business shall be entitled to compensation at the current IRS rate. No employee will be required to drive her/his car, except between school job assignments, for training or professional development activities within the district or during an extreme emergency. Employees will not be obligated to use their cars to transport children.

Article 17
Job Descriptions

The Board shall notify the Union about the content of any new job descriptions after they are written but before they are implemented.

Article 18
Professional Development

1. Time for participation in educational institutes, seminars (e.g., First Aid, CPR), workshops or meetings which will improve the individual's on-the-job performance may be granted by the Superintendent. Upon the written approval of the Superintendent, the Board will reimburse the individual the cost of participation in educational institutes, seminars, workshops or meetings. Employees will be reimbursed for all approved professional development activities (even if taken during the summer).

2. If a nurse is required by the Superintendent to attend a professional training course designed to improve her/his job performance and promote professional growth, the Board shall pay the full cost (in advance) of said course, as well as all supplies, books, etc. that are required. Attendance during the regular work day shall result in no loss of pay. Attendance outside the regular work day shall be compensated at the regular per diem rate of pay. The Superintendent may grant the employee early dismissal from work with no loss of pay.

3. The Board shall reimburse each nurse up to $200 each year for membership dues in a related professional organization approved by the administration.

4. Employees will be reimbursed up to $200 per year for professional expenses (including Connecticut licensing renewal fees).

Article 19
Longevity

1. Employees hired on or before June 30, 2020 shall be eligible for longevity compensation as set forth in this section. Employees hired on or after July 1, 2020 shall not be eligible for longevity compensation.

2. Each year, longevity payments shall be awarded to employees based on years of completed employment service with the Board as of November 1 of that year. Longevity payments shall be made based on the following schedule:

15 years of completed service	$900.00
20 years of completed service	$1,000.00
25 years of completed service	$1,100.00

2. The annual longevity payment shall be due and payable in one (1) installment, no later than November 30. Longevity payments shall be included in employees' total earnings for the purpose of determining their pension benefits.

Article 20
Extended Work Year

For all days worked beyond the regular work year, a nurse shall be paid pro rata at one and one-half of her/his per diem rate, provided that all such days must be pre-approved by the Superintendent of Schools or designee.

Article 21
Savings Clause

If any section, sentence, clause or phrase of this Agreement shall be held for any reason to be inoperative, void or invalid, the validity of the remaining portions of this Agreement shall not be affected thereby, it being the intention of the parties in adopting this Agreement that no portion hereof or provision herein shall become inoperative or fail by reason of the invalidity of any other portion or provision, and the parties do hereby declare that they would have approved of and adopted the provisions contained herein, separately and apart from the other. The parties agree to

immediately negotiate a substitute for the invalidated article, section, sentence, clause or phrase.

Article 22
Wages

1. The salary schedule for school nurses shall be:

	2024-25	2025-26	2026-27
Step 1, 0-4 years	$55,564.00	$57,092.00	$58,519.00
Step 2, 5-8 years	$56,815.00	$58,377.00	$59,836.00
Step 3, 9-13 years	$58,093.00	$59,691.00	$61,183.00
Step 4, 14-16 years	$60,271.00	$61,928.00	$63,476.00
Step 5, 17+ years	$61,778.00	$63,477.00	$65,064.00

2. The Superintendent shall determine step placement of new hires based upon years of verified nursing experience.

4. The Nursing Supervisor shall receive an annual stipend of $4,200 for the 2024-25 school year, $4,400 for the 2025-26 school year and $4,600 for the 2026-27 school year. Such stipend shall be applied as salary or paid each year in one installment, no later than January 1, whichever the Nursing Supervisor elects.

Article 23
Duration

1. This Agreement shall be effective as of the first day of July 2024 and remain in full force and effect until the thirtieth day of June 2027. This Agreement shall remain in full force and be effective during the period of negotiations.

2. Either party may notify the other in writing of its desire to bargain collectively with respect to the successor Agreement, however, neither party shall be obligated to take part in any such collective bargaining session prior to February 1, 2027.

IN WITNESS WHEREOF, the parties hereto have set their hands on the date(s) indicated below.

East Hampton Board of Education

By: Stacy Kohler

Date: 7.18.24

Municipal Employees Union Independent

By:

Date: 7-18-24

Cigna Healthcare Financial Exhibit for:

East Hampton Board of Education

DPPO

Effective Date: July 01, 2023

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.
Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.

