Collective Bargaining Agreement

Between

The Town of South Kingstown, RI

And

International Association of Fire Fighters
Local #3365, AFL-CIO

Date
July 1, 2015 – June 30, 2018

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ARTICLE 1 - GENERAL

SECTION 1.01 - AGREEMENT

Pursuant to the provisions of Title 28, Chapter 9.01 of the General Laws of Rhode Island, 1956, as amended, entitled "Fire Fighters' Arbitration"; this contract is made and entered into this 28 day of July 2015, by and between the TOWN OF SOUTH KINGSTOWN AND LOCAL 3365, INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS, AFL-CIO.

SECTION 1.02 - RECOGNITION

Pursuant to an election conducted by the State Labor Relations Board on January 11, 1991, the Town of South Kingstown recognizes Local 3365 of the International Association of Fire Fighters, AFL-CIO as the sole and exclusive bargaining agent for those permanent uniformed employees of the South Kingstown Emergency Medical Services as defined in Case No. EE3482. Said recognition is for the purpose of Collective Bargaining relative to wages, salaries, pensions, hours and other terms and conditions of employment.

SECTION 1.03 - UNION SECURITY

A. Any member of the department who is a member of Local 3365 as of July 1, 1991, and any member of the department who becomes a member of Local 3365 during the term of this Agreement, shall remain a member of Local 3365 for the duration of this Agreement.

B. All present employees of the department who are not members of Local 3365, International Association of Fire Fighters, AFL-CIO on the effective date hereof, shall not be required to become members of Local 3365 during the term of this Agreement, but shall, as a condition of employment, pay to Local 3365, the employees exclusive Collective Bargaining Representative, an amount of money equal to that paid by other employees in the bargaining unit who are members of Local 3365, which shall be limited to an amount of money equal to Local 3365's regular and usual initiation fees and its regular and usual dues and its general and uniform assessments levied upon its members in connection with its responsibilities as the collective bargaining agent for employees of the South Kingstown EMS Service.

C. The treasurer of the Union shall certify the amount of membership dues and assessments to the Town Manager. The Town shall thereafter deduct such dues and assessments each month from the salaries of all employees covered by this Agreement and remit this amount to the Union Treasurer. It is understood that the Town is not responsible for the application or use of such membership dues and the Union agrees to hold harmless and indemnify the Town to the extent the Town may be liable for the misuse of such membership dues.

D. The failure to maintain membership in Local 3365, in accordance with the terms of this Agreement, or the failure to pay to Local 3365 charges and assessments in accordance with sub-paragraph (B) hereof, shall be considered a ground for dismissal under the provisions of this Agreement; provided, however, that nothing contained herein shall be construed so as to place any obligation upon the Town to discharge any employee for non-membership in Local 3365 if, (1) the Town has reasonable grounds for believing that such membership was not available to the employee on the same terms and conditions generally applicable to other employees, or (2) if the Town has reasonable grounds for believing that membership was denied or terminated for reasons other than the failure of the employee to tender the periodic dues and initiation fees uniformly required as a condition of acquiring and retaining membership. Local 3365 agrees to indemnify and hold harmless the Town of South Kingstown from any lawsuits, damages, judgments, results, ramifications, and or effects occurring pursuant to said assessments and/or deductions made by the Town at the request of Local 3365.

E. The EMS Director shall be excluded as a member of this Bargaining Unit, and therefore not be subject to the above section.

SECTION 1.04 - MANAGEMENT RIGHTS

A. The Union acknowledges that the Town retains the responsibility for the administration of the Emergency Medical Services Department of the Town which it shall exercise under the provisions of Law and in fulfilling its responsibilities under this Agreement.

B. Except as modified by the terms of this Agreement, the Town retains and reserves unto itself all right, power, authority, duty, and responsibility confirmed on and vested in it by the laws and constitutions of the United States of America and the State of Rhode Island.

C. The Town further retains the right to make and promulgate reasonable rules and regulations governing the conduct of the EMS Department.

SECTION 1.05 - DISCHARGE AND DISCIPLINE

A. The Town shall have the right to discharge and/or discipline employees at any time for just cause; and in the case of discharge shall give the Union and the employee at the time of said discharge the reasons for discharge in writing by giving a copy to the employee and the Local Union President. In the event the Union and/or the employee shall claim that any such discharge has been made without just cause, such claim shall be presented in writing within five (5) business days from the date of such discharge and shall be disposed of under the grievance procedure. A permanent employee shall have

the right to challenge said discipline and/or discharge under the grievance procedure of the Collective Bargaining Agreement.

B. Probationary employees shall be subject to discharge at any time within their probationary period without recourse to any legal remedies including but not limited to the grievance procedure of this Collective Bargaining Agreement.

C. All members shall maintain a valid driver's license and State of Rhode Island Department of Health license appropriate to position. Failure to maintain said licenses shall result in unpaid suspension up to and including termination.

D. Any unauthorized absences without notification shall be cause for disciplinary action up to and including termination.

SECTION 1.06 - TIME OFF WHILE PERFORMING UNION DUTIES

The Town agrees to replace without loss of pay or the requirement to make up such time the President of Local 3365 and one Executive Board member or delegate to attend the following Union functions as follows:

A. Formal Contract Negotiations with Town	President and One Board Member
B. Arbitration Hearings	President and One Member
C. Meetings Called by the Town Manager	President Only
D. Independent Medical Exam (IME)	President or Designee

SECTION 1.07 - BULLETIN BOARD/UNION NOTICES

The Town agrees to allow the Local to post notices in any EMS facility for members of this Collective Bargaining Agreement.

SECTION 1.08 - LEAVE BALANCE REPORTS

Individual employee Leave Balances are provided bi-weekly on employee pay stubs.

ARTICLE 2 - EMPLOYEE BENEFITS

SECTION 2.01 - SENIORITY

Seniority of members of the Bargaining Unit shall be calculated after the member successfully completes the six (6) month probationary period and shall then revert back to the date of original appointment to a permanent full-time position in the EMS program. Up to date seniority lists shall be posted annually by the Town in each EMS Facility and shall be distributed to the Union President.

A. When two or more appointments are effective on the same date; the EMS Director shall determine the order of seniority based on the ranking of candidates from the applicant pool.

SECTION 2.02 - BID SYSTEM

A. Placements on shifts will be made annually in May, to take effect during the first full pay period in July, on the basis of a bid system by seniority.

    1. The shift bid will begin from a cleared grid of both lieutenant and staff ranks.

    2. Lieutenants selected according to Article 6 will bid to available lieutenant positions according to cumulative time in grade.

    3. EMS staff will bid to the available staff positions according to seniority within the department.

B. All yearly bids shall be binding except in those situations where vacancies and other shifts arise mid-year and require filling. In this situation, the following system shall be instituted:

    1. All vacancies shall be posted for four (4) days. A copy of the notice shall be sent to the Union President and to any employee sick or injured.

    2. Mid-year shift bids will be voluntary unless otherwise stated. The choice to move to another shift or vacate their current shift and move will be at the employee's discretion.

C. All probationary employees shall be placed on shifts at the discretion of the EMS Director to assure their proper training. At the end of their probationary period, said employees shall be placed on shifts according to the bid system that is then in effect.

D. Nothing in this agreement shall be construed as to limit, interfere with, or otherwise challenge the management rights of the Town through the EMS Director to transfer any

member from any shift to another shift where such transfer is in the best interest of and conducive to the harmony, productivity and good order and discipline of the department.

SECTION 2.03 - ACCESS TO PERSONNEL FILES

After twenty-four (24) hours notice, the Town agrees to allow any member of the EMS Department to view any and all records maintained by the Town that refer to the selection, performance, promotion, or any other aspects of salary, wages or working conditions of said employee.

