AGREEMENT BETWEEN

THE
EAST WINDSOR
BOARD OF EDUCATION

AND

THE
EAST WINDSOR ADMINISTRATORS' ASSOCIATION

Covering the Period
July 1, 2023 to June 30, 2025

Table of Contents

ARTICLE I: RECOGNITION *3*

ARTICLE II: SABBATICAL LEAVE *3*

ARTICLE III: LEAVES OF ABSENCE *4*

ARTICLE IV: PERSONAL BUSINESS *4*

ARTICLE V: EMERGENCY LEAVE *5*

ARTICLE VI: RETIREMENT/SEPARATION OF SERVICE *5*

ARTICLE VII: FRINGE BENEFITS *6*

ARTICLE VIII: SALARIES *8*

ARTICLE IX: LEGAL HOLIDAYS *9*

ARTICLE X: GRIEVANCE PROCEDURE *9*

ARTILE XI: DURATION CLAUSE *11*

ARTICLE XII: WAIVER CLAUSE *12*

ARTICLE XIII: REDUCTION IN FORCE/INVOLUNTARY TRANSFER *12*

ARTICLE XIV: AGENCY SHOP *14*

ARTICLE XV: JUST CAUSE *14*

ARTICLE XVI: ADMINISTRATOR PROTECTION *14*

ARTICLE XVII: TRAVEL ALLOWANCE *15*

WAGE SCALE *15*

APPENDIX A: CT PARTNERSHIP PLAN 2.0 .... *17*

APPENDIX B: PRESCRIPTION PLAN *25*

APPENDIX C: HEP PROGRAM *28*

APPENDIX D: DENTAL A & ABCD *34*

APPENDIX E: CIGNA VISION *40*

SIGNATURE BLOCK *46*

ARTICLE I
RECOGNITION

1.1 EWAA- Exclusive Representative. Subject to and in accordance with the law, the Board recognizes that East Windsor Administrators' Association for purposes of professional negotiation as the exclusive representative of the Administrators' Association as defined by the General Statutes of Connecticut consisting of all Professional employees of the Board other than substitutes who are employed in position requiring intermediate administrator or supervisory certificate or the equivalent thereof and who are not excluded by Section 10-153b to 10-153f of the General Statutes of Connecticut, (hereinafter referred to as "administrators") pursuant to and with all the rights and privileges as provided by law.

ARTICLE II
SABATICAL LEAVE

Administrators who have served for ten (10) years may, upon the recommendation of the Superintendent and with the approval of the Board, be granted leave of absence for study or travel upon the following conditions:

2.1 Applicants must file with the Superintendent of Schools a statement of the definite purpose for which such leave of absence is desired. In case of sabbatical leave for study, this statement must include the institution at which the individual is to study and the courses to be pursued. In case of sabbatical leave for travel, a plan of the travels must be submitted, stating specific objectives which are to be sought, through such travel, and indicating the school system or institute which will be studied.

2.2 Applicants must file with the Board a written agreement to remain in the service of the Board for two (2) years after the expiration of such leave. In the event the Administrator does not return to work when sabbatical expires or does not complete two years following sabbatical leave, the Administrator will be required to reimburse the East Windsor Board of Education for contributions to the plan made on their behalf prorated for the unexpired portion of the two (2) year period.

2.3 Such leave shall not be granted for less than one full semester nor more than one (1) year. Administrators taking leave shall not be eligible for such leave again until ten (10) years have expired after return.

2.4 At any time not more than one (1) administrator regularly employed shall be on leave of absence. In case the number of applications shall exceed one (1), selection shall be made in accordance with the following principles:

   a. Length of service; preference being given to those longest in the service.
   b. Distribution by schools, care being taken that the number from any school shall not be comparatively excessive.
   c. Nature of service, provision being made that the benefits of such leave of absence shall be distributed as fairly as possible among all elementary, secondary, and supervisory positions.

2.5 An administrator on sabbatical leave will receive no salary for that period of time. During the period of the leave, the Board will pay for the cost of health insurance as specified in Article VIII.

2.6 Regular annual salary increments shall be given for the time on leave, the same as for regular services in the school.

2.7 Applications for such leave of absence for any school year shall be acted on by the Board of Education at its first regular meeting in January of the preceding year. Deviations from the above may be recommended by the Superintendent.

2.8 An Administrator who has been granted sabbatical leave shall return to the administrative position in which he/she was employed when the leave became effective or to a comparable administrative assignment in status and pay, unless mutually agreed otherwise.

ARTICLE III
LEAVES OF ABSENCE

3.1 Administrators may be absent without the loss of pay (time not chargeable to sick leave) because of, but not limited to, the following reasons:

a. Death in the immediate family- up to three (3) days per occurrence.
b. Special requests other than immediate family, may be granted at the Superintendent's discretion.
c. Definition of "immediate family" includes:

Husband	Father-in-law
Wife	Sister
Domestic partner	Brother
Children	Sister-in-law
Mother	Brother-in-law
Father	Grandmother
Mother-in-law	Grandfather

Any other person who is domiciled in such Administrator's house.

3.2 Each 12-month administrator shall receive leave of absence with full pay for sickness at the rate of eighteen (18) days per year. These days are accumulative to two hundred fifteen (215) days.

3.3 Each 10-month Administrator shall receive leave of absence with full pay for sickness at the rate of fifteen (15) days per year. These days are accumulative to two hundred (200) days.

3,4 Subject to the approval of the Superintendent, one (1) Administrator shall be allowed to attend a national professional meeting each year,

3.5 In the event of a catastrophic illness, special consideration or extension of sick leave may be given by application to the Board of Education.

3.6 Association Leave. If negotiation meetings between the Board and the Association are scheduled during normal working hours of a school day, not more than two (2) representatives of the Association shall be relieved from all regular duties without loss of pay, as necessary, in order to permit their attendance at such meetings.

3.7 Parenthood Leave. When an Administrator has been on parenthood leave, upon return to duties, the Administrator shall be assigned to his/her original position or to another professional position, if one is available, consistent with the Administrator's certification and qualifications.

ARTICLE IV
PERSONAL BUSINESS

4.1 In the event an Administrator has personal business which cannot be transacted other than during the school day, an annual maximum of three (3) days of leave will be granted at full pay. Such days may be taken on a half-day basis.

4.2 Such leave is not cumulative from year to year.

4.3 In order to use personal leave days, the Administrator must submit his/her request to the Superintendent for approval at least forty-eight (48) hours prior to taking the leave, where possible.

4.4 In the event an administrator needs leave for the observance of a religious holy day, the Superintendent shall grant the administrator up to two and one half (2 ½) personal days, provided that the request or approval is submitted at least five (5) school days prior to the date of the leave.

4.5 Personal leave may be used to extend periods or holidays with prior notice to the Superintendent or his/her designee so long as the holiday does not land on a day school is in session.

ARTICLE V
EMERGENCY LEAVE

5.1 In cases of emergency which must be attended to during the school day, an annual maximum of one (1) day of leave will be granted at full pay.

5.2 Such leave is not cumulative.

5.3 Prior notification to the Superintendent is required where applicable.

ARTICLE VI
RETIREMENT/SEPARATION OF SERVICE

6.1 An administrator who intends to terminate his/her individual contract must give at least thirty (30) days written notice.

6.2 Upon the retirement or impending retirement of the administrator who has served in the school system for at least ten (10) consecutive years, he/she will elect one of the following options:

a. Subject to any restrictions or limitations imposed by the State Teachers' Retirement Board or other agencies, if the Administrator gives one year's prior written notice of his/her retirement, he/she shall receive additional salary in the last year of his/her employment equal to the amount equivalent to one (1) day's compensation established by the Administrator's current daily wage at the time of written notification for each year of service to the town of East Windsor provided the Administrator has served a minimum of ten (10) years in the East Windsor School System.

b. The amount above set forth may be made payable to a Section 403(b) plan at the administrator's discretion. Over a one (1) to five (5) year payment schedule, except as otherwise provided by law.

6.3 If the retiring administrator does not receive the benefits listed above in 6.2, the Board will pay fifty dollars ($50.00) per year for each year in the system provided the Administrator has served a minimum of ten (10) years in the system without interruption. In the event of retirement, the Administrator who has served a minimum of fifteen (15) years in the system without interruption will receive one hundred twenty-five dollars ($125) per year for each year of service. Military, maternity, and sabbatical leave will not be considered an interruption in service. Payment will be made upon verification of eligibility of the state retirement benefits in the case of the administrator's retirement from the Connecticut State Teachers' System. Payments shall be made at the time of severance.

6.4 Any Administrator who retires from the Connecticut Teachers Retirement System shall be entitled to purchase any health insurance plan in force at the time of retirement.