Plan Design	Total Cigna DPPO	Out-of-Network
Calendar Year Maximum		
(Class I, II, III Expenses)	Unlimited	Unlimited
Calendar Year Deductible		
Per Individual	$0	$0
Per Family	$0	$0
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Sealants Non-Routine X-rays Brush Biopsy	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Emergency Care to Relieve Pain Fillings (Amalgam and composite on all teeth) Oral Surgery - Simple Extractions Minor Periodontics Root Canal Therapy / Endodontics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Stainless Steel/Resin Crowns Fluoride Application	80%, No Deductible	80%, No Deductible
Anesthetics	Not Covered	Not Covered
Class III Expenses - Major Restorative Care		
Space Maintainers (limited to non-orthodontic treatment) Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Crowns/Inlays/Onlays Major Periodontics	67%, No Deductible	67%, No Deductible
Bridges	Not Covered	Not Covered
Dentures	Not Covered	Not Covered
Class IV Expenses - Orthodontia		
	Not Covered	Not Covered
Dental Plan Reimbursement Levels	Based on Contracted Fees	95th Percentile of Submitted Charges***
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between the member's dentist's billed charges and the dental plan reimbursement level***
Student/Dependent Age	26/26	

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APPENDIX A

Cigna Healthcare Financial Exhibit for:

East Hampton Board of Education

DPPO

Effective Date: July 01, 2023

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two routine and 2 periodontal cleanings following active therapy per calendar year
Fluoride	2 per calendar year for people under 16
X-Rays (routine)	Bitewings: 1 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 5 calendar years. Panorex: 1 every 5 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns	Replacement every 7 years
Prosthesis over Implants	1 per every 7 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Bridges	Not Covered
Dentures and Partials	Not Covered
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior teeth. One treatment per tooth every three years up to age 18
Space Maintainers	Limited to non-Orthodontic treatment. No frequency limit for participants under age 19.
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Missing Tooth Provision	No Limitation (teeth missing prior to the effective date of coverage are covered)
Late Entrant Limit****	No coverage until next open enrollment period
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons;
* Replacement of a lost or stolen appliance;
* Replacement of a bridge or denture within five years following the date of its original installation;
* Replacement of a bridge or denture which can be made useable according to accepted dental standards;
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion;
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
* Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type;
* Instruction for plaque control, oral hygiene and diet;
* Dental services that do not meet common dental standards;
* Services that are deemed to be medical services;
* Services and supplies received from a hospital,
* Charges which the person is not legally required to pay;
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
* Experimental or investigational procedures and treatments;
* Any injury resulting from, or in the course of, any employment for wage or profit;
* Any sickness covered under any workers' compensation or similar law;
* Charges in excess of the reasonable and customary allowances;
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

*** In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.*

**** Charges are based upon an independent third party organization that is the industry standard. Percentile data is based upon the third party organization's aggregated industry-wide claims data*

***** Late Entrant coverage limitation does not apply to New Mexico Residents for Insured Dental Products.*

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that most of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can access articles on behavioral conditions that impact oral health.

Prepared by Underwriting.

Memorandum of Understanding Between

The East Hampton Board of Education
and
Municipal Employees Union Independent Local 506, SEIU, AFL-CIO School Nurses

This Memorandum of Understanding is made by and between the **East Hampton Board of Education (the "Board")** and the **Municipal Employees Union Independent Local 506, SEIU, AFL-CIO School Nurses (the "Union")**. The purpose of this Memorandum is to set forth the terms and conditions of the Board's adoption and implementation of a medical and prescription drug insurance plan through Anthem Blue Cross Blue Shield's Century Preferred PPO Choice CSV PCP$0/SPEC$0/$0/$250/$0 Rx $5/$35/$40 (the "Anthem Plan").

WHEREAS, the Board currently provides health insurance benefits through the United Healthcare Block Purchasing Group medical and prescription drug insurance plan (the "United Plan") pursuant to a memorandum of understanding that was entered into by the Board and the Union on or around June 15, 2023 (the "United Plan MOU"), and;

WHEREAS, the Board was quoted a 2024-25 renewal premium for the United Plan of approximately 23%, and;

WHEREAS, the Board and the Union mutually desire to reduce the cost of insurance while preserving existing benefits and;

WHEREAS, the Board and the Union (collectively referred to as the "Parties") agree that it is in their mutual interest for the Board to adopt and implement the Anthem Plan pursuant to the terms and conditions set forth in this Memorandum.

