# 2011-2015 PS&T Unit Agreement
# Frequently Asked Questions

## Compensation:

**Q. What are the across the board increases in the agreement?**

A. FY 2011-12 – 0%
FY 2012-13 – 0%
FY 2013-14 – 0%
FY 2014-15 – 2%

**Q. Will I receive my performance advance/increment/step?**

A. Yes. Employees who are eligible to receive performance advances/increments/steps will continue to receive them during the 2011-2015 Agreement.

**Q. What happened to job rate parity? Will that continue?**

A. Yes. Job rate parity adjustments were fully incorporated into the salary schedules in 2010. Employees now reach the "parity" job rates with their last performance advance to job rate as a result of their normal progression through the performance advance system. This will continue without modification in the 2011-2015 Agreement.

**Q. What about my performance/longevity award?**

A. The performance award program also continues unchanged in the 2011-2015 Agreement. Thus, the rights of eligible employees to receive performance awards will be contractually protected through April 2015. If there is no successor agreement in April 2016, the performance awards of employees who received them in April 2015 will be protected under Triborough. The parties continue to "agree to disagree" about whether employees who are newly eligible to receive performance awards in April 2016 will do so.

**Q. Will my location pay continue?**

A. Yes. Location pay, inconvenience pay and hazardous duty pay all continue at the same rates and on the same terms and conditions as existed at the conclusion of the 2007-2011 Agreement. Standby pay and recall pay will also continue to be paid consistently with how they were paid under the 2007-2011 Agreement.

**Q. I see there is a change in how overtime is calculated? What is it?**

A. Currently, when overtime eligible employees work extra hours, all paid leave time is counted, along with actual hours worked, as "time worked" to calculate whether they

have exceeded 40 hours per week for overtime pay purposes. The 2011-2015 Agreement modifies how overtime pay is calculated to some extent. When ***voluntary*** overtime is worked in a work week, ***unscheduled*** absences charged to ***sick leave*** in the same week will not count as time worked in that week. However, if the sick leave absence is prescheduled ***or*** if the overtime is mandated, the entire sick leave absence will continue to count as time worked for overtime purposes. All other time charged to leave accruals, including Deficit Reduction Leave time, will also count as time worked for calculating overtime pay.

## Deficit Reduction Leave (furloughs):

**Q. How will the Deficit Reduction Leave (DRL) program work?**

A. The 2011-2015 Agreement provides for a reduction in pay on a bi-weekly basis that will result in a total withholding of 9 days of pay by the end of March 2013. All monies withheld from your pay during this period will be fully repaid to you beginning in March 2015 or upon separation from service, whichever occurs earlier. The DRL reduction for FY 2011-12 will result in roughly 4.2 days of withholding over the balance of FY 2011-12. The DRL reduction for FY 2012-13 will result in roughly 4.8 days of withholding in FY 2012-13. In exchange, full time employees will receive 9 days of deficit reduction leave which is available for charge at any point between November 4, 2011 and March 31, 2013.

**Q. How will the money for the deficit reduction leave be taken from my pay?**

A. For FY 2011-12, your total bi-weekly compensation (not including overtime) will be reduced by 4.198% for each of the last 10 pay periods of 2011-12. In FY 2012-13, your total bi-weekly compensation (not including overtime) will be reduced by 1.847% for all 26 pay periods. All reductions cease in April 2013.

**Q. Will the DRL reduction affect my overtime pay, standby pay or recall pay?**

A. No. Overtime, standby pay and recall pay are exempt from the deficit reduction calculation. Other components of total compensation in addition to base pay, such as location pay or geographic or shift differentials will be included in the DRL reduction calculation.

**Q. I understand that all 9 DRL days will be repaid to me. How will this occur?**

A. Employees who remain on payroll will be repaid the value of the 9 days divided equally over 39 pay periods during the 18 month period beginning in March 2015. Employees who separate from service prior to repayment will be repaid the value of all money owed to them at the time of separation from service. In all cases, the amount repaid to employees will be identical to what was originally withheld.

