Memorandum of Understanding
between
the State of New York
and
the District Council 82

1. **Term:** April 1, 2023, to March 31, 2026.

2. Remove/replace all gender specific references.

3. **Bill of Rights**

   (K) Any employee who is subject to questioning by **the Employer** ~~his/her Department's Inspector General's Office~~[1] shall, whenever the nature of the investigation permits, be notified at least 24 hours prior to the interview. **Such notification shall include facts sufficient to reasonably inform the employee of the particular nature of the investigation.**

   (L) Any employee who was notified that there was an investigation pending against **them** ~~him or her~~ by **the Employer** ~~their Department's Inspector General's Office~~ shall be notified by the Employer of the closure of the investigation within two weeks of the closure of such investigation related to such employee.

   (O) While the routine questioning of an employee by the employer to obtain factual information about an occurrence, incident or situation does not entitle an employee to union representation, if during such questioning the employer determines that the employee is entitled to union representation as provided in paragraph (G), the questioning of the employee will stop and the employee will be given the opportunity to obtain representation as outlined in the Bill of Rights unless the employee declines representation on the record or in writing.

4. **Article 5 – Union Rights**
   a. Increase bank of leave from 122 to 130.
   b. Amend Article 5.5 as follows:

   5.5 ~~Agency Shop~~ **Duty of Fair Representation**
   ~~Mandatory agency shop fee deductions shall be continued for the period required by law.~~
   The State recognizes that the Union's duty of fair representation to an employee it represents, but who is not a member of the Union, is set forth in Civil Service Law Section 209-a(2).

5. **Article 7 – Grievance and Arbitration**
   a. Amend second paragraph of article 7.2 to read as follows:

[1] Throughout this MOU, bold/underlined text is new text being added and stricken text is old text being removed.

Prior to initiating a formal written grievance pursuant to this Article, the employee, the Union **and the appropriate immediate supervisor, local administration, or agency or department are strongly** encouraged to **meet in good faith and** resolve disputes subject to this Article informally -**prior to the expiration of 30-day period in which to file a grievance. The parties may accomplish this by exchanging relevant documentation and positions as soon as practicable after the grievance trigger date, as specified in Step 1, below.**

b. Increase filing period for grievances upon ratification from 20 to 30 days. This shall be effective for all grievances that accrue on or after the date of ratification.
c. Meetings at step 1 shall be remote at the request of either party.

6. **Article 8 – Discipline**
   a. Add suspension review procedure as Article 8.10 of Article 8.

7. **Article 9 – Out-of-Title Work**
   a. Agree to amend Article 9 per attached *Attachment A.*

8. **Article 10 – Review of Personal History Folder**
   a. Amend Article 10 as follows:

10.3 An employee may, at any time, request and be provided copies of all documents and notations in his official personal history folder of which ~~he~~ **the employee** has not previously been given copies. If such file is maintained at a location other than the region or facility in which the employee works, it shall be forwarded to the employee's region or facility for requested review by the employee. **Where feasible, review of personal history folders shall be through electronic transmission of such file.**

10.5 ~~Upon an employee's written request, a counseling memorandum over three years old shall be removed from the official personal history folder, provided that the employee has received no additional counseling memoranda or notice of discipline during that period. Any reference to such counseling memorandum appropriately removed shall not be contained in the official personal history folder.~~ **Upon an employee's written request, material over three (3) years old shall be removed from the personal history folder, except performance evaluations, personnel transactions, pre-employment materials and notices of discipline and all related records. Any material may be removed from the employee's personal history folder upon mutual agreement of the employee and the official designated by the agency.**

10.9 The parties agree to meet and confer, as appropriate, over any planned move from paper to electronic personal history folders.

9. **Article 11 – Compensation**
   a. Article 11.2 – Across the Board Increases to Salary Schedule
      i. Members of the bargaining unit shall receive a 3% each year of the contract.
   b. Article 11.13 (new) - Retention Bonus

i. One-time $3000 bonus to all members of the bargaining unit on payroll for the period of date of this MOU to September 4, 2024. Members of the bargaining unit on payroll full time during that period shall receive the full $3000. Members of the bargaining unit on the payroll on a part-time, hourly, or per diem basis shall receive a prorated portion of the bonus. This bonus is not pensionable. Employees retiring directly from State service during this period shall be eligible to receive the payment.

c. Article 11.6 – Longevity Payment
   i. Starting on December 1, 2025, members of the bargaining unit who have completed 11 years of service as of November 1 shall receive an annual longevity payment of $750 every year until separation from service. This new compensation is pensionable and overtime eligible and will be a lump sum payment.

d. Article 11.7 – Location Compensation
   i. Arb Eligible Mid-Hudson (currently $1359)
      1. April 1, 2023: increase to $1400.
      2. April 1, 2024: increase to $1442.
      3. April 1, 2025: increase to $1846.
   ii. Arb Eligible Downstate (currently $3649) (Consolidate NYC, R, W, N,S)
      1. April 1, 2023: increase to $3758.
      2. April 1, 2024: increase to $3871.
      3. April 1, 2025: increase to $4623.
   iii. Arb Ineligible Mid-Hudson (currently $975)
      1. April 1, 2023: increase to $1004.
      2. April 1, 2024: increase to $1111.
      3. April 1, 2025: increase to $1650.
   iv. Arb Ineligible Downstate (currently $1827)
      1. April 1, 2023: increase to $1882.
      2. April 1, 2024: increase to $2195.
      3. April 1, 2025: increase to $3400.

e. Article 11.7 – Inconvenience Pay
   i. Effective April 1, 2025, increase by 3%.
   ii. Update Article 11.7 (b)(2)(i) for Interest Arbitration eligible employees to define the night shift as "any shift that begins at or between 7:00 pm or at 2:59 am." Times exclude pre-shift.
   iii. Update Article 11.7 (b)(2(ii) for Interest Arbitration eligible employees to define the evening shift as "any shift that begins at or between 11:00 am or 6:59 pm." Times exclude pre-shift.

f. Article 11.10 – Command Pay (currently $2874).
   i. April 1, 2024: increase to $3174.
   ii. April 1, 2025: increase to $3674.

g. Article 11.11 Hazardous Duty Pay – effective upon ratification remove one-year requirement for receipt of this benefit.
   i. Arbitration Ineligible (currently $200)
      1. April 1, 2024: increase to $575.
      2. April 1, 2025: increase to $1075.

ii. Arbitration Eligible (currently $1500)
  1. April 1, 2024: increase to $1875.
  2. April 1, 2025: increase to $2375.

10. **Article 12**

a. Health insurance agreed changes per *Attachment B* effective 1/1/25.
b. Site of Care side letter for drug infusion programs per *Attachment C*
c. Access Protections Appendix per *Attachment D*
d. Across the board percentage increases will be applied to Joint Committees on Health and Dental Benefits.
e. Productivity Enhancement Program (PEP) side letter per *Attachment E.*

11. **Article 13**

a. Increase funding amounts in 13.1, 13.5 and 13.6 by across-the-board percentage increases annually.
b. Side Letter per *Attachment F* for transferring funds ear-marked from one fund to another.

12. **Article 14**

a. Amend 14.1 (e) Vacation credits may be accumulated up to a maximum of 40 days provided, however, that in the event of death, retirement, or separation from service, employees shall be compensated in cash for accrued and unused vacation credits only up to a maximum of 30 days. **Effective upon ratification, an employee's vacation credit accumulation may exceed the maximum, provided, however, that the employee's balance of vacation credits may not exceed 40 days** ~~An employee at the vacation accrual maximum (40 days) or who will exceed the accrual maximum at the next accrual period whose written request for the use of vacation credits is denied, in writing, may accumulate more than 40 days of such credits during a year, provided, however, that the employee's balance of vacation credits does not exceed 40 days~~ on ~~October~~ April 1 of each year.
b. Agree to Paid Parental Leave in new paragraph Article 14.13 implementing Side Letter *Attachment G*.
c. Agree to Side Letter *Attachment H* regarding Employer information hub to easily apprise employees of various family and parental leave options.

13. **Article 15**

a. New Article 15.1 (i):

An employee who is on duty for 16 consecutive hours and then is mandated to immediately work time beyond that 16 hours shall receive double time for all hours worked in excess of those 16 hours. In calculating eligibility, only time on duty shall be counted. Time charged to leave accruals or on other full paid leave status shall not count toward determining the 16 hours of actual work.

An employee who is on duty for 16 consecutive hours and is then mandated to work an additional shift beyond 16 hours which abuts their next regularly scheduled shift, shall be instructed to go home for their regularly scheduled shift, unless emergency circumstances prevent them from being instructed to go home, and shall be paid for this shift without charge to leave accruals.

b. New Article 15.1 (j)

Nothing in paragraphs 15.1(a), 15.1(b), 15.1(c) and 15.1(i) above shall prevent the establishment of mutually agreed to local arrangements regarding the method by which overtime is offered to employees.

Article 16

a. Agree to amend Article 16.5 to add Juneteenth as a paid holiday.

14. **Article 17**

a. Article 17.1 shall be replaced by the following:

The State agrees to reimburse employees who are eligible for travel expenses, on a per diem basis, for their expenses incurred while in travel status in the performance of their official duties pursuant to the rules, bulletins, guidelines and regulations of the Comptroller.

b. Agree to Side Letter *Attachment I* regarding labor-management committee meetings to discuss the current system for work-related passaged under Article 17.3 (Triborough Bridge Tolls).

15. **Article 18**

a. Agree to add new paragraph Article 18.4 – **Direct Deposit**
All employees hired into a bargaining unit position after the date of ratification shall receive their paychecks through direct deposit.

16. **Article 22**

a. Amend Article 22.5 and add Article 22.6 as follows:
    i. Article 22.5 At an institution or facility where appropriate medical staff and facilities are normally available, when a medical emergency resulting from an injury or sudden illness occurs to an employee while on the premises, the injured or ill employee should be given emergency first aid by any qualified staff member who is on duty and reasonably available for medical duties. The employee will be assisted in arranging transportation as necessary to a general hospital, clinic, doctor or other location for more complete treatment as appropriate.
    ii. Article 22.6 Grievances alleging failure to comply with this Article shall be processed pursuant to Article 7, paragraph 7.1(b).

17. **Article 25**

a. Increase funding amounts in 25.6, 25.9 and 25.10 by across-the-board percentage increases annually.
b. One time $5000 deposit into EBF and eliminate Article 21.8.

18. **Article 29 Printing of Agreement**

Amend as follows: Each party shall be responsible for the costs of reproducing its own copies of this Agreement. Distribution to the State and to employees will occur as soon as practicable following the execution of this Agreement.

19. The parties agree, after ratification, to commence discussions and finalize a system replacing certified, registered and/or regular mail with electronic mailing of grievances, decisions, appeals and other communications under Article 7, Article 9 and where possible Article 8.