NOW THEREFORE, the Parties agree to the following:

1. Effective July 1, 2024, or as soon as the Board may do so, the Board shall apply to the appropriate entity for coverage under the Anthem Plan. Upon the first day of the month after being accepted into the Anthem Plan, or as soon thereafter as may occur, the Board will cease providing health insurance and prescription benefits through the United Plan and will instead provide health insurance and prescription benefits through the Anthem Plan. A summary of this insurance plan and benefits of the Anthem Plan is attached as Exhibit A to this Memorandum. If the Board's application to provide health insurance through the Anthem Plan is not accepted, the Board shall continue to provide such insurance through the United Plan pursuant to the terms of the United Plan MOU or as otherwise permitted pursuant to the parties' collective bargaining agreement.

2. The Board agrees that the Anthem Plan shall provide benefit levels and coverages, which are substantially equivalent to or better than the United Plan Medical and Pharmacy plan benefits, as it relates to copays, coinsurance, deductibles, and plan maximums. In the event a teacher or his/her dependents have a denied service previously covered by the United Plan, the Board shall instruct Anthem to amend the Anthem Plan to reflect its coverage position and, if needed, reprocess the claim and/or reimburse the member of any out-of-

pocket expenses exceeding the Anthem Plan's copay requirement, except when there is a clinical, medical policy that precludes it and in cases where there is a difference in prescription drug formulary.

3. To minimize disruption to covered employees as a result of changing plans, the Anthem Plan shall feature a six-month transition of care benefit program ("TOC") through which the Parties have agreed to cooperate in attempting to bring into the Anthem network, employee physicians who are in the current United Network, but are not in the Anthem network. With respect to medications: A. For any medication that a member was taking prior to enrolling in the Anthem Plan that is listed as non-formulary medication under the Anthem Plan, the member's provider may seek authorization from Anthem to allow the member to continue taking said medication if they feel it is clinically necessary. Anthem has committed to authorizing all such requests; B. Anthem has committed to covering all generic medications at the Tier 1 co-pay level.

4. For the term of this Memorandum, the Anthem Plan shall be fully-insured and shall comply with all state mandates for fully-insured insurance plans.

5. Similar to the United Plan, the Anthem Plan will offer in-network provider designations enabling members to pay $0 copay for Value Tier 1 In-Network Providers, or $15 copays for all other in-network office and specialist visits.

6. Diabetic medication and supplies will be covered 100.%.

7. The Anthem Plan shall not include Health Enhancement Plan ("HEP") compliance requirements and/or similar wellness plan requirements.

8. The Anthem Plan shall include Anthem's Preventative Rx Plus Drug List for preventive medications covered at 100%, a copy of which is attached hereto as Exhibit B.

9. Anthem shall obtain, and the Anthem Plan shall honor, all prior authorizations in place with United.

10. The Board shall continue the current Dental Plan through CIGNA with premium cost share increases for 2024-25 as set forth in the Parties' 2022-2025 collective bargaining agreement.

11. Vision Plan benefits will continue to be provided through Anthem. In accordance with current practice, employees will pay the same premium cost share for vision benefits as is paid for health and Rx benefits. The terms of such vision coverage shall be as set forth in the attached Anthem Proposed Blue View Vision Plan Summary which is attached hereto as Exhibit C.

12. The Board shall coordinate meeting times in May and/or June of 2024 so that members can familiarize themselves with the Anthem Plan, reach out to Anthem representatives,

research alternative care providers and medications, and, with Union assistance, help facilitate outreach to member's providers who are not currently in the Anthem network.

13. Except as otherwise expressly provided for herein, nothing in this Agreement shall be deemed to impair or supersede the insurance provisions set forth in the Parties' collective bargaining agreement.

14. Effective July 1, 2024, employees shall pay 20.5% of the premium cost share for the medical and Rx coverage set forth in this Agreement.

15. The Parties agree that the Board and the Union have fully complied with all requirements with respect to notification of a potential change in carrier as set forth in the Parties' collective bargaining agreement, and the Union expressly waives any and all claims with respect to such notification process.