SECTION 2.04 - ISSUED EQUIPMENT

A. All members of the bargaining unit shall receive a complete initial issue of uniforms and equipment. The Town will replace articles of clothing and equipment as needed due to wear with the approval of the EMS Director, within thirty (30) calendar days of the employee's request. The Town will replace lost or stolen items; however the individual member is financially liable for their issued equipment in the event of loss or theft due to negligence. Uniforms and equipment are the property of the Town and shall be surrendered to the EMS Director when issued new uniforms or equipment, or upon the employee leaving the Town's service. All items below will be agreed upon by the Town and the bargaining unit.

   - Four EMS uniform pants color navy blue
   - Four EMS short sleeve shirts
   - Four EMS long sleeve shirts
   - One pair duty boots, to be replaced as needed
   - One trouser belt
   - One helmet color appropriate for position
   - One extrication gloves
   - One multi-season coat

B. Departmental issued clothing will be cleaned by the Town on the following basis:

   - 3 shirts per week
   - 3 pants per week

SECTION 2.05 - EDUCATION EXPENSES

A. The Town will provide an annual stipend, to be disbursed no later than August 7th to compensate for the cost of continuing education. This shall be issued in a check

separate from the bi-weekly pay check. Members will not be eligible for the education stipend until the first disbursement after they have completed probation.

1. Paramedics will receive $599.00
2. EMT-Cardiacs will receive $250.00

B. The Town will provide internet based education materials through a Computer-Based Learning Management System for each member that provides for a minimum of 12 credits towards National Registry of EMT's recertification requirements.

C. The Town will provide the members with ACLS, PALS, and BLS classes annually. Attendance is not mandatory.

D. The Town will not grant education leave associated with recertification. Recertification hours off duty will not be eligible for compensation.

E. Mandatory education may be required at the discretion of the EMS Director. In the event that the EMS Director requires members to attend training, members will be granted one hour of compensation leave for each hour of education.

SECTION 2.06 - LEGAL INDEMNIFICATION

A. In the event that any employee covered by this Agreement is sued in any civil proceeding as a result of actions performed by said employee in the performance of his/her duties as an employee of the South Kingstown EMS Division, the Town of South Kingstown agrees to provide such employee with all necessary legal assistance and further agrees to pay any judgment subject to the limitations imposed by R.I.G.L. 9-31-3 rendered against such employees in such proceeding.

B. This section shall not apply to tortuous conduct of an employee which is willful, deliberate, or beyond the scope of his/her employment.

ARTICLE 3 - COMPENSATION

SECTION 3.01 - SALARIES

A.

2015-2016	Step 0	Step 1	Step 2	Step 3
Lieutenant				51,205
Paramedic	42,149	44,627	46,486	48,966
EMT-Cardiac	37,245	38,799	40,415	42,030
2016-2017	**Step 0**	**Step 1**	**Step 2**	**Step 3**
Lieutenant				52,357
Paramedic	43,097	45,631	47,532	50,068
EMT-Cardiac	38,083	39,672	41,324	42,976
2017-2018	**Step 0**	**Step 1**	**Step 2**	**Step 3**
Lieutenant				53,535
Paramedic	44,067	46,657	48,602	51,194
EMT-Cardiac	38,940	40,565	42,254	43,943

Step 0: Probationary period of six (6) months
STEP 1: 12 months
STEP 2: 12 months
STEP 3: 12 months

B. Shift Differential: Employees working as an Acting Lieutenant will receive the rate of pay of a Lieutenant for the time worked as Acting Lieutenant.

SECTION 3.02 - LONGEVITY PAY

Longevity pay shall be paid in semi-annual payments with the first payment due on the second pay date in July and second payment due on the first pay date in January. Members first becoming eligible for longevity pay after June 30 but before January 1 shall receive a longevity check on the first pay date in January. Members first becoming eligible for longevity pay on or after January 1st, but before July 1st shall receive a longevity check on the second pay date in July. Semi-Annual payments will be calculated using the following formula:

(Base Salary x Longevity Percentage) divided by 2 = Semi-Annual Payment

Longevity pay shall be considered as a part of base salary for pension purposes only.

Service Years	FY 2015-2016 Percentage of Base Salary	FY 2016-2017 Percentage of Base Salary	FY 2017-2018 Percentage of Base Salary
Five (5) years of service But less than ten (10) years	3.75%	3.75%	4.00%
Ten (10) years of service But less than fifteen (15) years	4.25%	4.25%	4.50%
Fifteen (15) years But less than twenty (20) years	4.75%	4.75%	5.00%
Twenty (20) years of service or more	5.25%	5.25%	5.50%

In addition, on June 30, 2018 at 11:59pm, the Longevity Schedule will increase by 0.25% for each of the four (4) service year groups listed above, to 4.25%, 4.75%, 5.25%, and 5.75% respectively.

SECTION 3.03 - PAID HOLIDAYS

A. Employees covered by this Agreement shall be granted uniformly an additional eight (8) hours pay per holiday and four (4) hours pay per half-day holiday.

B. The following are designated as holidays:

New Year's Day	Mothers' Day	Fathers' Day	Good Friday (1/2 day)
Easter Sunday	Memorial Day	Independence Day	Labor Day
Columbus Day	Thanksgiving Day	Christmas Eve	Christmas Day
New Years' Eve			

C. The Collective Bargaining Unit shall receive holiday pay in two (2) checks payable in the first pay period of December and in July retroactively.

SECTION 3.04 - OVERTIME

A. Overtime will be awarded whenever any member works past the end of their shift or fills for a vacancy and will be calculated at one and one-half (1 ½) times the hourly rate of pay. For each hour or part of an hour worked, overtime and compensatory time shall be earned in fifteen minute increments.

B. Employees performing in the role of an Acting Lieutenant on overtime will receive one and one-half (1 ½) times the hourly rate of the Lieutenant pay.

C. Any Shift vacancies will first be offered to full-time employees and then the EMS Director. If shifts remain unfilled by the cutoff date posted when advertised, they will then be offered to per diem employees.

D. It is the intent of the Town that overtime work shall be equally distributed among qualified employees. Qualified employees shall be defined as those employees who have the skills, and certification where required, to perform the overtime assignment. The overtime process will be agreed upon by both the Town and the Union. The Lieutenants will be responsible for proper implementation of the overtime process. When necessary, employees will be required to work overtime for all or part of a shift if no other employee is available to work overtime voluntarily. Mandatory overtime shall be enforced under the following conditions:

1. **Mandatory Holdover**:
   A holdover procedure will be maintained by the Town and the Local for purpose of holding an employee beyond the end of their current shift. A holdover shall be classified as being held a minimum of four (4) hours past the end of the normal scheduled end to the shift. In each case, the least senior employee with the least recent holdover will be required to stay. No employee shall be required to work longer than thirty-six (36) continuous hours unless required by the Town Manager. No employee shall be held over if doing so will interrupt an approved leave, unless required by the Town Manager. Where possible, a member working an overtime shift will be the last considered for a holdover that occurs on the subsequent shift.

2. **Order Back:**
   In the event that mandatory holdover is unavailable as a means to fill a vacancy, a Mandatory Order Back list will be used. Order back shall be done beginning with the least senior member of the department and utilizing a rotating list. No employee shall be ordered back while on approved leave, unless required by the Town Manager. Any member ordered back or ordered in for duty for less than a full shift shall be compensated at the rate of time and one-half (1 ½) for a minimum of four (4) hours. The Mandatory Order Back List will be reset on July 1st annually and begin with the least senior member of the department.