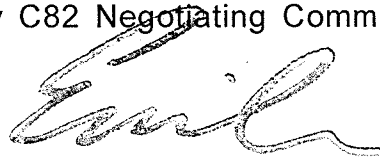
20. **Unchanged Provisions**

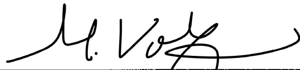
    Except as otherwise provided herein, all existing contractual provisions, side letters and MOUs remain in effect.

21. **Reopener** – see side letter on reopener attached as Attachment J.

22. **Ratification**.

    This agreement shall be subject to approval by C82 Negotiating Committee and ratification by the bargaining unit.





State of New York

Council 82

Dated: May 9, 2024

Dated: 5/9/2024

ATTACHMENT A – ARTICLE 9 – OUT-OF-TITLE WORK

9.1(a) No employee shall be employed under any title not appropriate to the duties to be performed and, except upon assignment by proper authority during the continuance of a temporary emergency situation, no person shall be assigned to perform the duties of any position unless ~~he has~~ **they have** been duly appointed, promoted, transferred or reinstated to such position in accordance with the provisions of the Civil Service Law, Rules and Regulations.

(b) The term "temporary emergency" as used in this Article shall mean an unscheduled or non-periodic situation or circumstance which is expected to be of limited duration and either (a) presents a clear and imminent danger to person or property, or (b) is likely to interfere with the conduct of the agency's or institution's statutory mandates or programs.

9.2 ~~(a) Grievances alleging violation of this Article shall be processed pursuant to Article 7, paragraph 7.1(b), and shall be filed utilizing an out-of-title grievance form.~~

~~(b) If appealed to Step 3, the Director of the Governor's Office of Employee Relations shall seek an opinion from the Director of Classification and Compensation concerning whether or not the assigned duties which are the subject of the grievance are substantially different from those appropriate to the title to which the employee is certified. The Union shall be given the opportunity to present to the Director of Classification and Compensation, a written brief of the facts surrounding the grievance. The Director of Classification and Compensation shall, within 60 calendar days of the filing of the appeal, forward his opinion to the Director of the Governor's Office ofEmployee Relations, and the Union, for implementation.~~

~~(c) If it is the opinion of the Director of Classification and Compensation that the assigned duties which are the subject of the grievance are substantially different from those appropriate to the title to which the employee is certified, the Director of the Governor's Office of Employee Relations, or his designee, shall direct the appointing authority forthwith to discontinue such assigned duties.~~

~~(1) If such substantially different duties are found to be appropriate to a lower salary grade or to the same salary grade as that held by the affected employee, no monetary award may be issued.~~

~~(2) If, however, such substantially different duties are found to be appropriate to a higher salary grade than that held by the affected employee, the Director of the Governor's Office of Employee Relations shall issue an award of monetary relief. The amount of monetary relief shall be the difference between what the affected employee was earning at the time he performed such duties and what he would have earned at that time in the entry level of the higher salary grade title, but in no event shall such monetary award be retroactive to a date earlier than 15 calendar days prior to the date the grievance was filed in accordance with this Agreement.~~

(a) A grievance alleging violation of this Article shall be filed directly with the agency head or designee by the employee or C82 in writing on forms provided by the State with a copy of that grievance being simultaneously filed with the facility or institution head or designee. The filing of the grievance, appeals and decisions at this Step shall be made by personal service or by registered or certified mail. An opinion shall be issued by the agency as soon as possible, but no later than 20 calendar days following receipt of the grievance. The distribution of that opinion shall include the grievant and C82 [insert appropriate title].

(b) (1) If not satisfactorily resolved at the agency level, an appeal may be filed by C82 with the Director of the Office of Employee Relations within ten

calendar days of receipt of the agency opinion. Such appeal shall include a copy of the original grievance and the agency opinion. After receipt of such appeal, the Director of the Office of Employee Relations shall seek an opinion from the Director of Classification and Compensation. Such appeal shall be processed in accordance with the provisions of Article 9.2(c), (d) and (e).

(2) If the grievance is sustained by the agency and a monetary award is recommended, a request for affirmation of the agency decision shall be filed by the agency with the Director of Classification and Compensation within fifteen calendar days of issuance of the agency opinion. Copies of the request for affirmation shall be sent to the Director of the Office of Employee Relations and C82, such requests shall be processed in the manner of an appeal in accordance with the provisions of Article 9.2(c), (d) and (e). The request for affirmation shall include a copy of the original grievance and agency opinion. No monetary award may be granted without an affirmative recommendation by the Director of the Classification and Compensation.

(c) After receipt of an appeal, the Director of Classification and Compensation shall review and formulate an opinion concerning whether or not the assigned duties are substantially different from those appropriate to the title to which the employee is certified. The Director of Classification and Compensation shall within sixty (60) calendar days of receipt of the appeal, forward their opinion to the Director of the Office of Employee Relations for implementation.

(d) If such opinion is in the affirmative, the Director of the Office of Employee Relations or the Director's designee shall direct the appointing authority forthwith to discontinue such assignment.

(1) If such substantially different duties are found to be appropriate to a lower salary grade or to the same salary grade as that held by the affected employees, no monetary award may be issued.

(2) If, however, such substantially different duties are found to be appropriate to a higher salary grade than that held by the affected employee, the Director of the Office of Employee Relations shall issue an award of monetary relief, provided that the affected employee has performed work in the out-of-title assignment for a period of one or more days. And, in such event, the amount of such monetary relief shall be the difference between what the affected employee was earning at the time he or she performed such work and what he or she would have earned at that time in the higher salary grade title, but in no event shall such monetary award be retroactive to a date earlier than fifteen (15) calendar days prior to the date of filing the grievance with the agency head or designee, or date filed with the facility or unit head or designee, whichever is later.

(3) In the event a monetary award is issued, the State shall make every effort to pay the affected employee within three (3) bi-weekly payroll periods, after the issuance of such award.

(e) Notwithstanding the provisions of subdivisions (d), if such substantially different duties were assigned by proper authority during the continuance of a temporary emergency situation, the Director of the Office of Employee Relations or the Director's designee shall dismiss the grievance.

9.3 Where C82 alleges that there exists a dispute of fact, C82 may, within thirty (30) calendar days of the date of the decision, file an appeal with the Director of the Office of Employee Relations. Such appeal shall include documentation to support the factual allegations. The appeal shall then be forwarded by the Director of the Office of Employee Relations to the Director of Classification and Compensation for reconsideration. The Director of Classification and Compensation shall reconsider the matter and shall, within thirty (30) calendar days, forward an opinion to the Director of the Office of Employee Relations. The latter shall act upon such opinion in accordance with the provisions of Article 9.2(d) and (e) above.

9.4 Grievances hereunder may be processed only in accordance with this Article and shall not be arbitrable.

Attachment B - Health, Dental and Prescription Drug Insurance

12.1 The State shall continue to provide all the forms and extent of coverage as defined by the contracts and Interest Arbitration Awards in force on March 31, ~~2016~~ **2023** with the State health and dental insurance carriers unless specifically modified or replaced pursuant to this Agreement.

Eligibility

12.2(a)(1) A permanent full-time employee who loses employment as a result of the abolition of a position shall continue to be covered under the State Health Insurance Plan for one year following such layoff or until re-employment by the State or employment by another employer, in a benefits eligible position, whichever occurs first. The premium contribution required of preferred list eligibles for such continuation shall be the same as the premium contribution required of an active employee.

12.2(a)(2) Covered dependents of employees who are activated for military duty as a result of an action declared by the President of the United States or Congress shall continue health insurance coverage with no employee contribution for a period not to exceed 12 months from the date of activation, less any period the employee remains in full pay status. Contribution free health insurance coverage will end at such time as the employee's active duty is terminated, 12 months have expired, or the employee returns to State employment whichever occurs first.

12.2(a)(3) ~~Pursuant to the 2010 Federal Patient Protection and Affordable Care Act,~~ Dependents up to age 26 shall be eligible for health insurance including prescription drug benefits. **Effective January 1, 2024, dependents up to age 26 are also eligible for Dental and Vision Program coverage.**

12.2(a)(4) Domestic Partners who meet the definition of a partner and can provide acceptable proofs of financial interdependence, as outlined in the Affidavit of Domestic Partnership and Affidavit of Financial Interdependency shall continue to be eligible for health, dental and vision coverage.

12.2(a)(5) A permanent full-time employee who is removed from the payroll due to an assault as described in Article 14.9 and is granted Workers' Compensation for up to 24 months shall remain covered under the State Health Insurance Plan for the same duration and will be responsible for the employee share of premium.

Benefits Management Program

12.3(a)(1) Pre-certification will be required for all elective inpatient confinements and prior to certain specified medical procedures to provide an opportunity for a review of diagnostic procedures for appropriateness of setting and effectiveness of treatment alternatives.

12.3 (a)(2) Pre-certification will be required prior to maternity admissions in order to highlight appropriate prenatal services and reduce costly and traumatic birthing complications. **Effective January 1, 2020, the requirement for pre-certification of maternity admissions for the birth of a child was eliminated.**

12.3 (a)(3) A call to the Benefits Management Program will be required within 48 hours of admission for all emergency or urgent admissions to permit early identification of potential "case management" situations.

12.3 (a)(4) Precertification will be required prior to an admission to a Skilled Nursing Facility (SNF). ~~Effective as soon as practicable~~, Admission to a skilled nursing facility shall be covered up to 120 days of medically necessary care. Each day in a skilled nursing facility counts as one-half benefit day of care.

12.3 (a)(5) The hospital deductible amount imposed for non-compliance with pre-certification requirements will be $200. This deductible will be fully waived in instances where the medical record indicates that the patient was unable to make the call. In instances of non-compliance, a retroactive review of the necessity of services received shall be performed.

12.3 (a)(6) Any day deemed inappropriate for an inpatient setting and/or not medically necessary after exhausting the internal and external appeal processes will be excluded from coverage under the Empire Plan.

12.3 (a)(7) The Prospective Procedure Review Program (PPR) will screen for the medical necessity of certain listed diagnostic procedures which, based on Empire Plan experience, have been identified as potentially unnecessary or over-utilized.

12.3 (a)(8) The Empire Plan Benefits Management Program Prospective Procedure Review requirement will include Magnetic Resonance Imaging (MRI). The list of procedures will undergo annual evaluation by the Medical Carrier.

A managed approach to radiological procedures will include:

- The Medical Component Insurer will improve the effectiveness of the benefit by re-enforcing credentialing requirements and "best practices" with Radiologists and other providers involved in providing radiological services to Empire Plan enrollees.
- The current Prospective Procedure Review notification requirement for MRIs will expand to include CAT and PET scans, nuclear medicine and MRAs performed at the outpatient department of a hospital, a participating provider office or a free-standing facility.
- Enrollees will be required to call the Benefits Management Program for Pre-certification when a listed procedure is recommended. Enrollees will be requested to call two weeks before the date of the procedure.
- Current co-insurance levels will apply for failure to comply with the requirements of the Prospective Procedure Review Program.