**Q. What happens if I leave State service before they have collected nine days' worth of compensation?**

A. If you leave State service before the end of FY 2012-13, the State will not collect for the "balance" of the 9 days of compensation at your separation. However, if you have charged more DRL time than has been collected in compensation at the time of your separation, the State will certainly "reconcile the account" in some manner at separation. This might occur by substitution of other unused accruals for overcharged DRL time, or it might involve recouping the value of the overcharged DRL time from your final paycheck. Our suggestion would be to only charge DRL time equivalent to the amount of money that you anticipate will be withheld by the time of separation, if possible.

**Q. Will the DRL days affect my retirement service credit?**

A. No. The DRL days will not affect your service credit.

**Q. Will the DRL days affect my final average salary (FAS) for retirement?**

A. No. The DRL days will have no impact one way or the other on retirement benefits (or on final average salary in particular). All 9 DRL days will be treated as paid work days for pension purposes. The salary reduction is a temporary one because all 9 days will be repaid. In essence, the days off are treated as paid leave for retirement purposes because, ultimately, there is no reduction in compensation.

**Q. Do I have to take DRL days in full days or may I charge partial day absences to DRL time?**

A. DRL time will be credited to you in hours and may be charged in ¼ hour increments.

**Q. How will the Deficit Reduction Leave (DRL) days be scheduled? Will my agency designate days that we must take off?**

A. Your agency cannot dictate when you take your DRL days. You will have the ability to schedule your DRL days at your option, subject to supervisory approval, much like requests for vacation are scheduled now. The major difference is that the DRL days are guaranteed days off. You must be allowed to use all 9 DRL days on or before March 31, 2013. If you are a ten-month teacher, you will be allowed to carry and charge your DRL credit at any time through the end of the 2012-2013 academic year.

**Q. What if multiple employees submit conflicting requests which cannot all be granted simultaneously, what happens?**

A. Conflicting requests must be resolved by seniority.

**Q. My facility is short staffed. What happens if my management won't let me take the time off before March 31, 2013?**

A. In the event that an agency does not allow employees who have requested the time off reasonable opportunity to take it on or before March 31, 2013, we will file a contract grievance alleging a violation of the new Article 21. However, if it becomes clear before then that employees in a particular agency/facility are routinely being denied the time off, contact your PEF Field Representative. S/he will intervene with agency/facility management or, if necessary, will contact the PEF Contract Administration Department who will intervene with GOER to attempt to resolve the situation before grievances become necessary.

**Q. I am near the annual leave cap. If I take DRL days, I'm afraid I'll just lose annual leave on April 1. What can I do?**

A. The 2011-2015 Agreement contains a temporary relaxation of the annual leave accrual cap. Usually, annual leave accrual balances are capped at a maximum of 40 days each April 1. However, on April 1, 2012 only, PS&T Unit employees will be permitted to carry up to a maximum of 45 days of annual leave. This cap will return to 40 days on April 1, 2013. You may also want to consider enrolling in the Productivity Enhancement Program (see below) and cash in vacation time that you are saving as you charge DRL time to reduce your bi-weekly health insurance premium expenses.

**Q. My position is supported by federal funds. Am I still subject to the DRL reduction?**

A. All employees, regardless of how their positions are funded, will be subject to the deficit reduction leave provisions. The contract language in the new Article 21 reflects this and contains no exemptions from the requirement that all employees will have their total compensation reduced by the value of the DRL days.

**Q. I work part-time. How will the DRL reduction be applied to me?**

A. Both the amount of the DRL reduction and the amount of the DRL time credited will be pro-rated for employees who work less than full-time.

**Q. I am on Voluntary Reduction in Work Schedule (VRWS). How will the DRL reduction be applied to me?**

A. You will be credited with a prorated amount of DRL based on your VRWS percentage. VRWS credits earned in each pay period will not be affected by the DRL reduction.

**Q. I am a per diem employee who works intermittently on an "as needed" or "substitute" basis. How does the DRL reduction apply to me?**

A. The State has announced that the deficit reduction program will apply to intermittent per diem employees. As a result, compensation earned by per diem employees will be reduced by the DRL percentage and per diem employees will be credited with a proportionate amount of DRL time. We have asked the State for additional information about how they intend to implement this for per diems who work intermittently and will update this answer when we have additional information.