E. No employee, full time or per diem, will be allowed to return to work after working thirty-six (36) consecutive hours without twelve (12) hours off duty unless required under an emergency situation by the Town Manager or EMS Director.

SECTION 3.05 - COURTTIME

A. All members of the Department when required to appear in court for any department related reason shall be compensated for each hour or part of an hour worked. Overtime and compensatory time shall be earned in fifteen minute increments at the overtime rate.

B. Should the employee be scheduled for duty, he/she will be allowed the necessary time away from duty and compensated at the straight time pay rate.

ARTICLE 4 - LEAVE

For the purposes of these sections, a twelve (12) hour period shall refer to 0700 to 1900, or 1900 to 0700.

Paid Holidays are listed in section 3.03.

In the event that more than one member of the Collective Bargaining Unit submits a leave request for the same date and time, the date of the submission will be used to select the order of approval. In the event that more than one member has the same date of submission, seniority will be used.

At any given time a minimum of one (1) full time member must staff each vehicle that is in service. Personal Leave notwithstanding, a maximum of three (3) members of the Collective Bargaining Unit may be granted leave time during the day shift (0700-1900) and a maximum of two (2) members may be granted leave during the night shift (1900-0700) provided that leave can be approved based upon the limitations described within this article and the workday is not listed in section 3.03. For the purposes of this section, Military Leave, OJI, and Vacant positions will count towards the total number of allowed leave slots per shift.

Short notice leave will be allowed if there is an available leave slot open, the shift lieutenant fills the shift and appropriate staffing levels are maintained. If the employee is next eligible to be held on their shift they must agree to return to work in the event that a mandatory holdover occurs on the subsequent shift or make arrangements to cover the holdover. Leave requests will be filled by Lieutenants or the EMS Director. At no time shall an employee find a replacement to fill their leave time.

The parties recognize that employees and the Town have rights as provided by federal and state FMLA laws, as they may be amended from time to time. If an employee is granted a leave as set forth in this article where FMLA applies, FMLA leave shall run concurrently with said leave.

SECTION 4.01 - SICK LEAVE

A. Sick leave will be accrued based on the following schedule:

Hours Annually	Hours Per Pay Period	Maximum Accumulation
120	4.6154	1,440 hours

B. Sick leave will be granted for absence from duty because of personal illness or physical incapacity due to injury. A personal illness or physical incapacity shall include exams, therapy, and other treatments which involve a life threatening disease and which cannot be administered at any time other than during the regular work day. Pre-operative surgery testing and oral surgery with a physician's confirmation shall be included.

C. In the event of an unexpected illness, the employee is required to notify Dispatch, by calling the designated non-emergency phone number, of intent to use sick leave no later than one (1) hour before the start of the employee's shift. Dispatch will then notify the on duty Lieutenant. At no time should there be a direct call to the on duty Lieutenant to notify of intent to use sick leave.

D. The Town may require a physician's certificate as satisfactory evidence in support of any request for future sick leave for a period of one (1) year, provided the employee has been notified of this requirement. At the end of one (1) year, the employee will not have to provide a physician's certificate unless the Town informs the employee that such evidence shall be required.

E. Bargaining Unit members with five (5) or more years of service who resign or leave the Town's service in good standing shall receive payment for not more than twenty-five (25%) percent of the unused sick leave that has been accrued provided that the member has accrued a minimum of three hundred sixty (360) hours.

F. Sick leave will be granted in twelve (12) hour increments.

G. All employees who retire from the Town will be eligible for seventy-five (75%) percent of all accumulated sick leave if that member has accrued a minimum of three hundred sixty (360) hours. To determine payments made under this provision, the hourly rate shall be defined as the annual salary rate of pay excluding longevity and divided by 2080.

H. Employees retiring due to job related disability will be eligible for payment of all accumulated sick leave hours.

I. Any employee covered by this Agreement who is in need, who has not previously abused his/her sick leave, and has exhausted all available paid leave, may be eligible to receive donated sick leave from other members of the bargaining unit. Written requests for consideration shall be submitted to the Town Manager by the employees both offering to donate and requesting to receive donated sick leave. The Town Manager will have final determination on the ability to donate and/or receive sick leave, as well as the number of days of sick leave that will be allowed for transfer. Employees who receive said donated sick leave shall not be required to reimburse employees who make said donations or to pay back the Town.

SECTION 4.02 - BEREAVEMENT LEAVE

A. Bereavement leave may be used in the event of a death occurring in the immediate family of a member. The town agrees to pay the employee for the time lost between the day of demise and the date of burial, not to exceed forty-eight (48) working hours

for the purpose of attendance at the funeral. The term immediate family as relevant to this section includes parents, spouse, children (natural or adopted), siblings, spouses' parents, grandparents, grandchildren, step children, and step parents.

B. In the event of a death of a relative or household member other than as provided above, such leave of absence with pay may be granted at the discretion of the EMS Director or his/her designee.

SECTION 4.03 - PERSONAL LEAVE

Personal leave will be accrued based on the following schedule:

A. Each permanent member will be granted twenty-four (24) hours of personal time on July 1st of each year.

B. For employees hired on July 1st through December 31st, twenty-four (24) hours of personal leave will be awarded upon hire. For employees hired on January 1st through June 30th, twelve (12) hours of personal leave will be awarded upon hire.

C. In addition to the foregoing, the Town shall grant an additional six (6) hours of personal leave to employees who did not utilize sick leave during the previous three (3) month period. Three (3) month periods are defined as July 1 – September 30, October 1 – December 31, January 1 – March 31, and April 1 – June 30 of each year. Personal time for non use of sick leave will be credited to the employee's accrual record the second pay period of the month following the end of the three (3) month period. This additional personal leave shall be utilized according to the guidelines in this section. Separate three (3) month periods shall be required to qualify for the personal leave bonus.

D. Personal Leave may not be carried over at the end of the fiscal year. Members of the Collective Bargaining Agreement will be paid for unused Personal Leave time by the second pay period in July at the June 30th pay rate.

E. Absences due to OJI which are longer than thirty (30) days will not count toward the six (6) consecutive months of attendance necessary to receive the bonus personal leave.

F. Personal Leave shall not be taken on holidays listed in section 3.03 of this agreement.

G. Submission of a request for use of a personal day must be made to the EMS Director at least twenty-four (24) hours in advance of the affected shift. Approval is not contingent on voluntary overtime to fill the vacancy and mandatory overtime will be used when necessary.

H. Personal leave will be granted in twelve (12) hour increments.

SECTION 4.04 - LEAVE OF ABSENCE

A. It is agreed that an employee with permanent status may be granted a leave without pay or employment benefits for a period not exceeding six (6) months for good cause. Such request must include the approximate date of return. Written application of intent to take leave and notice of intent to return must be filed with the Personnel Administrator at least sixty (60) days prior to the start of said leave, unless emergency conditions requiring less notice should arise, and thirty (30) days prior to the end of said leave. Requests for leave without pay for three (3) days or less shall be made in writing to the EMS Director. All other requests shall require the approval of the Town Manager.

B. Failure to return to work at the expiration of a leave of absence shall result in termination of employment.

SECTION 4.05 - VACATIONS

A. Vacation will be accrued based on the following schedule:

Years of Service (beginning – completion)	0-4 Years	5-9 Years	10-14 Years	15+ Years
Hours per Pay Period	3.6923	4.6154	6.4616	7.0770
Hours Per Year	96	120	168	184

Full years of service shall be defined in this section as the employee's anniversary date of hire.

