AGREEMENT

BETWEEN THE

PITTSFIELD SCHOOL COMMITTEE

AND THE

PITTSFIELD FEDERATION OF SCHOOL EMPLOYEES
LOCAL 1315, AMERICAN FEDERATION OF TEACHERS (AFT)
AFT MASSACHUSETTS, AFL-CIO
CAFETERIA UNIT

SEPTEMBER 1, 2018 – AUGUST 31, 2021

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ARTICLE I
FEDERATION RECOGNITION, JURISDICTION, AND DEFINITIONS

A. FEDERATION RECOGNITION

The Pittsfield School Committee recognizes the Pittsfield Federation of School Employees, Local 1315, AFT MA, AFL-CIO as the exclusive bargaining representative for all cafeteria employees, excluding the Director, for bargaining on questions of wages, hours and other terms and conditions of employment.

B. JURISDICTION

The terms of this Agreement shall apply to those persons who perform the duties and functions of the categories of employees in the bargaining unit.

C. DEFINITIONS

1. The term "Committee" as used in this Agreement means the Pittsfield School Committee.

2. The term "parties" as used in this Agreement refers to the Committee and the Federation as participants in this Agreement.

3. The term "school" as used in this Agreement means any work location or functional division maintained by the School Department.

4. The term "Administration" or "The Administration" shall be understood to mean the same as "Superintendent" or his Deputies.

5. The term "Director" as used in this Agreement means the responsible administrative head of the cafeteria system of the Pittsfield School Department.

6. The term "satellite programs" as used in this Agreement means any program under which meals other than the normal school lunch or breakfast are prepared.

7. The term “Federation” as used in this Agreement means the party recognized by the Committee in Article I § A, above.

8. Wherever the singular is used in this Agreement, it is to include the plural.

9. Wherever in this Agreement a personal pronoun is used, such pronoun shall be understood to apply equally to both male and female members of the bargaining unit.

D. AGENCY SERVICE FEE

The Committee will respect the position of the Pittsfield Federation of School Employees, Local 1315, AFT MA, AFL-CIO, Cafeteria Unit, as the sole and exclusive bargaining unit of all employees in the Cafeteria Unit on matters of wages, hours, and conditions of employment for the life of this Agreement.

1. Effective thirty (30) days after the commencement of the 1999-2000 school year, or the commencement of employment, whichever comes later, each employee, in accordance with the G.L. c.150E, § 12, shall be required to pay the agency service fee to the Pittsfield Federation of School

Employees, Local 1315, AFT MA, AFL-CIO, Cafeteria Unit, as a condition of his/her employment in the district.

2. Any employee who fails to pay the agency fee in lieu of dues to the exclusive bargaining agent will be subject to legal action by the Pittsfield Federation of School Employees for collection of said fee. Any cost of collecting said fees will be added to the individual's total service fee due. The Pittsfield Federation of School Employees will be solely responsible for enforcing the provisions of this Section. The Committee will not be responsible to enforce any provision of the Section.

3. The Pittsfield Federation of School Employees will indemnify, defend and hold harmless the Committee against any all claims, actions, or lawsuits of any kind or description, whether at law or inequity, and whether based on statute, constitution or common law, made or instituted against the Committee or its agents, employees, or administrators, resulting from this Section. Specifically, the Pittsfield Federation of School Employees will have no right of action by way of contribution, counterclaim, or other basis against the Committee. Should any administrative agency or court of competent jurisdiction find the Committee liable for any damages as a result of this Section, the Pittsfield Federation of School Employees will pay any and all of those damages, including interest and charges.

4. If any court or competent jurisdiction determines that any part of this Section 1, 2, or 3, is unconstitutional, in violation of statute, or otherwise unenforceable, all of the other parts of this 1, 2, and 3, will be null and void.

5. The service fee shall be calculated in accordance with the provisions of the M.G.L. c.150E, § 12, and applicable state and federal constitutional law. Payment of said fee will not entitle the fee payer to be a member in good standing with the Pittsfield Federation of School Employees.

E. NON-DISCRIMINATION. It is the policy of the Pittsfield Public Schools to abide by the letter and spirit of the laws of the Commonwealth and of the United States that guarantee the equal and unbiased treatment of all students, parents, and employees of the Pittsfield Public Schools. The General Laws cited in the policies generally require that no person be discriminated against in employment practices including, but not limited to, hiring, promotion, transfer, discharge, pay, fringe benefits, or access to educational programs and services on the basis of race, color, sex, religion, national origin, age, handicap, sexual orientation, union activity, military/veteran status, or gender activity.

ARTICLE II
CONDITIONS OF EMPLOYMENT

A. No current condition of employment which affects mandatory subjects of bargaining will be changed by the COMMITTEE without affording the FEDERATION notice and an opportunity to bargain regarding the impact of the change prior to its implementation.

B. The Federation shall not contest or obstruct by any means or in any forum the Committee's pursuit of removal from civil service classification and jurisdiction of all positions identified in Article I; and the Committee agrees to include language in the new Agreement that provides rights in the areas of seniority, layoff, recall, bumping, and just cause for disciplinary action that are comparable to those possessed by unit employees who are covered by civil service. However, all current employees who are employed as of the effective date of this Agreement shall be covered by the Civil Service to the extent provided by law.

ARTICLE III
COMPENSATION

A. BASIC SALARY SCHEDULE

1. The salaries of the members of the bargaining unit set forth in Appendix A, which is attached to and made a part of this Agreement.

2. Presently employed personnel shall be placed on the step appropriate for their creditable years of experience as determined by their initial date of employment, and shall advance to the next step as provided in salary schedule in Appendix A.

3. The following designation of cafeteria employees shall be used for salary purposes:

- High and Middle School Cook Manager
- Community School and Crosby School Cook Manager
- Elementary School Cook Manager
- Baker - High, Middle, Community, Crosby
- Cafeteria Van Driver – Taconic High School
- Cafeteria Helper

B. METHOD AND TIME OF SALARY PAYMENT

1. Employees shall be paid twenty (20) bi-weekly installments. The twenty (20) installments shall include payment for ten (10) vacation days and ten (10) paid holidays.

2. Bi-weekly paychecks will be delivered to all employees by Wednesday. The pay day shall be changed from Wednesday to Friday effective upon the City of Pittsfield's implementation of same. Any employee hired on or after September 1, 2014 shall be required to receive their compensation by

direct deposit.

3. The following holidays shall be allowed with pay: Labor Day, Columbus Day, Thanksgiving Day, Christmas Day, New Year's Day, Martin Luther King Day, Presidents' Day, Good Friday, Patriots' Day, Memorial Day and Veterans' Day. Holidays will be paid in the paycheck covering the period in which they occur.

4. In order to qualify hereunder for compensation for any such holiday, such employee must have worked all of her last regularly scheduled workday prior to, and the next regularly scheduled workday following such holiday, unless the absence of such regularly scheduled workday is due to jury service, a verifiable bona fide illness of the employee or of a sick relative of the first degree (as defined in Article VII(A)(7)(a), an approved personal day, or bereavement leave as provided for under this Agreement.

5. The following vacation pay shall be allowed to all members of the bargaining unit:

Upon completion of one (1) year of creditable service		Two (2) Weeks
Upon completion of five (5) years of creditable service		Three (3) Weeks
Upon completion of ten (10) years of creditable service		Four (4) Weeks

6. Such pay will be taken throughout the school year in the paycheck due during regularly scheduled vacation except that the fourth week shall be paid in the final paycheck of the school year. An Employee who is eligible for a fourth week of vacation pursuant to section 5 may choose to have said monies paid on the first five (5) days when school is not in session due to inclement weather, scheduled half days, or scheduled vacation breaks instead of in the final paycheck. Remaining vacation time, if any, will be paid in the final paycheck of the school year. In order to be eligible for this option, the Employee must notify the Cafeteria Director no later than June 30th of the preceding year.

7. Vacation time shall continue for Cook Managers throughout the term of the contract. After September 1, 1997 all new hires shall not be entitled to vacation time unless hired as a Cook Manager.

8. In order to qualify for vacation pay in a given year, an employee must have completed two (2) full months of employment to be eligible for one (1) week, four (4) months to be eligible for two (2) weeks, and six (6) months to be eligible for three (3) weeks and eight (8) months to be eligible for four (4) weeks.

9. If an employee terminates her/his service after October 31st, such employee shall receive one (1) week vacation pay if qualified for vacation under Section 5.

10. If an employee terminates her/his service after December 31st, such employee shall receive two (2) weeks vacation pay if qualified for vacation under Section 5.

11. If an employee terminates her/his service after February 28th, such employee shall receive three (3) weeks vacation pay if qualified for vacation under Section 5.

12. If an employee terminates her/his service after April 30th, such employee shall receive four (4) weeks vacation pay if qualified for vacation under Section 5.

C. WORKING BEFORE AND/OR AFTER THE REGULAR SCHOOL YEAR

1. Volunteers will be solicited for work before and or following the close of the school year before any employee shall be required to work at such times.

2. Any employee who works in excess of the school year shall be compensated in accordance with the salary schedule set forth in Appendix A.

3. Cafeteria workers will be notified by June l[st] of any meetings, workshops, seminars, etc. which may only be scheduled the last two (2) weeks before school starts for the time period between the close of the school year and the opening of the school year.

D. OVERTIME

1. Employees who work beyond or prior to their normal workday shall be compensated at their regular rate unless the total number of hours worked in one week exceeds forty (40) hours. The rate for hours worked in excess of forty (40) hours shall be paid at the rate of time and a half.

2. In the event that an employee is unable to report for work at the scheduled time, such employee shall not suffer loss of pay except for the actual time not worked.

3. All evening work after 5 p.m. will be at the rate of time and one-half.

4. The rate for hours worked on Saturdays and Sundays shall be paid at the rate of time and a half.

E. MINIMUM CALL BACK

In a situation where an employee is called back to work after having left the workplace upon the conclusion of the employee's regular work day, or when an employee is required to come to the workplace when school is not normally in session, said employee shall receive a minimum of two (2) hours pay regardless of the length of time the employee actually works, and the Director has the right to require the employee to work the full two (2) hours. This minimum call back does not apply if the additional work is contiguous to the employee's regular work day.

F. ITEMIZED PAYROLL DEDUCTIONS

A statement of bi-weekly payroll deductions shall be provided to each employee.

G. ANNIVERSARY DATES

For purposes of salary payment, employees serving more than ninety (90) school days in one school year will be given credit for one year's service.

H. MILEAGE ALLOWANCE

Employees covered by this Agreement who are authorized to use private automobiles for school

business shall be reimbursed at the rate in effect in March of each year as established by the Internal Revenue Service. Such rate shall be used for mileage reimbursement during the ensuing contract year.

I. NEW POSITIONS

If any new position is established within the bargaining unit covered by the Agreement, the School Committee shall negotiate with the Federation regarding the wages, hours, and conditions of employment for said position.