12.4 Hospital Services

12.4(a)(1) The copayment for emergency room services is $100. ~~Outpatient services covered by the hospital contract are subject to a $40 copayment per outpatient visit.~~ Outpatient services covered by the hospital contract will be subject to a $50 copayment per

outpatient visit. The copayment for hospital outpatient physical therapy visits is $25.

Services rendered at an Urgent Care Center covered under the Hospital Program require $50 copayment. Hospital outpatient surgery will be subject to a $95 copayment.

The Emergency room and hospital outpatient copayment will be waived for persons admitted to the hospital as an inpatient directly from the outpatient setting, and for the following covered chronic care outpatient services: chemotherapy, radiation therapy, and hemodialysis.

12.4(a)(2) Coverage for services provided in the outpatient department of a hospital includes services provided in a remote location of the hospital (hospital owned and operated extension clinics). Emergency care provided in such remote location of the hospital is subject to the $100 emergency room copayment. Outpatient services provided in such remote location of the hospital are subject to the $50 outpatient hospital copayment. The outpatient surgery copayment is $95. These copayments will be waived for persons admitted to the hospital as an inpatient directly from the outpatient setting. **Effective February 1, 2023 hospital extension clinic facility fees shall be waived; applicable hospital outpatient service copayment(s) remain in effect.**

12.4(a)(3) The copayment for all pre-admission testing/pre-surgical testing prior to an inpatient admission will be waived.

12.4(a)(4) The Hospital component (inpatient and outpatient services) of the Empire Plan is as follows:

- The Hospital carrier will establish a network of hospitals (acute care general hospitals, skilled nursing facilities and hospices) throughout the United States.
- Any hospital that does not enter into a participating agreement with the hospital carrier will be considered to be a non-network facility.
- Covered inpatient services received at a network hospital will be paid-in-full. Covered outpatient services (outpatient lab, x-ray, etc. and emergency room) received at a network hospital will be subject to the appropriate copayment.
- Covered inpatient services received at a non-network hospital will be reimbursed at 90 percent of charges. Covered enrollee expenses for non-network inpatient hospital services will be included in the combined annual coinsurance maximum set forth in Article 12.5(f) of the Agreement.
- Covered outpatient services received at a non-network hospital will be reimbursed at 90 percent of charges or a $75 copayment whichever is greater. Covered enrollee expenses for non-network outpatient hospital services will be included in the combined annual coinsurance maximum set forth in Article 12.5(f) of the Agreement.
- Services received at a non-network hospital will be reimbursed at the network level of benefits under the following situations:
  - i. Emergency outpatient/inpatient treatment
  - ii. Inpatient/outpatient treatment only offered by a non-network hospital
  - iii. Inpatient/outpatient treatment in geographic areas where access to a network hospital exceeds 30 miles or does not exist
  - iv. Care received outside of the US
- Anesthesiology, pathology and radiology services received at a network hospital will be paid-in-full less any appropriate copayment even if the provider is not participating in the Empire Plan participating provider network under the medical component.

12.4(a)(5) Effective January 1, 2025, The Empire Plan will implement a Site of Care (SOC) Redirection Program for drug infusions for Empire Plan-primary

members only. Drugs used to treat cancer and hemophilia are excluded from this program. The Program shall be administered pursuant to the Site of Care Redirection Program for Infusions Sideletter.

The Joint Committee on Health Benefits will meet regularly to discuss and oversee the implementation and administration of the program, including how access to care and medical concerns will be addressed.

Upon implementation, the medical or prescription drug copayments associated with drugs on the Site of Care Drug List will be waived when the enrollee uses a non-hospital infusion site of care.

Medical Services

12.5 The Empire Plan shall include medical/surgical coverage through use of participating providers who will accept the Plan's schedule of allowances as payment in full for covered services. Except as noted below, benefits will be paid directly to the provider at 100 percent of the Plan's schedule not subject to deductible or coinsurance.

12.5(a)(1) Office visit charges by participating providers will be subject to a $25 copayment per covered individual. Covered surgical procedures rendered by participating providers during an office visit are subject to a $25 copayment.

12.5 (a)(2) All covered radiology services rendered by participating providers are subject to an $25 copayment per covered individual. All covered outpatient laboratory services rendered by participating providers are subject to a $25 copayment per covered individual. All covered services provided at a participating ambulatory surgical center are subject to a $50 copayment by the enrollee. All anesthesiology, radiology and laboratory tests performed on-site on the day of surgery shall be included in this single copayment.

The office visit, office surgery, outpatient radiology and laboratory copayment amounts may be applied against the combined annual coinsurance maximum, however, they will not be considered covered expenses for basic medical payment.

12.5 (a)(3) The Empire Plan medical carrier ~~will implement~~ **has implemented** a Guaranteed Access Program for primary care physicians and core provider specialties. Under the Guaranteed Access Program, if there are no participating providers available within the access standards, enrollees will receive paid-in-full benefits (less any appropriate copayment).

12.5(b) The State shall require the ~~insurance carriers~~ **Program Administrators** to continue to actively seek new participating providers in regions that are deficient in the number of participating providers, as determined by the Joint Committee on Health and Dental Benefits.

12.5(c) The Empire Plan participating provider schedule of allowances ~~and the basic medical reasonable and customary levels~~ will be no less than the levels in effect on March 31, ~~2016~~ **2023**.

12.5(d) Covered charges for medically appropriate local professional ambulance transportation will be a covered major medical expense subject only to a $70 copayment. Volunteer ambulance transportation will continue to be reimbursed for donations at the current rate of $50 for under 50 miles and $75 for 50 miles or over. These amounts are not subject to deductible or coinsurance.

12.5(e) The combined annual deductible shall be $1,250 per enrollee, $1,250 per enrolled spouse/**domestic partner**, and $1,250 per all dependent children combined. Covered expenses for basic medical services, mental health and/or substance abuse treatments and home care advocacy services will be included in determining the combined annual deductible.

Covered expenses for physical medicine services are excluded in determining the combined annual deductible.

12.5(f) The basic medical component shall pay 80 percent reimbursement of reasonable and customary charges for covered expenses in a calendar year until the combined annual coinsurance maximum is reached, then 100 percent of reasonable and customary covered expenses as described below. **Effective January 1, 2024, enrollees can assign the payment of benefits directly to the provider.**

Effective January 1, 2025, when non-participating providers are used, benefits will be paid at the rate of 80 percent reimbursement of 275 percent of the Medicare Physician Fee Schedule in effect on the date of service. Benefits will continue to be subject to deductible, coinsurance, and calendar year maximums.

The annual combined coinsurance maximum is $3,750 per enrollee, $3,750 for the enrolled spouse/domestic partner, and $3,750 for all dependent children combined.

Covered expenses for home care advocacy services and physical medicine services are excluded in determining the maximum annual coinsurance limit.

12.5 (g) Covered preventive care services, as defined in the 2010 Federal Patient Protection and Affordable Care Act, shall be paid-in-full (not subject to copayment) when received from a participating provider.

12.5 (h) Licensed and certified nurse practitioners and convenience care clinics will be available as participating providers in the Empire Plan subject to the applicable participating provider copayment.

12.5(i) Network Out-of-Pocket Limit. The amount paid for network services/supplies is capped at the out-of-pocket limit. Network expenses include copayments made to providers, facilities and pharmacies. Once the out-of-pocket limit is reached, network benefits are paid in full.

12.5(j) Effective January 1, 2025, the maximum out-of-pocket limit for covered, in-network services under the Empire Plan will be $4,000 for individual coverage and $8,000 for family coverage, split between the hospital, medical/surgical, mental health and substance use and prescription drug programs.

12.5(k) Effective January 1, 2026, and annually thereafter, the Network Out-of-Pocket Limit will increase by the percentage of the salary increase from the prior calendar year.

12.5(l) Acupuncture: The Empire Plan will continue to offer medically necessary acupuncture services through the participating provider network. Effective January 1, 2025, coverage for acupuncture services performed by an out-of-network provider will be limited to twenty (20) visits per calendar year per individual. This shall not apply to acupuncture visits performed by an in-network provider.

12.5(m) Massage Therapy: Effective January 1, 2025, therapeutic massage services including effleurage, petrissage, and/or tapotement (stroking, compression, percussion) will be subject to an annual visit limit of 20 visits per enrollee per calendar year. Other manual therapies, provided in conjunction with other physical medicine services covered based on medical necessity, are not subject to this calendar year maximum.

12.6 Council 82 Empire Plan Enhancements

In addition to the basic Empire Plan benefits, the Empire Plan for Council 82 enrollees shall include:

(a) The State agrees to continue to provide alternative Health Maintenance Organization (HMO) coverage.

(b) The annual and lifetime maximum for each covered person under the basic medical component shall be unlimited.

(c) Routine pediatric care including all preventive pediatric immunizations, both oral and injectable, shall be considered a covered medical expense under the participating provider component and the basic medical component. Influenza **and COVID-19** vaccine**s** will be on the list of pediatric immunizations, subject to appropriate protocols, under the participating provider and basic medical components of the Empire Plan.

(d) The newborn care allowance under the basic medical component shall not be subject to deductible or coinsurance.

(e) The Pre-Tax Contribution Program will continue unless modified or exempted by the Federal Tax Code.

(f) An employee retiring from State service may delay commencement or suspend his/her retiree health coverage and the use of the employee's sick leave conversion credits, provided that the employee applies for the delay or suspension, and furnishes proof of continued coverage under the health care plan of the employee's spouse, or from post-retirement employment. The surviving spouse of a retiree who dies while under a delay or suspension may transfer back to the State Health Insurance Plan on the first of any month coinciding with or following the retiree's death.

For Interest Arbitration eligible employees only, the actuarial table used to calculate the employees sick leave credit toward health insurance in retirement shall be the life expectancy tables for corrections officers. For non-Interest Arbitration eligible employees, the actuarial table used to calculate the employee's sick leave credit toward health insurance in retirement shall be the table in effect at the time of retirement.

(g) Office visit charges by participating providers for well childcare will be excluded from the office visit copayment.

(h) Charges by participating providers for professional services for allergen immunotherapy in the prescribing physician's office or institution and chronic care services for chemotherapy, radiation therapy, or hemodialysis will be excluded from the office visit copayment.

(i) In the event that there is both an office visit charge and office surgery charge by a participating provider in any single visit, the covered individual will be subject to a single copayment.

(j) Outpatient radiology services and laboratory services rendered during a single visit by the same participating provider will be subject to a single copayment.

(k) Effective January 1, 2024, the following covered services rendered by a participating provider in a single visit will be subject to a single $25 copayment per covered individual: office visit, office surgery, radiology or diagnostic/laboratory service.