ARTICLE VII
FRINGE BENEFITS

7.1 In each year of the contract, the Board shall offer employees one (1) option for health insurance, which is a Point of Service Plan (POS) offered by the State of Connecticut's State Partnership 2.0 Plan ("Partnership Plan"), including the State vision plan rider at no additional cost to employees. Summaries are attached in Appendix A and E, detailing a comprehensive listing of benefits for health and vision guaranteed to teachers (including dependent coverage to age 26). The Board will pay the following cost of the annual premium cost share for employees:

a. The Board shall pay:
- 80% of the cost of the health plan for full time employees, their spouses, and dependent children for the 2023-2024 school year.
- 79.5% of the cost of the health plan for full time employees, their spouses, and dependent children for the 2024-2025 school year.

b. The Board will pay the pro rata portion of the above amounts for the health insurance for part-time employees, their spouses and dependent children.

The State Partnership Plan contains a Health Enhancement Plan (HEP) wellness component, a summary of which is included in Appendix B. All employee participating in the Partnership Plan are subject to the terms and provisions of HEP. Within eighteen (18) months of joining the plan (or other period of time established by the Partnership Plan), all employees and dependents must meet the minimum requirements of HEP or may be subject to a non-participation or noncompliance monetary fee (NCMF) per month premium cost increase or deductible fee increase, paid by the non-participating or non-compliant employee. No portion or percentage shall be paid by the Board. The NCMF per month premium cost increase shall be implemented through claims administration.

Premium rates are established by the State Partnership Plan for the relevant periods, and shall be inclusive of medical, prescription drug (RX), vision, and dental. Based on such rates, the Board and Association shall agree on a blending methodology and establish a blended rate to provide the same rate to active and retired teachers in accordance with State Statute.

7.2 In each year of the contract, the Board of Education shall offer employees two (2) dental plans through the State Partnership Plan (which shall be equal to or better than the dental options available to Board employees upon the transition to the State Partnership Plan). The Partnership Plan tracks HEP compliance for these plans. Summaries with a comprehensive listing of benefits guaranteed to administrators is attached in Appendix D and the two (2) plans are further detailed as follows:

1. State Partnership Plan (Customized) Dental Plan 1 with Rider A ("Full A") (unlimited annual maximum, enhanced benefits as detailed in Rider A, no Orthodontia) which is outlined in Appendix D. The following annual premium cost share(s) paid by the Board and teachers shall apply.

    a. The Board shall pay 75% of the cost of Dental Plan 1 for full time employees, their spouses and dependent children.

    b. The Board will pay the pro rata portion of the above amounts for dental insurance for part-time employees, their spouses, and dependent children.

2. State Partnership Plan (Customized) Dental Plan 2 with Riders A, B, C, D ("Full ABCD") (unlimited annual maximum, enhanced benefits as detailed in Riders A, B, and C, and D, $600 Lifetime Orthodontia Max) which is outlined in Appendix D. The following annual premium cost share(s) paid by the Board and teachers shall apply:

    a. The Board shall pay 75% of the cost of Dental Plan 1 for full time employees, their spouses, and dependent children. Employees will be responsible for paying to "buy-up" to Dental Plan 2 (paying the difference between the costs of Dental Plan 1 and Dental Plan 2).

    b. The Board will pay the pro rata portion of the above amounts for dental insurance for part-time employees, their spouses, and dependent children. Employees will be responsible for paying to "buy-up" to Dental Plan 2 (paying the difference between the costs of Dental Plan 1 and Dental Plan 2).

The administration of the two dental plan options, including open enrollment, beneficiary eligibility and changes, and other administration provisions shall be as established by the Partnership Plan. If either dental plan is subsequently amended or modified by the State and its employee representatives, the Board and Association shall negotiate to maintain such plan(s) or the Board shall offer alternative plan(s) to maintain equal to or better level of benefits.

7.3 Employees shall notify the East Windsor School Business Office, in writing, of their choice for health insurance by the first day of June of each year or during the district Open Enrollment Period, if later.

7.4 The Board and the Association agree to maintain the I.R.S. Section 125 for premium costs.

7.5 All administrators who retire during the term of this Agreement may participate at their own expense in a package of insurance to the extent permitted by law.

7.6 The Board of Education shall offer a full flex benefits plan Section 125 pre-tax premium conversion account to all administrators for the purpose of allowing administrators to meet their insurance premium share contribution and to cover medical expenses and dependent care, on a tax-free basis to the extent permitted by law. The Board shall pay the set-up fee for such account and teachers shall pay the monthly service fee.

7.7 During the life of this Agreement, the Board may elect to change the insurance carrier(s) or third-party administrator(s) for any of the benefits specified in this article. The base plans used for comparison would be the insurance plans in effect during the 2017-2020 Collective Bargaining Agreement for the health insurance and dental plans. For all other insurance plans, the base plans used for comparison are the insurance plans in effect as of the current collective bargaining agreement. Prior to changing carriers (or third-party administrator) under this section, the Board shall notify the President of the Association at least sixty (60) days in advance of the nature of the change and the reasons for the change, and no less than thirty (30) days in advance if agreement with the carrier has not been reached before. Any changes in carrier (or third-party administrator) must provide comparable benefits, administration and network to the members of the bargaining unit and their dependents, considering the plan as a whole. If during the thirty-day period set forth above, the parties cannot agree that this is the case, either the Board or the Association may invoke arbitration as provided under this Agreement for the purpose of determining whether the proposed change or changes will result in comparable benefits, administration and network considering the plan as a whole. Any arbitration under this clause will be final and binding as provided by the contract, preferably before an arbitrator experienced in insurance matters.

7.8 Any administrator who has not notified the Board in accordance with Section 7.3 of this Article, and whose insurance coverage and participation has been canceled or any administrator not now participating in the insurance plan(s) who had a change in circumstances, may apply in writing to the Board to be included in the insurance plan(s). Upon such request and subject to any regulations, restrictions or waiting periods which may be in effect by the insurance carrier, the administrator shall be reinstated.

7.9 Any administrator who enrolls in the insurance plan(s) in accordance with Section 8.6 above shall receive pro rata payment for those months during which he/she was not participating in or covered by the insurance plan(s) at no expense to the administrator.

7.10 The administrators shall be eligible to participate in a tax-sheltered annuity plan through payroll deduction.

ARTICLE VIII
SALARIES

8.1 The salary schedule for the period from July 1, 2023 to June 30, 2025, is set forth on Appendix A attached hereto and hereby made a part of this Agreement.

8.2 Twelve-month Administrators shall be paid for 29 vacation days and 14 paid holidays, prorated for administrators starting after July 1st. Ten-month administrators shall work 195 days per year.

8.3 The salaries set forth herein are based on a 220-day work year. The Board will not alter the work year for any member of the Association employed by the Board on July 1, 2022. The Board reserves the right to establish a 195-day work year for Assistant Principals hired after July 1, 2022. In the event of such change, the existing salary shall be divided by 220 to obtain a per diem, which shall then be multiplied by 195 to establish the new salary.

8.4 Assistant Principals or Special Ed Supervisor who are assigned 10 months (195 to 205 workdays) shall be permitted to utilize time off (non-working days) during the school year in order to provide coverage for Principals' or Director of Special Education's summer vacations and assist them with summer duties.

8.5 Any additional days beyond the 185 days of the school year will be scheduled under the direction of the immediate supervisor (e.g., building principal, director of special education).

If the Superintendent requires any administrator to work more than the number of days specified in the contract, the administrator will be compensated at his/her per diem rate of pay.

8.6 The Superintendent of Schools shall establish the work year of administrator. Administrators may take at least three (3) consecutive weeks off during the summer. Up to five (5) consecutive days' vacation may be taken during the school year when school is in session, subject to the prior written approval of the Superintendent.

8.7 Any Administrator appointed to the position of TEAM District Facilitator shall receive a stipend in the amount of $4000.

8.8 An annual stipend for overseeing the Family Resource Program shall be $4000 for the building principal and $2000 for the assistant principal.

8.9 Longevity clause- Any building principal hired prior to July 1, 2015, shall receive longevity payment of

$3,500. Any assistant principal hired prior to July 1, 2015, shall receive longevity payment of $1,400.

8.10 An Administrator may carry-over a maximum of five (5) unused vacation days to be used in the month of July. An administrator may request to carry over an additional three (3) days to the Superintendent of schools by May 15 of that year. These vacation days are not cumulative.

ARTICLE IX
LEGAL HOLIDAYS

9.1 Administrative personnel will not be required to work on the following days:

1. New Year's Day
2. Martin Luther King Day
3. Presidents' Day
4. Good Friday
5. Memorial Day
6. Juneteenth
7. Independence Day
8. Labor Day
9. Columbus Day
10. Veteran's Day
11. Thanksgiving Day
12. Day After Thanksgiving
13. Christmas Day
14. Christmas Eve

9.2 If teachers are required to work on any of the days listed above, administrators will also be required to work and shall receive a "floating holiday" in lieu thereof to be scheduled by mutual agreement of the individual administrator and the superintendent.

ARTICLE X
GRIEVANCE PROCEDURE

10.1 Purpose

The purpose of this procedure is to secure, at the lowest possible level, equitable solutions to a problem which may arise affecting the welfare of Administrators. Both parties agree that proceeding shall be kept confidential as is appropriate.