J. SEVERANCE PAY

Upon retirement or death, an employee with ten (10) years or more of service shall receive a severance for one-half (1/2) of all accumulated sick leave days at a daily rate of pay. In the case of death, said amount shall be paid to the employee's estate. Retirement must meet the City's definition for retirement.

ARTICLE IV FRINGE BENEFITS

A. HEALTH INSURANCE

1. The Committee and the Union are parties to a Memorandum of Agreement, dated April 6, 2018 hereinafter "the Section 19 Agreement" which provides for health insurance benefits to be provided through the Massachusetts Interlocal Insurance Association/BlueCross BlueShield Massachusetts (MIIA/BCBSMA). Employees shall receive health insurance benefits in accordance with the Section 19 Agreement so long as said Agreement is in effect. The Section 19 Agreement is attached hereto, and incorporated herein by reference as Appendix B.

2. Health insurance premium deductions shall be equalized throughout the year based upon twenty (20) payroll periods. Health insurance premium increases effective July 1st will be deducted from an employee's paycheck during the month of June.

B. LIFE INSURANCE

The Committee agrees to pay that portion of the $5,000 Life Insurance premium paid for other city employees under terms of Chapter 32B of the General Laws of Massachusetts.

C. TAX-FREE ANNUITY

All members of the bargaining unit shall be allowed to take advantage of whatever federal law may be in force concerning tax-free annuities.

D. WORKERS COMPENSATION

All members of the bargaining unit shall be included under the provisions of the Workers Compensation Law.

ARTICLE V
WORKING CONDITIONS

A. NOTICES AND ANNOUNCEMENTS

1. All official circulars pertaining to cafeteria employees in a particular school shall be posted on that school's cafeteria bulletin boards and a copy furnished to the Federation Representative in the building.

2. A copy of the Rules and Regulations of the Pittsfield School Committee and amendments thereto will be made available to members of the unit in each school building.

3. A copy of the Directory of School Department Personnel will be made available to the manager of each school cafeteria in each school building.

4. The chairperson of the cafeteria employees unit shall be notified of any transfer, appointment, or resignation of members of the bargaining unit as a result of School Committee action.

5. No cafeteria worker shall be required to notify, discuss, or make arrangements for payment when a check is returned for insufficient funds or for any other reason.

6. No cafeteria worker shall be required to organize, conduct, or present workshops, classes or seminars.

B. SCHOOL FACILITIES

1. Cafeteria employees shall be allowed to use school telephones.

2. Adequate parking facilities for cafeteria employees shall be provided in all schools.

3. Where lockers are presently provided to cafeteria employees, they will continue to be provided.

C. SENIORITY, FAIR DISMISSAL, TERMINATIONS

Seniority, fair dismissal and terminations, layoffs, and recall shall be governed by Chapter 31 (Civil Service) of the General Laws of Massachusetts.

D. WORK YEAR

1. Cafeteria employees shall work each day when school lunches are being served. On days when school lunches are not being served, cafeteria workers shall have the option of working or being absent with loss of pay. On days during the student school year when breakfasts and school lunches are not being served, cafeteria workers will not have the option of working and must be absent with loss of pay. Cafeteria workers shall be provided with an opportunity to work a minimum of 180 school days

per year.

2. The pay schedule will be 40 weeks. They will be paid for snow days when they work the make-up day - not when the snow day occurs.

3. For each four (4) hours scheduled, an employee shall be entitled to a fifteen (15) minute break.

4. Cafeteria employees shall be given at least twenty-four (24) hours notice of the need to provide refreshments for meetings whenever possible.

5. The Director shall be solely responsible for supplies. No employee shall be required to pick up or deliver supplies.

6. Employees shall be scheduled to work a half (1/2) day following the final day of school for the academic year, when it will not be necessary to prepare meals, in order to clean the cooking facilities and equipment. Schools where the last day of student meals served is not the last day of school should not be scheduled for the additional half day. Managers may choose to schedule this cleaning work prior to the end of school at the appropriate rate of compensation.

7. Cook Managers shall receive one (1) hour additional time on the last working day of the month to conduct inventory. If a Cook Manager's designee does inventory, said person will receive the additional one (1) hour instead of the Cook Manager, if approved in advance by the Food Service Director.

8. All Cook Managers will be allowed to work an additional one-half (1/2) hour per day to complete paperwork.

E. EMPLOYEE FILES

1. Employee files shall be maintained under the following circumstances:

a. No material derogatory to an employee's conduct, service, character, or personality shall be placed in the files by an administrator unless the employee is sent a dated copy at the time.

b. The employee shall have the right to submit a response to the statement. The employee's answer shall also be included in the file.

c. An employee may review his file by making an appointment in advance.

d. Upon receipt of a written request, the employee shall be furnished a reproduction of any material in his file for a nominal fee.

2. Derogatory statements or reports kept by administrators at the school level are subject to the same provisions as official personnel files.

3. Official grievances filed by any employee under the Grievance Procedure as outlined in this Agreement shall not be placed in the personnel file of the employee; nor shall such grievance become a part of any other file or record which is utilized in the promotion process; nor shall it be used in any recommendations for job placement.

F. EMPLOYEE SUBSTITUTING

Whenever a Cook Manager or Baker is absent for one (1) or more full working days, the Helper or other bargaining unit member who substitutes in his/her place shall be compensated at the rate paid to an employee in the absent employee's job with the substitute's years of service.

G. APRONS & WORK SHIRTS

Plastic aprons shall be provided by the system as required. Cafeteria workers shall be provided with three (3) work shirts per school year. Effective at the end of the work day on June 30, 2011, cafeteria workers shall be provided with five (5) work shirts per school year.

H. NOTIFICATION

In the event that a cafeteria worker is to be laid off, she shall be notified by the end of the school year except in cases of extreme emergency.

I. KITCHEN SAFETY

1. All safety violations will be reported to the Director.

2. The Director shall investigate and, if necessary, take corrective action or recommend such corrective action to the building principal, the Director of Human Resources, or the Building Maintenance Department.

3. The Director will notify the union of action taken.

4. If the problem is not corrected a four member Committee shall be appointed - two members to be appointed by the Federation and two members by the Director.

5. The Committee shall investigate and write a joint report or separate reports.

6. If there are recommendations, they shall be presented at the next School Committee meeting.

7. Every employee must be safety conscious and make every effort to follow safety precautions in connection with her work and to eliminate safety hazards for students and staff personnel in the area of her responsibility.

J. CLOTHING ALLOWANCE

1. Effective upon ratification, all employees shall receive annually a clothing allowance of one hundred and seventy dollars ($170), which shall be available as follows: (1) the allowance shall be in the form of reimbursement of costs incurred by the employee; (2) reimbursement shall be made up to the amount of the allowance upon presentation of receipts for merchandise the employee purchases; and (3) reimbursement shall be for the purchase of items which are part of the standard uniform not provided by the employer. All receipts must be submitted no later than June 30th of each year. Effective September 1, 2017, up to fifty dollars ($50) of the above-referenced one hundred and seventy dollar ($170) clothing allowance may be used for tailoring and/or laundering costs. The allowance shall

be in form of reimbursement of costs incurred by the employee upon presentation of receipts for said tailoring and/or laundering costs.

2. All employees shall be required to wear the following standard uniform:

a. Pair of standard slip-resistant (non-skid) shoes.

b. Socks.

c. Black or white pants, excluding knit or sweatpants.

d. Collared polo shirt with food service logo (provided by employer).

e. Colored t-shirts with food service logo.

f. White or blue cobbler apron during meal preparation; colored apron during serving period (provided by employer).

g. Latex-free vinyl gloves during food preparation and serving (provided by employer).

h. Hair restraint: caps or visors (provided by employer).

i. Hair-nets and/or hair-ties.

ARTICLE VI
TRANSFERS, VACANCIES AND NEW POSITIONS

A. TRANSFERS

1. Employees may apply for a transfer to vacant positions when such vacancies are posted.

2. Assignments to fill such vacancies by transfer may be made during the school year.

3. Notice of transfer shall be given to an employee as soon as possible following granting of the request.

4. When a reduction in the number of cafeteria employees in a school is necessary, qualified volunteers will be considered first for transfer. Involuntary transfers will be governed by inverse seniority (i.e. the least senior employee will be transferred).

5. If a cafeteria helper's position becomes vacant through a resignation or retirement, the new employee hired will be assigned to the specific vacancy that occurs as the result of no more than two transfers.

B. VACANCIES AND NEW POSITIONS

1. TEMPORARY VACANCIES.

a. ABSENCE OF UP TO 20 DAYS**.** A unit position from which its occupant will be absent for up to twenty (20) working days shall be filled by the most qualified unit member who already works in the building in which the absence occurs, so long as there is an administrative determination made to fill the vacancy.

b. ABSENCE OF MORE THAN 20 DAYS**.** A unit position from which its occupant will be absent for

more than twenty (20) working days shall be posted for three (3) working days at the time the absence is known to be of said duration, so long as there is an administrative determination made to fill the vacancy.

c. FILLING TEMPORARY VACANCIES**.** The most qualified unit member who applies for said position shall be offered the position that is temporarily vacant, and where all qualifications are equal, seniority shall govern who is offered the position, so long as there is an administrative determination made to fill the vacancy.

d. POSITIONS VACATED BY TEMPORARY TRANSFERS**.** A position vacated by a temporary transfer arising under paragraph (c), above, shall not be posted, but shall be filled according to the procedure set forth in paragraph (a), above, so long as there is an administrative determination made to fill the vacancy.

e. EMPLOYMENT OF A SUBSTITUTE**.** Where there is no qualified unit member who applies for a position that is temporarily vacant then a substitute from outside the bargaining unit may be employed.

2. PERMANENT VACANCIES.

a. DEADLINE FOR FILLING PERMANENT VACANCY**.** Posting a permanent vacancy, as that term is defined in paragraph (d), below, shall be filled within thirty (30) calendar days of the posting of the position and the availability of a pertinent civil service list, so long as there is an administrative determination made to fill the vacancy.

b. CONTENT OF POSTING. Any posting under this section shall state accurately the qualifications and experience required for the position, the location of the primary building assignment, total number of hours per day for the vacancy, including travel time between school buildings.

c. REPOSTING AN UNFILLED VACANCY**.** A position posted under this subsection that is not filled pursuant to paragraph (a), above, shall be reposted before it is refilled, so long as there is an administrative determination made to fill the vacancy.

d. "PERMANENT VACANCY" DEFINED. A "permanent vacancy" shall be defined as a position in the bargaining unit (i) that is a new position, or (ii) whose previous regularly assigned occupant has resigned, or retired, or died while employed in the position.

3. Requests for transfers shall be filed in writing with the office of the Director.

4. Nothing in this Agreement shall prevent the Superintendent from making acting appointments until positions can be filled with permanent appointments as provided in this Agreement.

5. Promotions to a higher classification will be made in accordance with the regulations of Chapter 31 (Civil Service) of the General Laws of Massachusetts.