B. Vacation leave shall begin to accrue at the end of the first full pay period of employment.

C. Non-Holiday vacation requests must be submitted a minimum of two (2) weeks in advance in writing with the date and time of submission, affected shift, and employee signature on the department approved leave form.

D. One Leave Slot per twelve (12) hour period (day/night) may be used for vacation leave that will result in the use of mandatory overtime (hold). One additional member may use vacation leave contingent upon the availability of an open leave slot for the time period and mandatory overtime is not used.

E. Holiday Vacation requests must be submitted no more than ninety (90) days in advance and no less than sixty (60) days in advance. Notification of approval or denial will be made no less than fifty (50) days in advance. Holiday leave is contingent upon using voluntary overtime to fill the vacancy, and will not create a mandatory holdover. Approval is with the understanding that this leave may be revoked at any time in the event a mandatory holdover arises during any of the Holidays specified in Section 3.03

of this contract. The employee requesting the holiday leave must agree to report for duty should the need arise.

F. A maximum of three (3) weeks of vacation leave may be used consecutively; however, an employee may take a fourth consecutive week with the approval of the EMS Director, which approval will not be unreasonably withheld.

G. At any one time, employees will be allowed to accumulate a maximum of two hundred forty (240) vacation hours.

H. An employee who leaves the employment of the Town having unused vacation leave, shall be compensated for unused leave at the hourly rate of pay. Said rate is defined in 4.01(G).

I. Vacation leave will be granted in twelve (12) hour increments.

SECTION 4.06 - COMPENSATORY LEAVE

A. Compensatory leave may be accrued in lieu of paid overtime at the employee's request. Compensatory leave will be accrued at a rate of time and one half (1 ½) the amount of overtime hours worked. At any time, employees may accumulate a maximum balance of ninety-six (96) hours. Employees have the option of being paid for comp time balances at the end of the fiscal year or carrying over any unused leave to the new fiscal year. If the employee chooses to be paid for the balance, he/she must notify the Town by May 15th. Payment will be based on the employees' hourly rate in effect on June 30th of that year.

B. Compensatory leave will be granted in a minimum of six (6) hour increments.

C. Compensatory leave will not create overtime, unless approved by the EMS Director.

D. Compensatory leave requests must be made a maximum of two (2) weeks in advance.

E. Compensatory leave requests will be filled by the lieutenant. Approval is contingent upon the availability of staff to fill the vacancy.

SECTION 4.07 - FAMILY SICK LEAVE

A. Family sick leave may be used to attend to the illness of a family member. Family member shall mean the employee's spouse, child, or parent.

B. Family Sick leave is limited to forty-eight (48) hours per year.

C. Employees shall be eligible to apply to the Town Manager for the conversion of up to one hundred twenty-six (126) hours of accumulated sick leave to family sick leave over a rolling twelve (12) month term with the following restrictions:

1. Employees are eligible to apply for leave if they are full time employees and have been employed continuously for at least twelve (12) months.

2. Employees must first exhaust the forty-eight (48) hours allowed.

3. With the exception of forty-eight (48) hours of accrued vacation leave, employees must exhaust all other accrued personal leave, vacation leave, and compensatory time prior to using approved accumulated sick leave for Family Sick Leave.

4. This additional Family Sick Leave is to attend to the serious illness of a spouse, child, or parent. Serious illness is defined to mean a disabling physical or mental illness, injury, impairment or condition that involves in-patient care in a hospital, nursing home, or hospice, or out-patient care requiring continuous treatment or supervision by a health care worker.

SECTION 4.08 - SUBSTITUTIONS

Agreements between employees consenting to substitute for each other during all or part of any shift may be entered pending the approval of the EMS Director. The EMS Director reserves the right to terminate existing agreements without cause if a minimum of forty-eight (48) hours notice is given. Termination may be initiated by consenting employees if no part of the agreement has been executed, the termination request is in writing, and signed by both parties.

A. The following conditions must be met prior to any substitution agreement being considered:

1. All agreements presented for approval must be in writing and signed by both parties no more than thirty (30) days in advance and no less than forty-eight (48) hours in advance of the first affected shift.

2. All submitted agreements must show mutual fulfillment at the time of submission.

3. The substitution will not result in an employee having to work in excess of thirty-six (36) hours continuously.

4. The EMS Director may consider alternate substitution agreements when such agreements are being used to assist the employee specifically with issues related to family care or when the employee is furthering their education.

5. Both parties must agree to take the place of the other if either employee is next up for a mandatory holdover within their team.

B. Any employee who is liable to work another's shift due to a substitution agreement may default on the agreement if sick leave time is used in accordance with this contract. The employee defaulting on such an agreement will incur penalties based on the following schedule:

    1. The first instance will result in a suspension of substitution privileges for a period of thirty (30) days from the date of the default.

    2. In the event of a second default occurrence within six (6) months of the first, the employee will have substitution privileges suspended for ninety (90) days.

    3. In the event of a third default occurrence within twelve (12) months of the first, the employee will have substitution privileges suspended for one hundred eighty (180) days.

C. Any employee defaulting on a substitution with approved OJI, Military, or bereavement leave will not be subject to the above listed penalties.

SECTION 4.09 - TEMPORARY VACANCY

The EMS Director has the authority to fill a vacancy that is temporary in nature in order to maintain continuity of operations within the department. Effective dates, and expiration dates, will be at the EMS Director's discretion and employees accepting temporary assignment may be required to return to permanently assigned positions at any time.

In the event it is determined a vacancy occurs for a time period greater than one (1) month, but not exceeding three (3) months, the EMS Director may appoint a staff member to fill the vacancy based on seniority or eligibility of the staff member. In the event it is determined a vacancy will occur for a time period greater than three (3) months, the EMS Director may fill the vacancy based on seniority and eligibility utilizing the Bid System process in Section 2.02. Should the temporary vacancy become a permanent vacancy, it shall be filled in accordance with Sections 2.01, 2.02, and Article 6-Promotions/Lieutenants.

ARTICLE 5 - MEDICAL/LIFE INSURANCE/PENSION

SECTION 5.01 - MEDICAL AND DENTAL INSURANCE

A. All employees covered by this agreement shall be covered by Medical Insurance, family or individual health plan dependent on marital status. A summary of benefits provided under the current Medical Insurance Plan is attached as Appendix A.

B. All employees shall be required to contribute a twenty percent (20%) co-share toward the cost of health care premiums or working rate. The employee co-share shall be made through twenty-four (24) bi-weekly payroll deductions each year and, if permitted under IRS regulations, shall be made on a pre-tax basis. During months with three (3) pay dates, the cost share will be deducted from only two (2).

C. The Town shall pay for family or individual coverage, as the case may be, in Dental Insurance with an annual benefit level of $2,000.00, per insured individual.

D. The Employer agrees it shall not contract for healthcare insurance for members covered by this Agreement which does not meet the limitations herein without discussion with the Union.

E. If an employee's spouse or parent in the case of a covered minor is eligible for family medical and dental insurance from the Town or the South Kingstown School Department, then the Town shall not be required to furnish such insurance for the employee.

F. The Town agrees to provide the foregoing medical coverage for any employee who is retired as the result of a work related one hundred percent (100%) total disability incurred in the line of duty until the employee is Medicare eligible. The coverage shall be the same as an active member of the department and subject to the same health care co-payment requirements of an active employee. For the purposes of this section the definition of “work related one hundred (100%) total disability” shall mean a disability meeting eligibility for Social Security Disability Payments.

G. Employees shall be provided an eye wear (prescription eye glasses and/or contact lens) allowance of up to One Hundred Fifty Dollars ($150.00), to be paid by June 30th of the year; however, said payment shall be limited to a maximum of one (1) allowance every other fiscal year per employee. Said allowance shall be paid only upon presentation of a single receipt of purchase (with a purchase date on or after July 1, 2015) and acknowledgement that said eye wear was purchased for exclusive use of the employee.