**Q. I work "extra service". Does the DRL reduction affect my extra service?**

A. The State has announced that the deficit reduction program will apply to extra service. As a result, compensation earned by employees from extra service work will be reduced by the DRL percentage and employees will be credited with a proportionate amount of additional DRL time (in addition to the 9 days of DRL time already credited to them in their full time position). All DRL monies (including any additional withholding from extra service) will be paid back. PEF is in the process of reviewing the Department of Civil Service's DRL implementation memo, which announced the State's position on extra service, and evaluating a number of issues (including the State's position on applying the Deficit Reduction Program to extra service) for a possible state-wide class action grievance.

**Q. Will the DRL days impact my health insurance eligibility or how I earn leave accruals?**

A. No. The DRL program will have no impact on either your health insurance or how you earn leave accruals.

**Q. Will the DRL days affect voluntary benefits provided through the Membership Benefits Program such as: Life Insurance, Short-term disability insurance, Long-term disability insurance?**

A. No. There will be no impact on these or other payroll deducted programs.

**Q. When the DRL reduction starts will my union dues also decrease?**

A. Yes. Your union dues are a percentage of income. If your income decreases your union dues will also decrease proportionately.

## Health Insurance Premiums:

**Q. Does the 2011-2015 Agreement still contain a premium shift?**

A. Yes. The shift in the employee's share of total premium is 10% to 16% for individual coverage and from 25% to 31% for dependent coverage for employees SG 10

and above.   For employees SG 9 and below the shift is from 10% to 12% for individual coverage and from 25% to 27% for dependent coverage

**Q.  When is the premium shift effective?**

A.  It is effective retroactive to October 1, 2011.

**Q.  I am in a position at or above SG 10 and my spouse is in a position at or below SG 9.  Is there anything I can do to avoid the higher premium shift?**

A.   You may want to switch from NYSHIP family coverage in your name to NYSHIP family coverage in your spouse's name to take advantage of your spouse's lower employee premium share.

According to the NYS Department of Civil Service, a PEF-represented employee will be allowed to voluntarily cancel his or her NYSHIP family coverage during the current Special Option Transfer Period and, at the same time, his or her spouse may enroll in NYSHIP family coverage with an effective date of December 1, 2011.  It's important that each employee let their respective agency Health Benefits Administrator (HBA) know why the change is being requested so that the two HBAs can coordinate the enrollment transactions to ensure there is no break in coverage.

**Q.  What are the new October 1, 2011 rates?**

A.  The October 1, 2012 biweekly rates for the Empire Plan for employees SG 10 and above are $42.79 for individual coverage and $153.00 for family coverage.  The biweekly rates for employees SG 9 and below are $32.09 for individual coverage and $128.08 for family coverage.

By now, all members enrolled in the New York State Health Insurance Program (NYSHIP) should have received the November 2011 *NYSHIP Rate Changes* flyer, which the NYS Department of Civil Service released on November 7, 2011.  This flyer includes the new rates for The Empire Plan and each of the NYSHIP participating HMOs. Members can also access this flyer on the Civil Service web site www.cs.ny.gov.  From the home page, select "Benefit Programs" and then follow the instructions to access "NYSHIP Online."  Click on "Health Benefits & Option Transfer" and scroll down to "2011 Special Option Transfer Period."

**Q.  When will the State begin deducting the new October 1, 2011 rate from my paycheck?**

A. The higher deductions due to the premium shift will start with the paycheck dated 11/23/11 for the Administration Lag payroll, and the paycheck dated 12/1/11 for the Institution Lag payroll.

**Q. How will the State recover the retroactive premium owed for October and November?**

A. The State intends to collect the amount owed in retroactive premium from the six (6) biweekly paychecks beginning with the paycheck dated 12/29/11 for the Institutional Lag payroll and the paycheck dated 1/4/12 for the Administration Lag payroll. The amount of the adjustment will be based on the health plan option in which the employee is enrolled at the time the retroactive premium is collected (which may not be the same health plan option in which the employee was enrolled during the months of October and November). Once the six (6) biweekly adjustments are taken, the employee's biweekly premium deduction will decrease to the 2012 premium rate.