6. All cafeteria employees shall be notified by August 30 as to their assignment for the next school year.

C. NOTIFICATION

The Chairperson of the Cafeteria Unit shall be notified of all requests for transfers and also be notified of all permanent vacancies that exist within the Unit.

ARTICLE VII
LEAVES OF ABSENCE

A. SICK LEAVE

1. Permanent and provisional employees who have completed one (1) year employment shall be credited with sick leave at the rate of 15 days per work year. The work year extends from September 1 through August 31st.

2. Sick leave will be credited to each employee on the first full "work day" worked by an employee in the "work year."

3. An employee whose first full "work day" occurs after September 15th of the given "work year" shall be credited with sick leave with pay at the rate of one and one-half (1 1/2) days for each full calendar month worked between the first full "work day" worked and the end of the "work year."

4. New permanent and provisional employees will be credited with sick leave at the rate of one and one-half (1½) days per month following the completion of thirty (30) days of employment during their first year of employment.

5. Sick leave shall be capped at two hundred (200) days.

6. Such leave may be taken on any workday, including in-service days as long as the employee reported ill on the last regularly scheduled workday before and the regularly scheduled workday after the in-service day.

7. An employee shall provide his/her supervisor with at least one (1) hour notice when the employee is to be absent from work due to illness or injury. The Employer may request, and an employee shall provide, appropriate medical documentation for an absence due to illness or injury of more than five (5) consecutive days and/or FMLA forms from his/her medical provider for an absence due to illness or injury of more than three (3) consecutive days.

8. Employees may use a maximum of three (3) sick leave days during a school year to care for a sick relative of the first degree. A relative of the first degree shall be a spouse; a natural, adopted, or foster child; a parent; a brother or sister; or any other relative living in the same household as the employee.

9. An additional three (3) sick leave days may be taken from the annual accrual of fifteen (15) for the purpose of caring for a sick relative of the first degree. Such days may be taken only with documentation from a licensed health care provider, and are subject to approval by the Superintendent or her/his designee. Such approval shall not be withheld arbitrarily or capriciously.

10. Sick, vacation, and personal leave shall be paid in an amount equal to the employee's normally scheduled work day. Effective at the end of the work day on June 30, 2011, all paid leave shall be paid in an amount equal to the employee's normally scheduled work day.

B. PERSONAL LEAVE

Absences without loss of pay not to exceed three (3) days in any school year shall be granted by the School Committee for reasons other than personal illness, such as religious, legal business, household or family matters, provided application is made to the Superintendent in writing, if possible, in advance.

C. UNPAID LEAVE

An employee may request an unpaid leave not to exceed three (3) months.

D. BEREAVEMENT LEAVE

1. In the event of a death of a member of the immediate family, an employee will be entitled to leave for five (5) work days without loss of pay. Immediate family includes parents, spouse, life partner/companion, children, stepchildren, mother-in-law, father-in-law, siblings and a person for whom the employee has had the responsibility for making funeral arrangements.

2. An employee shall be entitled to leave for four (4) work days without loss of pay for the death of a grandparent, grandchild, brother-in-law, sister-in-law or someone living in the immediate household.

3. In the case of the death of a relative of the second degree, an employee shall be entitled to leave without loss of pay for one (1) day. Relatives of the second degree include uncles, aunts, nephews, nieces, cousins and in-laws other than mentioned above.

4. Leave under this section may be taken immediately following the death or commensurate with the funeral and/or memorial service, at the discretion of the employee. An employee will normally be required to take leave granted under this section within ten (10) work days of the date of death, however an employee may request he/she be allowed to take his/her leave at some point in time beyond ten (10) work days to accommodate for travel, legal obligations, or religious reasons. Any request to take leave beyond ten (10) work days from the date of death shall be made in writing to the Superintendent or his/her designee, and must include the dates requested and the reason for the request. Such requests shall not be unreasonably denied.

5. Permission to attend the funeral service of a member of the bargaining unit shall be granted to a

representative group of employees on the death of an employee.

E. MATERNITY LEAVE

1. A female cafeteria employee who has been employed by the COMMITTEE for at least three (3) consecutive months as a full-time employee, who is absent from such employment for a period not exceeding eight (8) weeks for the purpose of giving birth or for adopting a child under the age of eighteen (18) or for adopting a child under the age of twenty-three (23) if the child is mentally or physically disabled, said period to be hereafter called maternity leave, and who shall give at least two (2) weeks' written notice to her EMPLOYER of her anticipated date of departure and intention to return, shall be restored to her previous, or a similar position with the same status, pay, length of service, credit and seniority, wherever applicable, as of the date of her leave. Such leave shall be unpaid to the extent the employee's sick leave does not cover the eight (8) week period.

2. The COMMITTEE shall not be required to restore an employee on maternity leave to her previous or a similar position if other employees of equal length of service credit and status in the same or similar position have been laid off due to economic conditions or other changes in operating conditions affecting employment during the period of such maternity leave; provided, however, that such employee on maternity leave shall retain any preferential consideration for another position to which she may be entitled as of the date of her leave.

3. Such maternity leave shall not affect the employee's right to receive vacation time, sick leave, bonuses, advancement, seniority, length of service credit, benefits, plans or programs for which she was eligible at the date of her leave, and any other advantages or rights of her employment incident to her employment position; provided, however, that such maternity leave shall not be included, when applicable, in the computation of such benefits, rights, and advantages; and provided, further, that the EMPLOYER need not provide for the cost of any benefits, plans, or programs during the period of maternity leave unless such EMPLOYER so provides for all employees on leave of absence.

F. REQUESTS FOR LEAVE

All notification of leaves of absence or requests for leave under this Article shall be made through the Director of Food Services to the Superintendent of Schools or his designee.

G. MAINTENANCE OF RIGHTS

All benefits to which an employee was entitled at the time his leave of absence commenced, including unused accumulated sick leave, shall be restored to him upon his return, and he will be assigned to the same position which he held at the time said leave commenced or to a substantially equivalent position.

H. PHYSICAL EXAMINATIONS

Leave will be granted whenever a physical examination is required during working hours by the

Massachusetts Civil Service Commission and such leave will be credited as one of the three (3) personal leave days allowed under Section B of this article.

I. COURT APPEARANCES

Time necessary for appearances in any legal proceeding connected with the employee's employment or the school system, and requested by the School Committee and/or its agents, shall be granted without loss of pay or benefits.

J. JURY DUTY LEAVE

Employees summoned to Jury Duty shall serve without loss of pay or benefits provided:

1. The employee shall provide her supervisor with a copy of the summons to serve on a jury as soon as possible after its receipt.

2. The employee shall notify her supervisor as soon as possible if she is not required to report for jury duty on any given day and she will report for work that day.

3. The employee shall notify her supervisor as soon as possible if she is released early from jury duty on any day and, if so directed, shall promptly report to work for the balance of the workday.

4. Employees must turn in documentation of the days served on jury duty along with their jury duty pay to the Payroll Office.

K. PARENTING LEAVE

1. An employee who wishes to obtain an unpaid Leave of Absence to care for a newborn child or newly adopted infant shall submit a written notice to the Superintendent at least forty-five (45) days in advance of the anticipated date of birth or adoption.

2. Such leave shall be taken without pay, benefit accrual or co-payment of insurance. Parenting Leaves shall extend for the remainder of the school year in which the request is made. Written notice of intent to return in September must normally be given prior to May 1, but in no event later than May 31, of such calendar year.

3. If an employee fails to return to work by the second September, following the start of the Parenting Leave, his employment will be terminated.

L. SICK LEAVE BANK

1. POLICY. It shall be the policy of the Pittsfield School Committee to establish a Sick Leave Bank, the purpose of which shall be to enable the members of the bargaining unit to voluntarily contribute a portion of their sick leave accumulation for use by a participating member whose sick leave is exhausted through prolonged and/or catastrophic illness or injury, and who have no remaining unused sick leave, personal leave, and/or vacation time in their personal account.

2. ELIGIBILITY. Eligibility for membership in the Sick Leave Bank is gained by agreement by an

applicant to contribute one earned sick leave day to the bank. This agreement must be in written form (an e-mail to the Director of Human Resources with a copy to the Chapter Chairperson is sufficient). Application for membership is through the Director of Human Resources. Application for membership to the Sick Leave Bank must be made during the month of September. A new hire may complete an application for Sick Leave Bank membership within thirty (30) days of his/her starting date. New Sick Leave Bank members may not have entitlement to Sick Leave Bank benefits until one (1) year after his/her initial donation to the bank (note: for purposes of this provision, employees who contributed to the sick leave bank that was effective prior to July 1, 2014 shall not be considered new sick leave bank members and are not subject to the one (1) year wait period). Members of the Sick Leave Bank will contribute one (1) day upon application for membership.

3. SICK LEAVE BANK COMMITTEE. The Sick Leave Bank Committee shall consist of two (2) members appointed by the Chairperson of the School Committee, and two (2) members appointed by the bargaining unit chairperson. The Sick Leave Bank Committee shall govern all phases of the Sick Leave Bank, including the option to accept or reject applications for sick leave.

4. GRANT OF SICK LEAVE BANK BENEFIT. A grant of sick leave from the Sick Leave Bank shall be made by majority vote of those Sick Leave Bank Committee members present and voting, but no meeting shall be held and no vote shall be taken unless a quorum is present. The quorum for meetings of the Sick Leave Bank Committee is three members present. The Sick Leave Bank Committee shall consider the following factors when determining the eligibility of an employee to draw days from the Sick Leave Bank, and in determining the amount of leave to be granted:

- **i.** Written medical evidence (e.g., a note from the employee's medical provider) submitted by the employee indicating the inability of the employee to perform his/her duties. The medical evidence must include the specific nature of the illness and/or injury, and the date the employee may be expected to return to work.
- **ii.** The employee's prior utilization of his/her sick leave time.
- **iii.** The employee's prior requests for and/or use of Sick Leave Bank time.

5. In the event the Sick Leave Bank Committee denies a written request, the applicant may request an appeal meeting to reconsider said determination in writing within ten (10) work days of receipt of the denial. The applicant has the right to attend the appeal meeting, and present additional information. A majority vote of the Sick Leave Bank Committee is necessary to reverse its prior determination (Note: a tie vote results in a denial). The decision of the Sick Leave Bank Committee shall be final and binding and not subject to the grievance procedure and/or arbitration. The Sick Leave Bank Committee may not provide grants of sick leave from the Sick Leave Bank totaling more than thirty (30) days in

any given contract year. The Sick Leave Bank Committee may allow for an additional grant of thirty (30) days (i.e., a maximum of sixty (60) days) in any given contract year under extenuating circumstances. Payments from the Sick Leave Bank are made on a work day basis. Sick leave bank days are only available for a bargaining unit member's own prolonged and/or catastrophic illness or injury.

6. REVIEW OF LONG-TERM CASES. A review of long-term cases will be in order at any time if the Sick Leave Bank Committee suspects abuse of sick leave. In such case, an attending physician's statement must be forwarded to the Sick Leave Bank Committee by the attending physician.