H. Any member who has coverage or is eligible for coverage under another health insurance plan may elect to waive the Town health plan and receive an annual payment equal to Two Thousand Dollars ($2,000.00). Payments will be pro-rated over bi-weekly pay periods throughout the fiscal year. Members electing to participate in the health

buy-back program shall deliver a signed, witnessed waiver form to the Personnel Office prior to each June 15th as well as a letter from the organization providing the coverage. In the event that a member who has elected to drop the health coverage as provided above decides to reinstate health and/or dental coverages, the following shall apply:

1. Except as provide in (2) below, reinstatement may be effective only at the beginning of the plan year (July 1) and the application must be made in writing to the Personnel Office no later than June 15.

2. Reinstatement may be requested during the plan year if such request is due to loss of the other coverage for reasons beyond the member's control. A request for mid-year reinstatement must be made in writing to the Personnel Office. If the request is approved by the insurer, reinstatement shall be the first of the month which is at least fifteen (15) calendar days following such approval.

3. All reinstatement is subject to the insurer's rules and contingent upon the insurer's approval. It is the understanding of the Town that employees will not be denied reinstatement based on valid requests.

I. Covered former spouses must annually sign and return to the Personnel Office an affidavit certifying that they do not have a substantially equal or better health insurance plan available to them through a current spouse or employer. Upon the re-marriage of a covered former spouse, said former spouse is no longer eligible for medical coverage through the Town.

SECTION 5.02 - LIFE INSURANCE

The Town shall provide Fifty-Thousand ($50,000.00) Dollars term life insurance for each member.

SECTION 5.03 - MEDICAL EXPENSES FOR EMPLOYEE'S FAMILY

The Town agrees to pay all expenses for inoculations or immunizations for members of an employee's household when such becomes necessary as a result of said employee's exposure to contagious diseases in the line of duty. This will include screening for contagious disease when potential exposure is discovered after said employee has had contact with members of his household.

SECTION 5.04 - RETIREMENT PLAN

A. All full time members of the Bargaining Unit shall be members of the Municipal Employees Retirement System Optional Retirement Plan for Police & Firefighters (R.I.

General Laws 45-21.2) et esq. and in accordance with the provisions of 45-21-52(3) Plan and subject to the Rhode Island Retirement Security Act of 2011 settlement as approved in the 2015 session of the Rhode Island General Assembly and the Superior Court.

SECTION 5.05 - RETIREMENT HEALTH BENEFITS

Employees shall be eligible for post – retirement benefits, until Medicare eligible, as follows:

A. Thirty (30) years or more of service: For three (3) years, the annual cost of health insurance shall be split between the Town and the retiree. The Town shall pay $4,000 per year toward the annual cost, and the retiree shall pay the difference, payable on a monthly basis.

B. Twenty-five (25) years of service: For three (3) years, the annual cost of health insurance shall be split between the Town and the retiree. The Town shall pay $2,666 per year toward the annual cost, and the retiree shall pay the difference, payable on monthly basis.

C. Twenty (20) years of service: For three (3) years, the annual cost of health insurance shall be split between the Town and the retiree. The Town shall pay $1,333 per year toward the annual cost, and the retiree shall pay the difference, payable on a monthly basis.

D. To be eligible for post-retirement benefits, the employee must be eligible to retire under the MERS.

E. Any retired employee who is eligible for a substantially equal or better health insurance plan, either through subsequent employment or a spouse, shall not be eligible for health insurance provided by the Town. Upon retirement from the Town, and continuing health coverage, retirees must annually sign and return to the Personnel Office an affidavit certifying that they do not have alternative coverage available to them through a current spouse or employer. In the event the retired employee loses said coverage, the Town will place the retiree back on the Town's health care plan within thirty (30) days of written notice, if otherwise eligible under this section.

SECTION 5.06 - SURVIVOR BENEFITS

A. Upon the death of an employee covered under this agreement, the Town agrees to pay the surviving spouse all accrued leave time available to the employee. The Town will further provide medical insurance to the surviving spouse of an employee killed in the line of duty. Said medical insurance will continue for five (5) years following the date of death and shall be the same coverage awarded to the employee by this agreement.

B. Notwithstanding the foregoing, the Town may revoke this benefit if the surviving spouse remarries or has access to alternative medical insurance.

SECTION 5.07 - ILLNESS/INJURIES

A. Members of South Kingstown Emergency Medical Services who are injured in the line of duty shall be entitled to all rights and benefits as set forth in Section 45-19, R.I.G.L., 1956 as amended. All injuries and recurrence of injuries shall be reported as required by the Department regulation.

B. The Town agrees that an employee will be considered as injured in the line of duty if such injury occurs any time while such employee is actually performing EMS work for and on behalf of the Town, even though said employee may not actually be on his/her regular tour of duty.

C. The Town further agrees that once an employee reports for work, he/she is actually on duty and shall be covered under this section for any work related injuries sustained until his/her tour of duty is completed.

ARTICLE 6 - PROMOTION/LIEUTENANTS

SECTION 6.01 - SELECTION AND QUALIFICATIONS

A. Members of the department who are eligible to participate in the lieutenant promotional process will be selected according to the following process. The selection process shall include a written exam, oral interview, and a promotional potential for each candidate based on seniority and education.

The EMS Director and one (1) Union representative will participate in the verification and assignment of points to be weighted as follows:

Written Exam	35%
Oral Interview	45%
Promotional Potential	20%

Written Exam will be composed of the following materials:

Management of EMS, Brady Publishers ISBN-10:0-13-232432, or equivalent
Brady Paramedic, current edition or equivalent
Department Operations, Policies, and Guidelines
RI EMS Protocols, current approved version
RI EMS Rules and Regulations, current approved version

Oral Interview process composed of an odd number of persons, numbering no less than 3, agreed upon between the Union President and the EMS Director.

Pool of Questions – Randomly Selected Number
Graded on 4 point Likert Scale

Promotion Potential:

Education: Maximum of 3 points, points awarded for highest completed degree only.

Associate's Degree:	0.5 pt
Bachelor's Degree:	1.5 pts
Master's/Doctorate Degree:	3 pts

Seniority: Maximum of 17 points, 1 point per completed year of service.

B. Members serving in the lieutenant position shall be allowed to bid to a lieutenant shift based upon Article 2, Section 2.02.

C. Upon the selection of a lieutenant(s) the EMS Director will notify the Union President in writing.

D. Members promoted to the lieutenant position must be a member of the bargaining unit, a licensed paramedic in the State of Rhode Island, and have a minimum of five (5) years of service in the department.

E. Members are not eligible to participate in the promotion process if they have received disciplinary action in the last twelve (12) months beyond a formal verbal warning documented in their personnel file and/or they have been on a performance related action plan as a result of unsatisfactory performance during the last twelve (12) months.

SECTION 6.02 - REASSIGNMENT/REMOVAL

A. A lieutenant may be reassigned/removed at anytime if the employee's actions place a patient or co-worker in danger or exposes the Town to liability. In addition, employees who at the discretion of the EMS Director are not meeting the requirements of the position as listed in the Lieutenant job description will be advised in writing of the deficiencies and be given thirty (30) days to show improvement prior to reassignment/removal from the position.

B. In the event that a lieutenant is reassigned/removed from duty the member will be allowed to return to the staff ranks according to Article 2, Section 2.02.