16. The terms of this Memorandum shall remain in effect until July 1, 2025 or prior thereto if the Board elects to exercise its right to change insurance carriers in accordance with the provisions of the Parties collective bargaining agreement.

17. The Board and the Union agree that this Memorandum and its contents shall not be relied upon by either party as evidence of a) a violation of the parties' collective bargaining agreement (or any past practice) between them, b) an obligation to bargain over this matter, or c) a failure to bargain over terms and conditions of employment. This Memorandum and its contents shall not constitute a precedent or an instance of a past practice in any future matter. In addition, nothing herein shall be deemed to affect a) any provision of the collective bargaining agreement between the parties except as expressly stated herein, or b) any other condition or term of employment (including any past practice). The parties herewith reserve their rights in future negotiations and further reserve any and all rights that they may have. The Parties may only use this Memorandum in future proceedings if it is necessary to establish a breach of this Memorandum or to enforce the terms of this Memorandum.

18. This Memorandum shall become effective following full ratification by the Board and the Union.

[SIGNATURE PAGE FOLLOWS]

EAST HAMPTON
BOARD OF EDUCATION

By _____ 5/20/24
Duly Authorized Date

Municipal Employees Union Independent Local 506, SEIU, AFL-CIO School Nurses

Beth A Kilgore, RN 5/22/24
Its President Date

Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Century Preferred PPO Choice CSV PCP$0/SPEC$0/$0/$250/$0 Rx $5/$25/$40