7. APPLICATION FOR SICK LEAVE BANK BENEFIT. Participants must exhaust all accrued sick leave, personal leave, and/or vacation time before drawing from the Sick Leave Bank. Application to the Sick Leave Bank Committee must be made in writing at least two (2) weeks prior to the expiration of accrued sick leave to expedite benefits (an e-mail to the Director of Human Resources with a copy to the Chapter Chairperson is sufficient). All applications must include certification from the employee's medical provider.

8. MAXIMUM SICK LEAVE BANK ACCUMULATION. The maximum accumulation of days in the Sick Leave Bank shall not exceed one hundred and fifty (150) days.

9. REPLENISHMENT OF BANK. The Sick Leave Bank will be considered depleted if its number of days on deposit goes down to 1/2 of the total allowable accumulation (i.e., seventy-five (75) days). In this event, each member of the Sick Leave Bank shall be assessed at least one, but not more than four days of their personal entitlement of sick leave, and such assessed days of personal sick leave shall be added to the Sick Leave Bank. Such assessment shall be by vote of the Sick Leave Bank Committee, but the Sick Leave Bank Committee cannot assess more than four (4) days of personal sick leave per member of the Sick Leave Bank in any one school year. Each employee will be provided a form indicating that the applicable number of sick days will be deducted on a date certain, unless said employee signs and returns the form prior to the date certain indicating that they no longer wish to be a member of the Sick Leave Bank.

10. CARRY-OVER. Any unused sick leave remaining in the Sick Leave Bank at the end of any school year shall be automatically carried over to the next school year. The Committee shall make available to the Federation upon request the current balance of the Sick Leave Bank, as well as a detailed list of all donations/assessments to and withdrawals from the Sick Leave Bank.

M. FAMILY MEDICAL LEAVE ACT (FMLA)

1. An employee who meets the Federal requirements to qualify for leave under the FMLA is eligible for the following leaves upon completion of the appropriate FMLA forms and verification that the leave qualifies under the FMLA.

a. Up to twelve (12) weeks unpaid leave in any twelve (12) month period for the birth of a child; the placement of a child with the employee for adoption or foster care; to care for their spouse, son, daughter, or parent with a serious health condition; or for their own serious health condition.

b. An employee who is the son, daughter, parent, or next of kin of a current service member with a serious injury or illness shall be granted up to twenty-six (26) weeks of unpaid leave in any twelve (12) month period (military caregiver leave) (Note: Only 12 of the 26 total weeks may be for a FMLA-qualifying reason other than to care for a covered service member).

c. An employee whose spouse, son, daughter, or parent is a member of the National Guard or Reserves shall be granted up to twelve (12) weeks of unpaid leave in any school year for qualifying exigencies arising out of the military member's active duty or call to active duty in support of contingency operations (qualifying exigency leave).

d. The leaves above shall be added together to determine whether the twelve (12) or twenty-six (26) week maximum has been met.

2. No provision of this Article, or of any other provision of this Agreement, shall be construed as being in conflict with the terms and benefits available to employees under the Family and Medical Leave Act (FMLA). In the event that any provision herein is determined to be in conflict with the FMLA, the terms and conditions set forth in the FMLA shall be deemed those to which the employee is entitled; except that any benefit provided herein that exceeds what is required by the FMLA shall not be construed as being in conflict with the FMLA.

N. SMALL NECESSITIES LEAVE ACT (SNLA).

An employee who meets the statutory requirements to qualify for leave under the Small Necessities Leave Act (SNLA) is eligible for unpaid leave for the purposes allowed under M.G.L. c. 149, § 52D upon verification that the leave qualifies under the SNLA. An eligible employee may elect to take leave in increments of two (2) hours. Accumulated paid leave may only be substituted if the reason for the leave would have normally qualified for paid leave.

O. LEAVE FOR CONFERENCES, CONVENTIONS, ETC.

With the approval of the School Committee, no more than two (2) official delegates of the Cafeteria Unit of the Pittsfield Federation of School Employees may be granted by no more than three (3) days leave with pay to attend conventions of affiliated bodies, educational conferences or other functions which contribute to the advancement of educational welfare in the City of Pittsfield.

P. An employee who meets the statutory requirements to qualify for leave under the Domestic Violence Leave Act (DVLA) is eligible for unpaid leave for the purposes allowed under said laws upon verification that the leave qualifies under the laws. Accumulated paid leave may only be substituted if the reason for the leave would have normally qualified for paid leave.

ARTICLE VIII
FEDERATION RIGHTS AND RESPONSIBILITIES

A. FEDERATION REPRESENTATION

1. The Committee recognizes Local 1315 Building Representatives as the official representatives of the cafeteria employees in the schools.

2. The Federation representatives who meet with the Superintendent of Schools during the school year shall submit items for the agenda which apply to cafeteria personnel.

3. The chapter chairperson will be released with pay to attend union related meetings convened by the School Committee and Mayor.

B. INFORMATION

1. The Committee shall make available to the Federation, upon reasonable request, all records in the files of the School Committee available to the public relevant to negotiations, or necessary for the proper enforcement of this Agreement.

2. Names and address of newly employed cafeteria personnel shall be provided to the chairperson of the cafeteria unit of the Pittsfield Federation of School Employees following their selection by the Superintendent.

3. Copies of all Civil Service notices and seniority lists shall be provided to the chairperson of the cafeteria unit.

C. PRINTING OF AGREEMENT

1. The parties agree to share the cost of printing 100 copies of this Agreement in booklet form and to distribute copies of the Agreement to each member of the bargaining unit employed by the Committee. The cost of all additional copies will be paid by the party who desires them.

2. Such printing will be done in the Print Shop at the Taconic-Vocational High School, if possible.

3. If the printing is done outside the school system, it will be done in a union shop.

D. FEDERATION ACTIVITY AT THE SCHOOL LEVEL

1. SCHOOL MEETINGS

Before the opening of and after the close of school on school days, the Federation shall have the right to use designated areas in school buildings for meetings with cafeteria employees provided there is no interference with any scheduled school activities. The use of such designated areas shall be arranged with the Principal.

2. DISTRIBUTION OF MATERIALS

The Federation shall have the right to send materials to all employees.

3. BULLETIN BOARDS

Federation notices and other materials pertaining to cafeteria employees may be posted on Federation

bulletin boards. Space for posting notices in school kitchens will be provided where possible.

E. MEETINGS WITH THE DIRECTOR OF FOOD SERVICES

1. The Director shall meet with representatives of the cafeteria workers for the purpose of obtaining input on matters not covered by the collective bargaining agreement. The cafeteria workers may bring any matter to the attention of the Director at these meetings. However, the introduction of such matters by either the Director or by the cafeteria workers may not constitute a basis for negotiations and/or arbitration proceedings on such matters.

2. The meetings will be held once a month unless the parties mutually agree to cancel the meeting or hold additional meetings.

3. Representatives of the cafeteria workers at these meetings will be selected by the Federation members of the cafeteria workers unit.

F. DUES CHECK-OFF

1. The Federation may secure authorization for payroll deductions for Federation dues. Such authorizations may be revocable as provided by law. The Committee will request the Treasurer of the City of Pittsfield to submit such sums in total to the Federation.

2. The Federation shall be notified of any employee withdrawing or dropped from payroll deductions.

3. Any employee desiring to have the Committee discontinue deductions that he has previously authorized must provide written notice to the Committee.

4. The FEDERATION agrees to and does hereby indemnify, defend and hold harmless the COMMITTEE and the City of Pittsfield, and their members, agents and representatives from and against any and all claims, demands, liabilities, suits or any other form of action brought by members of the collective bargaining unit arising from or relating to any action taken by them in good faith in making or transmitting such deductions in accordance with the FEDERATION'S written instructions, provided that the COMMITTEE has given the FEDERATION timely notice of any such claims, demands, liabilities or suits, and that the FEDERATION has had an opportunity to intervene in and defend any such actions.

5. In the event of a strike as defined in Article XIII, Sections D and E of this Article shall no longer apply.

ARTICLE IX
GRIEVANCE PROCEDURE

SECTION A. DEFINITIONS:

1. A "grievance" is a complaint that there has been a violation, misinterpretation, or misapplication of

this Agreement or any amendment or supplement thereto.

2. A "grievant" on any issue covered by the terms of this Agreement is any cafeteria worker, group of cafeteria workers having a common grievance, or the FEDERATION.

3. A "party of interest" is a grievant, witness, person, group of persons or organization who might be required to take action or against whom action might be taken in order to resolve the grievance.

SECTION B. PROCEDURES:

1. **LEVEL ONE: (IMMEDIATE SUPERIOR LEVEL)**

   a. A grievant will first discuss a complaint with the immediate superior directly, together with or through a FEDERATION representative if the grievant so desires, with the objective of resolving the matter informally.

   b. If the grievance is not resolved informally, the grievant may submit directly, together with or through the FEDERATION, a written grievance to the principal of the building or to the immediate superior of the grievant. Within ten (10) calendar days after receiving the grievance, the principal or immediate superior shall communicate his decision in writing.

2. **LEVEL TWO: (SUPERINTENDENT LEVEL)**

   a. The decision of the building principal or the immediate superior may be appealed in writing by the aggrieved directly, together with or through the FEDERATION to the Superintendent of Schools or his designated representative within ten (10) calendar days after the decision of the principal or immediate superior has been received by the aggrieved.

   b. The Superintendent of Schools or his designated representative shall meet with the aggrieved directly, together with or through a FEDERATION representative within ten (10) calendar days after receipt of the appeal.

   c. If the Superintendent of Schools and the grievant satisfactorily resolve the grievance, the Superintendent of Schools shall submit his decision in writing within ten (10) calendar days.

3. **LEVEL THREE: (SCHOOL COMMITTEE LEVEL)**

   a. If the grievance is not resolved at Level Two, the grievance may be appealed in writing to the School Committee within ten (10) calendar days after the decision has been received by the aggrieved and the FEDERATION.

   b. The School Committee or the Negotiating Subcommittee of the School Committee shall meet with the grievant and the FEDERATION representative in executive session within fifteen (15) calendar days of receipt of the appeal.

   c. The School Committee shall communicate its decision in writing within fifteen (15) calendar days of the meeting with the grievant and the FEDERATION representative.