SECTION 6.03 - ACTING LIEUTENANT

A. An acting lieutenant will be a member who is eligible to serve as a lieutenant in the event of a lieutenant vacancy.

B. An acting lieutenant must be a member of the bargaining unit, a licensed paramedic in the state of Rhode Island, have a minimum of three (3) years of service in the department, and have successfully completed the lieutenant promotional process in Section 6.01, sub section A.

C. The EMS Director will provide the Union with a list of members eligible to serve as an acting lieutenant.

SECTION 6.04 - LIEUTENANT VACANCIES

When a vacancy occurs on a lieutenant shift the vacancy must be filled by another lieutenant, acting lieutenant or the EMS Director.

ARTICLE 7 - MUTUAL AID/WORKING CONDITIONS

SECTION 7.01 - MUTUAL AID

A. It is the understanding between the parties that in any case where the Town has mutual aid agreement with any other City or Town and the permanent paid Fire and/or EMS Department of such City or Town is involved in a labor dispute with said City or Town, members of Local 3365 shall not be ordered, directed or required to man any station in such City or Town or to stand by with any apparatus owned by said City or Town.

B. It is further understood by Local 3365 that its members may be required and shall report to provide mutual aid services in connection with any emergency medical requests in such City or Town even though a labor dispute may exist between the paid Fire or EMS Department of such City or Town.

SECTION 7.02 - WORKING CONDITIONS

Members of the EMS Department covered by this contract shall not be required while on duty to perform work normally performed by Building Trade Unions or other tradesmen except for minor repairs.

SECTION 7.03 - LAYOFF

A. In the event that the Town at any time during the term of this Agreement lays off members of the Bargaining Unit, layoff shall be conducted based on seniority, with the least senior member laid-off first.

B. The employee subject to layoff shall be entitled to 100% payment of all accrued vacation, compensatory, personal and administrative leave. In addition, an employee with five (5) or more years of full time service with the Town shall receive payment for not more than twenty-five (25%) percent of the unused sick leave that has been accrued provided that the member has accrued a minimum of three hundred sixty (360) hours.

C. Employees so laid off shall be called back from layoff by virtue of seniority. The employee with the highest seniority shall be recalled first. Employees laid off shall remain on a recall list for a period of two (2) years following the layoff.

SECTION 7.04 - HOURS

A. Shifts A, B, C, and D will work seven (7), twenty-four (24) hour shifts per month averaging forty-two (42) hours per week in a four (4) week period. Shifts will commence at 0700.

B. Shifts E and F will work 14 (fourteen), twelve (12) hour shifts per month averaging forty-two (42) hours per week in a four (4) week period. Shifts will commence at 0700.

C. Shift A will work each Monday and Friday with one (1) Friday off per month.

D. Shift B will work each Tuesday and work one (1) Friday, Saturday, and Sunday per month.

E. Shift C will work each Wednesday and Saturday with one (1) Saturday off per month.

F. Shift D will work each Thursday and Sunday with one (1) Sunday off per month.

G. Shifts E and F will work a rotating schedule of three (3) days on and three (3) days off.

ARTICLE 8 - GRIEVANCE PROCEDURE

SECTION 8.01 - GRIEVANCE PROCEDURE

The parties agree to resolve any grievance arising out of the terms and conditions of this Collective Bargaining Agreement in the following manner:

A. A grievance shall be presented by the Union to the EMS Director within ten (10) business days of the date of the occurrence of the grievance. The EMS Director shall meet with the Union representative within five (5) business days after the grievance is filed and shall give an answer to the grievance within five (5) business days of the grievance being heard.

B. If the Union is not satisfied with the response of the EMS Director, the Union may appeal the EMS Director's decision to the Town Manager. The appeal to the Town Manager shall occur within five (5) business days of the decision of the EMS Director. The Town Manager or his designee shall meet with the Union Representative within five (5) business days of the receipt of the grievance at this level and shall conduct a hearing and give an answer to the grievance within ten (10) business days of the grievance being heard.

C. If the Union is not satisfied with the response of the Town Manager, the grievance may be referred to arbitration. Said referral to arbitration shall occur within ten (10) business days after receipt of the grievance decision of the Town Manager and the proceedings shall be governed by the Voluntary/Labor Arbitration Rules of the American Arbitration Association.

D. The decision of an Arbitrator resolving said grievance shall be final and binding except that the Arbitrator shall not have the power to render any decision which adds to, subtracts from, or otherwise modifies the terms and conditions of the Agreement. Fees and expenses of the arbitration shall be borne equally by the parties.

ARTICLE 9 - DURATION/SEVERABILITY

SECTION 9.01 - DURATION

This contract shall be for a term of three (3) years commencing the First Day of July, 2015 and shall continue and remain in full force and effect until June 30, 2018.

SECTION 9.02 - SEVERABILITY

If any provision of this Agreement is or shall be at any time contrary to law, then such provisions shall not be applicable, or performed, or enforced, except to the extent permitted by law. In the event that any provision of this Agreement is or shall at any time be contrary to law, all other provisions of this Agreement shall continue in effect.

IN WITNESS WHEREOF, the Town of South Kingstown has caused this instrument to be executed and its corporate seal to be affixed by Stephen A. Alfred, its Town Manager duly authorized by the Town Council of the Town of South Kingstown as of the day and year first above written; and said Local 3365 of the International Association of Fire Fighters, AFL-CIO has caused this instrument to be signed by Francesco Capaldi Jr., its President and Melissa J. Davy, Member-At-Large thereunto duly authorized as of the day and year first above written.

IN THE PRESENCE OF:

Witness

Witness

TOWN OF SOUTH KINGSTOWN

Stephen A. Alfred, Town Manager

INTERNATIONAL ASSOCIATION
OF FIRE FIGHTERS, AFL-CIO

Francesco Capaldi Jr., President

Melissa J. Davy, Member-At-Large

APPENDIX A - HEALTHCARE SUMMARY OF BENEFITS

Please see the following pages for the Blue Cross Blue Shield of Rhode Island (BCBSRI) HealthMate Coast-to-Coast Summary of Benefits and Coverage for the coverage period July 1, 2015 – June 30, 2016. As the Summary of Benefits and Coverage documents for July 1, 2016 – June 30, 2017 and July 1, 2017 – June 30, 2018 become available, the documents will be appended to this agreement.

Blue Cross Blue Shield of Rhode Island **HealthMate Coast-to-Coast**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2015 - 06/30/2016
Coverage for: See below **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.BCBSRI.com or by calling 1-800-639-2227 or (401) 459-5000.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Out-of-Network providers **$200** for an individual plan **/ $600** for a family plan. Doesn't apply to services with a fixed dollar copay and prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For In Network providers **$6350** for an individual plan **/ $12700** for a family plan. For Out-of-Network providers **$6350** for an individual plan **/ $12700** for a family plan.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses in-network providers. See www.BCBSRI.com or call 1-800-639-2227 or (401) 459-5000 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.

Questions: Call 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051 or visit us at www.BCBSRI.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.BCBSRI.com or call 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051 to request a copy.

