

AGREEMENT

BETWEEN THE

PITTSFIELD SCHOOL COMMITTEE

AND THE

PITTSFIELD FEDERATION OF SCHOOL EMPLOYEES
LOCAL 1315, AMERICAN FEDERATION OF TEACHERS (AFT)
AFT MASSACHUSETTS, AFL-CIO
BUS DRIVERS' & ATTENDANTS' UNIT

SEPTEMBER 1, 2018 – AUGUST 31, 2021

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AGREEMENT

This Agreement entered into between the School Committee of the City of Pittsfield, Massachusetts (hereinafter referred to as the "Employer"), and the Pittsfield Bus Drivers Union - Pittsfield Federation of School Employees, Local 1315, AFT, AFL-CIO (hereinafter referred to as the "Federation") this 25th day of April, 2018.

ARTICLE I **RECOGNITION AND DEFINITIONS**

A. RECOGNITION

The Employer recognizes the Pittsfield Federation of School Employees, Local 1315, AFT, AFT-Mass, AFL-CIO as the sole and exclusive bargaining agent on questions of wages, hours and other conditions of employment for all school bus drivers and bus attendants employed by the Pittsfield School Committee excluding all other employees.

B. DEFINITIONS

1. The term "Federation," as used in this Agreement, refers to the Pittsfield Bus Drivers Union - Pittsfield Federation of School Employees, Local 1315, AFT, AFT-Mass, AFL-CIO.
2. The term "Employee," as used in this Agreement, refers to a person employed by the Committee in the bargaining unit as described in Article I. Whenever the term "employee" is used in a particular Article or Section of this Agreement, the terms of that Article or Section shall apply to both school bus drivers and to school bus attendants.
3. The term "Driver," as used in this Agreement, refers to a person employed by the Committee as a school bus driver. Whenever the term "Driver" is used in a particular Article or Section of this Agreement, the terms of that Article or Section shall apply only to school bus drivers and not to school bus attendants.
4. The term "Attendant," as used in this Agreement, refers to a person employed by the Committee as a school bus attendant. Whenever the term "Attendant" is used in a particular Article or Section of this Agreement, the terms of that Article or Section shall apply only to school bus attendants and not to school bus drivers.
5. The terms "Committee" and "Employer," as used in this Agreement, refer to the Pittsfield School Committee.

6. The term "parties," as used in this Agreement, refers to the Committee and the Federation as participants in this Agreement.
7. The term "Federation Representative," as used in this Agreement, refers to any official designee of the Federation.
8. A "permanent employee" is one who has been appointed to the position by the Superintendent.
9. An "intermittent employee" is a person who works on an as needed basis.
10. A "Mid-day Run," or Mid-day Route," is a route that has been posted as a mid-day route, which occurs between the hours of 9:00 a.m. and 1:30 p.m., and which is bid on and awarded in accordance with Article III, Section 5 of the contract.
11. Whenever the singular is used in this Agreement, it is to include the plural. Whenever 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.

ARTICLE II

GRIEVANCE PROCEDURE

SECTION 1. DEFINITIONS

- A. A "grievance" is a complaint that there has been a violation, misinterpretation, or misapplication of this Agreement or any amendment or supplement thereto.
- B. A "grievant" on any issue covered by the terms of this Agreement is any employee, group of employees having a common grievance, or the FEDERATION.
- C. 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 2. PROCEDURES

A. LEVEL ONE: (IMMEDIATE SUPERIOR LEVEL)

1. 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.
2. If the grievance is not resolved informally, the grievant may submit directly, together with or through the FEDERATION, a written grievance to the Director or Director's designee or to the

immediate superior of the grievant. Within ten (10) calendar days after receiving the grievance, the Director or Director's designee or immediate superior shall communicate her/his decision in writing.

B. LEVEL TWO: (SUPERINTENDENT LEVEL)

1. The decision of the Director or Director's designee 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 Director or Director's designee or immediate superior has been received by the aggrieved.
2. 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.
3. 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.

C. LEVEL THREE: (SCHOOL COMMITTEE LEVEL)

1. 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.
2. 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.
3. The School Committee shall communicate its decision in writing within fifteen (15) calendar days of the meeting with the grievant and the FEDERATION representative.

D. LEVEL FOUR: (ARBITRATION)

1. 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 AMERICAN ARBITRATION ASSOCIATION shall be the method of notifying the COMMITTEE of the FEDERATION'S intent to appeal. The date postmarked on the envelope containing the AMERICAN ARBITRATION ASSOCIATION demand shall be deemed the date of filing.
2. 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.

3. 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 AMERICAN ARBITRATION ASSOCIATION or the Arbitrator shall pay the full cost of any fees of the AMERICAN ARBITRATION ASSOCIATION and/or the Arbitrator.

4. If the COMMITTEE claims the FEDERATION has violated any provisions of Article IV, 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 3. GENERAL PROVISIONS

A. 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.

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

C. 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 or record utilized in the promotion process; nor shall such fact be used in any recommendations for job placement; nor shall such employee or employees who participate in any way in the grievance procedure be subjected to reprisal for having processed a grievance. 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.

D. At arbitration, the grievant and the School Committee shall have the following rights:

1. To be present at the hearing;
2. To hear testimony;
3. To give testimony;
4. To call others to give testimony;
5. To question whether personally or through a FEDERATION or COMMITTEE representative, any person giving testimony.

E. Except in cases of arbitration hearing, grievances shall ordinarily be processed at times that do not disrupt the educational programs in the schools or interfere with the employees' responsibilities. 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.

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

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

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

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

J. At a School Committee grievance hearing, the FEDERATION and/or the employee 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 III **SENIORITY, ASSIGNMENTS, VACANCIES AND TRANSFERS**

SECTION 1. SENIORITY

A. The date an employee is hired shall be established as a "service" date only, and shall be applicable to the salary schedule. It is agreed that this "service" date does not establish "seniority" as governed by Civil Service Law (M.G.L. c. 31, §15D.)

B. Effective September 1, 1991, seniority will be established by the date of assignment as a permanent route driver and attendant. The date of assignment becomes the seniority date for the selection of route assignment packages (Daily Route Assignments).

C. An updated Civil Service List and "Service" List will be provided to the Federation on the first day of school. The Federation will have fifteen (15) calendar days to submit a written challenge to the Civil Service List and/or the "Service" List. If no written challenge is filed within fifteen (15) calendar days, the Civil Service List and the "Service" List shall be final and not subject to challenge except that, if there are any new hires after the expiration of the fifteen (15) day challenge period, challenges may be made with regard only to those new employees for up to fifteen (15) days after the Federation has received written notice of the placement of these employees on the seniority list.

D. It shall be the responsibility of the Employer to forward the name and address of each new employee to the Federation within five (5) working days after appointment by the School Committee.

SECTION 2. DRIVER/ATTENDANT DAILY ROUTE ASSIGNMENTS

A. The route assignment package (Daily Route Assignments) for a Driver/Attendant shall consist of his/her Morning (A.M.) Route Assignment, his/her Afternoon (P.M.) Route Assignment, his/her Mid-Day Route Assignment (if any), and Additional Route Assignments (if any) including Nighttime Route Assignments (Nighttime Runs), selected by the Driver/Attendant in August (or September) prior to the start of each school year, and his/her Summer Route Assignment selected by the Driver/Attendant in

June of each school year. A Driver/Attendant's route assignment package (Daily Route Assignments) shall be considered his/her regular and ordinary compensation for the school year.

B. A list established by seniority date (Route Assignment Selection List) will be used to select and distribute Driver/Attendant Daily Route Assignments. A Driver/Attendant will select his/her Daily Route Assignments in August (or September), prior to the start of each school year. The selection process will continue until all Daily Route Assignments are distributed. Any Driver without Daily Route Assignments upon completion of the selection process will be assigned as a Spare Driver.

C. All information known to the Committee at the time of selection of Driver/Attendant Daily Route Assignments where it is known that supplementary route assignments may be added will also be posted. This information will include all Mid-Day Route Assignments, and Additional Route Assignments including Nighttime Runs known at the time of the Driver/Attendant's selection of their Daily Route Assignments. Mid-Day Route Assignments or Additional Route Assignments including Nighttime Runs which become available after initial selection of Driver/Attendant Daily Route Assignments shall be distributed in the same manner as provided herein.