~~(k)~~ **(l)** Dual Annuitant Sick Leave Credit

An employee who is eligible to continue health insurance coverage upon retirement and who is entitled to a sick leave credit to be used to defray any employee contribution toward the cost of the premium, may elect an alternative method of applying the basic monthly value of the sick leave credit.

Employees selecting the basic sick leave credit may elect to apply up to 100 percent of the calculated basic monthly value of the credit toward defraying the required contribution to the monthly premium during their own lifetime. If employees who elect that method predecease their eligible covered dependents, the dependents may, if eligible, continue to be covered, but must pay the applicable dependent survivor share of the premium.

Employees selecting the alternative method may elect to apply only up to 70 percent of the calculated basic monthly value of the credit toward the monthly premium during their own lifetime. Upon the death of the employee, however, any eligible surviving dependents may also apply up to 70 percent of the basic monthly value of the sick leave credit toward the dependent survivor share of the monthly premium for the duration of the dependents' eligibility. The State has the right to make prospective changes to the percentage of credit to be available under this alternative method for future retirees as required to maintain the cost neutrality of this feature of the plan.

The selection of the method of sick leave credit application must be made at the time of retirement, and is irrevocable. In the absence of a selection by the employee, the basic method shall be applied.

(l) The Home Care Advocacy Program (HCAP) will continue to provide services in the home for medically necessary private duty nursing, home infusion therapy and durable medical equipment, **and diabetic supplies** under the participating provider component of the Empire Plan.

Durable Medical Equipment

- Benefits are available for the most cost-effective equipment as meets the patient's functional need.
- Benefits are provided for a single unit of equipment and repair or replacement as necessary.

The Home Care Advocacy Program (HCAP) non-network benefit for individuals who fail to have medically necessary designated HCAP services and supplies pre-certified by calling HCAP and/or individuals who use a non-network provider will be subject to the following provisions:

- Where nursing services are rendered, the first 48 hours of nursing care will not be a covered expense;
- Services (including nursing services), equipment and supplies will be subject to the **combined** annual ~~basic medical~~ deductible and reimbursed at 50 percent of the HCAP network allowances; the **combined annual** ~~basic medical out-of-pocket~~ **coinsurance** maximum will not apply to HCAP designated services, equipment and supplies.

Diabetic shoes: an annual diabetic shoe benefit will be available through the Home Care Advocacy Program under the medical carrier. Network Coverage: Benefits paid at 100% with no out-of-pocket cost up to a $500 annual maximum. Non-network Coverage: For diabetic shoes obtained other than through the Home Care Advocacy Program, reimbursement will be made under the basic medical component of the Empire Plan, subject to deductible and the remainder paid at 75% of the network allowance up to a maximum annual allowance of $500.

(m) All professional component charges associated with ancillary services billed by the outpatient department of a hospital for emergency care for an accident or for sudden onset of an illness (medical emergency) will be a covered expense under the participating provider or the basic medical component of the Empire Plan not subject to deductible or coinsurance, when such services are not otherwise included in the hospital facility charge covered by the hospital carrier.

(n) Employees and their covered spouses 40 years of age and older shall be allowed reimbursement of up to 100% of the ~~reasonable and customary charge~~ **allowed amount** annually towards the cost of a routine physical examination **by a non-participating provider**. These benefits shall not be subject to a deductible or coinsurance.

(o) Services for examinations and/or purchase of hearing aids shall be a covered basic medical benefit not subject to deductible or coinsurance. The hearing aid reimbursement is $1,500, per hearing aid, per ear, once every four years, not subject to deductible or coinsurance. For children 12 and under the same benefits can be available after 24 months, when it is demonstrated that a covered child's hearing has changed significantly and the existing hearing aid(s) can no longer compensate for the child's hearing impairment. Coincident with the implementation of the hearing aid allowance, if a significant change in hearing occurs and the existing hearing aid(s) can no longer compensate for the hearing impairment, eligible enrollees over the age of 12 may be eligible to receive the benefit prior to 4 years.

(p) The Empire Plan participating provider and basic medical coverage for the treatment of infertility will be modified as follows:

- Access to designated “Centers of Excellence” including a travel benefit;
- Treatment of ~~“couples” as long as both partners are covered either as enrollee or dependent~~ **covered enrollees and covered dependents** under the Empire Plan;

- The lifetime coverage limit per individual is $50,000.

Effective January 1, 2020, Empire Plan fertility benefits will cover enrollees for a minimum of three IVF cycles per lifetime which will not be subject to the $50,000 Lifetime Maximum. Covered services include: patient education and counseling, diagnostic testing, ovulation induction/hormonal therapy, surgery to enhance reproductive capability, artificial insemination and Assisted Reproductive Technology procedures. Effective January 1, 2020, standard fertility preservation services are covered when a medical treatment, such as treatment for cancer (radiation therapy or chemotherapy), will directly or indirectly lead to infertility. No prior authorization will be required. Exclusions include: experimental infertility procedures, costs for and relating to surrogacy (however, maternity services are covered for you when acting as a surrogate), donor services/compensation charged in facilitating a pregnancy.

~~- Prior authorization required for certain procedures.~~

(q) The medical component of the Empire Plan shall include a voluntary nurse-line feature to provide both clinical and benefit information through a toll-free phone number.

(r) (1) Mastectomy Brassieres prescribed by a physician, including replacements when it is functionally necessary to do so, shall be a covered benefit under the basic medical component of the Empire Plan. **Effective January 1, 2024, mastectomy brassieres shall be a covered-in-full benefit, not subject to deductible or coinsurance.**

(2) External mastectomy prostheses is a covered in full benefit, not subject to deductible or coinsurance. Coverage is provided by the medical carrier as follows:

- Benefits are available for one single/double mastectomy prosthesis in a calendar year.
- Pre-certification through the Home Care Advocacy Program is required for any single external prosthesis costing $1,000 or more. If a less expensive prosthesis can meet the individual's functional needs, benefits will be available for the most cost-effective alternative.

(s) The cost of certain injectable adult immunizations shall be a covered expense, subject to copayments, under the participating provider portion of the Empire Plan. No copayment shall be required ~~(Herpes Zoster for patients under age 60 will be subject to copayment)~~. The list of immunizations shall include Influenza, Pneumococcal **(**Pneumonia**)**, Measles, Mumps, Rubella, Varicella, Herpes Zoster **(Shingles)**, Human Papilloma Virus (HPV), Meningoccocal **(**Meningitis**)**, **Diphtheria, Pertussis (Rd/Tdap), Hepatitis A, Hepatitis B, COVID-19** and Tetanus. ~~and shall be subject to protocols developed by the medical program insurer~~. **Adult vaccines shall be administered consistent with guidance provided by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices or other federal entity.**

(t) A Medical Flexible Spending Account (MFSA) shall be available to eligible employees. Eligible expenses under the Medical Flexible Spending Account include over-the-counter medications according to guidelines developed by the Medical Flexible Spending Account Administrator.

(u) The Empire Plan hospital program will include a voluntary "Centers of Excellence" program for organ and tissue transplants. The Centers will be required to provide pre-transplant evaluation, hospital and physician service (inpatient and outpatient), transplant procedures, follow-up care for transplant related services and any other services as identified during implementation as part of an all-inclusive global rate. A travel allowance for transportation and lodging will be included as part of the Centers of Excellence program.

(v) The Empire Plan Centers of Excellence Programs includes Cancer Resource Services. The Cancer Resource Program will provide:

- Direct telephonic nurse consultations;
- Information and assistance in locating appropriate care centers;
- Connection with cancer experts at Cancer Resource Services network facilities;
- There is no lifetime maximum for travel and lodging expenses; and
- Paid-in-full reimbursement for all services provided at a Cancer Resource Services network facility when the care is pre-certified.

(w) The Empire Plan medical carrier will make available a network of prosthetic and orthotic providers established by the Empire Plan medical carrier. Prostheses or orthotics obtained through an approved prosthetic/orthotic network provider will be paid in full under the participating provider component of the Empire Plan, not subject to copayment. For prostheses or orthotics obtained other than through an approved prosthetic/orthotic network provider, reimbursement will be made under the basic medical component of the Empire Plan, subject to deductible and coinsurance.

If more than one prosthetic or orthotic device can meet the individual's functional needs, benefits will be available for the most cost-effective piece of equipment. Benefits are provided for a single-unit prosthetic or orthotic device except when appropriate repair and/or replacement of devices are needed.

(x) A Basic Medical Provider Discount Program is available through the basic medical component of the Empire Plan.

- Empire Plan enrollees will have access to an expanded network of providers through an additional provider network;
- Basic Medical provisions will apply to the providers in the expanded network option (deductible and 20 percent coinsurance);
- Payment will be made by the Plan directly to the discount providers, no balance billing of discounted rate will be permitted;
- This program is offered as a pilot program and will terminate on December 31, ~~2020,~~ **2023,** unless extended by agreement of both parties;

(y) The Empire Plan medical component shall include a voluntary disease management program.

~~(z) An annual diabetic shoe benefit will be available through the Home Care Advocacy Program under the medical carrier. Network Coverage: Benefits paid at 100% with no out-of-pocket cost up to a $500 annual maximum. Non-network Coverage: For diabetic shoes obtained other than through the Home Care Advocacy Program, reimbursement will be made under the basic medical component of the Empire Plan, subject to deductible and the remainder paid at 75% of the network allowance up to a $ maximum annual allowance of $500.~~

(z) Prosthetic wigs shall be a covered basic medical benefit and shall be reimbursed up to a lifetime maximum of $1500 not subject to deductible or coinsurance.

(aa) The Empire Plan medical carrier shall contract with Diabetes Education Centers accredited by the American Diabetes Education Recognition Program.

(bb) The State and the Council 82 Joint Committee on Health Benefits will explore the possible implementation of additional Disease Management and/or Wellness activities to support enrollees with chronic illnesses and employees seeking to improve their general health and well-being.

(cc) A disease management program for chronic kidney disease will be implemented under the Empire Plan Medical Component.

(dd) The travel allowance for the Centers of Excellence Programs shall be modified to reimburse meals and lodging at the Federal Government rate.

(ee) Effective January 1, 2023, the Telemedicine Program for medical and mental health visits will be a permanent offering to Empire Plan members at no cost-share.

12.7 Prescription Drug Services

12.7(a) The Prescription Drug Program will cover medically necessary drugs requiring a physician's prescription and dispensed by a licensed pharmacist. Coverage will be provided under the Empire Plan Prescription Drug Program for prescription vitamins and contraceptives.

12.7(a)(1) The Prescription Drug Program will continue to utilize a preferred provider community pharmacy network.

12.7(b) Mandatory generic substitution will be required for all brand-name multi-source prescription drugs (a brand-name drug with a generic equivalent) covered by the Prescription Drug Program.

On a case-by-case basis, when a physician provides sufficient medical justification of the need for a brand-name drug where a generic equivalent is available, the Program administrator will review the physician's request and rule on the appropriateness of a waiver of the mandatory generic substitution.