Do I need a referral to see a specialist?	No. You don't need referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	$10 copay plus 20% coinsurance after deductible per visit	————————none————————
	Specialist visit	$10 copay per visit	$10 copay plus 20% coinsurance after deductible per visit	————————none————————
	Other practitioner office visit	$10 copay per visit	$10 copay plus 20% coinsurance after deductible per visit	Chiropractic Services are limited to 12 visits per year; $15 copay for allergy and dermatology office visits
	Preventive care/screening/immunization	No Charge	$10 copay plus 20% coinsurance after deductible	Member liability for Out-of-Network is based on services received; For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance after deductible	Preauthorization is recommended for certain services

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance after deductible	Preauthorization is recommended
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BCBSRI.com.	Tier 1 generally low cost generic drugs	20% coinsurance per prescription (retail/mail-order)	Not covered	No Charge for certain preventive drugs
	Tier 2 generally high cost generic and preferred brand name drugs	20% coinsurance per prescription (retail/mail-order)	Not covered	Preauthorization is required for certain drugs
	Tier 3 non- preferred brand name drugs	20% coinsurance per prescription (retail/mail-order)	Not covered	Preauthorization is required for certain drugs
	Tier 4 specialty prescription drugs	20% coinsurance per prescription (specialty pharmacy only)	50% coinsurance	Infertility drugs: 20% coinsurance; Preauthorization is required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance after deductible	Preauthorization is recommended
	Physician/surgeon fees	No Charge	20% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room services	$75 copay per visit	$75 copay per visit	Copay waived if admitted
	Emergency medical transportation	$50 copay per trip	$50 copay per trip	——————none——————
	Urgent care	$10 copay per urgent care center visit	$10 copay plus 20% coinsurance after deductible per urgent care center visit	Applies to the visit only. If additional services are provided additional out of pockets costs would apply based on services received.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance after deductible	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fee	No Charge	20% coinsurance after deductible	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay/office visit No Charge for outpatient services	$10 copay plus 20% coinsurance after deductible/office visit 20% coinsurance after deductible for outpatient services	Preauthorization is recommended for certain services
	Mental/Behavioral health inpatient services	No Charge	20% coinsurance after deductible	Preauthorization is recommended
	Substance use disorder outpatient services	$10 copay/office visit No Charge for outpatient services	$10 copay plus 20% coinsurance after deductible/office visit 20% coinsurance after deductible for outpatient services	Preauthorization is recommended for certain services
	Substance use disorder inpatient services	No Charge	20% coinsurance after deductible	Preauthorization is recommended
If you are pregnant	Prenatal and postnatal care	No Charge	20% coinsurance after deductible	——————none——————
	Delivery and all inpatient services	No Charge	20% coinsurance after deductible	Preauthorization is recommended

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance after deductible	————————none————————
	Rehabilitation services	20% coinsurance	20% coinsurance after deductible	Includes Physical, Occupational and Speech Therapy. Speech Therapy preauthorization is recommended for all visits.
	Habilitative services	20% coinsurance	20% coinsurance after deductible	Includes Physical, Occupational and Speech Therapy. Speech Therapy preauthorization is recommended for all visits.
	Skilled nursing care	No Charge	20% coinsurance after deductible	Preauthorization is recommended; Custodial Care is not covered
	Durable medical equipment	20% coinsurance	20% coinsurance after deductible	Preauthorization is recommended for certain services.
	Hospice service	No Charge	20% coinsurance after deductible	Preauthorization is recommended
If your child needs dental or eye care	Eye exam	$10 copay	$10 copay plus 20% coinsurance after deductible	Limited to one routine eye exam per year.
	Glasses	Not Covered	Not Covered	————————none————————
	Dental check-up	Not Covered	Not Covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Glasses, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. Contact Customer Service for more information.
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051. You may also contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-639-2227.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-639-2227.
如果需要中文的帮助，请拨打这个号码 1-800-639-2227.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-639-2227.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,490
- **Patient pays** $50

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$20
Limits or exclusions	$30
Total	**$50**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,500
- **Patient pays** $900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$60
Coinsurance	$800
Limits or exclusions	$40
Total	**$900**

These examples are based on coverage for an individual plan.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051 or visit us at www.BCBSRI.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.BCBSRI.com or call 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051 to request a copy.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.BCBSRI.com or by calling 1-800-639-2227 or (401) 459-5000.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Out-of-Network providers **$200** for an individual plan **/ $600** for a family plan. Doesn't apply to services with a fixed dollar copay and prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For In Network providers **$6350** for an individual plan **/ $12700** for a family plan. For Out-of-Network providers **$6350** for an individual plan **/ $12700** for a family plan.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses in-network providers. See www.BCBSRI.com or call 1-800-639-2227 or (401) 459-5000 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.

Questions: Call 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051 or visit us at www.BCBSRI.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.BCBSRI.com or call 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051 to request a copy.

Do I need a referral to see a specialist?	No. You don't need referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	$10 copay plus 20% coinsurance after deductible per visit	————————none————————
	Specialist visit	$10 copay per visit	$10 copay plus 20% coinsurance after deductible per visit	————————none————————
	Other practitioner office visit	$10 copay per visit	$10 copay plus 20% coinsurance after deductible per visit	Chiropractic Services are limited to 12 visits per year; $15 copay for allergy and dermatology office visits
	Preventive care/screening/immunization	No Charge	$10 copay plus 20% coinsurance after deductible	Member liability for Out-of-Network is based on services received; For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance after deductible	Preauthorization is recommended for certain services

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance after deductible	Preauthorization is recommended
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BCBSRI.com.	Tier 1 generally low cost generic drugs	20% coinsurance per prescription (retail/mail-order)	Not covered	No Charge for certain preventive drugs
	Tier 2 generally high cost generic and preferred brand name drugs	20% coinsurance per prescription (retail/mail-order)	Not covered	Preauthorization is required for certain drugs
	Tier 3 non- preferred brand name drugs	20% coinsurance per prescription (retail/mail-order)	Not covered	Preauthorization is required for certain drugs
	Tier 4 specialty prescription drugs	20% coinsurance per prescription (specialty pharmacy only)	50% coinsurance	Infertility drugs: 20% coinsurance; Preauthorization is required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance after deductible	Preauthorization is recommended
	Physician/surgeon fees	No Charge	20% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room services	$75 copay per visit	$75 copay per visit	Copay waived if admitted
	Emergency medical transportation	$50 copay per trip	$50 copay per trip	——————none——————
	Urgent care	$10 copay per urgent care center visit	$10 copay plus 20% coinsurance after deductible per urgent care center visit	Applies to the visit only. If additional services are provided additional out of pockets costs would apply based on services received.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance after deductible	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fee	No Charge	20% coinsurance after deductible	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay/office visit No Charge for outpatient services	$10 copay plus 20% coinsurance after deductible/office visit 20% coinsurance after deductible for outpatient services	Preauthorization is recommended for certain services
	Mental/Behavioral health inpatient services	No Charge	20% coinsurance after deductible	Preauthorization is recommended
	Substance use disorder outpatient services	$10 copay/office visit No Charge for outpatient services	$10 copay plus 20% coinsurance after deductible/office visit 20% coinsurance after deductible for outpatient services	Preauthorization is recommended for certain services
	Substance use disorder inpatient services	No Charge	20% coinsurance after deductible	Preauthorization is recommended
If you are pregnant	Prenatal and postnatal care	No Charge	20% coinsurance after deductible	——————none——————
	Delivery and all inpatient services	No Charge	20% coinsurance after deductible	Preauthorization is recommended

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance after deductible	————————none————————
	Rehabilitation services	20% coinsurance	20% coinsurance after deductible	Includes Physical, Occupational and Speech Therapy. Speech Therapy preauthorization is recommended for all visits.
	Habilitative services	20% coinsurance	20% coinsurance after deductible	Includes Physical, Occupational and Speech Therapy. Speech Therapy preauthorization is recommended for all visits.
	Skilled nursing care	No Charge	20% coinsurance after deductible	Preauthorization is recommended; Custodial Care is not covered
	Durable medical equipment	20% coinsurance	20% coinsurance after deductible	Preauthorization is recommended for certain services.
	Hospice service	No Charge	20% coinsurance after deductible	Preauthorization is recommended
If your child needs dental or eye care	Eye exam	$10 copay	$10 copay plus 20% coinsurance after deductible	Limited to one routine eye exam per year.
	Glasses	Not Covered	Not Covered	————————none————————
	Dental check-up	Not Covered	Not Covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Glasses, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. Contact Customer Service for more information.
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051. You may also contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-639-2227.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-639-2227.
如果需要中文的帮助，请拨打这个号码 1-800-639-2227.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-639-2227.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,490
- **Patient pays** $50

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$20
Limits or exclusions	$30
Total	**$50**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,500
- **Patient pays** $900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$60
Coinsurance	$800
Limits or exclusions	$40
Total	**$900**

These examples are based on coverage for an individual plan.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051 or visit us at www.BCBSRI.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.BCBSRI.com or call 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051 to request a copy.