D. The date and time for a Driver/Attendant to select his/her Daily Route Assignments for the school year will be given to all employees prior to the day of orientation. The date and time for a Driver/Attendant to select his/her Summer Route Assignment will be given to all employees a minimum of two (2) days prior to the selection process.

E. A Driver/Attendant must select his/her Daily Route Assignments within their allotted fifteen (15) minute time frame. A Driver/Attendant unable to be present at his/her scheduled selection time may provide another employee written permission to select his/her Daily Route Assignments. This written permission must be presented to the Director of Bus Operations prior to the absent employee's scheduled selection time. A Driver/Attendant not present at his/her scheduled selection time, who has not provided another employee with written permission to select his/her Daily Route Assignments, will be by-passed and the selection process will continue until all employees have selected Daily Route Assignments. Upon completion of the selection process, the remaining Daily Route Assignments will be distributed to eligible Drivers/Attendants at the discretion of the Director of Bus Operations. The selection process will then be final and not subject to challenge.

F. The Daily Route Assignment selection process will be monitored by Union Representatives and the Director of Bus Operations or his/her designee. The Director of Bus Operations or his/her designee will

be available to address questions concerning routes. When ability and qualifications are relatively equal, seniority shall prevail in the selection and distribution of Daily Route Assignments.

G. All Driver/Attendant Daily Route Assignments selected in August (or September) shall be for the duration of the school year, or for its posted duration, unless the route is eliminated or the need for transportation ends, in which case, the Driver/Attendant will be offered alternate work.

H. The Director of Bus Operations may, in an emergency, require a Driver/Attendant to work a route assignment other than his/her assigned Daily Route Assignments: Morning (A.M.) Route Assignment, Afternoon (P.M.) Route Assignment, Mid-Day Route Assignment, or Additional Route Assignment.

SECTION 3. MID-DAY ROUTE ASSIGNMENTS (MID-DAY RUNS)

A. No Driver/Attendant will be allowed to select a Mid-Day Run unless he or she is working both a Morning (A.M.) and an Afternoon (P.M.) Route Assignment. Drivers/Attendants assigned to a Mid-Day Run at the end of each school year will have the right-of-first-refusal on all Mid-Day Route Assignments for the duration of this Agreement.

B. Any break in service by a Driver/Attendant on this list which hereof in service is not the result of pregnancy, illness, approved leaves of absence or accidental injury and which break in service continues for more than thirty (30) days discontinues that employee's right-of-first-refusal.

C. Any Driver/Attendant who is currently grandfathered for a Mid-Day Route Assignment who chooses to select a Spare Driver slot could do so and remain grandfathered for Mid-Day Runs with the stipulation that the Driver/Attendant could not return to a Mid-Day Run for the remainder of the school year unless one was currently available. The Driver/Attendant would maintain his/her standing on the grandfathered Mid-Day seniority list.

D. Upon the vacancy of a Mid-Day Route Assignment, the particular Mid-Day Run shall be offered first to the most senior grandfathered Driver/Attendant, and then in turn to the most senior Driver/Attendant who selects the route.

SECTION 4. ADDITIONAL ROUTE ASSIGNMENTS (ADDITIONAL RUNS)

A. No Driver/Attendant will be allowed to select an Additional Route Assignment including Nighttime Route Assignments (Nighttime Runs), unless he or she is working both a Morning (A.M.) and an Afternoon (P.M.) Route Assignment. All Additional Runs, including Nighttime Route Assignments (Nighttime Runs), shall be selected by and distributed to Drivers/Attendants using the route assignment selection process identified in Section 2, above. Additional Route Assignments, including Nighttime

Route Assignments shall be for the posted duration, unless the route is eliminated, or the need for transportation ends. Notwithstanding the provisions of Section 2 above, the Union agrees to waive reduction in force impact bargaining if an Additional Route Assignment needs to be eliminated prior to its posted duration due to operational needs.

B. Upon the vacancy of an Additional Route Assignment, the particular Additional Run shall be offered first to the most senior Driver/Attendant, and then in turn to the other Drivers/Attendants by seniority, provided the employee is available and qualified to perform the work.

SECTION 5. SUMMER ROUTE ASSIGNMENTS (SUMMER RUNS)

A. Summer Route Assignments will be posted as soon as possible after June 1st when information on these route assignments is available. Summer Route Assignments are mandatory work assignments for members of the bargaining unit, and shall be subject to the route assignment selection process identified in Section 2, above. Summer Route Assignments shall be offered first to the most senior Driver/Attendant, and then in turn to the other Drivers/Attendants by seniority, provided the employee is available to perform the work.

B. Summer Route Assignments start between the day after school gets out in June, and continue until the first day of school in August (or September). A Driver/Attendant who works a Summer Route Assignment shall perform the duties of the Summer Run until the first day of school in August (or September), or for its posted duration.

C. All Drivers/Attendants who work a Summer Route Assignment may not select any non-driving work that precludes them from fulfilling any portion of their assigned route. Employees who work a Summer Route Assignment must be available to perform the required duties of the Summer Run at all times except in a case of an emergency at the employer's discretion. If the need for the Summer Route Assignment no longer exists or the Summer Run is eliminated, the employee(s) will be offered alternate work.

D. A Driver who works a Summer Route Assignment will be paid two (2) hours to learn his/her Summer Run. Drivers/Attendants who work a Summer Route Assignment will be awarded July 4th as a paid holiday in accordance with Article XV of this contract.

SECTION 6. CHARTER WORK ASSIGNMENTS (CHARTER RUNS)

A. A Charter Work Assignment (Charter Run) is an additional work opportunity, which is not a part of a Driver or Attendant's regular Daily Route Assignments, offered to qualified employees on a rotating basis. A Charter Run is defined as any bus run to and/or from an academic or sporting event.

B. Drivers and Attendants may bid on runs for Charter Work Assignments from an alphabetically established list (the Charter List). Bidding would continue until the list is exhausted and return to the top of the list for further bidding. The Director of Bus Operations has the option to reject bids for assignments that would make the Driver or Attendant eligible for compensation at the rate of time and one half. Substituting for bids on Charter Run for interscholastic events may be permitted at the discretion of the Director of Bus Operations.

C. Attendants will be assigned a Charter Run, when needed, from the established seniority list (the Charter List). Each September, the list will start with the most senior attendant until the list is exhausted and return to the top of the list for further assignment until the last day of school. Attendants shall receive their hourly rate of pay for charter work.

D. In the event that a Charter Run for an interscholastic event is cancelled and the Employer is not able to telephone the Employee's residence regarding the cancellation prior to the Employee reporting to the terminal, the Employer shall, at its option, provide the Employee with either two (2) hours of pay or two (2) hours of alternate work within the Employee's job description (Note: a three (3) hour minimum shall apply on Sundays and Holidays) and the next available Charter Run.

E. Normally, Charter Work Assignments will be assigned by 9:00 A.M. on Thursday for Charter Runs that are known for the following Friday, Saturday, Sunday, and Monday. All Charter Runs that are known for the following Tuesday, Wednesday, and Thursday will be assigned by 9:00 A.M. on Monday. Subsequent Charter Runs must be assigned by 2:00 P.M. on the day before said run. In the event that a Charter Work Assignment is turned in or received after 2:00 P.M. on the day before, or is received and assigned on the same day, the Charter Run will be treated as an addition, and a Driver or Attendant who cannot accept the addition will not lose his/her place in the rotation.

F. Once a Charter Work Assignment has been assigned to a Driver/Attendant, the Director of Bus Operations may not require a Driver/Attendant to change their assigned Charter Run, without the consent of the Driver/Attendant.

G. Any Driver or Attendant who turns in a Charter Work Assignment after 2:00 P.M. on the day before an event will not be awarded a Charter Run on the next rotation.

H. The Employer shall make written directions available to each Driver for an out of county Charter Run, and the Drivers shall be required to follow the assigned route, unless specifically authorized to deviate therefrom.