12.7(b)(1) A third level of prescription drugs and prescription copayments was created to differentiate between preferred brand-name and non-preferred brand-name drugs. ~~The~~

~~copayment for prescription drugs purchased at a retail pharmacy or the mail service pharmacy for up to a 30-day supply is as follows:~~

- ~~$5 Generic~~
- ~~$15 Preferred-Brand~~
- ~~$40 Non-Preferred Brand~~

When a brand-name prescription drug is dispensed and an FDA-approved generic equivalent is available, the member will be responsible for the difference in cost between the generic drug and the non-preferred brand-name drug (ancillary charge), plus the non-preferred brand-name copayment; not to exceed the cost of the drug.

~~The copayment for prescription drugs purchased at a retail or mail service pharmacy for up to a 30-day supply shall be as follows:~~

- ~~$5 Generic~~
- ~~$25 Preferred-Brand~~
- ~~$45 Non-Preferred Brand~~

12.7(b)(2) The copayment for prescription drugs purchased at a retail, specialty, or mail service pharmacy for up to a 30-day supply shall be as follows:

- $5 Generic
- $30 Preferred-Brand
- $60 Non-Preferred Brand

~~The copayment for prescription drugs purchased at a retail pharmacy for a 31-90 day supply is as follows:~~

- ~~$10 Generic~~
- ~~$50 Preferred Brand~~
- ~~$90 Non-Preferred Brand~~

12.7(b)(3) The copayment for prescription drugs purchased at a retail pharmacy for a 31-90 day supply is as follows:

- $10 Generic
- $60 Preferred Brand
- $120 Non-Preferred Brand

12.7(b)(~~3~~ **4**) The copayment for prescription drugs purchased through the mail service pharmacy or the Specialty Pharmacy for a 31-90 day supply will be as follows:

* $5 Generic
* $55 Preferred Brand
* $110 Non-Preferred Brand

12.7(c) Level One, currently reserved for Generic Drugs only, may include brand name medications that are determined by the Prescription Drug Insurer/Administrator to be a "best value". ~~And/or g~~ **<u>G</u>**eneric drugs that are determined not to add value to the Plan or the enrollee may be placed in Level 2 or Level 3.

- The copayment for any brand name drug placed in Level 1 will be the same as the Level One copayment, similarly, any generic drug placed in Levels 2 or 3 will have the same copayment ~~of~~ as brand name drugs in that level.

~~12.7(d) Effective January 1, 2013 initial prescriptions for all "new to you" drugs dispensed at retail and/or mail will be limited to a 30 day supply. After two 30 day prescriptions have been filled, the 31 to 90 days supply option will be available. Effective January 1, 2019, the "new to you" provision shall be eliminated.~~

12.7(d)-A medical exception program is available for non-formulary prescription drugs that are excluded from coverage. If a physician's request for a medical exception is approved, the Level One copayment will apply for generic drugs and the Level Three copayment will apply for brand-name drugs.

12.7(e) A Dispense as Written exception request is available for medically necessary prescription non-preferred brand-name drugs that have a generic equivalent. If a physician's request for medical necessity is approved, the Level Three copayment is charged, but the member will not be responsible for the difference in cost between the generic drug and the non-preferred brand-name drug (ancillary charge).

12.7(~~e~~**f**) Specialty Medication Component:

The Empire Plan Specialty Drug Pharmacy Program will consist of a network of one or more Specialty Pharmacies.

1. For purposes of this Program, Specialty Drugs that are eligible for inclusion are defined as:
   - "orphan drugs"
   - drugs requiring special handling, special administration and/or intensive patient monitoring/testing
   - biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level
   - other drugs identified by the Program as used to treat patients with chronic or life- threatening diseases.
2. Enrollees currently using, and physicians currently prescribing drugs that will be Included in the Specialty Program will be notified in writing at least 30 days in advance of the implementation date.
3. Enrollees may fill no more **than** one prescription for a drug included in the Specialty Program at a Non-Specialty Network pharmacy (grace fill), except for those drugs identified as being used for short-term therapy for which a delay in starting therapy would not affect clinical outcome.
4. Enrollees initially filling a prescription for a Specialty Drug at a Non-Specialty Network pharmacy will be contacted by the Program and advised that they must obtain all refills after the allowed grace fill through the Specialty Drug Program. Thereafter, any additional claims for the same drug will be blocked at Non-Specialty Network pharmacies.

5 .Beyond the initial fill(s) described in (3) above, enrollees must contact the Specialty Referral Line, accessible through the NYSHIP toll-free telephone line, prior to obtaining a drug included in the Specialty Program, in order to receive the maximum available benefit. Enrollee calls will be transferred directly to the participating specialty pharmacy that has agreed to provide the drug in question.

6. Once an enrollee contacts the Specialty Referral Line, subsequent fills and refills for the same drug should be requested directly from the Specialty Pharmacy.

7. Any and all prescription(s), initial or refill, beyond those provided for in paragraph (b), for designated Specialty Drugs will be limited to a 30-day supply, unless otherwise agreed to by the State and the Program administrator.

8. All Specialty Pharmacies that are participating in the Specialty Drug Program will provide enrollees with 24/7/365 access to a pharmacist.

9. Drugs meeting the above definition of a "Specialty Drug" will be excluded from coverage under the "standard" Empire Plan Prescription Drug benefit and will be provided through the Empire Plan Specialty Drug Program.

10. Drugs meeting the above definition of a "Specialty Drug" that are not included in the Empire Plan Specialty Drug benefit will continue to be covered under the "standard" Empire Plan Prescription Drug Program.

11. Drugs included in the Specialty Drug Program will be assigned to tiers and subject to the same copayments as drugs covered under the "standard" Empire Plan Prescription Drug benefit.

12. Other than the accommodation described in (3) above, drugs included in the Specialty Program that are purchased without contacting the Specialty Referral Line will be treated as a subscriber submitted claims and will be reimbursed in the same manner as subscriber submitted claims under the Empire Plan Prescription Drug Program: the enrollee will be reimbursed the lesser of the pharmacy charge or the amount the Program would have paid through the Specialty Drug Program less the appropriate copayment.

12.8 Premium Contribution

12.8(a) The State agrees to pay 84 percent of the cost of individual coverage and 69 percent of the cost for dependent coverage under the Empire Plan.

12.8(b) The State agrees to pay 84 percent of the cost of individual coverage and 69 percent of the cost of dependent coverage toward the hospital/medical/mental health and substance use component of each HMO, not to exceed 100 percent of its dollar contribution for those components under the Empire Plan, and the State agrees to pay 84 percent of the cost of individual prescription drug coverage and 69 percent of the cost of dependent prescription drug coverage under each participating HMO.

12.8 (b)(1) NYSHIP enrollees who can demonstrate and attest to having other, non-State sponsored coverage may annually opt-out of NYSHIP's Empire Plan or Health Maintenance Organizations. Enrollees who choose to opt-out of NYSHIP coverage will receive an annual payment of $1,000 for opting out of individual coverage or $3,000 for opting out of family coverage. The opt-out program will allow for re-entry to NYSHIP during the calendar year subject to a Federally Qualifying Event and during the annual option transfer period. The enrollee must be enrolled in NYSHIP prior to April 1st of the previous plan year in order to be eligible to opt out, unless newly eligible to enroll. The opt-out payment will be pro-rated over the twenty-six (26) payroll cycles and appear as a credit to the employee's wages for each bi-weekly payroll period the eligible individual is qualified.

12.8(c) The unremarried spouse of an employee, who retires with ten or more years of active State service and subsequently dies, shall be permitted to continue coverage in the health insurance program with payment at the same contribution rates as required of active employees.

12.8(d) The unremarried spouse of an active employee, who, at the date of death was vested in the Employee's Retirement System and vested for the purpose of health insurance and within ten years of his/her first date of eligibility for retirement shall be permitted to continue coverage in the health insurance program with payment at the same contribution rates as required of active employees.

12.8(e) Any employee who is a member of the New York State Policemen's and Firemen's Retirement System and eligible to continue health insurance coverage upon retirement and who is entitled to sick leave credit to be used to defray his/her contribution toward the cost of the premium shall have the value of his/her sick leave credit calculated based upon the actuarial life expectancies chart used by the New York State Policemen's and Firemen's Retirement System.

12.9 Option Transfer

12.9(a) Eligible employees in the State Health Insurance Plan may elect to participate in a federally qualified or State certified Health Maintenance Organization (HMO) which has been approved to participate in the State Health Insurance Program by the Joint Committee on Health and Dental Benefits. Employees may change their health insurance option each year throughout the month of November unless another period is mutually agreed upon by the State and the Joint Committee on Health and Dental Benefits.

(a)(1) If the rate renewals are not available by the time of the option transfer period, then the option transfer period shall be extended to assure ample time for employees to transfer.

12.10 Joint Committees on Health and Dental Benefits

(a) The State and Council 82 agree to continue the Joint Committee on Health and Dental Benefits. The Committee shall consist of at least three representatives selected by Council 82 and three representatives selected by the State.

(b) The State shall seek the appropriation of funds by the Legislature to support committee initiatives and to carry out the administrative responsibilities of the Joint Committee. Funding for the Joint Committee shall be as follows:

- ~~$6,898 for the period April 1, 2016 to March 31, 2017~~
- ~~$7,036 for the period April 1, 2017 to March 31, 2018~~
- ~~$7,177 for the period April 1, 2018 to March 31, 2019~~
- ~~$7,321 for the period April 1, 2019 to March 31, 2020~~
- ~~$7,467 for the period April 1, 2020 to March 31, 2021~~
- ~~$7,616 for the period April 1, 2021 to March 31, 2022~~
- ~~$7,768 for the period April 1, 2022 to March 31, 2023~~
- **$8,001 for the period April 1, 2023 to March 31, 2024**
- **$8,241 for the period April 1, 2024 to March 31, 2025**
- **$8,488 for the period April 1, 2025 to March 31, 2026 and each year thereafter**

In no case will more than 50% of these appropriations be allocated to either the State or Council 82 individually.

(c) The Joint Committee on Health and Dental Benefits shall meet within 14 days after a request to meet has been made by either side.

(d) The Joint Committee shall work with appropriate State agencies to review and oversee the various health plans available to employees represented by Council 82.

(e) The Joint Committee on Health and Dental Benefits shall work with appropriate State agencies to monitor future employer and employee health plan cost adjustments.

(f) The Joint Committee shall be provided with each carrier rate renewal request upon submission and be briefed in detail periodically on the status of the development of each rate renewal.

(g) The State shall require that the ~~insurance carriers~~ **Program Administrators** for the State Health Insurance Plan submit claims and experience data reports directly to the Joint Committee on Health and Dental Benefits in the format and with such frequency as the Committee shall determine.