4. **LEVEL FOUR: (ARBITRATION)**

a. If the grievance is not settled at Level Three and the FEDERATION determines the grievance is meritorious, it may file for Arbitration. If the FEDERATION files for Arbitration, it shall notify the Committee within thirty (30) calendar days of the decision at Level Three. The filing of a written demand for Arbitration with the AAA shall be the method of notifying the COMMITTEE of the FEDERATION'S intent to appeal. The date postmarked on the envelope containing the AAA demand shall be deemed the date of filing.

b. The arbitrator so selected will confer with representatives of the School Committee and the FEDERATION and hold hearings promptly, and will issue his decision not later than twenty (20) days from the date of the close of the hearings; or, if oral hearings have been waived, then from the date the final statements and evidence are submitted to him. The arbitrator's decision will be in writing and will set forth his findings of fact, reasoning and conclusions on the issues submitted. The arbitrator will be without power or authority to make any decision which requires the commission of an act prohibited by law, or which is violative of the terms of this Agreement. The arbitrator shall be without power or authority to extend beyond the submission agreement, or to add to, delete from, modify or alter the terms of this agreement. The decision of the arbitrator shall be submitted to the School Committee and to the FEDERATION and shall be final and binding.

c. The costs for the services of the arbitrator, including per diem expenses, if any, and actual and necessary travel and subsistence expenses, will be borne equally by the School Committee and the FEDERATION provided, however, a party who cancels or postpones a hearing without the required notice to the AAA or the Arbitrator shall pay the full cost of any fees of the AAA and/or the Arbitrator.

d. If the COMMITTEE claims the FEDERATION has violated any provisions of Article XIII, the No Strike Clause, it may present such claim to the FEDERATION, in writing, and if the parties fail to settle the matter within ten (10) calendar days, the COMMITTEE may submit the dispute to arbitration under the provisions of Level Four of this Article.

SECTION C. GENERAL PROVISIONS:

1. REPRESENTATION: Any "party of interest" may be represented at any level of this procedure by a person of his own choosing, except that a grievant may not be represented by an officer or a representative of any organization other than the FEDERATION. Whenever a grievant is not represented by the FEDERATION, the FEDERATION shall be given five (5) days prior notice of a hearing, have the right to be present and to state its views at all levels of this procedure. The FEDERATION shall have the right to appeal the disposition of a grievance if such disposition is alleged to be a violation of this Agreement.

2. TIMELINESS: In order for a grievance to be timely, it must be filed in writing within thirty (30) days

after the occurrence or knowledge of the situation, condition, or action giving rise to the grievance.

3. Failure of a grievant to file in writing a complaint within thirty (30) days or to proceed to the next step as provided in the procedures shall cause the grievance to be deemed to have been waived. Failure of the COMMITTEE and/or its agents to respond as provided in the procedures at any step shall constitute a denial of the grievance and the grievant shall have the right to proceed to the next step in the procedure.

4. Any time limits specified in the Article may be extended only by mutual agreement of both parties reduced to writing.

5. NO REPRISAL: The fact that a grievance is raised by a member of the bargaining unit, regardless of the ultimate disposition of such grievance, shall not be recorded in the employee's file nor in any file nor record utilized in the promotion process; nor shall such fact be used in any recommendations for job placement; nor shall such cafeteria worker or cafeteria workers who participate in any way in the grievance procedure be subjected to reprisal for having processed a grievance.

6. All documents, communications and records dealing with the processing of a grievance will be filed separately from the personnel files of the participants, unless the individual in question files a written request that all such documents, communications and records be included in his personnel file.

7. At Arbitration, the grievant and the School Committee shall have the following rights:

a. To be present at the hearing;

b. To hear testimony;

c. To give testimony;

d. To call others to give testimony;

e. To question whether personally or through a FEDERATION or COMMITTEE representative, any person giving testimony.

8. Except in cases of arbitration hearing, grievances shall ordinarily be processed at times which do not disrupt the educational programs in the schools or interfere with the cafeteria workers' responsibilities.

9. If grievances are processed during the school day by mutual agreement of the parties, then released time shall be provided to all parties of interest without loss of pay or benefits.

10. TIME LIMITS: Time limits expressed in this procedure shall be considered maxima and may be extended by mutual agreement.

11. Nothing herein shall require the FEDERATION to process a grievance through arbitration.

12. Grievances shall be initiated at the administrative level giving rise to the grievance. If the administrator determines that the grievance has been improperly filed at his level, he/she shall so notify the grievant.

13. The original filing shall be valid for timeliness as provided in the various levels of the grievance process.

14. Class or group grievances involving more than one grievant shall identify the class affected by the grievance at Level One of the grievance procedure.

15. At a School Committee grievance hearing, the FEDERATION and/or the cafeteria worker shall have the right to fully present their position regarding the grievance, including the right to speak on their own behalf, to have FEDERATION representation and to produce support for their position through documents or other persons.

ARTICLE X
PROFESSIONAL TRAINING

The School Committee shall make the following training available in the specified frequencies, and employees will be paid for the time to travel, if any, and time at the training according to Article III(D):

TRAINING		FREQUENCY
Serve Safe		Every Five (5) Years
Epipen		Every Six (6) Months
CPR		Annually

ARTICLE XI
SAVINGS CLAUSE

A. If any provision of this Agreement is or shall at any time be contrary to law, then such provision shall not be applicable or performed or enforced, except to the extent permitted by law and substitute action shall be subject to appropriate consultation and prompt negotiation with the Federation.

B. In the event that any provision of this Agreement is or shall be contrary to law, all other provisions of this Agreement shall continue in effect.

ARTICLE XII
MANAGEMENT'S RIGHTS

A. The operation and management of the Pittsfield School Department, and the supervision of the employees and of their work, are the rights of the COMMITTEE alone. These rights include, by way of illustration and without being limited to, the following: The right to make reasonable rules to assure orderly and effective work; to make and oversee the implementation of policy; to determine the quantity and types

of equipment and materials to be used; to introduce new methods and facilities; to make and institute work schedules; to determine what and where duties will be performed and by whom; to evaluate employees competency; to hire, transfer, promote, layoff, and recall employees; and to demote, discipline or discharge employees for just cause.

B. The foregoing enumeration of the COMMITTEE'S rights shall not be deemed to exclude other rights not specifically set forth, the COMMITTEE therefore retaining all rights not otherwise specifically restricted by this Agreement.

C. The failure by the COMMITTEE to exercise any of the rights as provided in this Article shall not be construed as a waiver of these rights, nor of any of the rights of the COMMITTEE to control, operate and manage the schools. Nothing contained in this Agreement shall be construed or deemed to constitute a waiver of or any restriction upon the inherent rights of the COMMITTEE, except that none of these rights shall be exercised by the COMMITTEE contrary to any specific provision of this Agreement.

D. Except when it can be shown that conduct or action by the COMMITTEE is in violation of a specific provision of this Agreement, such conduct or action shall not be subject to the grievance or arbitration procedures of this Agreement.

ARTICLE XIII
NO STRIKE

A. The parties agree that there shall be no strikes of any kind whatsoever, no work stoppages, withholding of services, slowdowns, or interference with or interruption of the functioning of the School System by any employee or the FEDERATION.

B. Nor shall there be any strike or interruption of work because of any disputes or disagreement between any other persons, Employers, Associations, FEDERATION, or Unions who are not signatory parties to this Agreement.

C. Employees who violate this provision shall be subject to disciplinary action, including discharge for just cause.

D. The COMMITTEE reserves the right to immediately pursue all legal courses of action against both the FEDERATION, its affiliates and the employees in the event of a strike as defined above, including their right to go to Arbitration as set forth in Article X of this Agreement.

ARTICLE XIV
LABOR-MANAGEMENT COMMITTEE

A Labor-Management Committee shall be established which shall meet periodically to review labor-management issues. The Labor-Management Committee shall not be a forum for grievances or contract negotiations.

ARTICLE XV
JUST CAUSE

No employee who has completed the probationary period shall be disciplined or discharged without just cause.

ARTICLE XVI
DURATION

A. This Agreement and each of its provisions shall be in effect as of September 1, 2018, and shall continue in full force and effect until August 31, 2021. Negotiations for a subsequent agreement shall commence on or before August 1, 2021 on all items.

B. Being a mutual Agreement, this instrument may be amended at any time by mutual consent.

PITTSFIELD SCHOOL COMMITTEE	**PITTSFIELD FEDERATION OF SCHOOL EMPLOYEES LOCAL 1315, AMERICAN FEDERATION OF TEACHERS (AFT), AFT MASSACHUSETTS, AFL-CIO CAFETERIA UNIT**
_____	_____
Chairman	Chapter Chairperson

APPENDIX A

SALARY SCHEDULE

a. EFFECTIVE SEPTEMBER 1, 2018 INCREASE ALL HOURLY PAY RATES IN APPENDIX A BY ONE AND ONE-QUARTER PERCENT (1.25%).

2018-2019	1.25%						
Years of Service	Start	3	5	6	7	10	15
COOK MANAGER							
High/Middle	$15.92	$16.62	$16.88	$17.15	$17.51	$18.37	$18.89
Elementary	$15.19	$15.84	$16.17	$16.41	$16.80	$17.66	$18.17
BAKER	$13.26	$13.97	$14.24	$14.44	$14.81	$15.61	$16.12
CAFETERIA HELPER	$12.50	$13.12	$13.37	$13.56	$13.83	$14.54	$15.05

b. EFFECTIVE SEPTEMBER 1, 2019 INCREASE ALL HOURLY PAY RATES IN APPENDIX A BY ONE AND ONE-QUARTER PERCENT (1.25%).

2019-2020	1.25%						
Years of Service	Start	3	5	6	7	10	15
COOK MANAGER							
High/Middle	$16.12	$16.82	$17.09	$17.37	$17.72	$18.60	$19.12
Elementary	$15.38	$16.04	$16.37	$16.62	$17.01	$17.88	$18.39
BAKER	$13.43	$14.14	$14.41	$14.62	$15.00	$15.80	$16.32
CAFETERIA HELPER	$12.66	$13.28	$13.53	$13.73	$14.00	$14.72	$15.24

c. EFFECTIVE SEPTEMBER 1, 2020 INCREASE ALL HOURLY PAY RATES IN APPENDIX A BY ONE AND ONE-QUARTER PERCENT (1.25%).

2020-2021	1.25%						
Years of Service	Start	3	5	6	7	10	15
COOK MANAGER							
High/Middle	$16.32	$17.03	$17.31	$17.58	$17.95	$18.84	$19.36
Elementary	$15.57	$16.24	$16.57	$16.82	$17.22	$18.10	$18.62
BAKER	$13.59	$14.32	$14.59	$14.80	$15.19	$16.00	$16.53
CAFETERIA HELPER	$12.81	$13.45	$13.70	$13.90	$14.18	$14.90	$15.43

APPENDIX B

MEMORANDUM OF AGREEMENT

HEALTH INSURANCE

WHEREAS, the City Council of the City of Pittsfield voted on May 15, 2008 to accept M.G.L. c. 32B, §19, as amended by Chapter 67 of the Acts of 2007, (Section 19); and

WHEREAS the City of Pittsfield (hereinafter referred to as "City") and the duly-formed Public Employee Committee (hereinafter referred to as "PEC") has agreed to continue obtaining its health insurance from the Massachusetts Interlocal Insurance Association/BlueCross BlueShield Massachusetts (hereinafter referred to as "MIIA/BCBSMA"); and

WHEREAS, the City and PEC have negotiated terms and conditions relevant to this continued coverage;

NOW, THEREFORE, the City and the PEC agree as follows:

Effective Date and Duration of Agreement

1. The Agreement shall take effect on the date the City and the PEC execute the Agreement and shall remain in effect through June 30, 2024.