10.2 Definitions

a. "Grievance" shall mean a dispute between an administrator and/or the Association with the Board or administration over the violation of evaluation procedures, interpretations or application of a specific provision of this Agreement. An evaluation of an administrator's performance is not subject to grievance. Notwithstanding the foregoing, a procedural violation of the evaluation program is subject to the grievance procedure commencing at the Superintendent level. If the aggrieved administrator is not satisfied with the Superintendent's disposition of his/her grievance, involving a procedural violation of the school district's evaluation program, he/she shall request of the President of the Association, in writing within five (5) days of receipt of the Superintendent's decision, that his/her grievance be submitted to arbitration. The parties shall then proceed in accordance with "level three- Arbitration," subsections b-e, inclusive.

b. "Administrator" shall mean a certified professional employee covered by this Agreement.

c. "Party in interest" shall mean the aggrieved person or persons or their designated representative as provided herein or the Association, at the administrator's request.

d. "Days" shall mean days when the Central Office is open for business.

10.3 Time Limits.

a. Since it is important that grievances be processed as rapidly as possible, the number of days indicated at each step shall be considered as a maximum. The time limit specified may, however, be extended by written agreement of the parties in interest, at which time new evidence may be introduced by written agreement of the parties.

b. If an Administrator does not file a grievance in writing within twenty (20) days after which he/she knew or should have known of the act on which the grievance is based, then the grievance shall be considered to have been waived.

c. Failure by the aggrieved Administrator to appeal a grievance to the next level within the specified time limits shall be deemed to be acceptance of the decision rendered at that level.

d. Failure by the superintendent or Board to render a decision within the specified time limits shall be deemed to be a denial of the grievance submitted.

10.4 Informal Procedure.

a. If an Administrator feels that he/she may have a grievance, he/she shall first discuss the matter with his/her immediate supervisor or other appropriate Administrator, including the Superintendent, in an effort to resolve the problem informally.

b. If the Administrator is not satisfied with such disposition of the matter, he/she shall have the right to have the Association assist him/her in further efforts to resolve the problem informally with his/her supervisor or other appropriate Administrator.

10.5 Formal Procedure.

A. Level One- Superintendent of Schools

a. If the aggrieved Administrator is not satisfied with the outcome of informal procedures, he/she shall submit his/her claim as a written grievance to the Superintendent of Schools with a copy to the Association. The written statement of the grievance shall contain a statement of the facts, the remedy requested and a specific reference to the provision of this Agreement which the Administrator claims has been violated.

b. The Superintendent, or his/her designee, shall within ten (10) days after receipt of the grievance, meet with the aggrieved Administrator and with representatives of the Association (if the Administrator so desires) for the purpose of resolving the grievance.

c. The Superintendent shall, within ten (10) days after the hearing, render his/her decision and the reasons therefore in writing to the aggrieved Administrator, with a copy to the Association.

B. Level Two- Board of Education

a. If the aggrieved Administrator is not satisfied with the disposition of his/her grievance at Level One, he/she shall within five (5) days after receipt of the decision, file the grievance with the Board of Education.

b. The Board of Education shall, within twenty (20) days after receipt of the appeal, meet with the aggrieved and with representatives of the Association (if the Administrator so

desires) for the purpose of resolving the grievance.

c. The Board shall, within ten (10) days after such meeting render its decision and the reasons therefor in writing to the aggrieved Administrator.

C. Level Three-Arbitration

a. If the aggrieved administrator is not satisfied with the disposition of his/her grievance at Level Two he/she shall, within three (3) days after the decision, or within six (6) days after the Board meeting, request in writing to the President of the Association that his/her grievance be submitted to arbitration. The decision of the Board shall be final and binding on all other matters.

b. The Association may, within five (5) days after receipt of such request, submit the grievance to arbitration by so notifying the Board in writing.

c. The Board and the Association or their designated representatives shall, within five (5) days after such written notice, jointly select a single arbitrator who is an experienced and impartial person of recognized competence. If the parties are unable to agree upon an arbitrator within five (5) days, the American Arbitration Association shall immediately be called upon to select the single arbitrator.

d. The arbitrator selected shall confer promptly with representatives of the Board and the Association, shall review the records of prior hearings, and shall hold such further hearings with the aggrieved administrator and other parties in interest as he/she shall deem requisite. The Arbitrator shall hear and decide only one grievance in each case. He/she shall be bound by and must comply with all of the terms of this Agreement. He/she shall have no power to add to, delete from, or modify in any way any of the provisions of this Agreement.

e. The Arbitrator, within twenty (20) days after the close of the hearing, or as otherwise mutually agreed to by the parties, shall render his/her decision in writing to all parties in interest, setting forth his/her findings of fact, reasoning and conclusions on the issues submitted. The decision of the Arbitrator shall be final and binding upon any parties in interest.

10.6 Miscellaneous

a. All documents, communication, and records dealing with the processing of a grievance shall be filed separately from the personnel files of the participants.

b. Appropriate forms for filing and processing grievances and other necessary documents shall be prepared by the Association, with the approval of the Superintendent and be made available to the Association so as to facilitate operation of the grievance procedure.

ARTILE XI
DURATION CLAUSE

11.1 This Agreement contains the full and complete Agreement between the Board and the Association on all negotiable issues, and neither party shall be required during the term thereof to negotiate upon any issue, whether it is covered or not covered in this Agreement, except pursuant to Section 10-153f(e) of the Connecticut General Statutes.

11.2 This Agreement shall bind and inure to the benefit of the Board of Education and the Association.

11.3 This Agreement may be modified only by mutual consent of both parties duly executed by an instrument in writing.

ARTICLE XII
WAIVER CLAUSE

12.1 In the event that any portion or portions of this Agreement are found to be illegal, void, or voidable, it is agreed that such finding will have no effect on the remaining portion or portions of this Agreement.

ARTICLE XIII
REDUCTION/INVOLUNTARY TRANSFER

13.1 Seniority shall be determined by continuous length of administrative service in the system, including authorized paid or unpaid leaves and is to be established by the date the initial contract of administrative employment was signed by the certified staff member. Seniority shall not be broken by termination from employment due to reduction in force or displacement to a teaching position due to reduction in force and shall accrue while on any recall list if the certified staff member is re-employed within eighteen (18) months from termination of employment or displacement to a teaching position. If the administrative appointment dates are the same, the administrator with the most amount of East Windsor service, including non-administrative service, will have greater seniority. If the total amount of East Windsor service is equal, the administrator with the most amount of teaching and administrative service outside of East Windsor will be deemed to have greater seniority.

13.2 The Superintendent shall compile a seniority list of the complete certified staff in accordance with Section 14.1 of this Article as requested and shall furnish the Association with copies of the list by February 1 of each year. If the Association or any staff member shall disagree with any placement on the seniority list, the Association or the staff member shall file a written request for correction no later than the following March 1.

13.3 For purposes of reduction in force, should it become necessary, administrative positions will be assigned to the following employee group tiers:

Principal

Assistant Principal

Director of Special Education/Director of Curriculum/Director of Technology

Supervisor of Special Education

If it becomes necessary to reduce the administrative personnel, it shall be on the basis of seniority as defined above, certification and qualifications. The term "qualified" as used herein means recognized and satisfactory experience in the administrative or teaching area into which the administrator seeks to bump or to be recalled. Notwithstanding the foregoing, the superintendent may override the "seniority" criterion and displace a more senior administrator if the less senior administrator is "head and shoulders" above the more senior administrator or possesses unique skills or attributes that are needed for the position. The term "opening" as used herein shall refer to open or vacant positions which include those held by consultants, retirees, DSAP persons (teacher or administrator holding a Durational Shortage Area Permit), temporary assignees, or acting appointees. Notwithstanding the foregoing, temporary or

acting appointments, DSAP, consultant, and retiree appointments to vacant administrative positions may be made during the posting, application, and interview process or when the incumbent is on an authorized leave of absence. Except for extraordinary circumstances, temporary or acting appointments shall not be made for a period greater than one (1) school year.