**Q. What impact will this have on the amount of my biweekly premium?**

A. Since the retroactive premium owed will be added to the 2012 premium rates, the deductions from the six biweekly paychecks beginning with the paycheck dated 12/29/11 for the Institutional Lag payroll and the paycheck dated 1/4/12 for the Administration Lag payroll will be higher than the deductions for the remainder of the 2012 plan year. The State has advised us that the *NYSHIP Rates & Deadlines for 2012* flyer for PEF-represented employees will indicate both the 2012 rates with the retroactive premium added for the first six (6) biweekly paychecks and also the 2012 rates without the retroactive premium for the remainder of the year.

**Q. What will the health insurance premium rates be in January, 2012?**

A. The State has not yet finalized the 2012 premium rates so we can't provide this information at this time.

**Q. I am in a HMO. Does the premium shift apply to me?**

A. The change in premium share applies to all NYSHIP enrollees regardless of their health plan option. The 2011-2015 Agreement changes the percentage of the total premium cost paid by enrollees from 10% for individual coverage to either 12% (grade 9 and below) or 16% (grade 10 and above) and for dependent coverage from 25% to 27% (grade 9 and below) or 31% (grade 10 and above). The State's contribution to HMO premiums will remain subject to the Empire Plan premium cap.

## Productivity Enhancement Program (PEP):

**Q. Is there any way to reduce my health insurance premium expenses?**

A. Yes. Eligible PS&T Unit employees, can enroll in the Productivity Enhancement Program (PEP). Through PEP, eligible employees may offset health insurance premium expenses by exchanging previously accrued vacation and/or personal leave for a credit to be applied toward the employee share of premium. Under the 2011-2015 Agreement,

eligibility for PEP is expanded to employees in positions SG-24 and below, or equated to SG-24 and below.

For calendar year 2012, employees SG 24 and below will be allowed to exchange either 3 days of vacation or personal leave for a $500 credit or 6 days for a $1,000 credit to reduce their bi-weekly premium contributions. Eligible 10-month employees may exchange from one to six days of personal leave for a credit of $166.66 per day. Eligible part-time employees can participate on a pro-rata basis consistent with their regular work schedule percentage.

For 2013, the benefit for SG 18-24 employees will be improving to better reflect the cash value of a day for these employees. While the PEP program runs on a calendar year basis, this benefit improvement will phase in mid-year. Due to the mid-calendar year implementation of the change, the benefit will be prorated for 2013: at the 3 or 6 day level prior to April 1 and at a new 2 day for $500 or 4 day for $1,000 level after April 1. In sum, during 2013 only, SG 18-24 employees will receive $500 in exchange for 2¼ days or $1,000 for 4½ days. The benefit for employees SG 17 and below will continue at the 3 day and 6 day level.

For 2014 and 2015, the benefit for employees SG 17 and below the annual benefit will be 3 days or 6 days for a credit of $500 or $1,000. The 2014 and 2015 annual benefit for employees SG 18-24 will be 2 days or 4 days for a credit of $500 or $1,000.

**Q. How is the $500 or $1,000 credit paid to me?**

The credit will be applied beginning in the paycheck closest to January 1st and is divided equally among the biweekly pay periods during the year and applied as an offset against your health insurance contribution in each pay period.

**Q. When will I be able to enroll in PEP?**

A. The enrollment period for 2012 is currently ongoing and will conclude on Monday, December 5, 2011. For Calendar Years 2013, 2014 and 2015 the enrollment period for PEP will be in the October prior to each calendar year.