(h) The Joint Committee on Health and Dental Benefits shall work with appropriate State agencies to make mutually agreed upon changes in the Plan benefit structure through such initiatives as:

(1) HMO Workgroup (participation/efficiency);
(2) Ambulatory Surgery Center development;
(3) HCAP/ER benefit-review;
(4) The ongoing review of the Managed Physical Medicine Program;
(5) Review of the appropriateness of providing a benefit for autologous blood donations
(6) Review the appropriateness of additional chronic copayment waivers
(7) Work with the dental carrier to increase access to participating dental specialists such as orthodontist;
(8) Explore the addition of a Lyme Vaccine to the list of injectable adult immunizations should one become available
(9) Work with the State to monitor and oversee a voluntary disease management program under the medical component of the Empire Plan
(10) The ongoing review of a Medical Flexible Spending Account
(11) Work with the State to monitor and oversee the voluntary "Centers of Excellence" program for organ and tissue transplants within the hospital component of the Empire Plan
(12) work with the State and medical carrier to develop an enhanced network of urgent care facilities
(13) Work with the State to implement a direct debit vehicle or electronic submission option to be utilized under the Medical Flexible Spending Account
(14) Work with the State to implement and oversee a Bariatric Surgery Program
(15) Work with the State to implement and oversee a Healthy Back Disease Management Program
(16) Work with the State to develop a voluntary Pilot Telemedicine Program. The purpose of the Telemedicine Program is to increase access to health care services by establishing a program to use telecommunications to provide healthcare, [see 12.6(ee)]
(17) If an Alternative Prescription Drug Program is offered for Empire Plan enrollees, the appropriate steps will be taken to offer such program to Council 82 represented employees, if found advantageous and feasible, for members on a voluntary basis
(18) Effective as soon as practicable, the Medical Flexible Spending Account shall provide a direct debit card to all enrollees as permitted pursuant to Internal Revenue Code Section 125 and related regulations; **The MFSA will continue electronic submission and the direct debit vehicle shall remain a permanent offering, to the extent practicable and/or desirable by both parties.**
(19) The Joint Committee on Health **and Dental** Benefits will work with the State to develop a voluntary Value Based Insurance Design pilot program with the goal of improving health outcomes while lowering overall costs through copayment waivers or reductions.

(20) The Joint Committee on Health and Dental Benefits will review the role of network health care providers and facilities to ensure access needs are met.

(21) As soon as practicable, the Joint Committee on Health and Dental Benefits will work with the State to review the current voluntary, incentivized programs available through the medical program administrator and the hospital program administrator.

(22) The Joint Committee on Health and Dental Benefits and the State will explore the implementation and oversight of a voluntary Telemedicine program for sleep disorders.

(23) The Joint Committee on Health and Dental Benefits and the State will discuss the promotion and utilization of the Medical Program administrator's national network of laboratories.

(22) The Joint Committee on Health and Dental Benefits and the State will explore the implementation and oversight of a voluntary Center of Excellence for spine and orthopedic surgeries.

12.11 Vision Care Benefits

The State shall continue to provide for and pay the full cost for the vision care plan in effect as of March 31, ~~2016~~**2023**.

(a) The plan shall provide a $200 allowance for the cost of eye examination and contact lenses.

(b) The Plan shall provide the complete selection of frames available to other participants in the Plan including the frame selections designated as standard, supplemental and designer/metal.

(c) The State shall provide toll-free telephone service for insurance information and assistance to employees and dependents on vision care insurance matters.

(d) Dependents under 19 years of age will be eligible to receive vision care benefits every 12 months.

(e) Covered Plan eyeglasses (frames and lenses) and/or contact lenses may be obtained within (90) ninety days after a vision examination by a participating Vision Care Plan Provider. **Effective January 1, 2025, the 90-day requirement hall be eliminated. Contact lenses may be obtained within 12 months of the vision examination. Covered Plan eyeglasses (frames and lenses) may be obtained within 24 months of the vision examination.**

(f) If new lenses are required due to vision changes resulting from a medical condition for which the individual is under the care of a physician, vision care benefits, including an examination, new lenses and, if appropriate, new frames, shall be available sooner than once every two years, but not sooner than one year from the last use of vision care benefits, upon written documentation by an ophthalmologist that the medical condition has caused a vision loss that requires a new prescription. Documentation of the vision loss must be provided in writing by the ophthalmologist each time a new prescription is needed sooner than the standard two-year interval.

(g) Covered plan lenses shall include photosensitive lenses (plastic or glass), no-line bifocals, ultra thin lenses, and scratch resistant coating.

(h) Access to a network of providers to obtain Laser Vision Correction services at discounted employee -pay-all fees is provided.

(i) The Council 82 Vision Care Plan will offer:

1. Lasik and other corrective vision care procedures performed to correct nearsightedness and/or farsightedness and not covered by the Empire Plan or an HMO shall be a covered service for employees only.

2. Spouses/Domestic Partners and dependent children shall be eligible to participate in a "discount program" providing up to a 50 percent savings for the procedures identified in item #1 but will be responsible for any and all costs associated with such procedures.

3. Corrective Vision Care coverage shall only be available through a network of participating board eligible/board certified ophthalmologists trained in this field. The Vision Care Plan administrator shall be responsible for the network and will make every effort to recruit and retain providers throughout New York State.

4. Corrective Vision Care coverage shall include a preliminary exam, the actual procedure and up to two follow-up visits.

5. Employees receiving such services shall have a copayment equal to 10% of the discounted cost of the procedure up to an out-of-pocket maximum of $200.

6. Employees shall be eligible for one Corrective Vision Care procedure every 5 years per eye.

7. The Council 82 Joint Committee on Health Benefits shall review the Corrective Vision Care coverage component at regular intervals to monitor utilization, network adequacy and cost.

8. The five (5) year limit may be waived based on evidence of a significant vision change due to injury or illness.

(j) Contact lens wearers are eligible every 12 months for an eye exam, evaluation, fit and follow-up care provided their last contact lens purchase was covered by the Vision Care Program. Contact Lens exams under this provision by an out-of-network provider will be reimbursed up to the scheduled amount.

10. Ultra/digital lenses from participating providers will be covered subject to a $90 copayment.

12.12 Dental Care Benefits

The State shall continue to provide dental benefits at the same level as were in effect March 31, ~~2016~~**2023**, except as modified as follows:

(a) The allowances paid shall be at a level sufficient to retain or add participating dentists and specialists. The State shall continue to pay the full premium of the dental insurance plan.

(b) The Plan shall include coverage for the application of sealants to the primary teeth of dependent children ages 13 and under.

(c) The nonparticipating provider reimbursement will be increased to an amount equal to 100 percent of the schedule for basic and prosthetic services.

(d) The maximum annual benefit for covered participating and nonparticipating services is $3,000 per person

(e) The maximum lifetime benefit for orthodontic treatment is $3,000.

(f) Anesthesia administered in a dentist office shall be a covered benefit under the participating and nonparticipating components of the dental plan.

(g) The following upgraded materials are covered:

(1) posterior composite (white fillings)

(2) hi-noble materials for crowns, inlays, onlays, pontics and abutments

(3) flexible base dentures, and

(4) ceramic materials for onlays, crowns, pontics and abutments.

(h) ~~Effective as soon as practicable d~~ **D**ental implants are covered subject to a $600 limitation per implant.

12.13 At the demand of the Joint Committee on Health and Dental Benefits the State shall request proposals from existing or other carriers, or alternative third- party administrators, for the Empire Plan, Dental, Drug and Vision Plans providing the benefits are identical. A replacement insurance carrier or third party administrator will not be selected without Joint Committee consent.

12.14 Mental Health and Substance ~~Abuse~~**Use** Treatment

The Empire Plan shall continue to provide comprehensive coverage for medically necessary mental health and substance ~~ab~~**use** treatment services through a managed care network of preferred mental health and substance ~~ab~~**use** care providers. In addition to the network care, limited non-network care will be available. Benefits shall be as follows:

12.14(a) NETWORK BENEFIT

(1) Mental Health Coverage

- Paid-in-full medically necessary hospital services and inpatient physician charges when provided by, or arranged through, the network;
- Outpatient care provided by, or arranged through, the network will be covered subject to a $25 per visit copayment;
- Up to three visits for crisis intervention provided by, or arranged through, the network will be covered without copay.

(2) Alcohol and Other Substance ~~Abuse~~**Use** Coverage

- Paid in full medically necessary care for hospitalization or alcohol/substance **use** ~~abuse~~ facilities when provided by, or arranged through, the network;
- Outpatient care provided by, or arranged through, the network will be subject to the participating provider office visit copayment.

(3) Benefit Maximums: Medically necessary mental health and ~~inpatient~~ alcohol and substance use treatment will be unlimited.

(4) Disease Management Programs

Under the Mental Health and Substance Use Program a disease management program for depression is available. Disease management programs for eating disorders, including appropriate nutritional services; and ADHD ~~will~~ are **also** available.

(5) As soon as practicable following ratification, a Center of Excellence (COE) for Substance Use will be available to enrollees on a voluntary basis. Services will include:

- **Paid-in-full benefits**
- **Travel companion (due to treatment needs, as specified by COE)**
- **Detox and residential rehabilitation services**
- **Partial hospitalization services**
- **Intensive outpatient services**
- **Care coordination for transitions back to community**
- **Family supports**
- **Travel, lodging, and meal allowances**

12.14(b) NON-NETWORK BENEFIT

Mental Health **and Substance Use**

Medically necessary care rendered outside of the network will be subject to the following provisions:

~~Coincident with the increase in the Basic Medical deductible and coinsurance, the mental health basic medical deductible and coinsurance will increase accordingly.~~

(1) The methodology for calculating non-network inpatient and outpatient reimbursement will be the same as the methodology for non-network hospital and medical services; **Effective January 1, 2025, when non-participating providers are used, benefits will be paid at the rate of 275 percent of the Medicare Physician Fee Schedule in effect on the date of service. Benefits will continue to be subject to deductible, coinsurance, and calendar year maximums.**

(2) Covered expenses for non-network mental health and substance ~~ab~~use treatment will be included in the combined annual deductible and combined annual coinsurance maximum.

~~Substance Abuse~~

~~Medically necessary inpatient alcohol and substance abuse treatment will be unlimited effective January 1, 2010;~~

- ~~Coincident with the increase in the Basic Medical deductible and coinsurance, the substance abuse deductible and coinsurance will increase accordingly effective January 1, 2010;~~
- ~~Effective January 1, 2010 the methodology for calculating non-network inpatient and outpatient reimbursement will be the same methodology for non-network hospital and medical services;~~
- ~~Expenses applied against the deductible and coinsurance levels indicated above will not apply against any deductible or coinsurance maximums under the basic medical portion of the Plan. Effective January 1, 2012, covered expenses for non-network mental health and substance abuse treatment will be included in the combined deductible and combined coinsurance maximum.~~

12.15 Managed Physical Medicine Program (MPMP). The Empire Plan's medical care component will offer a comprehensive managed care network benefit for the provision of medically necessary physical medicine services, including physical therapy, **occupational therapy**, and chiropractic treatment as follows:

- Authorized network care will be available, subject only to the Plan's participating provider office visit copayments.
- Unauthorized medically necessary care, at enrollee choice, will also be available, subject to a $250 annual deductible per enrollee, $250 per spouse and $250 deductible for one or all dependent children and a maximum payment of 50 percent of the network allowance for the service provided.