13.4 Should an administrator lose all or part of his/her position due to elimination or reduction of that position, he/she:

a. Will be offered an administrative opening (if one exists) in his/her employee group tier for which he/she is certified and qualified.

b. If there are no administrative openings within the same employee group tier, the affected administrator will be able to bump the least senior administrator within the same employee group tier as listed in section 14.3, provided that the affected administrator is senior to the administrator to be bumped and is certified and qualified for that position.

c. If there is no opening within his/her employee group tier for which he/she is certified and qualified, and the affected administrator has the least amount of seniority in his/her employee group tier, then he/she will be offered an administrative opening, if one exists, for which he/she is certified and qualified (if one exists) in a lower employee group tier (i.e. Principal may move to Assistant Principal)

d. If there are no administrative openings, and the affected administrator has the least amount of seniority in his/her group tier, then the affected administrator will be able to bump the least senior administrator in any lower employee group tier, as listed in Section 14.3, provided that the affected administrator is senior to the administrator to be bumped and is certified and qualified for that position.

e. If there are no administrative openings or positions as aforementioned, the administrator will be offered a teaching opening, if one exists, for which he/she is certified and qualified.

f. If there are no teaching openings for which the affected administrator is certified and qualified, then the affected administrator will be offered a teaching position for which he/she is certified and qualified and which is held by a teacher with fewer years of service in the East Windsor School System, subject to the law appertaining and the relevant terms, if any, of the collective bargaining agreement between the Board and the East Windsor Education Association

g. Any administrator relieved of his/her duties and employed as a teacher will be given the experience credit on the salary schedule according to the teacher contract for his/her administrative and teacher experience within the East Windsor School System and elsewhere, if applicable, and shall retain all accumulated sick leave.

h. Any administrator who has been displaced as aforesaid or terminated from employment, due to a reduction in force, shall be placed on a reappointment list for his/her former administrative position, or another similar position of comparable pay and status and shall remain thereon until reappointed or for one year from the effective date of displacement or termination, whichever occurs first, provided such administrator does not refuse a reappointment. Administrators shall be recalled to positions for which they are certified and qualified and in which they have had previous acceptable experience, according to their administrative seniority in the East Windsor Public School System, as defined in Section 14.1. If reappointment is offered consistent with the above and is refused by the administrator, he/she shall thereupon be removed from the reappointment list.

13.5 In order to be eligible for recall, an administrator must:

a. Submit his/her request to be placed on the recall list, in writing, to the Superintendent within thirty (30) days of termination or displacement; such request must include the administrator's address.

b. Advise the Board, in writing, within ten (10) days of any change in address.

c. Advise the Superintendent, in writing, of acceptance of recall within two (2) weeks after notification of recall; or be removed from the recall list.

d. All notices provided for in this section must be in writing and transmitted by certified mail.

e. The Board's obligation will be limited to sending notice of recall to the administrator's last address in the Board's files.

13.6 Administrators may be reassigned to any position within the bargaining unit for which they are certified and qualified if the Superintendent, in his or her sole discretion, determines that such a reassignment is in the best interests of the East Windsor Public Schools. If the Superintendent exercises his or her authority under this provision or, in accordance with 14.4 of this Article, an administrator is reassigned to a position within the bargaining unit with a salary lower than that applicable to his or her prior position, he or she shall be paid the salary he or she was last paid in his or her prior position until the salary for the position into which he or she was reassigned reached the level of the last salary paid to the administrator in his or her prior position. Thereafter, he or she shall be paid the salary applicable to his or her new position. Notwithstanding the foregoing, no administrator shall be displaced to a teaching position by way of involuntary transfer except for just cause.

13.7 Any administrator who is displaced or reassigned to a teacher position shall be paid the salary he or she was last paid in his or her prior position for one year. Thereafter, he or she shall be paid in accordance with the teachers' collective bargaining agreement.

ARTICLE XIV
AGENCY SHOP

14.1 All administrators employed by the East Windsor Board of Education may join the Association.

14.2 The Association agrees to indemnify and hold the Board of Education harmless against any and all claims, demands, suits, or other forms of liability including attorneys' fees and the cost of administrative hearings that shall or may arise out of, or by reason of, action taken by the Board of Education for the purpose of complying with the provisions of this Article.

ARTICLE XV
JUST CAUSE

No administrator shall be disciplined (i.e., written reprimand or suspended without pay or demoted) without just cause. The provisions of this Article shall not apply to a demotion caused by a reduction in force.

ARTICLE XVI
ADMINISTRATOR PROTECTION

Administrators shall be subject to all applicable legal protections in accordance with applicable state and federal law.

16.1 Administrators shall report immediately in writing to their immediate supervisors, cases of assault and/or battery suffered by them in connection with their employment.

16.2 When an administrator is absent from his/her regular assignment in the event of a disability caused by an accident that has been deemed compensable under Worker's Compensation, the Board shall pay the administrator the difference between the compensation payment and his/her regular salary to a maximum of ninety (90) days without reduction to sick leave. Thereafter, the Board shall pay the administrator the difference between the compensation payment and his/her regular salary by proportionate reduction to sick leave, except that an administrator on workers' compensation due to an assault occurring in the line of duty shall not have such absence charged against the administrator's sick leave, vacation, or personal leave days.

16.3 If criminal proceedings are brought against an administrator, alleging that he/she committed an assault in connection with his/her employment, the Board shall, upon request from the administrator, retain legal counsel acceptable to both parties, to defend him/her in such criminal proceedings. However, if the administrator pleads guilty or is found guilty, or invokes the "Alford Doctrine" with respect to the original or substitute criminal charges, then the cost of legal counsel must be borne, and paid for in full, by the administrator.

ARTICLE XVII
TRAVEL ALLOWANCE

All administrators shall be paid a flat annual stipend of one thousand two hundred dollars ($1200) for building administrators and one thousand eight hundred dollars ($1,800) for K-12 Directors and the Supervisor of Special Education to reimburse them for travel by automobile on school business. School business shall include, but not be limited to, travel between buildings in East Windsor during the school day and travel to and from East Windsor for conferences and workshops within the state of Connecticut. Additional mileage costs will be reimbursed for attending special projects or conferences outside of the state.

WAGE SCALE

2023-2024 School Year 2.75% Increase				
Job Title	**Step1**	**Step 2**	**Step 3**	**Step 4**
Principal Broad Brook	$143,930	$146,772	$150,392	$153,686
Principal - Middle School	$145,802	$148,641	$152,264	$157,071
Principal - High School	$156,552	$159,680	$163,672	$167,432
Asst. Principal – BBS	$130,974	$133,559	$136,855	$139,716
Asst. Principal – MS	$134,809	$137,507	$140,532	$143,068
Asst. Principal – HS	$142,056	$144,897	$148,520	$151,664
Dir. Of Special Education	$156,552	$159,680	$163,672	$167,432
Dir. Of Curriculum	$156,552	$159,680	$163,672	$167,432
Dir. Of Technology	$156,552	$159,680	$163,672	$167,432

10-Month Positions (195 workdays) 2023/2024 School Year 2.75% Increase				
Job Title	**Step1**	**Step 2**	**Step 3**	**Step 4**
Supervisor of Special Education	$113,652	$114,797	$116,258	$117,526
Asst. Principal – BBS	$116,091	$118,382	$121,304	$123,840
Asst. Principal – MS	$119,490	$121,882	$124,563	$126,811
Asst. Principal – HS	$125,914	$128,432	$131,643	$134,430

In addition to the amounts set forth above, any administrator with a Ph.D., Ed.D., or J.D. shall receive a stipend of $2,000 annually.

2024-2025 School Year 2.95% Increase				
Job Title	**Step1**	**Step 2**	**Step 3**	**Step 4**
Principal Broad Brook	$148,176	$151,102	$154,829	$158,220
Principal - Middle School	$150,103	$153,026	$156,756	$161,704
Principal - High School	$161,170	$164,390	$168,500	$172,371
Asst. Principal – BBS	$134,838	$137,499	$140,892	$143,838
Asst. Principal – MS	$138,786	$141,564	$144,678	$147,289
Asst. Principal – HS	$146,247	$149,171	$152,901	$156,138
Dir. Of Special Education	$161,170	$164,390	$168,500	$172,371
Dir. Of Curriculum	$161,170	$164,390	$168,500	$172,371
Dir. Of Technology	$161,170	$164,390	$168,500	$172,371

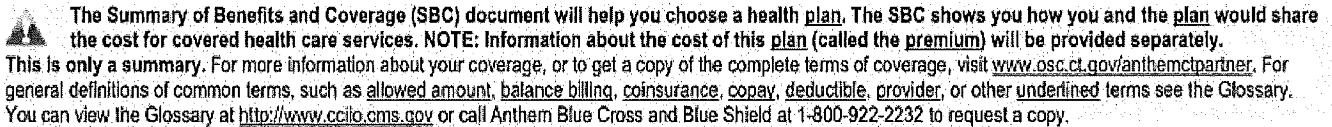
10-Month Positions (195 workdays) 2024-2025 School Year 2.95% Increase				
Job Title	**Step1**	**Step 2**	**Step 3**	**Step 4**
Supervisor of Special Education	$117,005	$118,184	$119,688	$120,993
Asst. Principal – BBS	$119,516	$121,875	$124,882	$127,493
Asst. Principal – MS	$123,015	$125,478	$128,238	$130,552
Asst. Principal – HS	$129,629	$132,220	$135,526	$138,396

Each individual not on maximum step shall advance one step.

In addition to the amounts set forth above, any administrator with a Ph.D., Ed.D., or J.D. shall receive a stipend of $2,000 annually.