## Health Insurance Opt-Out:

**Q. What is the Opt-out program? Who qualifies?**

A. The Opt-out is a new enrollment option for employees who are eligible for coverage under the New York State Health Insurance Program (NYSHIP). This option allows employees to receive an annual incentive payment for choosing not to enroll in NYSHIP of $1,000 annually for waiving individual coverage or $3,000 annually for waiving family coverage. The eligibility requirements for enrolling in the opt-out option are:

- Unless newly eligible for coverage, you must be enrolled in NYSHIP by April 1st of the previous plan year and remain enrolled through the end of that year. For

example, to be eligible for plan year 2012, you must have been enrolled in NYSHIP by 4/1/11 and remain enrolled through the end of plan year 2011.
- If you were not previously eligible for NYSHIP coverage (e.g. you are a new hire or you are working a qualifying schedule for the first time) you must elect to opt out within 56 days of becoming eligible for NYSHIP coverage.
- You must demonstrate and attest to having other health insurance coverage.

If you enroll in the opt-out option you continue to be eligible for dental and vision coverage, and may still enroll in the Health Care Spending Account.

**Q. When can I exercise my Opt-out option?**

A. You will be able to enroll in the opt-out option each year during the annual option transfer period. The Annual Option Transfer Period for 2012 will open after 2012 rates are approved. If you opt-out your NYSHIP coverage will end and the opt-out payments will begin with the paycheck closest to January 1st (the start of the new plan year). If you first become eligible for NYSHIP coverage during the plan year, you may elect to opt-out within 56 days of becoming eligible.

**Q. If I have opted-out, can I opt back in?**

A. All employees who have enrolled in the opt-out option may re-enroll in NYSHIP during the next annual option transfer period. At any other time during the year, only employees who experience a "qualifying event" may withdraw from the opt-out and reenroll in NYSHIP health coverage. Examples of qualifying events include a change in family status (e.g. marriage, birth, death, legal separation or divorce) or a change in your spouse's employment status which results in either acquiring or losing eligibility for health insurance coverage.

**Q. Is the Opt-out payment made every year? Is it a lump sum or included in my paycheck?**

A. You will receive $1,000 recurring annually for waiving individual coverage or $3,000 recurring annually for waiving family coverage. The incentive payments will be divided by 26 pay periods, paid biweekly, and will be taxable income. It will not be added to base salary nor is it pensionable.

**Q. I am not currently enrolled in the State health insurance program since I'm covered through my spouse's private plan. Would I still be entitled to opt-out?**

A. You only qualify for the opt-out payment if you are enrolled in NYSHIP continuously from the prior April 1. If you are not currently enrolled, you cannot opt-out. Keep in mind, however, that you can enroll in NYSHIP at any time (subject to the waiting period for late enrollees). If you do decide to enroll in NYSHIP during the term of the contract, and then subsequently decide to opt-out during the next option transfer period, you can qualify for the payment when you opt out of NYSHIP. The contract language makes clear that eligibility in each year of the Agreement requires enrollment in NYSHIP from

April 1 of the prior year only. Once you are opted out, the payment is available annually for as long as you remain opted out. And if you were to lose coverage through your spouse, you could immediately opt back in even before the option transfer period.

**Q. My spouse and I are both state employees. Only one carries family coverage, is the other eligible for the family coverage opt-out?**

A. For many years, all of the NYS labor agreements, including PEF's have prohibited a "dual" State employee couple from having two family enrollments. Given this limitation, the opt-out program will not cover switching family enrollment from one "dual" spouse to the other. That being said, there is no prohibition against "dual" spouses carrying one family enrollment and one individual enrollment. Given this, a spouse who is enrolled in individual coverage should be permitted to opt-out of the individual coverage in favor of coverage under his/her spouse's family plan. In this circumstance we believe that spouse should be eligible to receive the $1,000 individual opt-out for each year s/he remains opted out.