Maximum benefits for non-network care will be limited to $1,500 in payments per person per calendar year. Deductible/coinsurance payments will not be applicable to the Plan's annual basic medical deductible/coinsurance maximums.

ATTACHMENT C – SIDE LETTER – SITE OF CARE PROGRAM

Site of Care Redirection Program for Infusions

Effective January 1, 2025, the Empire Plan will implement a Site of Care (SOC) Redirection Program for Infusions. Drugs used to treat cancer and hemophilia are excluded from this program. This Program will apply to Empire Plan-primary members only.

The Site of Care Redirection Program shall be administered as described below. The Joint Committee will meet regularly to discuss the rollout of the program and jointly oversee the implementation, administration, and any future development of the program.

Effective January 1, 2025, the Hospital Program administrator's current medical necessity review for infusions of drugs included on the Hospital Program Administrator's Site of Care Drug List in the hospital outpatient setting will expand to include a review of the site of care. The site of care review will determine the clinical appropriateness of administering the infusion in the hospital outpatient setting versus provider office/suite, freestanding infusion center, or home. If it is determined that an alternate site of care is clinically appropriate for the infusion to be administered, the Hospital Program administrator will coordinate with the enrollee's provider and the Home Care Advocacy Program (HCAP) to recommend an alternate site of care for the infusion. If the provider or enrollee disagrees with the alternate site of care recommendation, they may exercise the enrollee's appeal rights to obtain services in the hospital outpatient setting.

Effective January 1, 2025, the medical or prescription drug copayments associated with infusions will be waived when the enrollee uses a non-hospital infusion site of care. In addition, requests for infusion therapy reviewed by the Hospital Program administrator will not be subject to additional review by the Empire Plan Medical or Prescription Drug Program administrators.

There will be a six-month grace period for members receiving infusions of drugs included on the Site of Care Drug List in the outpatient hospital setting on January 1, 2025. Members may continue receiving infusions in the hospital outpatient setting until the end of the grace period when the Hospital program administrator will require a site of care review.

Members receiving infusion therapy of a drug on the Site of Care Drug List at an alternate site of care on or after January 1, 2025, will not be subject to the medical or prescription drug copayments associated with infusions. Members will continue to be subject to continued medical necessity authorization through the medical or prescription drug program, as applicable.

The Hospital Program administrator's Site of Care Specialty Pharmaceuticals UM Guideline # CG-MED-83 will be the clinical criteria used when determining the medical

necessity of the hospital outpatient setting for infusions of medications on the Site of Care Drug list.

Site of Care Redirection Program for Infusions
Empire Plan Carrier Responsibilities

Hospital Program administrator (Empire BlueCross):

- Use clinical criteria to conduct a site of care review. This will be the only review for medical necessity. No additional medical necessity review, prior authorization or SGM prior authorization from the Empire Plan Medical Program administrator (currently, United HealthCare) or The Empire Plan Prescription Drug Program administrator (currently CVS Caremark), will occur.
- Approve the hospital outpatient setting for an initial dose of infusion of SOC medication (extension of hospital outpatient setting as necessary to allow the hospital administrator to coordinate patient transfers to an approved alternate site of care).
- Notify providers that a drug is on the SOC drug list and that alternate sites of care will be explored.
- Discuss with provider and make necessary referrals to the Home Care Advocacy Program (HCAP) for redirection of the infusion to an alternate site of care.

Medical Program administrator (UnitedHealthcare):

- The Medical Program administrator will continue to recruit and contract with additional nursing agencies, freestanding infusion centers and physician infusion suites across New York State, and outside of the State where Empire Plan members receive treatment to ensure adequate number of alternate settings for drug infusion under the Site of Care Redirection Program for Infusions.
- HCAP will work with the provider (and enrollee, if necessary – but should be seamless to enrollee) to find an appropriate alternate setting for the drug infusion to be administered.
- HCAP will source the specialty drug from The Empire Plan's Prescription Drug Program (currently CVS Caremark), if the infusion will be administered in the enrollee's home. HCAP will notify providers of drug sourcing opportunities through CVS Caremark.

The Empire Plan Prescription Drug Program (CVS Caremark):

- Provide drugs for infusion through The Empire Plan's Prescription Drug Program, currently CVS Caremark, for HCAP providers, medical providers or freestanding infusion centers (as noted above).

Site of Care Redirection Program for Infusions

Empire Plan Carrier Responsibilities

Hospital Program administrator (Empire BlueCross):

- Use clinical criteria to conduct a site of care review. This will be the only review for medical necessity. No additional medical necessity review, prior authorization or SGM prior authorization from the Empire Plan Medical Program administrator (currently, United HealthCare) or The Empire Plan Prescription Drug Program administrator (currently CVS Caremark), will occur.
- Approve the hospital outpatient setting for an initial dose of infusion of SOC medication (extension of hospital outpatient setting as necessary to allow the hospital administrator to coordinate patient transfers to an approved alternate site of care).
- Notify providers that a drug is on the SOC drug list and that alternate sites of care will be explored.
- Discuss with provider and make ~~direct~~ necessary referrals to the Home Care Advocacy Program (HCAP) for redirection of the infusion to an alternate site of care.

Medical Program administrator (UnitedHealthcare):

- The Medical Program administrator will continue to recruit and contract with additional nursing agencies, freestanding infusion centers and physician infusion suites across New York State, and outside of the State where Empire Plan members receive treatment to ensure adequate number of alternate settings for drug infusion under the Site of Care Redirection Program for Infusions.
- HCAP will work with the provider (and enrollee, if necessary – but should be seamless to enrollee) to find an appropriate alternate setting for the drug infusion to be administered.
- HCAP will source the specialty drug from The Empire Plan's Prescription Drug Program (currently CVS Caremark), if the infusion will be administered in the enrollee's home. HCAP will notify providers of drug sourcing opportunities through CVS Caremark.

The Empire Plan Prescription Drug Program (CVS Caremark):

- Provide drugs for infusion through The Empire Plan's Prescription Drug Program, currently CVS Caremark, for HCAP providers, medical providers or freestanding infusion centers (as noted above).

ATTACHMENT D – APPENDIX – ACCESS PROTECTIONS FOR EMPIRE PLAN

Empire Plan Protections to Ensure Network Access

This Appendix reflects the access protections in place as of the date of this Agreement and may be updated during the term of the Agreement due to changes in laws, rules, regulations, and other mandates. Please refer to the Empire Plan Certificate of Insurance for the most current access protections.

Out-of-Network Referral Mandate

Under NYS Law, the Empire Plan must provide access to primary care and specialty providers if services are not available within a 30-mile radius or 30-minute travel time from your home address. This requirement applies to Empire Plan primary enrollees residing within the United States. Contact the appropriate Empire Plan administrator if you require access to a certain provider.

Out-of-Network Referrals

Under NYS law, if the Empire Plan network does not have a provider accessible to you who has the appropriate level of training and experience to treat a condition, you have the right to request an out-of-network referral to a qualified provider. You or your provider must first request approval from the appropriate Plan administrator to receive consideration for the service to be paid at an in-network level.

If the Plan approves the request, you must use the approved out-of-network provider. Covered services will be paid at the in-network benefit level, with any applicable network copayment owed.

If the Plan denies the request, benefits for covered services are available under out-of-network benefit provisions, subject to deductible and coinsurance. The enrollee and the enrollee's referring provider can file an external appeal through the NYS Department of Financial Services (DFS).

Surprise Bills

Provisions of state and federal law protect patients from being responsible for healthcare charges that may have been provided and were not in the patient's control. Under these laws, the patient's out-of-pocket responsibility may be limited to the network out-of-pocket charges for any bill deemed to be a surprise bill.

Surprise Bills anywhere in the United States/U.S. Territories

When you receive healthcare services from a non-participating doctor, the bill you receive for those services will be considered a surprise bill if:

You received services at a network hospital or ambulatory surgical center and nonparticipating health care professional charges are billed separately for anesthesiology, pathology, radiology, and neonatology; care provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services (including radiology and laboratory services).

You received other services at a network hospital or ambulatory surgical center and a participating doctor was not available and you did not sign a consent form with the nonparticipating health care professional agreeing to be financially responsible beyond your network copayment.

Surprise Bill within New York State

A participating health care professional sends a specimen taken from the patient in the office to a nonparticipating laboratory or pathologist without your explicit written consent.

Unforeseen medical circumstances arose at the time the healthcare services were provided.

A nonparticipating healthcare professional provided services without your knowledge in the participating healthcare professional's office or practice during the same visit.

Contractual and Other Protections:

Network Benefits at a Non-Network Hospital/Facility

Network benefits will be approved at a non-network hospital/facility;:

When no network facility is available within 30 miles of your residence.

When no network facility within 30 miles of your residence can provide the covered services you require.

When the admission is deemed an emergency or urgent inpatient or outpatient service.

When care is received outside the United States.

When another plan, including Medicare, is providing primary coverage.

Network Benefits through the Home Care Advocacy Program

The Empire Plan's Home Care Advocacy Program provides home care services, certain durable medical equipment, and medical supplies. You must call HCAP to arrange for services and use an HCAP approved provider to receive paid in full benefits under

network coverage. Call the Empire Plan at 1-877-769-7447 and choose the Medical/Surgical Program, then choose the option for the Home Care Advocacy Program.

Guaranteed Access - Chiropractic Treatment, Physical Therapy and

Occupational Therapy

You are guaranteed that network benefits will be available to you under the Managed Physical Medicine Program.

Should a member not be able to find an in-network provider within a reasonable distance from their home, they should contact the Empire Plan's Managed Physical Medicine Program to request in-network level of benefits. Call the Empire Plan at 1-877-769-7447 and choose the Medical/Surgical Program.

MPMP will make arrangements for you to receive medically necessary chiropractic treatment, physical therapy, or occupational therapy, and you will pay only your applicable copayment for each visit. But you must call first and you must use the provider with whom MPMP has arranged your care. You must follow program requirements if you seek treatment anywhere in the United States, including Alaska and Hawaii.

Medical and Specialty Services

Guaranteed Access Medical and Specialty Services

The Empire Plan will guarantee access to network benefits for covered services provided by primary care physicians and specialists (listed below) in New York State or bordering counties in Connecticut, Massachusetts, New Jersey, Pennsylvania and Vermont when there are no participating providers within a reasonable distance from the enrollee's residence.