Your Network: Century Preferred Tiered

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	No charge

Covered Medical Benefits	Cost if you use a Value Tier 1 In-Network (INET) Provider	Cost if you use a Participating Tier 2 In-Network (INET) Provider	Cost if you use an Out-of-Network (OON) Provider
Overall Deductible	$0 person / $0 family		$300 person / $900 family
Overall Out-of-Pocket Limit	$2,000 person / $4,000 family		$2,000 person / $4,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Non-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Non-Network out-of-pocket limit amounts are separate and do not accumulate toward each other. The out-of-pocket limits for Value Tier 1 In-Network (INET) and Participating Tier 2 In-Network (INET) cross apply, meaning satisfying one helps satisfy the other.			
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*			
Primary Care (PCP) *virtual and office*	No charge	$15 copay per visit	20% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	No charge	$15 copay per visit	20% coinsurance after deductible is met
Specialist Care *virtual and office*	No charge	$15 copay per visit	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Value Tier 1 In-Network (INET) Provider	Cost if you use a Participating Tier 2 In-Network (INET) Provider	Cost if you use an Out-of-Network (OON) Provider
Other Practitioner Visits			
Routine Maternity Care (Prenatal and Postnatal)	No charge	No charge	20% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	No charge	No charge	20% coinsurance after deductible is met
Manipulation Therapy *Coverage is unlimited per benefit period for in network visits and limited to 30 visits per benefit period for non-network visits.*	No charge	No charge	20% coinsurance after deductible is met
Acupuncture *Coverage is limited to services provided for pain management. Coverage is limited to 20 visits per benefit period.*	No charge	No charge	20% coinsurance after deductible is met
Other Services in an Office			
Allergy Testing	No charge‡	$15 copay per visit‡	20% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	No charge‡	$15 copay per visit‡	20% coinsurance after deductible is met
Surgery	No charge‡	$15 copay per visit‡	20% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	No charge	20% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	No charge	20% coinsurance after deductible is met
Diagnostic Services			
Lab			
Office	No charge‡	$15 copay per visit‡	20% coinsurance after deductible is met
Freestanding/Site of Service Lab	No charge	20% coinsurance deductible does not apply	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance deductible does not apply	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Value Tier 1 In-Network (INET) Provider	Cost if you use a Participating Tier 2 In-Network (INET) Provider	Cost if you use an Out-of-Network (OON) Provider
X-Ray			
Office	No charge‡	$15 copay per visit‡	20% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	No charge	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	No charge	20% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans* *Member cost share will not exceed $375 copayment maximum for MRI, MRA, CAT, CTA, PET, and SPECT scans, per member per benefit period.*			
Office	No charge‡	No charge	20% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	No charge	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	No charge	20% coinsurance after deductible is met
Emergency and Urgent Care			
Urgent Care *Includes doctor services. Additional charges may apply depending on the care provided.*	$15 copay per visit	$15 copay per visit	20% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$250 copay per visit	$250 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	No charge	Covered as In-Network
Ambulance *Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	No charge	No charge	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility			
Facility Fees	$15 copay per visit	$15 copay per visit	20% coinsurance after deductible is met
Doctor Services	No charge	No charge	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Value Tier 1 In-Network (INET) Provider	Cost if you use a Participating Tier 2 In-Network (INET) Provider	Cost if you use an Out-of-Network (OON) Provider
Outpatient Surgery			
Facility Fees			
Hospital	No charge	No charge	20% coinsurance after deductible is met
Ambulatory Surgical Center/Site of Service Provider	No charge	No charge	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*			
Hospital	No charge	No charge	20% coinsurance after deductible is met
Ambulatory Surgical Center/Site of Service Provider	No charge	No charge	20% coinsurance after deductible is met
Hospital (including Maternity, Mental Health and Substance Use Disorder Services) *If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*			
Facility Fees	No charge	No charge	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*	No charge	No charge	20% coinsurance after deductible is met
Home Health Care *Coverage is limited to 200 visits per benefit period. Limits are combined for all home health services.*	No charge	No charge	20% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies is unlimited per benefit period for in network visits and limited to 30 visits per therapy per benefit period for non-network visits.*			
Office	No charge	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	No charge	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Value Tier 1 In-Network (INET) Provider	Cost if you use a Participating Tier 2 In-Network (INET) Provider	Cost if you use an Out-of-Network (OON) Provider
Pulmonary rehabilitation			
Office	No charge	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	No charge	20% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	No charge	No charge	20% coinsurance after deductible is met
Dialysis/Hemodialysis			
Office	No charge‡	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	No charge	20% coinsurance after deductible is met
Chemo/Radiation Therapy			
Office	No charge‡	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	No charge	20% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is unlimited per benefit period for in network visits and limited to 60 visits per benefit period for non-network visits.*	No charge	No charge	20% coinsurance after deductible is met
Inpatient Hospice	No charge	No charge	20% coinsurance after deductible is met
Durable Medical Equipment	No charge	No charge	20% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	No charge	No charge	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Value Tier 1 In-Network (INET) Provider	Cost if you use a Participating Tier 2 In-Network (INET) Provider	Cost if you use an Out-of-Network (OON) Provider
Hearing Aids *Coverage is limited to 1 item per ear every 24 months.*	No charge	No charge	20% coinsurance after deductible is met
Bariatric Surgery	Coverage is based on place of service	Coverage is based on place of service	20% coinsurance after deductible is met
Temporomandibular Joint (TMJ) Services	Coverage is based on place of service	Coverage is based on place of service	20% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	$4,600 person / $9,200 family	$4,600 person / $9,200 family
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Essential***		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic	$5 copay per prescription (retail) and $5 copay per prescription (home d elivery)	20% coinsurance (retail and home delivery)
Tier 2 – Typically Preferred Brand	$25 copay per prescription (retail) and $25 copay per prescription (home delivery)	20% coinsurance (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand	$40 copay per prescription (retail) and $40 copay per prescription (home delivery)	20% coinsurance (retail and home delivery)

Covered Vision Benefits		Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Adult and children's vision services count towards your out-of-pocket limit.			
Child Vision exam *Limited to 1 exam every 2 benefit periods.*		No charge	20% coinsurance after deductible is met
Adult Vision exam *Limited to 1 exam every 2 benefit periods.*		No charge	20% coinsurance after deductible is met
Vision Therapy *Unlimited visits per benefit periods.*	No charge	No charge	20% coinsurance after deductible is met

Notes:

If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
Certain screening and diagnostic testing for the detection of ovarian and breast cancer are covered in full as required by state mandate.
Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
Breast biopsies, prophylactic mastectomies, and breast reconstructive surgery are covered in full as required by state mandate.
The first two office visits for Mental Health or Substance Use Disorder services are covered in full.
The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
‡ You will pay the PCP's office visit copay when services are provided in their office.
The representations of benefits in this document are subject to CT Department of Insurance (CT DOI) approval and are subject to change.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Questions: (833) 899-7070 or visit us at www.anthem.com

PreventiveRx Plus Drug List
PreventiveRx Plus Plan (Essential)

Anthem

PreventiveRx covers drugs that may keep you healthy because they may prevent illness and other health conditions. You can get the products on this list at low or no cost to you depending on your benefit.
This list includes only prescription products. Brand-name drugs are listed with a first capital letter. Non-brand drugs (generics) are in lowercase letters.