Health Insurance Benefit Changes

2. Effective July 1, 2018, and through June 30, 2020, all plans (HMO and PPO) will move to the MIIA/BCBSMA Benchmark v1 plan design. The Plan Design for each of these plans is attached and made part of this agreement as Exhibit A.

3. Effective July 1, 2020, and through June 30, 2022, all plans (HMO and PPO) will move to the MIIA/BCBSMA Benchmark v2 plan design. The Plan Design for each of these plans is attached and made part of this agreement as Exhibit B.

4. Effective July 1, 2022, and through June 30, 2024, all plans (HMO and PPO) will move to the MIIA/BCBSMA Benchmark v3 plan design. The Plan Design for each of these plans is attached and made part of this agreement as Exhibit C.

5. Effective July 1, 2018, in addition to the Fiscal Year 2018 health insurance plans offered to members through MIIA/BCBSMA, the following additional plans will be offered: a Health Savings Account ("HSA") qualified High Deductible Health Plan with a $1,500.00 Individual and a $3,000.00 Family Deductible and an Out of Pocket maximum of $3,000.00 Individual/$6,000.00 Family, including medical and prescription (RX), (HMO and PPO). The Plan Design for each of these High Deductible Plans is attached and made part of this Agreement as Exhibit D.

APPENDIX B

MEMORANDUM OF AGREEMENT

HEALTH INSURANCE

HSA Contribution

6. For the term of this Agreement, the City agrees to make an annual employer contribution of the plan deductible to an HSA for eligible and participating members, pursuant to the chart below. Any new hire who opts for the High Deductible Health Plan will get the same 6-year cycle of employer contributions beginning in the fiscal year they enter the plan.

FY	HSA Employer Contribution
19	100%
20	100%
21	75%
22	75%
23	50%
24	50%

7. All administrative costs for establishing and maintaining the HSA shall be provided by the City.

8. The PEC shall use up to 100% of its portion of the Healthcare Trust in FY 21-24 to supplement the Employer Contribution to the individual HSA from the percentage indicated above up to a maximum of 100% for individuals who are enrolled in a High Deductible plan in those years. The exact percentage shall be determined by the PEC each year this section is implemented.

Contribution Splits
HMO, PPO, High Deductible Plans Splits

9. For the duration of this Agreement, the City shall contribute the appropriate percent of the premium or cost for any HMO, PPO, or High Deductible plans offered by MIIA/BCBSMA as indicated in the chart below and the subscriber shall contribute remaining percent.

FY	HMO	PPO	High Deductible
19	83.5	83.5	85
20	82	82	85
21	82	82	85
22	81	81	85
23	81	81	85
24	80	80	85

If MIIA/BCBSMA offers any new or additional HMO, PPO, PPO-Type, and/or Indemnity plans during the life of this agreement, the same contribution rate shall apply.

APPENDIX B

MEMORANDUM OF AGREEMENT

HEALTH INSURANCE

Medicare Enrollment and Retiree Plan Splits

10. As soon practical, but no later than July 1, 2019, the City shall transfer all post-65 non-Medicare benefit eligible subscribers into Medicare Part A & B (a.k.a. Medicare buy-in) pursuant to applicable laws. The terms and conditions for reimbursement of Medicare fees and penalties, paid by the City, shall be subject of collective bargaining with the PEC. The agreed upon terms and conditions for reimbursement shall be added as an addendum to this agreement.

11. For the duration of this Agreement, the City shall contribute the eighty-five (85) percent of the premium cost for any plans offered by MIIA/BCBSMA and the subscriber shall contribute fifteen (15) percent as the pre-Medicare rate for the plan selected. If MIIA/BCBSMA offers any new or additional plans during the life of this agreement, the same contribution rate shall apply. The City does not contribute toward Medicare Part B coverage.

Future Meetings of City and PEC

12. The PEC shall be comprised of a representative of every collective bargaining unit who shall be appointed by the union President that negotiates with the City under M.G.L. c.150E, and a retiree representative designated by the Retired State, County and Municipal Employees Association. Each union representative and the retiree representative shall have the option of allowing one additional representative to attend meetings of the PEC and the City or their designee.

13. The parties shall establish a regular schedule of meetings to discuss the implementation of this Agreement and any issues relating to the effectiveness and efficiency of health coverage for subscribers. Such meetings shall take place quarterly, unless mutually agreed otherwise in writing. Meetings shall be held at times and places that are mutually agreed upon by the City and the PEC. In addition, either party may convene a meeting upon seven days' notice to the other party, unless there is an emergency that requires shorter notice. Meeting notices shall be provided to the City and to the PEC in writing. The City may provide notice of a meeting or a series of meetings up to twelve months in advance of a meeting. Any employee who is a representative of the PEC shall receive time off to attend meetings between the PEC and the City with full pay and benefits.

Wellness Committee

14. The PEC shall designate representatives to serve on the City's Employee Wellness Committee to help make informed recommendations relative to focus wellness initiatives against general cost drivers and coordinate subscriber educational initiatives.

Initial and Annual Accounting

15. The City will provide an accounting of both the Healthcare Trust and any remaining funds in the Employee Mitigation Fund after final disbursements are made (September 1, 2018, see previous PEC agreement). At that time the parties shall jointly determine how said funds will be used.

16. The City will provide annual account statements of both the relevant costs incurred via MIAA/BSBSMA and the Healthcare Trust account balance to the PEC.

Correspondence and Information

17. The City shall make available to the PEC copies of any correspondence between the City, the GIC, MIIA/BCBSMA or between the City and any provider of health care on a quarterly basis. Likewise, the PEC shall make all like correspondence from any healthcare provider available to the City within the same timeframe. Correspondence or information protected by HIPPA will remain confidential.

Health Insurance Coverage After June 30, 2024

18. The parties agree to complete a thorough cost and benefit review of the health plans with recommendations for potential changes in carrier and/or coverage, as done in 2017. If appropriate, the parties agree to place the health plans out to bid, no later than December 1, 2023 for a July 1, 2024 effective date. The bid request shall be jointly developed by the City and the PEC commencing no later than September 1, 2023. Costs associated with the review and/or the RFP shall be absorbed by the City. The review and/or the RFP shall compare or be issued to not less than three health insurance carriers and shall additionally include a cost and benefit comparison to the GIC and a self-funding option, unless mutually agreed to by the parties.

19. The City or its designee and the PEC shall begin negotiations for a successor agreement pursuant to Section 19 no later than February 1, 2024. If the parties have not reached a successor agreement by April 1, 2024, the terms of this Agreement shall constitute the terms of the successor agreement except that all of the terms contained herein shall be modified to be consistent with a termination date of June 30, 2030.

20. In accordance with the provisions of the successor agreement, the City shall notify MIIA/BCBSMA no later than April 1, 2024, either that subscribers shall continue coverage through MIIA/BCBSMA effective July 1, 2024, the interval specified in the Agreement, or that the City is withdrawing its subscribers effective July 1, 2024.

21. The parties shall meet for the purposes of impact bargaining in the event any healthcare plans are modified as a result of the Patient Affordable Care Act or other changes to healthcare effectuated by the government. In addition, either party may require a re-opener of this Memorandum of Agreement by giving the other party to the Agreement, a seven (7) calendar day advance notice. After the notice is given the parties will meet within seven (7) days to discuss any suggested changes to this Agreement.

APPENDIX B

MEMORANDUM OF AGREEMENT

HEALTH INSURANCE

Life and Dental Insurance

22. After subscribers are transferred to MIIA/BCBSMA, the City shall offer life insurance and dental insurance to subscribers at the same terms and contribution splits as were provided to group insurance participants prior to transfer to MIIA/BCBSMA.

Surviving Spouse Coverage

23. The parties agree that a surviving spouse will pay the same amount as the employee and/or retiree for health coverage in the event the employee and/or retiree dies.

Effect of Agreement

24. This Agreement shall be binding on all subscribers and shall supersede any conflicting provisions of any City policies, codes, or any collective bargaining agreements between the City, School Committee, and any unions representing City and/or School Committee employees.

Cancellation

25. In the event the City is delinquent in making payments as required by MIIA/BCBSMA and MIIA/BCBSMA notifies the City that it intends to exercise its option to cancel coverage pursuant to Section 19, the City shall immediately notify the PEC, present it a proposal for plans that are at least the actuarial equivalent of those offered by MIIA/BCBSMA, and engage in negotiations with the PEC for replacement coverage.

Arbitration of Disputes

26. Either party may submit a dispute between the parties concerning the interpretation or application of this Agreement to the American Arbitration Association for arbitration under its Labor Arbitration Rules. A request for arbitration by the PEC shall be in accordance with M.G.L. c. 32B, §19, as amended by Chapter 67 of the Acts of 2007, (Section 19).

Savings Clause

27. If any provision or portion of the Agreement is found to be unenforceable or unlawful, the remaining provisions or portions shall remain binding.

Scope and Modification

28. This Agreement shall constitute the whole of the Agreement between the City and the PEC. The Agreement may be modified only through a mutual agreement between the City and the PEC.

APPENDIX B

MEMORANDUM OF AGREEMENT

HEALTH INSURANCE

Dated: _____

For the City of Pittsfield:

_____

Chair, Pittsfield Public Employee Committee

_____

For the Pittsfield Federation of School Employees, Local 1315:

_____

For the Teamsters, Local 404:

_____

For the United Educators of Pittsfield:

_____

For the Pittsfield Educational Administrators Association:

_____

APPENDIX B

MEMORANDUM OF AGREEMENT

HEALTH INSURANCE

For the International Association of Firefighters:

_____

For the International Brotherhood of Police Officers, Local 447 Police:

_____

For the International Brotherhood of Police Officers, Local 4475 Superior Officers:

_____

For the Pittsfield Supervisory and Professional Employees Association:

_____

For the Emergency Telecommunication Dispatchers, I.U.E. CWA 81256:

_____

For the Berkshire Athenaeum Employees Association:

_____

For the Retired Employees of the City of Pittsfield:

_____

Your Care

Your Primary Care Provider.

When you enroll in Network Blue New England, you must choose a primary care provider (PCP) who is available to accept you and your family members and participates in our network of providers throughout the New England states. For children, you may designate a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYNs: visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call our Physician Selection Service at 1-800-821-1388. If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care–Wherever You Are* for emergency care services). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is probably someone affiliated with your PCP's hospital or medical group. You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield concerning referrals, and the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review and services requiring referral from your PCP is detailed in your benefit description.

Your Cost Share.

This plan has two levels of hospital benefits. You will pay a higher cost share when you receive certain inpatient services at or by "higher cost share hospitals." See the chart on the opposite page for your cost share amounts.