I. Notwithstanding any other provisions of this Agreement, the following rates of compensation are established for all Charter and Athletic assignments. Effective upon ratification of the 2014-2017 collective bargaining agreement through 8/31/2017:

REGULAR

City	\$63.00
County	\$94.00
Other	\$126.00

SUNDAYS AND HOLIDAYS

City	\$94.00
County	\$142.00
Other	\$189.00

J. The Director of Bus Operations may, in an emergency, require a Driver/Attendant to work a Charter Work Assignment in lieu of his/her Daily Route Assignments: Morning (A.M.) Route Assignment, Afternoon (P.M.) Route Assignment, Mid-Day Route Assignment (if any), or Additional Route Assignment (if any). A Driver/Attendant required to work a Charter Run in lieu of his/her Daily Route Assignments, or any portion thereof, will be entitled to his/her regular hourly rate of pay for all hours he/she was scheduled to work on his/her Daily Route Assignments, which shall be considered regular and ordinary compensation for the day. In addition, the Driver/Attendant shall receive pay for the Charter Work Assignment, at the applicable Charter Run rate, less any amount he/she received as regular and ordinary compensation for the day.

K. In the event a Driver/Attendant, through no fault of their own, must work extended time beyond the anticipated end of the Charter Work Assignment, and as a result the hourly rate of pay for a Charter Run would be less than the Driver/Attendant's regular hourly rate of pay, then he/she will be paid for all hours worked on that Charter Work Assignment at his/her regular hourly rate of pay.

L. An overnight Charter Run will be treated as an addition. All pertinent information including the amount to be paid to the Driver or Attendant for that particular Charter Run will be posted.

M. Charter Runs that are one hundred and twenty-five (125) miles or more one-way receive a \$50.00 premium. Charter Runs into Boston or New York City receive a \$75.00 premium (Note: this amount is not in addition to the amount listed in the preceding sentence). Neither of the above amounts applies to trips which involve a one-way drop or a one-way pickup.

N. Any Charter Work Assignment (Charter Run) scheduled between the last scheduled day of school in June and the first scheduled day of school in August (or September) shall be assigned in accordance with this section. Only a Driver/Attendant who works a Summer Route Assignment will be eligible for summer Charter Work Assignments, i.e., any (Charter Runs) that occur after the end of the school year (in June) and prior to the beginning of the following school year in August (or September).

SECTION 7. DAILY PROGRAM TRANSPORTATION RUN (PROGRAM RUN)

A. A Daily Program Transportation Run (Program Run) is an additional work opportunity, which is not a part of a Driver or Attendant's regular Daily Route Assignments, offered to qualified employees on a rotating basis. A Program Run is defined as any bus run which transports students to and/or from a field trip or similar event, initiated and completed between the hours of 8:40 A.M. and 2:15 P.M.

B. A rotating list (the Program List) established by date of service will be used ~~for~~ to distribute Program Runs. The Program List will begin each week with the name at the top of the list. Programs Runs will be assigned on the first day of school each week and continue until the last day of that week. If the program list is exhausted before the end of the week, programs will be assigned by returning to the top of the Program List.

C. Attendants will be assigned a Program Run, when needed, from the established Program List. Each September, the Program List will start with the most senior Attendant and return to the top of the list for further assignment until the last day of school. Attendants shall receive their hourly rate of pay for all work performed on a Program Run.

D. If a Driver is notified of a Program Run on the same day that it is scheduled, then that Driver has a the right to refuse said Program Run and not lose his/her place on the Program List. If a Daily Program Transportation Run is cancelled after it has been assigned the Driver or Attendant will be assigned the next available Program Run.

E. A Driver/Attendant who subsequently finds that he/she cannot complete his/her assigned Program Run must turn in said Program Run to the Director of Bus Operations or his/her designee before 12:00 P.M. (noontime) on the day before the event. Any Driver/Attendant who turns in a Program Run to the

Director of Bus Operations or his/her designee after 12:00 P.M. (noontime) on the day before the event will lose their turn on the Program List, and will not be offered the next available Program Run.

F. Any Program Run turned in by a Driver/Attendant to the Director of Bus Operations or his/her designee must be awarded to the next available Driver/Attendant by 1:00 P.M. or said Program Run becomes an addition.

G. All Drivers and Attendants will be paid continuous time from the start of a Program Run to its ultimate completion. Drivers and Attendants on a Program Run will call in to the Manager of Bus Operations to make themselves available for additional duties as required between the drop-off and pick-up time.

SECTION 8. SPARE DRIVERS

A. Spare Drivers will be assigned at the discretion of the Director of Bus Operations. There shall be no required reassignment if a subsequent route becomes available. The regular and ordinary compensation for the two (2) Spare Drivers shall be six and one quarter (6 ¼) hours per day. When not driving a school bus, a Spare Driver can be required to perform other assignments.

B. The first two (2) replacements for Mid-Day Route Assignments for absent drivers will be the least senior spare driver first, and then the most senior spare driver.

SECTION 9. NON-DRIVING WORK

A. On occasion extra work is needed in School Bus Operations unrelated to driving a school bus. The work includes vehicle repair and maintenance, timing routes, repairing damaged seats, installing seat belts, cleaning offices and toilets or delivering school mail.

B. If a Driver or Attendant is used to do this work, the work will be posted and given to the most senior driver or attendant who applies under the following conditions:

1. The Driver or Attendant can complete the work during the time period specified.
2. The Driver or Attendant is qualified to do the work.
3. The Driver or Attendant can do the work without it resulting in the payment of overtime.

C. A Driver or Attendant who performs such work shall be paid at his/her applicable hourly rate of pay, and for all hours worked. If an Attendant performs non-driving work equal to a driver, he or she will be paid on the same pay schedule as the Driver.

D. The training of Drivers/Attendants and/or fueling vehicles will be posted as an Additional Route Assignment, however the Director of Bus Operations will have discretion to select an applicant for the position/work.

1. An employee who performs duties related to the fueling of vehicles shall work and be paid for not less than one and one-half (1 ½) and not more than three (3) hours per day in addition to his/her Daily Route Assignments, dependent upon operational needs.
2. An employee who perform duties related to in-service training shall work and be paid for not less than one and one-half (1 ½) and not more than three (3) hours per month in addition to his/her Daily Route Assignments, dependent upon operational needs.
3. An employee who perform duties related to training new Drivers/Attendants shall work and be paid for not less than one and one-half (1 ½) and not more than three (3) hours per day in addition to his/her Daily Route Assignments, dependent upon operational needs. Based on historical trends at Pittsfield Bus Operations the training of new Drivers/Attendants typically requires between 150 and 300 hours of additional work per year, dependent upon operational needs.
4. The combination of an employee's Daily Route Assignments and any Additional Route Assignment for training and/or fueling of vehicles shall not exceed forty (40) hours per week.
5. An Employee who performs such work shall be paid at his/her applicable hourly rate of pay, and for all hours worked, which shall be considered part of the employee's regular/ordinary compensation.

E. Any work under this section performed in lieu of an employee's Daily Route Assignments shall be considered part of his/her regular/ordinary compensation.

F. A list of Non-Driving Work (if any) for the summer months of June, July, and August shall be posted as Summer Route Assignments, in accordance with Section 5, above.

SECTION 10. PROBATIONARY PERIOD

A. No permanently appointed driver receiving beginner's rate of pay may be allowed to bid on any program or charter work during his or her first one hundred (100) working days of employment unless another driver with one hundred (100) working days or more of service is not available.

B. No permanently appointed intermittent driver may be allowed to bid on charter work unless that driver has had one hundred (100) consecutive days of employment which includes at least three hundred (300) hours of work during the one hundred (100) day period.

C. If the consecutive count is interrupted of a driver's own accord, then their one hundred (100) day count begins again on the date of their return to work.

D. No intermittent driver will lose their continuity of one hundred (100) driving days due to lack of work unless the lack of work consists of ten (10) consecutive working days. After such a period of time, the one hundred (100) day count would start from zero.

SECTION 11. UNION NOTIFICATION

Procedures for implementing the bidding provisions of this contract will be discussed with at least two union representatives prior to instituting said procedures.

SECTION 12. INVOLUNTARY TRANSFERS

Involuntary transfers may be made at any time. Such transfers shall be subject to all steps of the Grievance Procedure but not subject to the binding arbitration provisions of Step 4.

SECTION 13. LOSS OF SENIORITY RIGHTS

An employee's seniority rights shall cease and his employment with the Employer shall terminate:

A. If he/she voluntarily quits. However, if the employee should report for the start of his/her next scheduled shift (not to exceed three (3) calendar days) and no substitute has been called in or replacement hired, the Committee shall give consideration to the employee's request to be reinstated with full seniority.