Most brand-name drugs that have a generic equivalent available are not covered under this PreventiveRx benefit.

Drugs* listed below may be covered for plans with the Essential Drug List. If your plan has a different drug list, please check to see if these drugs are included on your drug list. PreventiveRx Plus drugs are only covered if they are included on your specific drug list.
*Some drugs and supplies may be excluded from your benefits. Please refer to your Certificate or Evidence for Coverage for coverage limitations and exclusions.

Please note: The drug list is subject to change and all previous versions of the drug list are no longer in effect.

HEART HEALTH AND HIGH BLOOD PRESSURE
acebutolol
amlodipine/ benazepril
atenolol
atenolol/ chlorthalidone
benazepril
benazepril/ hctz
betaxolol
bisoprolol fumarate
bisoprolol/ hctz
captopril
captopril/ hctz
carvedilol
enalapril
enalapril/ hctz
fosinopril
fosinopril/ hctz
labetalol
lisinopril
lisinopril/ hctz
metoprolol succinate er
metoprolol tartrate
metoprolol/ hctz
moexipril
nadolol
nebivolol
perindopril
pindolol
propranolol
propranolol er
propranolol/ hctz
quinapril
quinapril/ hctz
ramipril
sorine
sotalol
sotalol af
timolol
trandolapril
trandolapril/ verapamil

OSTEOPOROSIS
alendronate sodium
amabelz
calcitonin salmon
Climara Pro
Combipatch
dotti
estradiol
estradiol/ norethindrone
evamist
Fosamax Plus D
fyavolv
ibandronate sodium
jinteli
lopreeza
mimvey
mimvey lo
Premarin (oral)
Premphase
Prempro
raloxifene
risedronate
risedronate DR

ASTHMA
Arnuity Ellipta
Breo Ellipta
budesonide suspension
budesonide/ formoterol
Flovent Diskus
Flovent HFA
fluticasone/ salmeterol inhalation powder
fluticasone/ vilanterol
formoterol nebulization solution
QVAR RediHaler
Trelegy Ellipta
wixela inhub

DIABETES
(Diabetic supplies including blood glucose meters, test strips and lancets require a prescription to be covered by this plan. Only blood glucose meters & blood glucose test strips for OneTouch and Accu-Chek products will be covered by this benefit. Continuous Glucose Monitors (CGMs) are not included in PreventiveRx Coverage.
acarbose
alogliptin
alogliptin/metformin
alogliptin/pioglitazone
Farxiga
glimepiride
glipizide
glipizide er
glipizide xl
glipizide/ metformin
glyburide
glyburide micronized
glyburide/ metformin
Glyxambi
Humalog
Humalog Junior Kwikpen
Humalog Kwikpen
Humalog Mix 50/50
Humalog Mix 50/50 Kwikpen
Humalog Mix 75/25
Humalog Mix 75/25 Kwikpen
Humulin 70/30
Humulin 70/30 Kwikpen
Humulin N
Humulin N Kwikpen
Humulin R
Humulin R U-500
Humulin R U-500 Kwikpen
Insulin Glargine
Insulin Glargine Solostar
Insulin Lispro
Insulin Lispro Junior Kwi
Insulin Lispro Kwikpen
Insulin Lispro Protamine
Janumet
Janumet XR
Januvia
Jardiance
Lantus
Lantus Solostar
Levemir
Levemir Flextouch
Lyumjev
Lyumjev KwikPen

PreventiveRx Plus Drug List
PreventiveRx Plus Plan (Essential)

Anthem

metformin
metformin er (generic for Glucophage XR)
miglitol
nateglinide
Ozempic
pioglitazone
pioglitazone/ metformin
pioglitazone/ glimepiride
repaglinide
Rybelsus
Soliqua
Symlinpen 120
Symlinpen 60
Synjardy
Synjardy Xr
tolbutamide
Toujeo Max Solostar
Toujeo Solostar
Tresiba
Tresiba Flextouch
Trijardy XR
Trulicity
Victoza
Xigduo XR
Xultophy