**Q. What is PEF's position regarding the eligibility of a PEF-represented state employee to enroll in the individual coverage opt out if s/he is married to another state employee enrolled in NYSHIP family coverage?**

A: Article 9.2(j) of the 2011-2015 PS&T Contract identifies two requirements for a PEF-represented state employee to be eligible to enroll in the Opt-out Program: 1) the employee must be enrolled in NYSHIP prior to April 1st of the previous plan year; and 2) the employee must be able to demonstrate and attest to having *other coverage* (emphasis added). During bargaining, PEF did not agree to any restrictions or limitations on what is meant by *other coverage*. Therefore, it is PEF's position that a PEF-represented state employee who is covered as a spouse under another state employee's NYSHIP plan satisfies the requirement of having *other coverage.*

**Q: How does this differ from the Department of Civil Service's position regarding the eligibility of a PEF-represented state employee to enroll in the Opt-out Program if s/he is married to another state employee enrolled in NYSHIP family coverage?**

A: Based on the information that appears in the November 2011 *Planning for Option Transfer* flyer, the Department of Civil Service's interpretation of *other coverage* is different from PEF's interpretation. The Department of Civil Service is asserting that the PEF-represented employee's *other coverage* cannot be NYSHIP coverage provided through employment with the State of New York. This interpretation effectively prohibits a PEF-represented state employee married to another state employee, both of whom may be enrolled in NYSHIP, from meeting the eligibility requirements for the Opt-out Program.

**Q: How does PEF intend to resolve this dispute?**

A: If we cannot resolve this dispute informally, PEF's Contract Administration Department will be filing a class-action contract grievance to challenge the State's interpretation of Article 9.2(j).

**Q: What is the likelihood that this dispute will be resolved before the deadline for enrolling in the Opt-out Program for 2012?**

A: The State has given us no reason to believe that this dispute will be resolved quickly. It's our expectation that, in order to resolve this dispute, we will have to pursue this grievance to arbitration before a neutral arbitrator. That process is time consuming. It is extremely unlikely that we will have a resolution of this dispute before the Opt-out Program enrollment deadline.

**Q. If I have opted-out, will I still be eligible for retiree health insurance when I retire?**

A. Yes. To be eligible for retiree health insurance coverage you must satisfy three eligibility criteria: (1) at least 10 years of service as an employee eligible to enroll in NYSHIP; (2) be eligible for retirement in a NYS administered retirement plan; and (3) be enrolled in NYSHIP at the time you separate from service. Employees who have exercised their opt-out option will be deemed to be "enrolled" in NYSHIP for the purposes of satisfying the third criteria.

**Q. Will the number of sick leave days I can use for my sick leave credit change under the 2011-2015 Agreement?**

A. No. You will still be able to use up to 200 days of sick leave to fund the sick leave credit for retiree health insurance.

**Q. Does the service requirement to establish eligibility for retiree health insurance change under the 2011-2015 Agreement?**

A. No. The service requirement remains at 10 years of benefits-eligible service. There is no change from the service requirement contained in the prior 2007-2011 PS&T Unit Agreement.

**Q. When will the new sick leave credit life expectancy tables be effective?**

The effective date for implementation of the new tables is December 1, 2011. Employees retiring on or after that date will have their sick leave credit calculated using the new tables.

**Q. How will the new life expectancy actuarial tables affect the value of my sick leave credit?**

A. When you enroll in retiree health insurance, your accrued sick leave is converted to a monthly credit which offsets your retiree health insurance premium. This monthly credit is determined by dividing the total dollar value of your sick leave accruals by the number of months of remaining life expectancy as reflected in the actuarial life expectancy tables. The result is a lifetime monthly sick leave credit that is used to offset your retiree health insurance premium for as long as you remain enrolled in NYSHIP. Since the new tables reflect longer anticipated life expectancies than the current tables, they reduce the available monthly credit when used in the sick leave credit calculation. Generally, use of the new tables will reduce the value of the monthly credit by roughly 20%. However, for many of our members, particularly those who carry individual retiree coverage, their monthly credit exceeds their monthly premium cost. As long as this remains the case, their monthly share of premium will be completely offset by the value of their sick leave credit. A memorandum with additional information about how the sick leave credit is calculated and the impact of the change in the life expectancy table is posted on the PEF website in the Contract Resource Center.