B. If he/she retires or resigns.

C. If he/she is discharged for just cause.

D. If he/she fails to report for work for a period of three (3) working days, without permission and fails to notify his Supervisor during said period of any valid reason for his/her absence.

E. If he/she is laid off, and his/her layoff is continuous for a period in excess of fifteen (15) months.

F. If he/she fails to report his/her availability to report back to work following his/her layoff, within three (3) working days after being recalled by a written notice of recall sent by the Employer to said employee's last known address on the Employer's records, unless such failure to report back is due to reasons beyond said employee's control, satisfactory proof thereof is offered to the Employer, and the employee notifies his Supervisor of said reasons as soon as possible. It is agreed by the parties that the employee shall report for work immediately following a two-week notice period to any interim Employer.

G. If a driver operates a school bus with a suspended or expired commercial driver's license or school bus license.

SECTION 14. MORNING, MID-DAY, AND AFTERNOON ROUTE NOTIFICATION

Employees must provide at least two (2) hours notice to the Employer if they are unable to report for any scheduled mid-day or afternoon route. Employees must provide at least forty-five (45) minutes notice to the Employer if they are unable to report for any scheduled morning route.

SECTION 15. MISCELLANEOUS

A. No smoking on school buses and school department vehicles.

B. No mechanical work is to be conducted on any buses without prior permission from management.

C. No unauthorized mechanical, electrical or electronic equipment shall be placed on any of the buses nor wired into the existing electrical system at any time without prior authorization from the Superintendent or his or her designee.

D. It is the sole responsibility of the driver to maintain a clean bus and he/she is required to sweep his/her buses daily and wash them once every week in which bus is in operation. This will also apply to spare drivers. Any driver with a program or charter is required to ensure the cleanliness of the bus used at the end of the trip.

ARTICLE IV LEAVES OF ABSENCE

A. UNPAID LEAVE OF ABSENCE. An approved leave of absence without pay may be granted to a member of the unit for a period up to one (1) year. Approved leaves of absence shall not be considered breaks in service, but time spent out on leave shall not count as accrued service unless otherwise required by Civil Service Law (Chapter 31).

B. Requests for such leave shall be made in writing to the Superintendent of Schools at least forty-five (45) days prior to the commencement of such leave. The forty-five (45) day time requirement may be waived by written agreement of the parties. The Superintendent of Schools or her/his designee shall respond in writing to leave of absence requests within ten (10) working days of receipt of the leave request. The granting of leaves of absence shall be subject to the Superintendent's discretion, and his/her decision shall not be subject to the grievance and arbitration procedure.

C. Reasons for the leave shall be clearly stated in the written request.

D. In all cases, the member of the unit shall notify the Personnel Office at least thirty (30) calendar days prior to the stated leave termination date as to whether he/she plans to return or resign. Failure to do so shall result in a waiver of the rights to return. Where appropriate, prior to return, the member must produce a certificate from his/her physician to the effect that he/she is physically fit and ready to commence working.

E. Drivers and Attendants on authorized leave of absence of thirty (30) days or less will be assigned to their regular bid runs including Mid-Day runs when they return to work after the leave of absence. If an unpaid leave not covered by Federal or State Law is for more than thirty (30) days, the Driver or Attendant will lose his/her regular bid run and be placed at the bottom of the bidding seniority list.

F. JURY DUTY. Drivers and Attendants who are absent because of jury duty will receive the difference between their compensation for jury duty and their regular compensation so that such drivers suffer no reduction in regular income as the result of jury duty provided the employee immediately gives the Employer proper notice of said jury duty and thereafter provides the Employer with appropriate proof of service and the amount which she/he was paid for jury service.

G. PERSONAL DAYS. Employees shall receive one (1) Personal Days during the first year of employment. Employees shall receive two (2) Personal Days after their first year of employment, and may carry over unused Personal Days from year to year, accumulating them to not more than five (5) days. The Personal Days must be requested in writing with at least forty-eight (48) hours advance notice. Employees must use their Personal Days before requesting any other personal leave without pay. No more than two (2) employees may be granted a Personal Day on a given day. The employee shall be compensated for his/her Daily Route Assignments at his/her regular hourly rate of pay.

H. FAMILY AND MEDICAL LEAVE ACT (FMLA). 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.

1. 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.
2. 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).

3. 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).

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

5. 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. Accumulated paid leave may only be substituted if the reason for the leave would have normally qualified for paid leave.

I. 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.

J. An employee who meets the statutory requirements to qualify for leave under the Domestic Violence Leave Act (DVLA), or the Parental Leave Act (PLA) 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.

K. LEAVE FOR CONFERENCES, CONVENTIONS, ETC. Two (2) official delegates of the Bus Driver and Attendants Unit of the Federation may be granted up to three (3) days leave with pay to attend conventions of affiliated bodies, conferences, or other functions.

ARTICLE V
GROUP INSURANCE

An eligible employee may participate in group insurance plans offered by the City of Pittsfield through the Massachusetts Interlocal Insurance Association/BlueCross BlueShield Massachusetts (MIIA/BCBSMA) as provided in the memorandum of agreement, hereinafter “the Section 19 Agreement”, between the City of Pittsfield and the Public Employee Committee dated April 6, 2018. Eligible employees shall receive health insurance benefits in accordance with provisions of the Section 19 Agreement. A copy of the Section 19 Agreement is attached hereto, and incorporated herein by reference as Exhibit D. 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.

ARTICLE VI
WORKER'S COMPENSATION

All employees covered by this Agreement shall be entitled to Worker's Compensation benefits as provided in Chapter 152 of the General Laws of Massachusetts.

ARTICLE VII
PHYSICAL EXAMINATIONS

SECTION 1: GENERAL PROVISIONS

Drivers shall be required to submit to an annual United States Department of Transportation (DOT) physical examination and to process said examination through their health insurance provider. The examination must be performed by a Medical Doctor (MD) who is registered with the Federal Motor Carrier Safety Administration (FMCSA) National Registry of Certified Medical Examiners. The Committee agrees to reimburse Employees for up to one hundred and fifty dollars (\$150.00) of the cost of DOT physical examination or the Employee’s co-payment for said examination, whichever is less. Drivers are responsible for any other costs associated with the examination, including but not limited to any additional and/or follow-up tests associated with said examination.

SECTION 2: EXAMINATION RESULTS AND CERTIFICATION

Drivers must submit a copy of the full annual examination results performed by a MD along with written evidence that the MD is registered with the FMCSA National Registry of Certified Medical Examiners to the Superintendent or his/her designee. Any such results received shall be kept secure by the Superintendent or his/her designee, and the information therein shall not be shared with any person or party except as has a legal right to said information.

SECTION 3: RESTRICTED USE OF CERTAIN MEDICAL DOCUMENTS

No such results received from a MD shall be used to make a referral to the City Physician or other MD for further medical examination without reasonable grounds. A driver so referred to the City Physician shall not be required to meet with said physician for at least five (5) working days in order to permit the driver to consult with a Federation representative; nor shall said driver be removed from payroll for medical reasons until the Superintendent or her/his designee has received the City Physician's report.

SECTION 4: ADMINISTRATIVE RIGHT TO SECURE MEDICAL EVALUATION

The Superintendent or her/his designee shall have the right to refer any driver to the City's Physician if the Director of Bus Operations or any other Pittsfield Public Schools administrator has reasonable grounds to believe that a medical evaluation of that driver is advised.

ARTICLE VIII SNOW DAYS

Employees will receive a minimum of two (2) hours compensation if schools are closed because of inclement weather or emergency conditions unless notice of such closing is made through the news media prior to 6:30 A.M. on the day of the closing. Effective upon ratification by both constituent bodies, employees will receive a minimum of two (2) hours compensation if schools are closed because of inclement weather or emergency conditions, unless notice of such closing is made through Connect-Ed prior to 6:00 a.m. on the day of the closing. If the opening of school is delayed, the employee will receive up to one (1) hour of compensation after reporting to work.