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, call 1-800-639-2227 or (401) 459-5000 or TDD 711 or visit us at www.BCBSRI.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-639-2227 or (401) 459-5000 or TDD 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-Network: **$200** individual, **$600** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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. Emergency room care, emergency medical transportation and some specialty drugs	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	In-Network: **$6,350** individual, **$12,700** family Out-of-Network: **$6,350** per individual, **$12,700** 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, 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.BCBSRI.com or by calling 1-800-639-2227or (401) 459-5000 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	None
	Specialist visit	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	Chiropractic Services are limited to 12 visit(s) per year
	Preventive care/screening/ immunization	No charge	$10 copay/office visit plus 20% coinsurance	Member liability for Out-of-Network is based on services received You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Preauthorization is recommended for certain services.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BCBSRI.com.	Tier 1/Generic drugs	20% coinsurance/prescription (retail & mail-order)	Not covered	No charge for certain preventive drugs; Preauthorization is required for certain drugs; Infertility drugs: 20% coinsurance; deductible does not apply.
	Tier 2/Preferred brand drugs	20% coinsurance/prescription (retail & mail-order)	Not covered	
	Tier 3/Non-preferred brand drugs	20% coinsurance/prescription (retail & mail-order)	Not covered	
	Tier 4/Specialty drugs	20% coinsurance/prescription (specialty pharmacy only)	50% coinsurance deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Preauthorization is recommended.
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit; deductible does not apply	Emergency room: Copay waived if admitted. Urgent Care: Visit only; additional services received are subject to additional out-of-pocket costs.
	Emergency medical transportation	$50 copay/trip	$50 copay/trip; deductible does not apply	
	Urgent care	$10 copay/urgent care center visit	$10 copay/urgent care center visit plus 20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit No charge /outpatient services	$10 copay/office visit plus 20% coinsurance 20% coinsurance /outpatient services	Preauthorization is recommended for certain services.
	Inpatient services	No charge	20% coinsurance	
If you are pregnant	Office visits	$10 copay/office visit	$10 copay/visit plus 20% coinsurance	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is recommended.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	None
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes Physical, Occupational and Speech Therapy. Physical and Occupational. Speech Therapy preauthorization is recommended for all visits. No charge for services to treat autism spectrum disorder and preauthorization is not required
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	No charge	20% coinsurance	Preauthorization is recommended. Custodial Care is not covered.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is recommended for certain services.
	Hospice services	No charge	20% coinsurance	Preauthorization is recommended.
If your child needs dental or eye care	Children's eye exam	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	Limited to one routine eye exam per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Glasses, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Chiropractic care • Hearing aids	• Infertility treatment • Most coverage provided outside the United States. Contact Customer Service for more information.	• Private-duty nursing • Routine eye care (Adult)

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 us and those agencies is: the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711, state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. or 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 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: contact the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 1-800-639-2227.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-639-2227.

如果需要中文的帮助，请拨打这个号码 1-800-639-2227.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-639-2227.

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, copayments 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	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$10
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$90**

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$1200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1360**

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$230**

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

DELTA DENTAL®

Benefit Highlights

TOWN OF SOUTH KINGSTOWN

Product Name: Delta Dental PPO/Delta Dental Premier
Plan Type: National Coverage

The information listed here is not a guarantee of payment. Payment is based on the Delta Dental allowance for each procedure. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office. These benefits are listed according to the level of coverage (i.e. 100%,80%) . Your group number is **5885-0605**. **Coverage for benefits with time limitations (i.e. 6,12,24,36 or 60 months) is calculated to the exact day.**

The annual maximum is:	$2,000.00 per member per calendar year (Periodontal services limited to $400.00)
The annual deductible is:	$0.00
The maximum lifetime cap:	Unlimited

Pretreatment estimates are recommended for underlined procedures.

Periodontal Maximum $400.00 (Your periodontal benefits are applied to your Annual Maximum total.)

Plan pays 100%; Member Coinsurance 0%

- Oral exam - once per calendar year performed by a general dentist
- Cleaning - twice per calendar year
- Fluoride treatment - for children under age 19 once per calendar year
- Bitewing x-rays - one set per calendar year
- Complete x-ray series or panoramic film once every 36 months
- Single x-rays as required
- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for an amalgam filling. Patient is responsible for the balance up to the dentist's charge.
- Space maintainers once every 60 months for lost deciduous (baby) teeth
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy on permanent teeth - one procedure per tooth per lifetime. Vital pulpotomy and apicoectomies also covered once per tooth per lifetime.
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months
- Crowns over natural teeth, build ups, posts and cores - replacement limited to once every 60 months

Plan pays 50%; Member Coinsurance 50%

- Periodontal maintenance following active therapy - two per year
- Root planing and scaling once per quadrant every 24 months.
- Osseous (bone) surgery once per quadrant every 36 months (bone grafts are not covered).
- Gingivectomies once per site every 36 months.
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per site every 60 months

Dependent coverage - Dependent children are covered up until the end of the year that they turn age 19.

DELTA DENTAL®

Exclusions & Limitations

Unless specifically covered by your dental plan, the following are not covered:

- Services that are not dentally necessary and appropriate according to our review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; orthodontics; and oral surgery. We will make a decision whether a service is dentally necessary based on these guidelines. A service may not be covered under these guidelines even if it was recommended by a dentist. Our guidelines can be found on our website at www.deltadentalri.com. You can have your dentist send us a request for a pre-treatment estimate in advance of the service to see if the service meets our guidelines.
- Services greater than the annual maximum.
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- An illness or injury that Delta Dental decides is employment-related.
- Services you would not have to pay for if you did not have this Delta Dental coverage.
- Services or supplies that are experimental in terms of generally accepted dental standards.
- Services done by a dentist who is a member of your immediate family.
- An illness, injury or dental condition for which benefits are, or would have been available, through a government program if you did not have this Delta Dental coverage.
- Services done by someone who is not a licensed dentist or a licensed hygienist working as authorized by applicable law.
- Exams by specialists, except for periodic oral exams.
- Consultations.
- Disorders related to the temporomandibular joints (TMJ), including night guards and surgery.
- Services to increase the height of teeth or restore occlusion.
- Restorations needed because of teeth grinding or due to erosion, abrasion or attrition.
- Services done mainly to change or to improve your appearance.
- Occlusal guards.
- Implants.
- Bone grafts.
- Splinting and other services to stabilize teeth.
- Laboratory or bacteriological tests or reports.
- Temporary, complete dentures or temporary, fixed bridges or crowns.
- Prescription drugs.
- Guided tissue regeneration.
- General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.
- General anesthesia or intravenous sedation given by anyone other than a dentist.

Delta Dental can adopt; and, apply, policies that we deem reasonable when we approve the eligibility of subscribers; and, the appropriateness of treatment plans and related charges.

All claims must be filed within one year of the date of service.