**Q. I am planning on selecting the 70% dual annuitant option on my sick leave credit to assure continuing retiree coverage for my spouse. Thus, I am particularly concerned about the impact the life expectancy table change will have on my already reduced sick leave credit. Is there anything I can do?**

A. First, you do not have to select the 70% dual annuitant option to assure that your spouse has continuing health insurance coverage after your death. That benefit is available to you regardless of whether you choose to spread the value of your sick leave credit from 100% over your life time to 70% over both your and your spouse's life times. Second, while you are alive you will be carrying family coverage for both yourself and your spouse. If you predecease your spouse, unless you have other dependents, your spouse will switch to individual coverage, thereby reducing his/her health insurance premium contribution. Given this, you might wish to consider choosing the 100% sick leave credit option while you are alive, to maximize the value of your sick leave credit while you have more expensive family coverage, knowing that your spouse will switch to less expensive individual coverage after your death and thus have less need for the sick leave credit at that time.

**Q. I am leaving State service on or before November 30, 2011, but I am deferring my enrollment in retiree health insurance until a later date. Will my sick leave credit be calculated under the old life expectancy table or the new life expectancy table?**

A. Your sick leave credit will be calculated using the old life expectancy table. The change in the life expectancy table is effective December 1, 2011 ***for employees who leave service on or after December 1***. As long as you retiree before December 1, 2011

your sick leave credit will be calculated using the old actuarial tables, even if you defer enrollment in retiree health insurance to a later date.

## Other Health Insurance Provisions:

**Q. What are the co-payments for: office visits, outpatient procedures and/or emergency room visits?**

A. There will be no increase in any Empire Plan medical, hospital outpatient, ambulatory surgery or emergency room (ER) copays during the term of the 2011-2015 Agreement. The current office visit/lab/radiology copay of $20 will remain at $20 under the 2011-2015 Agreement. This is the first time that PEF has avoided an office visit copay increase when other bargaining units have accepted one.

**Q. The Empire Plan is now a "non-grandfathered" plan under the federal health care reform law and will have to cover "preventive services" provided by a participating provider with no copay. Does this mean that our copays are now zero?**

A. For certain preventive services, yes, the Empire Plan may no longer require a copay. Effective October 1, 2011, the Empire Plan became a "non-grandfathered" plan under the federal Patient Protection and Affordable Care Act (PPACA). As a result, certain office visits, tests, and immunizations considered to be "preventive care" under PPACA will now be exempt from copayment. These include (but are not limited to):

- Adult immunizations such as: Influenza, Pneumococcal conjugate (Pneumonia), Measles, Mumps, Rubella (MMR), Varicella (chicken pox), Tetanus (Td/Tdap), Human Papilloma Virus (HPV), Meningococcal Meningitis and Herpes Zoster (shingles - adults age 60 and above) vaccines.

- Immunizations for children such as: Influenza, Measles, Mumps, Rubella (MMR), Varicella, Tetanus (Td/Tdap), Haemophilus influenza (Hib), Pneumococcal conjugate (Pneumonia)Polio, Rotavirus and Human Papilloma Virus (HPV) vaccines.

- Preventive screening services such as: screening for colorectal cancer, elevated cholesterol and lipids; screening for certain sexually transmitted diseases and HIV; screening and counseling in a primary care setting for alcohol abuse, tobacco use, obesity, and diet and nutrition; screening for depression, high blood pressure and Type 2 diabetes in adults with high blood pressure.

- Preventive screening services for women such as: contraception and contraceptive counseling; breast feeding support supplies and counseling; genetic counseling and evaluation for genetic testing for BRCA breast cancer gene; screening mammography beginning at age 40; screening for cervical cancer including Pap smears; screening for gonorrhea, Chlamydia, syphilis; osteoporosis screening (age 60 or older) and pre-natal screenings.

Additional information regarding PPACA preventive care services may be found at: www.helathcare.gov.