ARTICLE IX
DUES CHECK-OFF

A. Upon receipt of a written authorization from an employee covered by this Agreement, the Committee shall, pursuant to such authorization, deduct uniform dues from the wages due said employee, commencing with the first payroll in September, and continuing through forty (40) regular payrolls. Dues deductions for employees hired after September 14 will begin within thirty (30) days upon receipt of the written authorization.

B. The FEDERATION shall certify to the COMMITTEE, at the time of the signing of this Agreement, the amount of Federation dues charged each member. Any change in dues shall require a statement from the President of the Federation that the dues were changed by a vote of the Federation at a duly constituted meeting called for the purpose. Such change shall not become effective for a period of at least thirty (30) days after such vote and the chapter chairperson of the FEDERATION shall notify the Director of Bus Operations and the City Treasurer, in writing, of such change.

C. The Committee shall be exempt from any obligations to deduct and remit dues of any employee covered by this Agreement whose authorization card has not been furnished and filed with the Director of Bus Operations.

D. The chapter chairperson of the FEDERATION shall certify to the City Treasurer the authorized FEDERATION representative to accept the remittance of dues.

E. The authorization for the dues deduction will be accepted only if submitted on the approved dues check-off authorization card, which shall be personally signed and submitted complete in all respects. All check-off authorization cards shall be dated as of the date of submission to the Director of Bus Operations or her/his designee.

F. It is the understanding and agreement of the parties that this check-off system is only for the collection of the dues and initiation fees of the Federation and shall not be used for collection of any FEDERATION-imposed fines, penalties or assessments or for the collection of any other monies including funds to support candidates for public office.

G. The COMMITTEE shall not be obligated to make dues deductions of any kind from any employee who, during any period of deduction, shall have failed to receive sufficient wages to equal the dues deduction.

H. Once the funds are remitted to the designated representatives of the Federation their disposition thereafter shall be the sole and exclusive obligation and responsibility of the FEDERATION.

- I.** The COMMITTEE shall be relieved from making such "check-off" deductions upon the employee's:
- 1.** Termination of employment whether by resignation, discharge, non-renewal of contract, reduction in staff, or the like.
 - 2.** Transfer or promotion to a position outside the bargaining unit.
 - 3.** Absence as a result of unpaid leave.
 - 4.** Revocation of the "check-off" authorization.
- J.** The "check-off" authorization shall continue to be in effect unless revoked by the signer upon thirty (30) days written notice to the Director of Bus Operations or her/his designee.
- K.** The COMMITTEE agrees to deduct initiation fees as long as such deductions are in equal amounts deducted concurrently with deductions for dues.
- L.** The Union agrees to, and does hereby indemnify, defend and hold harmless the Employer from and against any and all claims, demands, liabilities, suits or any other form of action arising from or relating to any action taken by the Employer in reliance upon information furnished by the Union to the Employer for the purpose of complying with any of the provisions of this Article.

ARTICLE X

IN-SERVICE TRAINING AND ORIENTATION

- A.** All employees must attend two (2) hours of orientation prior to each school year.
- B.** All employees will be compensated at their regular rate of compensation for attending the orientation session.
- C.** Attendance at the orientation session will be considered as meeting the in-service training requirements for license renewal.
- D.** The COMMITTEE will provide twenty (20) hours of in-service training per year between the hours of 9:00 a.m. and 6:00 p.m. on days when school is in session. At least six (6) hours (three (3) in-services) will be scheduled in the evening. Additionally, the COMMITTEE will attempt to schedule monthly in-service meetings, however, it guarantees monthly meetings from February through June.
- E.** Drivers and attendants required to attend in-service sessions will be paid within the same payroll period.
- F.** Credit for attendance at an in-service training session for pay purposes will be counted only if the employee is in attendance during the complete session.

G. All schedules concerning in-service training shall be posted on the bulletin board. All employee in-service training hours shall be available from the Director of Bus Operations upon verbal request. Upon receipt of records showing that a driver has successfully completed the number of hours of in-service training, the Director of Bus Operations shall make available as soon as possible to those drivers all necessary certifications for obtaining a school bus driver's license or license renewal.

ARTICLE XI **BEREAVEMENT**

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

ARTICLE XII
PERSONNEL FILE

- A.** No material derogatory to an employee's conduct, character or performance shall be placed in his/her file unless the employee is sent a dated copy.
- B.** The employee shall have the right to respond in writing to the charges or statement.
- C.** When the Employer receives a written request from an employee, the Employer shall, normally within two (2) work days but not more than five (5) work days, provide the employee with the opportunity to review his/her personnel records. The review shall take place at a time designated by the Employer and in the presence of an Employer representative.
- D.** The Employer will provide a copy of an employee's personnel file in accordance with the provisions and limitations contained in M.G.L. c. 149, § 52C upon receipt of a written request by the employee.
- E.** Any statement or report going into the files is subject to these same provisions.
- F.** Official grievances filed by an employee shall not go into the employee's file.
- G.** Written reprimands may be grieved in accordance with the provisions of this Agreement.
- H.** No anonymous letters of complaint or referral will be placed in an employee's file. Employees will be able to respond to any complaint in writing and will be given a written copy of the final resolution of any action on such complaints.

ARTICLE XIII
REPRESENTATION

An employee has the right to be represented by the Federation in any meeting with management where there is a reasonable expectation that disciplinary action will be taken against the driver.

ARTICLE XIV
PAY SCHEDULE

SECTION 1.

- A.** The salary schedule is hereby attached and marked "Exhibit A."

B. Bi-weekly Pay Schedule: Pay day for all bus drivers and attendants will be advanced to Wednesday with a bi-weekly payroll. The pay day shall be changed from Wednesday to Friday effective upon the City of Pittsfield's implementation of same.

SECTION 2.

The Attendance Incentive Plan is hereby attached and marked "Exhibit B."

SECTION 3.

If employees who resign their position in previous school years are rehired, they will be rehired at the hourly rate of pay for 1-6 years of employment in the bargaining unit specified in Exhibit A.

SECTION 4.

Employees who are required to attend meetings with parents, administrators and principals will be paid their regular hourly rate for attendance at such meetings. Union representatives may attend such meetings if requested by the employee or if union representation is in accordance with the provisions of Article XIII.

SECTION 5.

A. Employees are responsible for accurately completing time sheets for their work week. Whenever the Employer guarantees a certain number of hours of pay in this Agreement, the Employer reserves the right in its discretion to reassign the employee to alternative work within the employee's job description for the specified hours.

B. Attendants will normally be scheduled and paid for two (2) hours of work for their Morning (A.M.) Route Assignment. Drivers will normally be scheduled and paid for two and one-quarter hours ($2\frac{1}{4}$) of work for their Morning (A.M.) Route Assignment. The purpose of the additional one-quarter ($\frac{1}{4}$) hour is for the Driver to do the Pre-Trip Inspection and to complete his/her written Defect Card which must be turned in before he/she leaves for his/her Morning (A.M.) Route Assignment.

C. A Driver/Attendant will normally be scheduled and paid for two (2) hours of work for their Mid-Day Route Assignment (if any), and Afternoon (P.M.) Route Assignments.

D. A Driver/Attendant's Morning (A.M.) Route Assignment, Mid-Day Route Assignment, or Afternoon (P.M.) Route Assignment, may be extended by twenty (20) minutes by starting before or ending after the normally scheduled time, and for the following reasons:

1. Any School District changes that affect transportation.
2. Where the timing of Route Assignments proves to be unrealistic.
3. The addition of temporary/permanent hazardous transportation by the School Committee.
4. Where the purchase of ticket transportation on school bus passes was larger than anticipated.
5. Increases/decreases in student enrollment.
6. Road/bridge construction or repairs.
7. New/unanticipated Additional Route Assignments including but not limited to:
 - a) Athletic Practice
 - b) SPED Integrated Programs
 - c) BCC Programs
 - d) Work Study Programs

E. A Driver/Attendant will be paid for all time worked in excess of his/her normal schedule for any work performed during his/her morning (A.M.) Route Assignment, Mid-Day Route Assignment (if any), or afternoon (P.M.) Route Assignment. All time worked in excess of a Driver/Attendant's normal schedule during his/her morning (A.M.) Route Assignment, Mid-Day Route Assignment (if any), or afternoon (P.M.) Route Assignment shall be considered a part of his/her regular and ordinary income for the day.

SECTION 6.