APPENDIX A

Connecticut Partnership Plan 2.0
Summary of Benefits and Coverage



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.osc.ct.gov/anthemctpartner. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.cciio.cms.gov or call Anthem Blue Cross and Blue Shield at 1-800-922-2232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$350**/individual; **$1,400**/family; **waived for HEP members** Out-of-network: **$300**/individual; **$900**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Once you or a family member meets the individual deductible amount, the plan begins to pay for you or that family member. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network primary care and specialist office visits, In-network preventive care, prescription drugs, emergency room care, In-network urgent care, In-network mental health and substance abuse outpatient services, and in-network eye exams are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: In-network: **$2,000**/individual; **$4,000**/family; Out-of-network **$2,300**/individual; **$4,900** family Prescription drugs: **$4,600**/individual; **$9,200**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.osc.ct.gov/anthemctpartner or call 1-800-922-2232 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copay** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Preferred In-Network Provider (You will pay the least)	What You Will Pay: In-Network Provider	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge. Deductible does not apply.	$15 copay/visit. Waived if no in-state preferred provider. Deductible does not apply.	20% coinsurance	None.
	Specialist visit	No charge. Deductible does not apply.			
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.		You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	40% coinsurance	Prior authorization required to avoid penalty: lesser of $500/20% of cost.

Common Medical Event	Services You May Need	What You Will Pay Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.osc.ct.gov/benefits/pharmacy.htm	Generic drugs	Preferred generic: Retail: $5 copay/fill; Mail order & maintenance drugs: $5 copay/fill. Non-preferred generic: Retail: $10 copay/fill; Mail order & maintenance drugs: $10 copay/fill.		20% coinsurance for non-participating pharmacy	Retail: 30-day supply; Mail order: 90-day supply. Deductible does not apply to prescription drugs. Check details of your Rx coverage at: www.osc.ct.gov/benefits/pharmacy.htm. Maintenance drugs must be filled by mail order or by Maintenance Network pharmacy after first retail fill. Penalty may apply if brand name drug is requested when a generic is available. Some drugs require prior authorization. No charge for preventive care drugs or FDA-approved generic contraceptives (or brand name contraceptives if generic is medically inappropriate).
	Preferred brand drugs	Retail: $25 copay/fill; Mail order & maintenance drugs: $25 copay/fill.		20% coinsurance for non-participating pharmacy	
	Non-preferred brand drugs	Retail: $40 copay/fill; Mail order & maintenance drugs: $40 copay/fill.		20% coinsurance for non-participating pharmacy	
	Specialty drugs	No charge for specialty drugs if enrolled in PrudentRx program. Same as non-preferred brand drugs if not enrolled in PrudentRx program.		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
	Physician/surgeon fees	No charge			
If you need immediate medical attention	Emergency room care	$250 copay/visit. Deductible does not apply.		$250 copay/visit. Deductible does not apply.	Copay waived if admitted or if no reasonable medical alternative.
	Emergency medical transportation	No charge		No charge	None.
	Urgent care	$15 copay/visit. Deductible does not apply.		20% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. No coverage in excess of cost of a semi-private room unless medically necessary.
	Physician/surgeon fees	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit. Deductible does not apply.		20% coinsurance	None.
	Inpatient services	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
If you are pregnant	Office visits	$15 copay/first visit only. Deductible does not apply.		20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copay, coinsurance, or deductible may apply. Maternity care may include tests & services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge		20% coinsurance	Prior authorization required for stay in excess of 48 hours (96 hours for cesarean delivery) to avoid penalty of lesser of $500 or 20% of covered services.
	Childbirth/delivery facility services				

Common Medical Event	Services You May Need	What You Will Pay Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge		20% coinsurance	Limit: 200 visits/calendar year.
	Rehabilitation services	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. In-network speech therapy limit: 30 visits/calendar year. Limit does not apply to treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of oropharynx. Out-of-network physical, occupational, chiropractic, speech & autism therapy limit: 30 visits/condition/calendar year.
	Habilitation services	No charge		20% coinsurance	None.
	Skilled nursing care	No charge		20% coinsurance	Out-of-network limit: 60 visits/ year/ person Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
	Durable medical equipment	No charge		20% coinsurance	Prior authorization required for items over $500 to avoid penalty of lesser of $500 or 20% of covered services.
	Hospice services	No charge		20% coinsurance	Inpatient services: prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. Out-of-network inpatient services limit: 60 days/person/calendar year. Out-of-network in-home services limit: 200 visits/calendar year

Common Medical Event	Services You May Need	What You Will Pay: Preferred In-Network Provider (You will pay the least)	What You Will Pay: In-Network Provider	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	$15 copay/visit. Deductible does not apply.		50% coinsurance	Limit: 1 visit/calendar year performed as part of an exam.
	Children's glasses	Not covered		Not covered	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered		Not covered	You must pay 100% of this service, even in-network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (adult and child)
- Non-emergency care when traveling outside the United States (urgent care covered)
- Long-term care
- Routine foot care (except when medically necessary for treatment of diabetes)
- Weight loss programs (except as required by law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limit: 20 visits per calendar year)
- Bariatric surgery (prior authorization required)
- Chiropractic care (limit: 30 visits per calendar year for out-of-network services)
- Hearing aids (limit: 1 set per 36 month period; prior authorization required)
- Infertility treatment (prior authorization required)
- Non-emergency care when traveling outside the United States (urgent care only)
- Private-duty nursing (prior authorization required)
- Routine eye care (adult, limit: 1 exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

Anthem Blue Cross and Blue Shield
108 Leigus Road
Wallingford, CT 06492
1-800-922-2232

CVS/Caremark
Prescription Claim Appeals MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

Additionally, a consumer assistance program can help you file your appeal. Contact the Connecticut Office of the Health Care Advocate at 1-866-466-4446

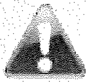
Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 1-800-922-2232.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-922-2232.
如果需要中文的帮助，请拨打这个号码1-800-922-2232.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-922-2232.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copays and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	**$350**
■ **Specialist copayment**	**$15**
■ **Hospital (facility)**	**$0**
■ **Other**	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copays	$25
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$435**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$350**
■ **Specialist copayment**	**$15**
■ **Hospital (facility)**	**$0**
■ **Other**	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copays	$190
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$310**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$350**
■ **Specialist copayment**	**$15**
■ **Hospital (facility)**	**$0**
■ **Other**	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copays	$320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$670**

NOTE: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please visit http://osc.ct.gov/benefits.htm

The plan would be responsible for the other costs of these EXAMPLE covered services.

APPENDIX B
Prescription Coverage

Your Personal Prescription Benefit Program

CT Partnership Groups

Your prescription benefit plan, administered by CVS Caremark, is designed to bring you quality pharmacy care that will help you save money.

	Acute Medications For short-term medications (Up to a 30-day supply)	**Maintenance Medications** For long-term medications (Up to a 90-day supply) Mandatory CVS Caremark Mail Service or State of CT Maintenance Drug Network* after initial 30-day fill at retail	**Diabetes Maintenance Medications** For long-term medications (Up to a 90-day supply)	**Health Enhancement Program Only** Enrolled participants with Asthma/ COPD, Heart Failure/Heart disease, Hyperlipidemia, or Hypertension qualify for reduced copays on condition-related maintenance medications (Up to a 90-day supply)
Where	Any participating CVS Caremark Retail Network Pharmacy. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Pharmacy" at **www.caremark.com** or call Customer Care toll-free at 1-800-318-2572.	You have the convenience of getting your long-term medications through CVS Caremark Mail Service Pharmacy or dispensed at one of our 9,600 CVS Pharmacy locations as well as a retail pharmacy that participates in the State of CT Maintenance Drug Network. When you use CVS Caremark Mail Service Pharmacy, your medications can be sent directly to your home or office. www.osc.ct.gov/benefits/pharmacy.htm		
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**$5** for lower cost generic prescriptions **$10** for higher cost generic prescriptions	**$5** for lower cost generic prescriptions **$10** for higher cost generic prescriptions	**$0** for a generic prescription	**$0** for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	**$25** for a preferred brand-name prescription	**$25** for a preferred brand-name prescription	**$0** for a preferred brand-name prescription	**$5** for a preferred brand-name prescription
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**$40** for a non-preferred brand-name prescription	**$40** for a non-preferred brand-name prescription	**$0** for a non-preferred brand-name prescription	**$12.50** for a non-preferred brand-name prescription
Maximum Out-of-Pocket	$4,600 per individual / $9,200 per family			
Web Services	Go to the State of CT Comptroller's website, www.osc.ct.gov/benefits/pharmacy.htm for drug cost tools, drug lists, forms, etc.			
Customer Care	Contact Customer Care at 1-800-318-2572.			

* State of CT Maintenance Drug Network- All CVS Pharmacies are included in the State of CT Maintenance Drug Network. Other retail participating pharmacies that elect to join are also included.

Any pharmacy interested in joining the State of CT Maintenance Drug Network, log on to www.caremark.com, click on "Pharmacists and Medical Professionals", click on "State of CT Custom Maintenance Drug Network process (PDF)" for more information.

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

HUBAAG

CVS/caremark

DD00 1

Frequently Asked Questions

CVS Caremark ID Cards

How do I get a new ID card?

New members will automatically receive 2 ID cards per family in the employee's name. If you have lost your ID card or need additional ID cards, please contact Customer Care at 1-800-318-2572. Become a registered user on www.caremark.com (Member Sign In) and print a copy of your ID card. You may also register and use the CVS Caremark mobile app.