Please note: If your PCP refers you to another provider for covered services (such as a specialist), it is important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain inpatient services at or by these hospitals, even if your PCP refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- North Shore Medical Center –Salem Campus
- North Shore Medical Center –Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

All other network hospitals will carry the lower cost share, including network hospitals outside of Massachusetts.

Your Deductible.

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for some benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. Your deductible is $250 per member (or $750 per family).

Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is $2,500 per member (or $5,000 per family). Your out-of-pocket maximum for prescription drug benefits is $1,000 per member (or $2,000 per family).

Emergency Care – Wherever You Are.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After the deductible, you pay a $100 copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay.

Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

Outside the Service Area.

If you're traveling outside your service area and you need urgent or emergency care, go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. Please see your subscriber certificate for more information.

Dependent Benefits.

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost
Preventive Care Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Hearing Benefits Routine hearing exams	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum
Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office visits • When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife • When performed by other network providers	 $20 per visit, no deductible $35 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year for members age 16 or older)	$20 per visit, no deductible
Mental health and substance abuse treatment	$15 per visit, no deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia • Office setting – When performed by your PCP, OB-GYN, nurse practitioner, or nurse midwife – When performed by other network providers • Ambulatory surgical facility, hospital, or surgical day care unit	 $20 per visit,*** no deductible $35 per visit,*** no deductible $150 per admission after deductible
Inpatient care (including maternity care) • In other general hospitals (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	 $300 per admission after deductible† $700 per admission after deductible†
Mental hospital and substance abuse facility care (as many days as medically necessary)	$200 per admission after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	Nothing after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** Cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This copayment applies to mental health admissions in a general hospital.

Prescription Drug Benefits	Your Cost*
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $10 for Tier 1** $25 for Tier 2 $50 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $20 for Tier 1** $50 for Tier 2 $110 for Tier 3

* Cost share waived for certain orally-administered anticancer drugs.

** Cost share waived for birth control.

Get the Most from Your Plan.

Visit us at www.bluecrossma.com/membercentral or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)	$150 per calendar year per policy
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions? Call 1-800-782-3675.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at www.bluecrossma.com.
Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to www.bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. Please note: Blue Cross and Blue Shield of Massachusetts, Inc., administers claims payment only and does not assume financial risk for claims.

Your Choice

Your Deductible.

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. Your deductibles are $250 per member (or $750 per family) for in-network services and $400 per member (or $800 per family) for out-of-network services.

When You Choose Preferred Providers.

The plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive inpatient services at or by "higher cost share hospitals." See the chart on the back page for your cost share amounts. Please note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you. It is also important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your preferred provider refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com/findadoctor
- Call our Physician Selection Service at 1-800-821-1388

When You Choose Non-Preferred Providers

If you have not satisfied your deductible, your provider may ask you to pay the actual charge for your care at the time of your visit. After the plan-year deductible has been met, you pay 20 percent coinsurance for most out-of-network covered services. Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out -of -Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your medical out-of-pocket maximum is $2,500 per member (or $5,000 per family) for in-network and out-of-network services combined. Your prescription drug out-of-pocket maximum is $1,000 per member (or $2,000 per family).

Emergency Room Services.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After your in-network deductible, you pay a $100 copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. Information concerning Utilization Review is detailed in your benefit description and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits.

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

EXHIBIT A

Blue Care Elect Deductible SM

MIIA PPO Benchmark Plan v.1

7/1/2018 – 6/30/2020

Your Medical Benefits

Plan Specifics		
Plan-year deductible	$250 per member $750 per family	$400 per member $800 per family
Plan-year out-of-pocket maximum	$2,500 per member/$5,000 per family for in-network and out-of-network services combined	
Covered Services	**Your Cost In-Network**	**Your Cost Out-of-Network**
Preventive Care Well-child care exams, including routine tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year from age 3 through age 18	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services–office visits	Nothing, no deductible	20% coinsurance after deductible
Hearing Benefits Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum	20% coinsurance after deductible and all charges beyond the benefit maximum
Other Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for an observation stay)	$100 per visit after in-network deductible (copayment waived if admitted or for an observation stay)
Office visits When performed by a family or general practitioner, geriatric specialist, internist, licensed dietitian nutritionist, optometrist, nurse midwife, nurse practitioner, OB/GYN, or pediatrician	$20 per visit, no deductible	20% coinsurance after deductible
When performed by other covered providers	$35 per visit, no deductible	20% coinsurance after deductible
Chiropractors' office visits (up to 20 visits per calendar year for members age 16 or older)	$20 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	$15 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (excluding routine tests)	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per date of service after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Surgery and related anesthesia Office setting – When performed by a family or general practitioner, geriatric specialist, internist, nurse midwife, nurse practitioner, OB/GYN, or pediatrician	$20 per visit,*** no deductible	20% coinsurance after deductible
– When performed by other covered providers	$35 per visit,*** no deductible	20% coinsurance after deductible
Ambulatory surgical facility, hospital, or surgical day care unit	$150 per admission after deductible	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** In-network cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient care (including maternity care)		
s In other general hospitals (as many days as medically necessary) s In higher cost share hospitals (as many days as medically necessary)	$300 per admission after deductible* $700 per admission after deductible*	20% coinsurance after deductible 20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$200 per admission after deductible	20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Prescription Drug Benefits**		
Plan-year out-of-pocket maximum	$1,000 per member $2,000 per family	None
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $10 for Tier 1*** $25 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $20 for Tier 1*** $50 for Tier 2 $110 for Tier 3	Not covered

* This cost share applies to mental health admissions in a general hospital.
** Cost share waived for certain orally-administered anticancer drugs.
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Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)	$150 per calendar year per policy
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Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care–Wherever You Are* for emergency care services). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is probably someone affiliated with your PCP's hospital or medical group.
You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield concerning referrals, and the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review and services requiring referral from your PCP is detailed in your benefit description.

Your Cost Share.

This plan has two levels of hospital benefits. You will pay a higher cost share when you receive certain inpatient services at or by "higher cost share hospitals". See the chart on opposite page for cost share amounts.

Please note: If your PCP refers you to another provider for covered services (such as a specialist), it is important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive inpatient services at or by these hospitals, even if your PCP refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

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- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

All other network hospitals will carry the lower cost share, including network hospitals outside of Massachusetts.

Your Deductible.

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. Your deductible is $300 per member (or $900 per family).

Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered medical services. Your out-of-pocket maximum for medical benefits is $2,500 per member (or $5,000 per family). Your out-of-pocket maximum for prescription drug benefits is $1,000 per member (or $2,000 per family).

Emergency Care—Wherever You Are.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After the deductible, you pay a $100 copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay.

Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area.

If you're traveling outside your service area and you need urgent or emergency care, go to the nearest appropriate healthcare facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. Please see your benefit description for more information.

Dependent Benefits.

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

EXHIBIT B

Network Blue New England Deductible SM

MIIA HMO NE Benchmark Plan v.2

7/1/2020 – 6/30/2022

Your Medical Benefits

Plan Specifics	
Plan-year deductible	$300 per member $900 per family
Plan-year out-of-pocket maximum	$2,500 per member $5,000 per family
Covered Services	**Your Cost**
Preventive Care Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams	Nothing, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Hearing Care Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum
Other Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Mental health and substance abuse treatment	$20 per visit, no deductible
Office visits • When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife • When performed by other network providers	 $20 per visit, no deductible $60 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year for members age 16 or older)	$20 per visit, no deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible
Surgery and related anesthesia in an office • When performed by your PCP or OB/GYN • When performed by other network providers	 $20 per visit**, no deductible $60 per visit**, no deductible
Diagnostic X-rays and other imaging tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible***
Prosthetic devices	Nothing after deductible
Home health care and hospice services	Nothing after deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$250 per admission after deductible
Inpatient Care (including maternity care) • In other general hospitals (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	 $275 per admission after deductible† $1,500 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$275 per admission, no deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

*** Cost share waived for one breast pump per birth.

† This copayment applies to mental health admissions in a general hospital.

Prescription Drug Benefits*	Your Cost
Plan-year out-of-pocket maximum	$1,000 per member $2,000 per family
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $10 for Tier 1** $30 for Tier 2 $65 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $25 for Tier 1** $75 for Tier 2 $165 for Tier 3

* Cost share waived for certain orally-administered anticancer drugs.
** Cost share waived for birth control.

Get the Most from Your Plan.

Visit us at www.bluecrossma.com/membercentral or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details)	$150 per calendar year per policy
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions? Call 1-800-782-3675.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at www.bluecrossma.com. Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to www.bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.

Your Choice

Your Deductible.

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield. Your deductibles are $300 per member (or $900 per family) for in-network services and $400 per member (or $800 per family) for out-of-network services.

When You Choose PreferredProviders.

The plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive inpatient services at or by "higher cost share hospitals." See the chart on the back page for your cost share amounts.

Please note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you. It is also important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your preferred provider refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com/findadoctor
- Call our Physician Selection Service at 1-800-821-1388

When You Choose Non-Preferred Providers

If you have not satisfied your deductible, your provider may ask you to pay the actual charge for your care at the time of your visit. After the plan-year deductible has been met, you pay 20 percent coinsurance for most out-of-network covered services. Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your medical out-of-pocket maximum is $2,500 per member (or $5,000 per family) for in-network and out-of-network services combined. Your prescription drug out-of-pocket maximum is $1,000 per member (or $2,000 per family).

Emergency Room Services.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After your in-network deductible, you pay a $100 copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. Information concerning Utilization Review is detailed in your benefit description and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits.

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics		
Plan-year deductible	$300 per member $900 per family	$400 per member $800 per family
Plan-year out-of-pocket maximum	$2,500 per member/$5,000 per family for in-network and out-of-network services combined	
Covered Services	**Your Cost In-Network**	**Your Cost Out-of-Network**
Preventive Care Well-child care exams, including routine tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year from age 3 through age 18	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services–office visits	Nothing, no deductible	20% coinsurance after deductible
Hearing Care Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum	20% coinsurance after deductible
Other Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for an observation stay)	$100 per visit after in-network deductible (copayment waived if admitted or for an observation stay)
Office visits • When performed by a family or general practitioner, geriatric specialist, internist, licensed dietitian nutritionist, optometrist, nurse midwife, nurse practitioner, OB/GYN, or pediatrician • When performed by other covered providers	$20 per visit, no deductible $60 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Chiropractors' office visits (up to 20 visits per calendar year for members age 16 or older)	$20 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	$20 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (excluding routine tests)	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per date of service after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Surgery and related anesthesia • Office setting – When performed by a family or general practitioner, geriatric specialist, internist, nurse midwife, nurse practitioner, OB/GYN, or pediatrician – When performed by other covered providers • Ambulatory surgical facility, hospital, or surgical day care unit	$20 per visit,*** no deductible $60 per visit,*** no deductible $250 per admission after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** In-network cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

EXHIBIT B

Blue Care Elect Deductible SM

MIIA PPO Benchmark Plan v.2

7/1/2020 – 6/30/2022

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient care (including maternity care)		
• General hospital care (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	$275 per admission after deductible* $1,500 per admission after deductible*	20% coinsurance after deductible 20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$275 per admission, no deductible	20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drug Benefits**		
Plan-year out-of-pocket maximum	$1,000 per member $2,000 per family	None
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 for Tier 1*** $30 for Tier 2 $65 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$25 for Tier 1*** $75 for Tier 2 $165 for Tier 3	Not covered

* This cost share applies to mental health admissions in a general hospital.
** Cost share waived for certain orally-administered anticancer drugs.
*** Cost share waived for birth control.