Drivers will be paid time and one half for all hours worked in excess of forty (40) hours in a week exclusive of Charter Work Assignments (Charter Runs). Drivers will be paid time and one half for all time worked on a holiday specified in Article XV or on Sunday exclusive of Charter Runs. There shall be no pyramiding of any premium, penalty or overtime pay or other benefit under this Agreement. When more than one premium, penalty, overtime rate or benefit may apply, the single highest rate only shall be paid.

SECTION 7.

On Staff Development Days, which fall between the first and last school day of the year, employees will be paid four (4) hours if they attend a four (4) hour in-service that is scheduled for the morning of said days.

SECTION 8.

Any employee hired on or after July 1, 2010 will be required to receive his/her compensation through direct deposit.

SECTION 9.

Effective September 1, 2014, any employee who has completed the required training to become a RMV Instructor/Trainer and whom the Director selects to provide said training shall be compensated at the rate of \$2.50 per hour above their regular rate of compensation for all hours worked while performing duties as an Instructor/Trainer, including any necessary preparation time and time required to document completed training. The amount of preparation time and documentation time must be approved in advance by the Director. Employees who perform such work shall be paid at his/her applicable hourly rate of pay, for all hours worked, which shall be considered part of the employee's regular/ordinary compensation.

ARTICLE XV **PAID HOLIDAYS AND VACATIONS**

A. Employees who are on the payroll of School Bus Operations at the time when the holidays and vacation days listed below occur will be entitled to compensation for such days in an amount equal to their rate of compensation for their daily fixed route assignments.

B. All eligible employees will be entitled to compensation on the following non-work days:

Labor Day	Day After Christmas
Columbus Day	New Years' Day
Veterans' Day	Martin Luther King Day
Thanksgiving Day	Presidents' Day
Day After Thanksgiving	Good Friday
Christmas Day	Patriot's Day
Memorial Day	

C. In order to be eligible to receive holiday pay, a new employee must have completed thirty (30) days of actual work and all employees must have worked their complete a.m. and p.m. package immediately before and immediately after the holiday.

D. All eligible employees will be entitled to fifteen (15) vacation days per year. Vacation days will be paid for those employees working a regular schedule. Any employee on an unpaid leave of absence will receive a prorated amount of vacation pay in the succeeding year.

E. All eligible employees after five (5) full years of service in the Pittsfield Public Schools will be paid vacation benefits according to TABLE I. A full school year will be considered as long as the employee begins work on or before October 1.

F. New employees will receive 1.5 vacation days for every 18 days worked during the first year for use in the succeeding school year up to a total of fifteen (15) days to be paid during school vacation/break periods. Vacation days are paid during school vacation/break periods.

TABLE I
VACATION BENEFITS
DRIVERS

Number of Years Worked	Additional Hours of Pay Earned
5-9	10
10-14	25
15	30
16	31
17	32
18	33
19	34
20	35
21	36
22	37
23	38
24	39
25	40

TABLE I
VACATION BENEFITS
ATTENDANTS

Number of Years Worked	Additional Hours of Pay Earned
5-9	20
10-14	30
15	31
16	32
17	33
18	34
19	35
20	36
21	37
22	38
23	39
24	40
25	41

ARTICLE XVI
REIMBURSEMENT FOR SECURING DRIVING RECORD
FROM REGISTRY OF MOTOR VEHICLES

The Committee shall, upon presentation of suitable documentation to the Superintendent or her/his designee, reimburse each driver for her/his having secured from the Registry of Motor Vehicles a copy of that person's driving record, to the extent that securing such a record is necessary for the driver's maintenance of her/his license to operate a school bus in Massachusetts.

ARTICLE XVII
FEDERATION RIGHTS AND RESPONSIBILITIES

SECTION 1. FEDERATION REPRESENTATION

The Employer recognizes the Federation representative as the official representative of the Employees.

SECTION 2. MONTHLY MEETINGS

The Assistant Superintendent for Personnel shall meet with a representative Committee of not more than three (3) Bus Employees on a monthly basis. The Assistant Superintendent and/or Bus Employees will submit an agenda for such meetings and the meetings shall take place at a mutually convenient time but no later than two (2) weeks after submission of an agenda. Formally filed grievances will not be discussed at these meetings. Attendance at such meetings will be without compensation.

At least once a year the meeting shall be for the purpose to discuss ways to reduce the cost per mile figure on school trips and Athletic Runs.

SECTION 3. INFORMATION

The Employer and the Union agree to provide one another with reasonable and necessary information in accordance with the mandates of Massachusetts General Laws Chapter 150E.

SECTION 4. PRINTING OF AGREEMENT

The Employer shall provide each employee with a single copy of this Agreement and five (5) copies for the Federation without charge. Each employee shall sign a form indicating receipt of a copy of this Agreement.

SECTION 5. FEDERATION ACTIVITY AT THE SCHOOL LEVEL

A. SCHOOL MEETING

The members of this bargaining unit may use designated areas in school buildings or the garage for meetings with the prior approval of the Superintendent or his designee provided said meetings do not interfere with School Operations or with employees carrying out the duties which they are paid to perform.

B. DISTRIBUTION OF MATERIALS

The Federation shall have the right to place materials in the time card slots of bus employees.

ARTICLE XVIII **VOIDABLE WAIVER CLAUSE**

A. Any previously adopted policy, practice, rule or resolution of the Committee which effects mandatory subjects of bargaining regarding wages, hours or conditions of employment of bargaining

unit employees will not 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 withholding or failure by either party to exercise any of its rights recognized or reserved by this Agreement shall not be deemed a waiver of such recognized or reserved rights in the future and shall not constitute a modification of this Agreement

ARTICLE XIX **HANDLING OF NEW ISSUES**

Matters of collective bargaining import not covered by this Agreement, may during the life of this Agreement, be handled in the following manner:

A. BY THE COMMITTEE:

With respect to matters not covered by this Agreement which are mandatory subjects for collective bargaining, the Committee agrees it will make no changes without prior consultation and negotiation with the Federation.

B. BY THE FEDERATION:

In any matter not covered in this Agreement which is a mandatory subject for collective bargaining, the Federation may raise issue with the Committee for consultation and negotiation.

ARTICLE XX **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 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 XXI
NO STRIKE, NO LOCKOUT CLAUSE

- A.** The parties hereto agree that there shall be no strikes of any kind whatsoever, work stoppages, slowdowns, or interferences or interruptions with the production or operations of the School System by any employee or the Union, and there shall be no lock-outs by the Employer.
- B.** Nor shall there be any strike or interruption of work during the term of this Agreement because of any disputes or disagreements between any other persons (or other employers or unions) who are not signatory parties to this Agreement.
- C.** Employees who violate this provision shall be subject to disciplinary action, including discharge. 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 II of this Agreement.

ARTICLE XXII
MANAGEMENT'S RIGHTS CLAUSE

- 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 educational and transportation policy; to determine the quantity and types of equipment and materials to be used; to use video/audio recording on the school buses; 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 the 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 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 XXIII
**AGREEMENT NOT TO CONTEST UNIT POSITIONS' REMOVAL
FROM CIVIL SERVICE JURISDICTION**

A. 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 the job titles and positions recognized as members of the bargaining unit in Article I, above.

B. In the event that positions in the bargaining unit are duly removed from civil service jurisdiction, the COMMITTEE shall provide unit members affected by this removal with rights comparable to those possessed by unit employees who are covered by civil service, in the following areas: (a) seniority, (b) layoff, (c) recall, (d) bumping, and (e) just cause for disciplinary action. However, all current employees who are employed as of the effective date of this Agreement shall retain their civil service status to the full extent of the law.

ARTICLE XXIV
PRIVATIZATION OF TRANSPORTATION

In the event that the Committee determines to secure the services of a private contractor to provide pupil transportation for the Pittsfield Public Schools, the COMMITTEE shall timely notify the FEDERATION of its intent, and also shall timely meet with the FEDERATION to bargain the impact of that determination. In the event that pupil transportation is privatized, the COMMITTEE shall use its good offices to seek to ensure continuation of as many conditions of employment as possible within the privatized workforce as obtained prior to privatization.