MENTAL HEALTH
citalopram
escitalopram oxalate
fluoxetine
fluoxetine DR
fluvoxamine
fluvoxamine ER
paroxetine
paroxetine ER
sertraline

HIGH CHOLESTEROL
amlodipine/ atorvastatin
atorvastatin
ezetimibe/ simvastatin
fluvastatin
lovastatin
pravastatin
rosuvastatin
simvastatin

Group Name: East Hampton BOE

Proposed Blue View Vision plan design

Blue View Vision plan benefits	In-Network	Out-of-Network	Frequency
Routine Eye Exam			
A comprehensive eye examination	$15 copay	Up to $45 reimbursement	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$175 allowance, then 20% off any balance	Up to $126 reimbursement	One every 12 months
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses:			
○ Single vision lenses	$0 copay	Up to $40 reimbursement	One every 12 months
○ Bifocal lenses	$0 copay	Up to $65 reimbursement	
○ Trifocal lenses	$0 copay	Up to $75 reimbursement	
○ Lenticular lenses	$0 copay	Up to $100 reimbursement	
Contact Lenses[1] *(instead of eyeglass lenses)*			
○ Elective conventional (non-disposable); OR	$360 allowance, 15% off any balance	Up to $345 reimbursement	Once every 12 months
○ Elective disposable; OR	$360 allowance (no additional discount)	Up to $345 reimbursement	
○ Non-elective (medically necessary)	Covered in full	Up to $345 reimbursement	

EXHIBIT C

[1] *Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over*

Group Name: East Hampton BOE
Proposed Blue View Vision plan design
Additional savings available from Access in-network providers
When obtaining covered eyewear from a Blue View Vision provider, members may choose to upgrade their new eyeglass lenses at a discounted cost. Costs shown are after any applicable eyeglass lens copayment.

Blue View Vision plan benefits	In-Network Member Copay	Out-of-Network	Frequency
Eyeglass Lens Enhancements			
◦ Transitions Lenses (pediatric)	$75	N/A	Same as covered eyeglass lenses
◦ Standard polycarbonate (pediatric)	$0	N/A	
◦ Factory scratch coating (pediatric)	$15	N/A	
◦ Transitions Lenses (adults)	$75	N/A	
◦ Standard polycarbonate (adults)	$40	N/A	
◦ Factory scratch coating (adults)	$15	N/A	
◦ Progressive Lenses			Same as covered eyeglass lenses
◦ Standard	$65	Up to $65 reimbursement	
◦ Premium Tier 1	$85	Up to $65 reimbursement	
◦ Premium Tier 2	$95	Up to $65 reimbursement	
◦ Premium Tier 3	$110	Up to $65 reimbursement	
◦ Premium Tier 4	20% off retail price	Up to $65 reimbursement	
◦ Anti-Reflective Coating			Same as covered eyeglass lenses
◦ Standard	$45	N/A	
◦ Premium Tier 1	$57	N/A	
◦ Premium Tier 2	$68	N/A	
◦ Premium Tier 3	20% off retail price	N/A	
◦ Tint (Solid and Gradient)	$15	N/A	Same as covered eyeglass lenses
◦ UV Coating	$15	N/A	
◦ Oversized Lenses	$0	N/A	
◦ Other lens upgrades and add-ons	20% off retail price	N/A	
◦ Retinal Imaging (obtained at same time as covered eye exam)	Up to $39	N/A	
◦ Standard contact lens fitting and follow-up after comprehensive eye exam	Up to $55	N/A	
◦ Premium contact lens fitting and follow-up after comprehensive eye exam	10% off retail price	N/A	
◦ Additional supplies of conventional contact lenses after benefits have been used	15% off retail price	N/A	
◦ Additional complete pairs of eyeglasses	40% off retail price	N/A	
◦ Eyeglass materials purchased separately	20% off retail price	N/A	
◦ Other items including most non-prescription sunglasses, eyewear accessories such as lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price	N/A	

Other discount offers on LASIK surgery and much more available through Anthem's SpecialOffers program.

This information is intended to be a brief outline of plan benefits. The most detailed description of benefits, exclusions, and restrictions can be found in the Certificate of Coverage. Discounts are subject to change without notice. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan. Discounts will not apply when a manufacturer has imposed a no discount policy on the item.