**Q. What will my prescription drug co-pays be?**

A. No change in **Retail** copays for "Level One" (typically generic) drugs:
- 30 day supply - $5
- 31-90 day supply - $10

Effective 10/1/2011 - **Retail** copays increased as follows:
- Level Two (preferred brand)
  - 30 day supply - $25
  - 31 to 90 days - $50
- Level Three (non-preferred brand)
  - 30 day supply - $45
  - 31 to 90 days - $90

No change in **Mail Service** copays for "Level One" (typically generic) drugs:
- 30 day supply - $5
- 31 to 90 days - $5

Effective 10/1/2011 **Mail Service** copays increased as follows:
- Level Two (preferred brand)
  - 30 day supply - $25
  - 31 to 90 days - $50
- Level Three (non-preferred brand)
  - 30 day supply - $45
  - 31 to 90 days - $90

**Q. What is the Guaranteed Access Program?**

A. Effective January 1, 2012, the Empire Plan will implement a Guaranteed Access Program for participating primary care providers and "core" specialists. Under this program, Empire Plan enrollees will be guaranteed access to participating primary care physicians (PCPs) and "core" provider specialists within geographic proximity to their homes. Assuming implementation of United Health Care access standards currently used for other plans in New York State, you will be guaranteed access to one participating primary care provider within: 8 miles in urban areas; 15 miles in suburban areas; and 25 miles in rural areas. You will also be guaranteed access to one participating "core" specialist within: 15 miles in urban areas; 25 miles in suburban areas; and 50 miles in rural areas. Once in place, if there is not a participating primary care provider, or a physician in one of the designated specialties, within the specified distance from your home, you can see any provider and have the service treated as a "par-provider" visit subject only to the par provider co-pay.

This program will be implemented simultaneously with the increases to the annual deductible and coinsurance maximum for non-network providers. The general idea is that we want to be sure that enrollees who use non-par providers are doing so out of choice, not because of a lack of options in their area.

**Q. What are "First Launch" generics and why won't they be automatically placed on Level 1 of the formulary?**

A. When a brand name drug first loses patent protection, the first manufacturer to bring a generic equivalent to market is granted a six month period of exclusivity to be the sole manufacturer of the generic drug. During that time, it is very common that the exclusive generic is initially priced just below the cost of the brand name drug. In response, the manufacturer of the brand name drug may re-price the brand name drug so it is actually cheaper than the generic during this exclusivity period. Once multiple manufacturers are allowed to produce the generic drug and competition increases, the price of all the generics will likely drop. The change we negotiated will permit exclusion or placement of these more expensive "first launch" generics on Level 3 and the brand name drug on Level 1 during this period of exclusivity if it is cost effective for the Plan. Enrollees will be notified of the placement of drugs on these different levels as well as when they are changed when more generic alternatives are available.

**Q. What is the "New to You" program?**

A. Under the "New to You" program, enrollees who are prescribed a new medication will have to fill two 30 day supply scripts (subject to the applicable copay) before they can fill a script for a 90 day supply of the same medication. This limitation will not apply to changes in the dosage level of a medication which you are already prescribed. This new requirement is designed to reduce the wasted medication, and related cost, that occur when a doctor prescribes a 90 day supply, only to discover that the medication doesn't work or has adverse side effects which prevent you from continuing to take it.

**Q. Do the changes in drug copays apply to the HMO's?**

A. No. PEF only negotiates the level of benefits for the Empire Plan. The level of HMO benefits, including copays, are set each year by the HMOs themselves. For that reason we encourage all HMO enrollees to review their plan options carefully each year during the option transfer period as the level of benefits can and does change dramatically.

**Q. I see that the State is issuing a RFP to "self insure" the prescription drug program and is evaluating the possibility of expanding self insurance to other components of the Empire Plan. Why is this characterized as a "gain" for the membership?**

A. Currently, all of the health benefits provided under the Empire Plan are provided by the plan purchasing insurance. Just as you might do for your own assets, the Plan purchases insurance to insulate the Plan from catastrophic or extraordinary claims. For this, they pay the insurance companies a "risk" charge along with administrative fees. As you might know, the Empire Plan is an extraordinarily large plan with well over a million covered lives. That size alone helps stabilize the claims experience from year to year to the point that paying an insurance company for "risk" may be unwise financially. The Department of Civil Service estimated in 2009 that the plan would save nearly $200

million per year by providing the same benefits on a self-insured basis where they pay someone to administer the plan but avoid the risk charge by assuming the risk themselves. In the end, this is an administrative function and should not have any material impact on benefits. However, if the State moves to self-insurance, it should help to constrain future premium increases.