ARTICLE XXV
CERTIFICATION/LICENSE REIMBURSEMENT

Effective October 1, 2007, the Committee shall, upon presentation of suitable documentation to the Director of School Bus Operations, reimburse each driver paid at the experience rate for all fees to maintain and/or renew his/her school bus driver certificate, and the difference between the cost of a Class D license and a Class B license (CDL).

ARTICLE XXVI
EPIPEN/CPR/FIRST AID TRAINING

The School Committee agrees to provide training to bargaining unit members regarding the use of Epipen, CPR, and First Aid. The training is voluntary. Bargaining unit members will be eligible to take the CPR and/or First Aid training on a biannual basis. Any bargaining unit member who successfully completes the training and agrees to utilize said training in an emergency situation will be entitled to a lump-sum payment of \$125 for each training, to be paid within thirty (30) calendar days of the completion of the training. Bargaining unit members who are entitled to the stipend may be required, on a case by case basis, to remain with the students or in close proximity to the students on charters, and/or field trips. Charters and field trips will continue to be offered based on seniority regardless of whether the bargaining unit member is entitled to the stipend.

ARTICLE XXVII
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 identity.

ARTICLE XXVIII
DURATION OF CONTRACT

This AGREEMENT shall be effective September 1, 2018, and will continue and remain in full force and effect through midnight, August 31, 2021. IN WITNESS WHERE, the parties hereunto set their hands and seals this 23rd day of May, 2018.

PITTSFIELD SCHOOL COMMITTEE

**PITTSFIELD FEDERATION OF SCHOOL EMPLOYEES
LOCAL 1315, AFT, AFT-MA, AFL-CIO
BUS DRIVERS' AND ATTENDANTS' UNIT**

Chairman

Chapter Chairperson

EXHIBIT A
HOURLY PAY RATE SCHEDULE

BUS DRIVERS	2018-2019	2019-2020	2020-2021
1-6 YEARS OF EMPLOYMENT IN THE BARGAINING UNIT	\$15.68	\$15.88	\$16.08
AFTER 6 YEARS OF EMPLOYMENT IN THE BARGAINING UNIT	\$16.47	\$16.68	\$16.89
AFTER 10 YEARS OF EMPLOYMENT IN THE BARGAINING UNIT	\$17.26	\$17.48	\$17.70
AFTER 15 YEARS OF EMPLOYMENT IN THE BARGAINING UNIT	\$18.03	\$18.26	\$18.49
BUS ATTENDANTS	2018-2019	2019-2020	2020-2021
1-6 YEARS OF EMPLOYMENT IN THE BARGAINING UNIT	\$11.28	\$11.42	\$11.56
AFTER 6 YEARS OF EMPLOYMENT IN THE BARGAINING UNIT	\$11.66	\$11.80	\$11.95
AFTER 10 YEARS OF EMPLOYMENT IN THE BARGAINING UNIT	\$12.04	\$12.19	\$12.34
AFTER 15 YEARS OF EMPLOYMENT IN THE BARGAINING UNIT	\$12.80	\$12.96	\$13.13

- A. EFFECTIVE SEPTEMBER 1, 2018: INCREASE ALL HOURLY PAY RATES IN EXHIBIT A BY ONE AND ONE-QUARTER PERCENT (1.25%).**
- B. EFFECTIVE SEPTEMBER 1, 2019: INCREASE ALL HOURLY PAY RATES IN EXHIBIT A BY ONE AND ONE-QUARTER PERCENT (1.25%).**
- C. EFFECTIVE SEPTEMBER 1, 2020: INCREASE ALL HOURLY PAY RATES IN EXHIBIT A BY ONE AND ONE-QUARTER PERCENT (1.25%).**

NOTES:

1. October 1st shall be used as the calculation date to determine an employee's seniority for purposes of the Longevity salary increases above.
2. Effective September 1, 2011, if an individual receives training from the Pittsfield Public Schools to become a bus driver and subsequently is hired as a bus driver for the Pittsfield Public Schools, said individual shall receive a two hundred dollar (\$200) one-time bonus upon completion of one (1) continuous full year of service as a bus driver for the Pittsfield Public Schools.

EXHIBIT B
ATTENDANCE INCENTIVE PLAN

1. Payment to be made on the first payroll following the last day of each month during the school year.
2. An employee who has perfect attendance during the month and who works each day when schools are in session will receive additional compensation of Five Dollars (\$5.00) for each full day he/she works when schools are in session during that month.
3. An employee who is absent one and a half (1 1/2) days during the month and works every day but one and a half (1 1/2) days when schools are in session during the month will receive additional compensation of Four Dollars (\$4.00) for each full day he/she works when schools are in session during that month. An employee's taking up to one and one-half (1.5) unpaid personal days in a particular month will not be eligible for a monthly attendance bonus for that month.
4. An employee who is absent two (2) or more days during the month and who is absent on two (2) or more days when schools are in session during the month will receive no additional compensation other than his regular compensation. An employee's taking one or more paid personal days in a particular month will not count against that employee's monthly attendance bonus.
5. An employee who is absent for his/her morning run, but present for his/her afternoon run shall be credited with one-half day's absence if he/she notified the Director of Bus Operations prior to 5:45 a.m. Otherwise, he/she will be credited with a full day's absence.
6. An employee who is present for his/her morning run but absent for his/her afternoon run shall be credited with one-half day's absence if he/she notified the Director of Bus Operation's by 12 o'clock noon of his/her impending absence. Otherwise, he/she is credited with a full day's absence.
7. Absence from a mid-day run will not be counted as an absence if notification is given to the Director of Bus Operations prior to 9 A.M. on the day of the absence.
8. Absences due to bereavement as outlined in Article XI will not be considered as absences in regard to the Attendance Incentive Plan.
9. Absences for jury duty will not be considered as absences in regard to the Attendance Incentive Plan.
10. Effective October 1, 2007, an employee who is absent two (2) or less days in the school year shall receive a Three Hundred and Sixty Dollar (\$360.00) bonus at the end of the school year. An employee's taking one or more paid personal days in a particular school year will not count against that employee's annual attendance bonus. An employee's taking more than two (2) unpaid personal days in a particular school year will not be eligible for an annual attendance bonus for that year.
11. Effective September 1, 2010, an employee who has perfect attendance in the school year shall receive a Four Hundred and Eighty Dollar (\$480.00) bonus at the end of the school year.
12. Effective October 1, 2007, an employee who qualifies for a bonus for the previous two (2) consecutive years using the provisions either of (a) Section 10 of this Exhibit, or (b) Section 10 of this Exhibit in one year and Section 11 of this Exhibit in the other, shall receive an additional bonus of Two Hundred and Twenty Dollars (\$220.00).
13. Effective October 1, 2007, an employee who has perfect attendance for the previous two (2) consecutive school years shall receive an additional bonus of Three Hundred and Five Dollars (\$305.00). An employee who qualifies for a bonus under this section is not eligible for the bonus listed in Section 12 (i.e., the bonuses are not cumulative).

EXHIBIT C
ALCOHOL AND DRUG TESTING AGREEMENT

MEMORANDUM OF AGREEMENT
BETWEEN
THE PITTSFIELD SCHOOL COMMITTEE
AND
THE PITTSFIELD FEDERATION OF SCHOOL EMPLOYEES
LOCAL 1315, AFT, AFT MASSACHUSETTS, AFL-CIO
BUS DRIVERS AND ATTENDANTS UNIT
REGARDING
DOT DRUG AND ALCOHOL TESTING OF EMPLOYEES

1. Every affected driver will receive a copy of the new Federal DOT Drug and Alcohol Regulations dated effective April 1, 1996.
2. All materials and updates will be readily available to all affected personnel in the program. All new drivers will be given all pertinent information on this program.
3. Drug and Alcohol Testing is a **CONDITION OF EMPLOYMENT**. Refusal to be involved in this program will result in termination of employment at Bus Operations in conformance with federal DOT regulations.
4. All employees under this program are subject to random drug testing. If the employee is required to be removed from his/her scheduled bus route assignments to comply with a test, that employee will be reimbursed for that time.
5. Each time that an employee is randomly selected by the service provider and told to report for drug and/or alcohol testing, that initial drug and alcohol test will be free of cost to the affected employees.
6. If the initial random test is positive, the employee will be placed on immediate **UNPAID** leave and will be removed from all assignments. The employee will have the option to request, within 72 hours, a testing of the split sample at another DOT approved lab. The cost of this second test will be borne by the employee. If the results of the second test are negative, the School Bus Operations will pay for the second test and for time lost. The employee will be immediately returned to duty.
7. School Bus Operations has the right under DOT regulations to require and employee to be immediately drug and/alcohol tested under the Dot category of "Reasonable Suspicion" when observed and documented by a trained supervisor. Such employee shall be advised by the trained supervisor that there is a need to discuss a sensitive issue and that the employee has a right to have union representation. At this time the employee will be placed on administrative (paid) leave until the results of the test are received by School Bus Operations. If the test is negative, the employee will be returned to duty. If the test is positive, the employee will be placed on immediate **UNPAID** leave and will be removed from all assignments. The employee will have the option to request, within 72 hours, a testing of the split sample at another DOT approved lab. The cost of this second test will be borne by the employee. If the results of the second test are negative, the School Bus Operations will pay for the second test and for time lost. The employee will be immediately returned to duty.
8. Post-accident testing will be done under the regulations of DOT drug and alcohol testing and the employee will be paid his/her regularly scheduled time and the initial drug/alcohol test will be paid for by School Bus Operations.