About CVS Caremark Mail Service and the State of CT Maintenance Drug Network

Where can I fill maintenance (long-term) prescriptions?

The choice is yours. You can order up to a 90-day supply of maintenance medications at:

- **CVS Caremark Mail Service:** Register for mail service by phone at 1-800-875-0867 or log onto www.caremark.com/faststart and sign in or register, if necessary. Have your CVS Caremark ID, the names of your medications, your provider's information, and your payment information ready.
- **CVS Pharmacy:** Visit your local CVS Pharmacy. If you are currently using CVS Pharmacy to fill your maintenance medications, you can continue to do so.
- **State of CT Maintenance Drug Network:** If your pharmacy is participating in the State of CT Drug Network, you can utilize the pharmacy to dispense your maintenance medications.

Do I only have to use a CVS Pharmacy?

You can utilize any participating retail pharmacy to fill your acute (short-term) medications. For maintenance medications, you are allowed one 30-day fill only at any participating retail pharmacy. After the first 30-day fill, you must fill your prescription through the CVS Caremark Mail Service, CVS Pharmacy, or other pharmacies participating in the State of CT Maintenance Drug Network. A full list of pharmacies in the network can be found on the State of CT Comptroller's website at www.osc.ct.gov/benefits/pharmacy.htm.

How long does it take for my prescriptions to arrive by mail?

Please allow 7-10 days for delivery from the time the order is placed. You are able to check your refill status online or by calling 1-800-318-2572. **Please note:** mail order packaging accommodates all temperature sensitive drugs.

About the CVS Caremark Preferred Drug List

What is a preferred drug list and where can I get a copy of the updated drug list?

A preferred drug list is a list of preferred prescription medications that have been chosen because of their clinical effectiveness and safety. This list is typically updated every three months. The list promotes the use of preferred brand-name and generic drugs whenever possible. The U.S. Food and Drug Administration (FDA) requires generic drugs to be therapeutically equivalent to a brand-name drug in dosage, strength, route of administration, quality, performance, and intended use. Generally, generic drugs cost less than brand-name drugs.

You can get an updated preferred drug list in a few ways: As a registered user on www.caremark.com (Member Sign In); by contacting Customer Care at 1-800-318-2572; or by visiting the State of CT Comptroller's website at www.osc.ct.gov/benefits/pharmacy.htm.

Am I required to fill a generic medication?

For brand-name drugs with a generic equivalent available, you are responsible for the difference in cost between the generic and brand-name medication plus the copay if you or your provider request the brand-name drug.

For multi-source brand-name drugs, there are some that are formulary and others that are excluded. For formulary multi-source brand-name drugs, there is a coverage exception process based on medical necessity and other circumstances. The form can be located at www.osc.ct.gov/benefits/pharmacy.htm. If approved, the difference in cost will be waived. For multi-source brand-name drugs excluded from the formulary, this form **should not be utilized**. For the Formulary Exception/Prior Authorization Request Form, go to www.caremark.com/portal/asset/Global_Prior_Authorization_Form.pdf.

What is a prior authorization?

Certain medications require prior authorization before they receive coverage under the plan. Some medications are covered with restrictions on the quantity and other medications are excluded from the plan. Members can initiate a prior authorization by having their provider contact CVS Caremark at 1-800-626-3046 or by visiting www.caremark.com, click on "Pharmacists and Medical Professionals", next click on "Prior Authorization", then http://info.caremark.com/epa. For the Formulary Exception/Prior Authorization Request Form, go to www.caremark.com/portal/asset/Global_Prior_Authorization_Form.pdf.

What are compound medications and how are they covered?

Compound medications are made by combining, mixing, or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available. In most cases, these medications will require prior authorization before obtaining coverage under the plan. Your provider can follow the above prior authorization procedure.

©2014 Caremark. All rights reserved.

CVS/caremark

APPENDIX C
HEP Program

HEALTH ENHANCEMENT PROGRAM (HEP)

FAQ

Q: What is HEP?

A: HEP stands for "Health Enhancement Program." It encourages employees and their enrolled family members to take charge of their health and their health care by providing guidelines to follow for preventive and chronic care management. By signing up for and fulfilling all HEP requirements, you can save $100 per month in premiums ($1,200 per year) and become eligible for a waiver of an annual in-network deductible of $350 per member (up to a maximum of $1,400 per family).

Q: What are the requirements?

A: There are two parts to HEP: age/gender appropriate preventive requirements and chronic condition education requirements.

Preventive requirements:

2022 HEP REQUIREMENTS

MORE INFO: WWW.CTHEP.COM | (877) 687-1448

PREVENTIVE SCREENINGS	AGE						
	0-5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50-64: Every 3 years 65+: Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 5 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	N/A	1 screening between age 45-49**	As recommended by physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years to age 65
Colorectal Cancer Screening[1]	N/A	N/A	N/A	N/A	N/A	40-44: N/A 45+: Colonoscopy every 10 years, Annual FIT/FOBT to age 75 or Cologuard screening every 3 years	

* Dental cleanings are required for family members who are participating in a dental plan sponsored by your employer
** Or as recommended by your physician
1 NEW: colorectal screening age requirements lowered to 45 years of age for calendar year 2022 as recommended by US Task Force on Preventive Services

For those with a chronic condition: The household must meet all preventive and chronic requirements to be compliant.

Chronic condition education:

We provide support and education for participants with asthma, chronic obstructive pulmonary disorder (COPD), coronary artery disease (CAD), diabetes, heart failure, hypertension (high blood pressure), and hyperlipidemia (high cholesterol).

In order to meet the chronic education requirement, you have a few options. One option is to register on the portal at CTHEP.com and take a short survey, read a fact sheet, or watch a video on your specific condition. Another option is to call our care team at 1-877-687-1448.

If one of our dedicated nurse care managers calls you, you are required to have at least one conversation. If the nurse recommends that you participate in a support program, that decision is entirely up to you. It is not a requirement, but it is highly encouraged.

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

Q: How does Care Management Solutions determine compliance?
A: Each year, CMSI loads your age appropriate preventive and chronic requirements to your HEP portal. As you obtain your required screenings, CMSI receives the claims data from your insurance carrier and uploads that data to your HEP portal. As the claims come in you will see your requirements marked as complete.

Q: How can I track my progress toward my requirements?
A: The best way is to register on CTHEP.com. Once you sign in, your home page will display your requirements based on your age and gender. You will also see any chronic condition(s) requirements that apply to you. You can see any dependents' information, too. If they are under age 18, you will be able to view specific requirements and progress. If they are over age 18, you will be able to review a summary to see how many requirements they have and how many have been completed.

Q: How do I know if my family members are compliant?
A: As mentioned above, if you register at CTHEP.com, you will be able to view specific requirements for dependents under age 18, for dependent over 18 you can view a summary. Dependents over age 18, can create their own secure login to see their individual status in the HEP program. If they would like you to have access to their individual requirements, they can sign a personal health information (PHI) release form that would grant you access.

Q: I am a new employee. I tried to register at CTHEP.com, but it doesn't recognize me.
A: It takes about 45 days for CMSI to receive your enrollment information. We recommend you wait until the middle of the month after your insurance goes into effect.

Q: I don't have access to a computer. How will I know if I am missing a requirement?
A: Everyone is notified by mail towards the end of the compliance year of any missing requirements. Dependents ages 18 and over will receive their own letters. You typically receive the first letter at the end of September and will continue to receive letters until we receive the claims showing the requirement(s) have been completed. You can also call the dedicated customer service team at CMSI at 1-877-687-1448 to discuss your compliance status.

Q: A service is required less frequently than every year – every 2, 3, 4, 5, 7, and even 10 years. Do I have that long to complete it?
A: Here's how those work: We will look back at claims the appropriate number of years to see if the requirement has been completed. Requirements are measured using the current compliance year. For example, for Compliance year 2020, if you are 45 years old, and a vision exam is required once every four years, on Dec. 31, 2020 we will look back to see if it was completed in either 2017, 2018, 2019, or 2020.

Q: I had a service that I needed before this insurance went into effect. Do I have to have it again?
A: No, you do not. Have your health care provider fill out a provider notification form (PNF) with the date the service was done and submit it to us (instructions are on the form). For example: you are a new employee (or a new Partnership group) who is 57 years old and had your colonoscopy seven years ago. That satisfies your requirement for a colonoscopy, but you must submit the PNF. You can access a PNF at any time at CTHEP.com under "FORMS" at the top of the home page.

Q: I had my physical in December of last year, and my doctor is telling me I cannot get one sooner than December of this year because of the insurance. What do I do? I am afraid if it gets cancelled due to weather I will be out of compliance.
A: You do NOT have to wait 365 days to schedule a preventive visit. Your insurance pays for one every calendar year, regardless of when in the calendar year you have it. If your provider has a question about this, they should contact your health insurance company.

Q: Are there any alternate options to a colonoscopy?
A: While a colonoscopy is the most accurate way to test for colon cancer, we know that it is not appropriate for everyone. If your doctor agrees, you can take an annual FIT or FOBT test, or you may take a COLOGUARD® test every 3 years.