Get the Most from Your Plan.

Visit us at www.bluecrossma.com/membercentral or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details)	$150 per calendar year per policy
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions? Call 1-800-782-3675.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at www.bluecrossma.com. Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail? Go to www.bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.

Your Care

Your Primary Care Provider (PCP)

When you enroll in Network Blue New England, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call the Physician Selection Service at 1-800-821-1388.

If you have trouble choosing a doctor, the Physician Selection Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

Your Cost Share

This plan has two levels of hospital benefits. You will pay a higher cost share when you receive certain inpatient services at or by "higher cost share hospitals." See the chart for your cost share.

Note: If your PCP refers you to another provider for covered services (such as a specialist), it is important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your PCP refers you.

Higher Cost ShareHospitals

Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- Baystate Medical Center
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- UMass Memorial Medical Center

All other network hospitals will carry the lower cost share, including network hospitals outside of Massachusetts.

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost sharing level may apply.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is $500 per member (or $1,000 per family). Your deductible for prescription drugs is $100 per member (or $200 per family).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is $2,500 per member (or $5,000 per family). Your out-of-pocket maximum for prescription drug benefits is $1,000 per member (or $2,000 per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

You are covered for certain medical and behavioral health services for conditions that can be treated through video visits from an approved Telehealth provider. These Telehealth services are available by using your computer or mobile device when you prefer not to make an in-person visit for any reason to a doctor or therapist. For a list of Telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call the Physician Selection Service at 1-800-821-1388.

Service Area

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area

If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost
Preventive Care Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office visits, when performed by: • Your PCP, OB/GYN physician, network nurse practitioner or nurse midwife • Other network providers	 $20 per visit, no deductible $60 per visit, no deductible
Chiropractors' office visits (up to 20 visits per calendar year)	$20 per visit, no deductible
Mental health or substance abuse treatment	$10 per visit, no deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible
Diagnostic X-rays and lab tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**
Prosthetic devices	Nothing after deductible
Surgery and related anesthesia in an office, when performed by: • Your PCP or OB/GYN physician • Other network providers	 $20 per visit***, no deductible $60 per visit***, no deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$250 per admission after deductible
Inpatient Care (including maternity care) in: • Other general hospitals (as many days as medically necessary) • Higher cost share hospitals (as many days as medically necessary)	 $275 per admission after deductible† $1,500 per admission after deductible†
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$275 per admission, no deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** Cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
† This cost share applies to mental health admissions in a general hospital.

Prescription Drug Benefits*	Your Cost**
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 after deductible for Tier 1 $30 after deductible for Tier 2 $65 after deductible for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$25 after deductible for Tier 1 $75 after deductible for Tier 2 $165 after deductible for Tier 3

* Tier 1 generally refers to generic drugs; Tier 2 generally refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.
** Cost share may be waived for certain covered drugs and supplies.

Get the Most from Your Plan

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Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)	$150 per calendar year per policy
Blue Care Line®—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at www.bluecrossma.com. Interested in receiving information from us via e-mail? Go to www.bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.

Your Choice

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is $500 per member (or $1,000 per family) for in-network services and $500 per member (or $1,000 per family) for out-of-network services. Your deductible for prescription drugs is $100 per member (or $200 per family).

When You Choose Preferred Providers

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your "in-network" benefits.

This plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive certain inpatient services at or by "higher cost share hospitals." See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level–even if the preferred provider refers you.

Your cost will be greater when you receive certain inpatient services at or by the higher cost share hospitals listed below, even if your preferred provider refers you.

Higher Cost Share Hospitals

Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- Baystate Medical Center
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- UMass Memorial Medical Center

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost sharing level may apply.

How to Find a Preferred Provider

There are a few ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com/findadoctor
- Call the Physician Selection Service at 1-800-821-1388

When You Choose Non-Preferred Providers

You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your "out-of-network" benefits. Payments for out-of network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance). See the charts for your cost share.

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is $2,500 per member (or $5,000 per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is $1,000 per member (or $2,000 per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

You are covered for certain medical and behavioral health services for conditions that can be treated through video visits from an approved Telehealth provider. These Telehealth services are available by using your computer or mobile device when you prefer not to make an in-person visit for any reason to a doctor or therapist. For a list of Telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call the Physician Selection Service at 1-800-821-1388.

Utilization Review Requirements

You must follow the requirements of Utilization Review, including Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. For detailed information about Utilization Review, see your benefit description. If you need non-emergency or non-maternity hospitalization, you, or someone on your behalf, must call the number on your ID card for pre-approval. If you do not notify Blue Cross Blue Shield of Massachusetts and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

EXHIBIT C

Blue Care Elect Deductible SM

MIIA PPO Benchmark Plan v.3

7/1/2022 – 6/30/2024

Your Medical Benefits

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care Well-child care exams, including related tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year age 3 and older	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests, (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services–office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for observation stay)	$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office visits, when performed by: • Family or general practitioner, internist, OB/GYN physician, geriatric specialist, licensed dietitian nutritionist, optometrist, pediatrician, nurse practitioner, nurse midwife, physician assistant • Other covered providers	$20 per visit, no deductible $60 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Chiropractors' office visits (up to 20 visits per calendar year)	$20 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	$10 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays and lab tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per category per service date after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible**	20% coinsurance after deductible
Prosthetic devices	Nothing after deductible	20% coinsurance after deductible
Surgery and related anesthesia in an office, when performed by: • Family or general practitioner, internist, OB/GYN physician, geriatric specialist, pediatrician, nurse practitioner, nurse midwife, physician assistant • Other covered providers	$20 per visit***, no deductible $60 per visit***, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Ambulatory surgical facility, hospital, or surgical day care unit	$250 per admission after deductible	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** Cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient Care (including maternity care) • In other general hospitals (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	$275 per admission after deductible* $1,500 per admission after deductible*	20% coinsurance after deductible 20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$275 per admission, no deductible	20% coinsurance after deductible
Rehabilitation hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drug Benefits** At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 after deductible for Tier 1 $30 after deductible for Tier 2 $65 after deductible for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$25 after deductible for Tier 1 $75 after deductible for Tier 2 $165 after deductible for Tier 3	Not covered

* This cost share also applies to mental health admissions in a general hospital.
** Cost share may be waived for certain covered drugs and supplies.

Get the Most from Your Plan

Visit us at www.bluecrossma.com or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)	$150 per calendar year per policy
Blue Care Line®—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts. call 1-800-782-3675, or visit us online at www.bluecrossma.com. Interested in receiving information from us via e-mail? Go to www.bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.

EXHIBIT D

MIIA HMO High Deductible Health Plan

7/1/2018 – 6/30/2024

BENEFIT	MIIA HMO HIGH DEDUCTIBLE HEALTH PLAN
Deductible	$1,500 / $3,000 (member / family)
Out of Pocket Maximum	Medical and Prescription Services: $3,000 Individual / $6,000 famlly
Preventtve Care Visit	$0
PCP Office Visit	Covered In fu ll after deductible
Specialist Office Visit	Covered In full after deductible
Emergency Room	Covered In fu ll after deductible
lnpatient Hospital Admission	Covered In full after deductible
Ambulatory Day/Outpatient Surgical Day	Covered In full after deductible
Dia1nostlc X-rays and LabTests, excludlng MRI's, CT and PET Sansand Nuclear Imaging	Covered in full after deductible
CT and PETscans and Nuclear Imaging	Covered in full after deductible
Short-Term Physical and Occupational Therapy	Covered In fun after deductible (up to 100 visits per CY)
Skilled Nursing Facility Care	Covered In full after deductible (up to 100 days per CY)
Speech Theropy	Covered In full after deductible
Home Health and Hospice Care	Covered In full after deductible
Durable Medical Equipment	Covered In fun after deductible
Chiropractic Services	Covered In full after deductible
Routine Vision Exam	Covered In full after deductible (one visit every 24 months)
Prescription Drug Deductible ($100 / $200) (applles to retail and mail) - Retail RX (up to 30-day supply) - Mail Order Drug RX (up to 90-day supply)	 applies to retail and mail $10/30/65 after deductible $25/75/165 after deductible

EXHIBIT D

MIIA PPO High Deductible Health Plan

7/1/2018 – 6/30/2024

BENEFIT	MIIA PPO HIGH DEDUCTIBLE HEALTH PLAN	MIIA PPO HIGH DEDUCTIBLE HEALTH PLAN
Network	In-Network	Out-Of-Network
Deductible	$1500 / $3000 (Member / Family) *	$1500 / $3000 (Member / Family) *
Out of Pocket Maximum	Medical and Prescription Services: $3000 Individual / $6000 Family	Mecical Services: Combined In and Out
Preventtve Care Visit	$0	20% coinsurance after deductible
PCP Office Visit	Covered in full after deductible	20% coinsurance after deductible
Specialist Office Visit	Covered in full after deductible	20% coinsurance after deductible
Emergency Room	Covered in full after deductible	Covered In full after deductible
Inpatient Hospital Admission	Covered in full after deductible	20% coinsurance after deductible
Ambulatory Day/Outpatient Surgical Day	Covered in full after deductible	20% coinsurance after deductible
Dia1nostlc X-rays and LabTests, excludlng MRI's, CT and PET Sansand Nuclear Imaging	Covered in full after deductible	20% coinsurance after deductible
MRI, CT and PETscans and Nuclear Imaging	Covered in full after deductible	20% coinsurance after deductible
Short-Term Physical and Occupational Therapy	Covered in full after deductible (up to 100 visits per CY)	20% coinsurance after deductible
Skilled Nursing Facility Care	Covered in full after deductible (up to 100 visits per CY)	20% coinsurance after deductible
Speech Theropy	Covered in full after deductible	20% coinsurance after deductible
Home Health and Hospice Care	Covered in full after deductible	20% coinsurance after deductible
Durable Medical Equipment	Covered in full after deductible	20% coinsurance after deductible
Chiropractic Services	Covered in full after deductible	20% coinsurance after deductible
Routine Vision Exam	Covered in full after deductible (one visit every 24 months)	20% coinsurance after deductible
Prescription Drug Deductible ($100 / $200) (applies to retail and mail) - Retail RX (up to 30-day supply) - Mail Order Drug RX (up to 90-day supply)	 applies to retail and mail $10/30/65 after deductible $25/75/165 after deductible	 applies to retail and mail $20/60/130 after deductible not covered