EXHIBIT C
ALCOHOL AND DRUG TESTING AGREEMENT

CONSEQUENCES OF PROHIBITED CONDUCT EVENTS
(TERMINATION AFTER FIRST PROHIBITED CONDUCT EVENT)

After a prohibited conduct event, the employee or contractor relationship will be terminated. The individual will be advised of resources available in dealing with drug use and/or alcohol misuse.

OTHER CONSEQUENCES AS A RESULT OF THIS POLICY

As Independently Authorized, a driver sent out for reasonable suspicion testing will be required to accept employer arranged transportation or arrange for independent transportation home. Refusal to accept independent transportation may result in immediate dismissal.

As Independently Authorized, if a driver does not fully co-operate with the SAP or the MRO including but not limited to, meeting any required education and treatment whether in-patient or out-patient, the driver will be terminated.

OTHER ADMINISTRATIVE CONSEQUENCES AND REQUIREMENTS

If a driver has an AC of 0.02, but less than 0.04, he/she will not be permitted to perform safety-sensitive activities for one shift, which will be no less than 24 hours. As Independently Authorize, if no appropriate work is available that is not safety-sensitive based on a determination made by the employer, the driver will be placed on an unpaid leave of absence. The employer may require the driver to discuss the situation with the SAP.

OTHER REQUIREMENTS

As permitted by DOT regulations, if any drugs (defined herein) are prescribed for medical reasons by a licensed medical practitioner, that practitioner must certify in writing to the then-current Drug and Alcohol Program Manager at employer, the driver's fitness for fulfilling the safety-sensitive responsibilities prior to performing these activities.

This policy prohibits a driver from providing incorrect prior employment information and prior drug and/or alcohol information relating to the DOT Drug and Alcohol testing program.

FINANCIAL ISSUES FOR THE DRIVER
(TERMINATION AFTER FIRST PROHIBITED CONDUCT EVENT)

After a prohibited conduct event, the individual will be advised of resources available in dealing with drug use and/or alcohol misuse.

If the driver requests a re-test of the split portion of the drug test urine collection, it will be at his/her expense unless the re-test does not reconfirm the original positive test result.

If a request is made to re-test a drug test split specimen, an individual will be placed on an UNPAID leave of absence. If the split specimen re-test does not reconfirm the positive test result, back pay will be provided.

If any treatment is required, any cost not covered by insurance, if any, will be at the expense of the individual.

If an individual needs to get a medical opinion in a shy bladder or shy lung situation, the expense of this required activity is at the expense of the individual.

Drivers who are required to report for a drug and/or alcohol test outside of their regular working hours will be paid a flat rate of ten dollars (\$10.00). The flat rate will be effective July1, 1997.

EXHIBIT D
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.

EXHIBIT D
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.

EXHIBIT D
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.

EXHIBIT D
MEMORANDUM OF AGREEMENT
HEALTH INSURANCE

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.

EXHIBIT D
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.

EXHIBIT D
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:

EXHIBIT D
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.

EXHIBIT A
Network Blue New England DeductibleSM
MIIA HMO NE Benchmark Plan v.1
7/1/2018 – 6/30/2020

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	\$20 per visit, no deductible
When performed by other network providers	\$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	\$20 per visit,*** no deductible
– When performed by other network providers	\$35 per visit,*** no deductible
Ambulatory surgical facility, hospital, or surgical day care unit	\$150 per admission after deductible
Inpatient care (including maternity care)	
In other general hospitals (as many days as medically necessary)	\$300 per admission after deductible [†]
In higher cost share hospitals (as many days as medically necessary)	\$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.

EXHIBIT A
Network Blue New England DeductibleSM
MIIA HMO NE Benchmark Plan v.1
7/1/2018 – 6/30/2020

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.) 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 \$150 per calendar year per policy
Blue Care Line SM —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.

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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 DeductibleSM
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 When performed by other covered providers	\$20 per visit, no deductible \$35 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	\$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 — When performed by other covered 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	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible

EXHIBIT A
Blue Care Elect DeductibleSM
MIIA PPO Benchmark Plan v.1

7/1/2018 – 6/30/2020

* 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)	\$300 per admission after deductible*	20% coinsurance after deductible
s In higher cost share hospitals (as many days as medically necessary)	\$700 per admission 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.

*** 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 SM —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.

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 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.

- 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

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 DeductibleSM
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	\$20 per visit, no deductible
When performed by other network providers	\$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	\$20 per visit**, no deductible
When performed by other network providers	\$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)	\$275 per admission after deductible [†]
In higher cost share hospitals (as many days as medically necessary)	\$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.

EXHIBIT B
Network Blue New England DeductibleSM
MIIA HMO NE Benchmark Plan v.2
7/1/2020 – 6/30/2022

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.

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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 SM —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 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 B
Blue Care Elect DeductibleSM
MIIA PPO Benchmark Plan v.2
7/1/2020 – 6/30/2022

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 Hearing aids (up to \$5,000 per ear every 36 months)	Nothing, no deductible All charges beyond the benefit maximum	20% coinsurance after deductible 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 DeductibleSM
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 SM —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 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

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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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:	
<ul style="list-style-type: none"> • 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.

EXHIBIT C
Network Blue New England DeductibleSM
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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 DeductibleSM
MIA 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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

EXHIBIT C
Blue Care Elect DeductibleSM
MIA PPO Benchmark Plan v.3

7/1/2022 – 6/30/2024

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** 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) <ul style="list-style-type: none"> 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.

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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
Blue Care Line™—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions?

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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 family
Preventive Care Visit	\$0
PCP Office Visit	Covered In full after deductible
Specialist Office Visit	Covered In full after deductible
Emergency Room	Covered In full after deductible
Inpatient Hospital Admission	Covered In full after deductible
Ambulatory Day/Outpatient Surgical Day	Covered In full after deductible
Diagnostic X-rays and Lab Tests, excluding MRI's, CT and PET Scans and Nuclear Imaging	Covered in full after deductible
CT and PET Scans and Nuclear Imaging	Covered in full after deductible
Short-Term Physical and Occupational Therapy	Covered In full after deductible (up to 100 visits per CY)
Skilled Nursing Facility Care	Covered In full after deductible (up to 100 days per CY)
Speech Therapy	Covered In full after deductible
Home Health and Hospice Care	Covered In full after deductible
Durable Medical Equipment	Covered In full 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) (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

EXHIBIT D

MIIA PPO High Deductible Health Plan

7/1/2018 – 6/30/2024

BENEFIT	IIIA PPO HIGH DEDUCTIBLE HEALTH PLAN	IIIA 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	Medical Services: Combined In and Out
Preventive 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
Diagnostic X-rays and Lab Tests, excluding MRI's, CT and PET Scans and Nuclear Imaging	Covered in full after deductible	20% coinsurance after deductible
MRI, CT and PET Scans 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 Therapy	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)	applies to retail and mail	applies to retail and mail
- Retail RX (up to 30-day supply)	\$10/30/65 after deductible	\$20/60/130 after deductible
- Mail Order Drug RX (up to 90-day supply)	\$25/75/165 after deductible	not covered