Q: I can't do one of the requirements because I have dentures, had a hysterectomy, or had a mastectomy.
A: Have your doctor fill out a PNF indicating that you should be exempt from the service. Be sure they indicate it is a permanent exemption. When we receive the form, we'll remove the requirement for you.

Q: My doctor does not feel I need to have one of the requirements. Why do I have to do it?
A: If your doctor feels one of the requirements is not appropriate for you, they can fill out a PNF. This will be required every year unless it is a permanent exemption, as in the cases above.

Q: My physician checks my eyes during my annual physical wellness exam. Does that count toward the required vision exam?
A: Your in-office vision exam counts long as your doctor submits a claim to your insurance company with a procedure code indicating they completed an eye exam as part of your wellness exam. If your doctor does not bill or submit a claim for the vision exam, you will need to have him/her fill out a PNF.

Q: I went to the doctor. Why am I still showing non-compliant with a requirement?
A: We typically receive claims one to two weeks after they are processed by your insurance company. This can, however, vary with doctors' offices and their billing processes. If a couple of months has passed and the portal continues to reflect that you're noncompliant for a screening that you have already completed, then call CMSI so one of our representatives can assist you.

Q: I went to the doctor months ago. Why am I still showing as non-compliant for my preventive visit?
A: Going to a doctor for a problem, such as a sore throat or headaches, or a medicine check for a chronic condition does not satisfy the preventive requirement. The visit has to be specifically for a preventive exam, which is also referred to as a routine physical or well visit. For an adult, it typically includes lab work and screenings. For a child, it typically incudes immunizations. Preventive visits are intended to prevent illness or detect problems before you have symptoms.

Q: Why does it seem like I always have to submit a provider notification form (PNF)?
A: There are only a few situations that require you to submit a PNF:

1. Your dependents have other insurance, and that insurance is primary. In this case we will never receive a claim for preventive services, and you will always have to submit a form. You should bring the form at the time of service and ask the provider to complete it and send us a copy.
2. You had the service done before this insurance went into effect. Since we do not have past claims history, you will need to submit a PNF as proof you had the service.
3. You just had the service, but the compliance deadline is two months away. We recommend submitting a PNF rather than waiting for the claim to be processed and sent to us.

Q: If I'm showing one of the chronic conditions, how do I complete the requirement?
A: The chronic condition requirement is an educational requirement that is separate from a doctor's visit or bloodwork for that condition. The education can be done in one of these ways:

1. You create an account on CTHEP.com, then take a survey, read a factsheet, or watch a video. After you finish, simply hit the "submit" button.
2. If you prefer not to register, you can print a factsheet from the log-in page. You click the chronic conditions button, select the appropriate condition, print the fact sheet, fill it out and send it in to us.
3. You can call us at 877-687-1448 and a representative will help you take a quiz over the phone.

This is an annual requirement due by December 31 along with the preventive requirements. Please remember, too, that if one of our dedicated HEP nurses calls you, you must accept the call to be considered in compliance.

Q: I didn't get the mailing you sent. It went to my old address.
A: Make sure you notify your employer of your address change through your benefit officer, payroll officer, benefit administrator, or human resources department. They will send the change to us. This could take up to six weeks, depending on when we receive the notice.

Q. Why does my child have to be compliant? He/she will be turning 26 and coming off my health plan before the end of the year.
A: The state changed medical coverage requirements for dependents in 2019. Dependents who turn 26 during the year now stay on a parent's plan until the end of the calendar year instead of the first of the month following their 26th birthday.

Q: My spouse is a state retiree on Medicare and doesn't have to comply with HEP. If it's his policy, why do I have to meet the requirements?
A: If you are under 65 and a dependent of a retiree in the Medicare Advantage plan who based on retirement date (10/2/2011 and later) would otherwise be required to meet the requirements of HEP, the benefit provided to you includes all the components of HEP. You must be compliant with the requirements to continue to receive the financial benefits of the program.

Q: I am a new employee – do I have to be compliant with HEP? Or, I just added a dependent – do they have to be compliant with HEP?
A: HEP compliance is measured once you are in the program for a full year. For example, if the effective date of your insurance is Jan. 1, 2019, you must be compliant by Dec. 31, 2019. If the effective date of your insurance July 1, 2019, you must be compliant by Dec. 31, 2020.

Q: I am divorced and have no contact with my children who are in HEP.
A: You may download and print a non-custodial parent form from CTHEP.com. Find it under the "Forms" tab. Follow instructions on the form to complete and return it.

Q: My child is serving in the military. How can I get him/her to comply?
A: You may download and print a military exemption form from CTHEP.com. Find it under the "Forms" tab. Follow instructions on the form to complete and return it.

Q: Why can't I see my dependents' requirements? I pay for the insurance.
A: The Health Insurance Portability and Accountability Act (HIPAA) prevents us from disclosing this information without express consent from your dependent. Your dependent may give us permission by going to CTHEP.com and clicking on the "Help, Forms & Contact" box. Download and print the release of personal health information (PHI) form and follow the instructions.

Your dependent may also give consent for us to talk to you by registering at CTHEP.com. Then, he or she can sign in and click on the "Contact" information tab, scroll to the bottom, and fill out the HIPAA release section. Make sure to "save" before navigating away from the page.

Q: How do I get access to my adult dependents' requirements/status?
A: There are several ways:

- Have your dependent fill out a PHI release form (see above).
- Have your dependent register on the portal and give us permission (see above).
    - These two options allow you to call us and get information on your dependents.
- Have all your dependents 17 and over fill out the PHI release form and complete the cover sheet. This allows you access to their requirements thru the portal at CTHEP.com. This must be done annually.

Q: Why did I have extra money taken out of my paycheck?
A: When you are placed into a non-compliant status, your premium contribution increases by $100 a month. You should check CTHEP.com and get your missing requirement(s) done as quickly as possible. Once you've completed them, fill out the reinstatement form (find it on the portal) and send to CMSI. It can take one or two pay cycles before you see the change in your paycheck.

Q: If I'm out of compliance and being penalized, will I automatically be reinstated once I complete the requirement?
A: No, you won't be automatically reinstated. If you've completed a requirement, you must have a **reinstatement form** filled out by a health care provider and sent to us right away. That begins the reinstatement process. Claims for the service alone will not automatically reinstate you.

Q: I removed a non-compliant person from my insurance. Why wasn't I reinstated?
If you have removed a non-compliant person, please contact us right away so we can verify it and start the reinstatement process.

Q: I just completed my missing requirement and sent in my reinstatement form. When will I be reinstated?
A: You will be reinstated the first day of the month following receipt of a completed reinstatement form.

Q: Do I have to wait until open enrollment to be reinstated?
A: No, you don't have to wait. Please send us a **reinstatement form** with proof of your missing requirements right away. Once you (and any family members) are 100% compliant, we will send your name for reinstatement. That reinstatement is effective on the first day of the month following when you send in the reinstatement form. If you find that you're compliant but are being charged, please contact us immediately so we can assist you with the reinstatement process. It is your responsibility to know your compliance status in HEP.

Q: There are so many different forms – I don't know which one to use
A: There are a number of different forms that address very different circumstances –

- Provider Notification Form (PNF) – this formed is used to report a service you have had done and must be signed by your provider

- Reinstatement Form – Looks similar to a PNF, but this form is used if you are currently in a non-compliance status and are being penalized. This form must be signed by your provider if you are missing a preventive requirement. If you are missing the chronic condition education and you completed it on the portal, no provider signature is required

- Non-Custodial Parent Form – This form is to be used if you have a dependent child on your insurance plan and you do not have custody, so you cannot ensure his/her requirements are complete.

- Military Exemption Form – This is to be used if you have a dependent on your insurance plan that is actively deployed in the military.

- Religious Exemption Form - This form should be used to claim an exemption from the requirements of the Health Enhancement Program based upon your adherence to religious beliefs.

- Permission to Release PHI – This is the form a participant would fill out to release their Protected Heath Information (PHI). If you want to be able to speak to a customer service representative about your spouses or overage dependents specific requirements they need to complete this form and follow the instructions to return to us.

- Permission to View PHI - This is the form you must fill out and submit with a Permission to Release PHI (above) in order to view your spouse and overage dependents requirements on the portal. Everyone on your plan that is 17 or over must complete the required forms for this option. This must be done on an annual basis

All of these forms can also be found at CTHEP.com by clicking on the Help, Forms & Contact button, or by clicking on the forms tab.

CARE
MANAGEMENT
SOLUTIONS
A DIVISION OF WELLSPARK

APPENDIX D

Dental Plan A
Dental Plan ABCD

Cigna Dental Benefit Summary
East Windsor Board of Education - Full A Plan
Plan Renewal Date: 07/01/2022

Insured by: Cigna Health and Life Insurance Company

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

Cigna Dental PPO				
Network Options	*In-Network:* **State of Connecticut Network**		*Non-Network:* **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II and III expenses	Unlimited		Unlimited	
Calendar Year Deductible Individual Family	$0		$0	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Oral Surgery: minor Repairs: Dentures Crowns: prefabricated stainless steel / resin	100% No Deductible	No Charge	100% No Deductible	No Charge
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: permanent cast and porcelain Space Maintainers: non-orthodontic Oral Surgery: major	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible
Benefit Plan Provisions:				
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.			
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 85th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.			
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.			
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.			
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.			
Late Entrant Limitation Provision	No coverage until next open enrollment. This provision does not apply to new hires.			
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.			
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. This provision does not apply to fillings.			

Oral Health Integration Program	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to [illegible] or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 16.
Space Maintainers	Limited to non-orthodontic treatment for children under age 14.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.

Benefit Exclusions:

Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services; instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Brush Biopsy
- Anesthetics
- Minor and Major Periodontal services
- Relines, Rebases, Adjustments, Repairs- Bridges, Crowns and Inlays
- Bridges, Dentures and Partials
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge.

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

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

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.
© 2021 Cigna / version 09152021

Cigna Dental Benefit Summary
East Windsor Board of Education - Full ABCD Plan
Plan Renewal Date: 07/01/2022

Insured by: Cigna Health and Life Insurance Company

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

Cigna Dental PPO				
Network Options	***In-Network;*** **State of Connecticut Network**		***Non-Network;*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II and III expenses	Unlimited		Unlimited	
Calendar Year Deductible Individual Family	$0		$0	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Oral Surgery: minor Repairs: Dentures Crowns: prefabricated stainless steel / resin	100% No Deductible	No Charge	100% No Deductible	No Charge
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: permanent cast and porcelain Space Maintainers: non-orthodontic Oral Surgery: major	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 19 Lifetime Benefits Maximum: $600	60% No Deductible	40% No Deductible	60% No Deductible	40% No Deductible
Class: VIII: Periodontal – Minor and Major Calendar Benefits Maximum: $500	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible
Benefit Plan Provisions:				
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.			
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 85th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.			
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.			
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.			
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.			
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III, IV, and VIII services for 12 months for eligible			

Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. This provision does not apply to fillings.
Oral Health Integration Program	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 16.
Space Maintainers	Limited to non-orthodontic treatment for children under age 14.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses.
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet.
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Brush Biopsy
- Anesthetics
- Relines, Rebases, Adjustments, Repairs- Bridges, Crowns and Inlays
- Implants: implants or implant related services;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge.

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

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

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

© 2021 Cigna / version 09152021

APPENDIX E

Cigna Vision

Summary of Benefits Cigna Health and Life Insurance Company

Cigna Vision
East Windsor Board of Education
C1 - Custom PPO Comprehensive Plan

Welcome to Cigna Vision
Schedule of Vision Coverage

Coverage	In-Network Benefit	Out-of-Network Benefit	Frequency Period **
Exam Copay	$15	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$0	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period)			
Single Vision	Covered 100% after Copay	Up to $40	12 months
Lined Bifocal	Covered 100% after Copay	Up to $65	12 months
Lined Trifocal	Covered 100% after Copay	Up to $75	12 months
Lenticular	Covered 100% after Copay	Up to $100	12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period)			
Elective	Up to $360	Up to $345	12 months
Therapeutic	Covered 100%	Up to $345	12 months
Frame Retail Allowance (one per frequency period)	Up to $175	Up to $126	12 months

** Your Frequency Period begins the day after your last visit (Date of service basis)

Definitions:
Copay: the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses).
Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance.
Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.
Materials: eyeglass lenses, frames, and/or contact lenses.

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes:
- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
  - Polycarbonate lenses for children under 18 years of age
  - Oversize lenses
  - Rose #1 and #2 solid tints
  - Minimum 20% savings on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults) all tints/photochromic (glass or plastic); and lens styles.
  - Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;

07/01/2022

- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

Healthy Rewards® - Vision Network Savings Program:
- When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:
- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription eyeglasses, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

1. Log in to **myCigna.com**, go to your Cigna Vision coverage page and select "View Details." Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to **myCigna.com**? Go to **Cigna.com** and click on the orange Find a Doctor tab at the top. Then select "Vision Directory", for routine eye exams and eyewear services, from the Other Directories listed below.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision

customer service representative.

2. Schedule an appointment
Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:
- Go to **Cigna.com** and go to Forms, Vision Forms
- Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Benefits are underwritten or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company. Any benefit information displayed is intended as a summary of benefits only. It does not describe all the terms, provisions and limitations of your plan. Participating providers are independent contractors solely responsible for your routine vision examinations and products.

"Cigna" is a registered service mark, and the "Tree of Life" logo, "Cigna Vision" and "CG Vision" are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries, including Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company, and not by Cigna Corporation. In Arizona and Louisiana, the Cigna Vision product is referred to as CG Vision. Healthy Rewards® - Vision Network Savings Program powered by Cigna Vision is a discount program, not an insured benefit.

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

ATTENTION: language assistance services, free of charge, are available to you. Call 1-877-478-7557 (TTY: 800-428-4833).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-478-7557 (TTY: 800-428-4833).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-478-7557（TTY：800-428-4833）

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-478-7557 (TTY: 800-428-4833).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-877-478-7557 (TTY: 800-428-4833) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

07/01/2022

Tumawag sa 1-877-478-7557 (TTY: 800-428-4833).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-478-7557 (телетайп: 800-428-4833).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-478-7557 (رقم هاتف الصم والبكم: 800-428-4833).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-478-7557 (TTY: 800-428-4833).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-478-7557 (ATS: 800-428-4833).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1-877-478-7557 (TTY: 800-428-4833).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-478-7557 (TTY: 800-428-4833).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-478-7557 (TTY: 800-428-4833) まで、お電話にてご連絡ください。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-478-7557 (TTY: 800-428-4833).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfugung. Rufnummer: 1-877-478-7557 (TTY: 800-428-4833).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 800-428-4833) 1-877-478-7557 تماس بگیرید.

CT

SIGNATURE BLOCK

IN WITNESS WHEREOF, the parties hereunto have caused these presents to be executed by their proper officers, hereunto duly authorized, and their seals affixed hereto as of the date and year first above written.

EAST WINDSOR BOARD OF EDUCATION

BY (Print): Patrick Tudryn
Superintendent

SIGNATURE: Patrick Tudryn

DATE: 4/12/23

BY (Print): Randi Reichle
Board Chair

SIGNATURE: Randi R

DATE: 4/12/2023

EAST WINDSOR ADMINISTRATORS' ASSOCIATION

EWAA BY (print): Laura L. Foxx
Union President

SIGNATURE: Laura L. Foxx

DATE: 4-18-23

MEMORANDUM OF UNDERSTANDING

The East Windsor Board of Education (the "Board") and the East Windsor Administrator Association (the "Association") have reached the following agreement concerning the position of Special Education Supervisor. The parties have agreed as follows:

1. The position of special education supervisor shall be added to the EWAA union. The position shall be a 10-month position, with a work year of 195 days.
2. The position shall be eligible for the following fringe benefits – 15 sick days, 3 personal days, 1 floating holiday, and 1 emergency day
3. Salary Scale below

FY23 Salary Scale – 10 month Sped Supervisor (195 work days)

Step	FY23
1	$110,610
2	$111,724
3	$113,146
4	$114,380

- The provisions of article 13.3 of the parties' collective bargaining agreement, concerning reduction of force, shall apply to this position.
- Except as provided in this memorandum, all other provisions of the parties' collective bargaining agreement shall apply to this position.
- Salary increases would be same as the union would negotiate which starts this fall, and shall take effect on July 1, 2023.

Patrick Tudryn 8/2/22
Patrick Tudryn, Ed.D. Date
For the East Windsor Board of Education

Laura L Foxx 8-10-22
Laura Foxx Date
For the East Windsor Administrator Association

MEMORANDUM OF UNDERSTANDING

The East Windsor Board of Education (the "Board") and the East Windsor Administrator Association (the "Association") have reached the following agreement concerning the position of Positive School Climate and Equity Director. The parties have agreed as follows:

1. The position of Positive School Climate and Equity Director shall be added to the EWAA union. The position shall be a 10-month position, and follow the provisions in the collective bargaining contract pertaining to 10-month administrators.
2. The travel stipend will be consistent with the positions of K-12 Directors and the Supervisor of Special Education ($1800 for FY25).
3. The salary and wage scale will follow the 10-month position of the HS Assistant Principal.

FY25 Salary Scale – 10 month Positive School Climate and Equity Director (195 work days)

Step	FY25
1	$125,914
2	$128,432
3	$131,643
4	$134,430

- The provisions of article 13.3 of the parties' collective bargaining agreement, concerning reduction of force, shall apply to this position.
- Except as provided in this memorandum, all other provisions of the parties' collective bargaining agreement shall apply to this position.
- The position will be added to the next collective bargaining contract.

Patrick Tudryn 8/6/24 Laura L Foxx 8-6-24

Patrick Tudryn, Ed.D. Date
For the East Windsor Board of Education

Laura Foxx Date
For the East Windsor Administrator Association