To receive network benefits, enrollees must call the Empire Plan Medical/Surgical Program at 1-877-769-7447 prior to receiving services and use one of the providers approved by the Program. You will be responsible for contacting the Provider to arrange care. Appointments are subject to Provider's availability and the Program does not guarantee that a Provider will be available in a specified time. Guaranteed access applies when The Empire Plan is Your primary health insurance coverage (pays benefits first, before any other group plan or Medicare), the enrollee lives in New York State or bordering counties in Connecticut, Massachusetts, New Jersey, Pennsylvania and Vermont and there is not an Empire Plan Participating Provider within a reasonable distance from the enrollee's residence.

Network benefits are guaranteed within the specified mileage standards for the following primary care and core specialties:

Primary Care: Family Practice, General Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology

Specialists: Allergy, Anesthesia, Cardiology, Dermatology, Emergency Medicine, Gastroenterology, General Surgery, Hematology/Oncology, Neurology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pulmonary Medicine, Radiology, Rheumatology, Urology

Reasonable distance from the enrollee's residence is defined by the following mileage standards:

Urban:	Primary Care 8 miles	Specialist 15 miles
Suburban:	Primary Care 15 miles	Specialist 25 miles
Rural:	Primary Care 25 miles	Specialist 50 miles

Guaranteed Access – Mental Health and Substance Use

The Empire Plan's Clinical Referral Line (CRL) provides guaranteed access under the Empire Plan's Mental Health and Substance Use Program (MHSU) when a network provider is not available for treatment of mental health or substance use disorder.

If you cannot locate a network provider in your area, contact the Clinical Referral Line (CRL) for an out-of-network referral. The CRL is available 24 hours a day, 7 days a week by calling 1-877-769-7447, select the option for the Mental Health and Substance Use Program and then choose Clinical Referral Line. If the referral is approved, the claim will be processed as network.

ATTACHMENT E – SIDE LETTER – PRODUCTIVITY ENHANCEMENT PROGRAM

Productivity Enhancement Program

This Appendix describes the Productivity Enhancement Program available to employees in the Security Supervisors Unit. Detailed guidelines on program administration will be issued by the Department of Civil Service.

Program Overview

Eligible employees may elect to participate in the Productivity Enhancement Program. As detailed below, this program allows eligible employees to exchange previously accrued annual leave (vacation) and/or personal leave in return for a credit to be applied toward their employee share NYSHIP premiums on a biweekly basis.

The program will be available during the entire calendar year in 2025 and 2026. During each of these years the credit will be divided evenly among the State paydays that fall between January 1 and December 31.

Disputes arising from this program are not subject to the grievance procedure contained in the Agreement.

Eligibility/Enrollment

In order to enroll an employee must:

- Be a classified or unclassified service employee in a title below Salary Grade 25 or equated to a position below Salary Grade 25, or be a non-statutory employee with an annual salary no greater than the job rate of the Salary Grade 24;
- Be an employee covered by the 2023-2026 New York State/C82 Collective Bargaining Agreement;
- Have a sufficient leave balance to make the full leave forfeiture at the time of enrollment without bringing their combined annual and personal leave balances below 8 days; and
- Be a NYSHIP enrollee (contract holder) in either the Empire Plan or an HMO at the time of enrollment.
- Part-time employees who meet these eligibility requirements will be eligible to participate on a prorated basis.
- Once enrolled for a given year, employees continue to participate unless they separate from State service or cease to be NYSHIP contract holders. Leave forfeited in association with the program will not be returned, in whole or in part, to employees who cease to be eligible for participation in the program.

During any calendar year in which an employee participates, the credit established upon enrollment in the program will be adjusted only if the employee moves between individual and family coverage under NYSHIP during that calendar year.

Open enrollment will be offered during November of each year PEP is offered. The exact dates of open enrollment will be established by the Department of Civil Service. Employees will be required to submit a separate enrollment for each calendar year in which they wish to participate.

Calendar Years 2025 and 2026

Eligible full-time employees:

- (SG 1-17) Full-time employees, up to and including SG-17 (or non-statutory employees with an annual salary no greater than the job rate of SG-17), who enroll in the program will be eligible to forfeit a total of either 4 or 8 days of annual and/or personal leave standing to their credit at the time of enrollment in return for a credit of up to either $800 or $1,600 to be applied toward the employee share of NYSHIP premiums and deducted from biweekly paychecks in that year. The credit will be divided evenly among the State paydays that fall between January 1 and December 31, of each year the employee elects to enroll.
- (SG 18-24) Full-time employees in SG-18 (or non-statutory employees equated to SG-18, or in the absence of that, employees with an annual salary exceeding the job rate of SG-17) up to and including SG-24 (or non-statutory employees with an annual salary no greater than the job rate of SG-24), who enroll in the program will be eligible to forfeit a total of 2.5 or 5 days of annual and/ or personal leave standing to their credit at the time of enrollment in return for a credit of up to either $750 or $1,500 to be applied toward the employee share of NYSHIP premiums deducted from bi-weekly paychecks in that year. This credit will be divided evenly among the State paydays that fall between January 1 to December 31 of each year the employee elects to enroll.

Eligible part-time employees:

- in Grades 1-17 who participate in any calendar year will forfeit a total of 4 or 8 prorated

days of annual and/or personal leave per year of participation and receive a prorated credit toward the employee share of their health insurance premiums based on their payroll percentage.

- in Grades 18-24 who participate in any calendar year will forfeit a total of 2.5 or 5 prorated days of annual and/or personal leave per year of participation and receive a prorated credit toward the employee share of their health insurance premiums based on their payroll percentage.

This program will expire on December 31, 2026, unless extended by the parties.

ATTACHMENT F – SIDE LETTER – LABOR-MANAGEMENT FUNDS

In the event that available funds in Article 13 and Article 25 are not fully expended for their purposes, the residual funds shall be made available to benefit members as mutually determined by the Director of OER and the President of C82 or their designees. In no event shall the aggregate labor management funds exceed the available funds for labor management committees.

ATTACHMENT G – SIDE LETTER – PAID PARENTAL LEAVE

On January 10, 2023, Governor Hochul announced that New York State will provide 12 weeks of Paid Parental Leave for executive branch state employees to bond with a newly born, adopted, or fostered child. The purpose of this Policy Bulletin is to set forth guidelines for the administration of this new Paid Parental Leave (PPL) benefit.

Effective upon ratification, Paid Parental Leave will become available to any gestational, non-gestational, adoptive, or foster parent who meets certain eligibility criteria for employees. All other childcare leave benefits, including sick leave accruals, family sick leave benefits, Family Medical Leave Act (FMLA) remain unchanged and available for use when applicable.

Eligibility
All employees who work full-time or who work at least 50% part-time are eligible for this benefit. Such employees are eligible beginning after six months of service. Employees are not required to have Attendance Rules coverage to be granted this benefit.

Use of Paid Parental Leave
Employees may take leave with pay for up to 12 weeks for each qualifying event, defined as the birth of a child or placement of a child for adoption or foster care. Paid Parental Leave is available for use once every 12-month period. The date of the qualifying event begins the 12-month period. Paid Parental Leave may begin on the date of birth, the day of adoption or foster care placement or anytime thereafter within seven months. An

employee's ability to use Paid Parental Leave ends seven months from the date of the qualifying event. If a qualifying event occurred within seven months before the effective date of this bulletin, an employee may use Paid Parental Leave, however the employee's use of Paid Parental Leave must end within seven months of the qualifying event.

Paid Parental Leave may be used in combination with all other paid and unpaid childcare leave benefits (see attached chart for examples of application and order of Paid Parental Leave benefits). Paid Family Leave and usage of accruals cannot run concurrently with Paid Parental Leave and may be taken at the appropriate time in addition to Paid Parental Leave.

If both parents are employed by a New York State Agency, both parents may use Paid Parental Leave, even if they work for the same appointing authority.

Paid Parental Leave cannot be used intermittently and must be taken in a block of time. Employees do not have to take the full 12 weeks, but once they return from Paid Parental Leave, they can no longer use this leave.

Status of Employees on Paid Parental Leave

For attendance and leave purposes, employees are deemed to be in leave without pay status while using Paid Parental Leave. They do not earn biweekly leave accruals or observe holidays, nor do they receive personal leave or vacation bonus days if their anniversary dates fall while they are using Paid Parental Leave. In such cases, the personal leave anniversary date changes to the date of return to work or placement on sick leave at half-pay, and the employee receives personal leave on the adjusted anniversary date. The vacation anniversary date is adjusted if the period of continuous absence on Paid Parental Leave and any other kind of childcare leave, except where the employee charges accruals on such leave, exceeds six continuous months. If such period is less than six months, the employee retains the same vacation anniversary date and is credited with vacation bonus days upon return to work.

Time on Paid Parental Leave does not count as service for earning additional eligibility for sick leave at half-pay.

While using Paid Parental Leave, employees continue to be covered by their existing insurance benefits. Employees continue to have health insurance premiums, retirement contributions, and other payroll deductions withheld from their paycheck.

Employees using Paid Parental Leave continue to receive retirement service credit for days while on leave as it is considered full pay status for this purpose.

Paid Parental Leave may not be used to extend employment beyond the point it would otherwise end by operation of law, rule, or regulation.

ATTACHMENT H – SIDE LETTER – APPENDIX ON PAID PARENTAL LEAVE

During negotiations the parties discussed the importance of sharing information on various leaves available for pregnancy, childcare and child rearing. While not possible to replicate in one place, the parties remain committed to ensure that unit members are aware of the availability of such leave.

To that end, the parties agreed to compile a non-exhaustive list of links to State policies pertaining to such leave in an effort to better inform unit members. Additionally, the parties are committed to ongoing discussions about other methods of ensuring that important and pertinent information is communicated to unit members.

For information on the State's policy for a leave of absence for pregnancy, child birth and childcare related to birth and for the State's policy related to adoption, please see 22.1 Leave of Absence; Duration - Rules Pages (ny.gov)

For information on the Federal Family and Medical Leave Act and its applicability to you as a State employee, please see Family Medical Leave Act (ny.gov).

Employees should contact their personnel or human resource office.

ATTACHMENT I – SIDE LETTER – TRIBOROUGH BRIDGE TOLLS

During negotiations, the parties discussed the current system for work-related passage under Article 17.3. The parties agreed that discussions should continue in a labor-management committee including the Union, the Office of Mental Health, the Office of Employee Relations. If the parties reach an agreement for an alternative to the current system, such agreement shall be communicated to the Director of the Office of Employee Relations to implement that agreement.

ATTACHMENT J – SIDE LETTER – REOPENER

As was discussed in negotiations for the 2023-2026 agreement, upon execution and ratification of the Agreement, C82 has the right to reopen negotiations, during the term of the agreement, with respect to the sole issue of a general salary increase for fiscal year 2023-2024, 2024-2025 and/or 2025-2026, if any other state bargaining unit agrees to and ratifies a general salary increase exceeding 3.0% in any of these fiscal years. This right is conditioned on taking into account the overall value of compensation increases for C82 members during the term of the C82 Agreement and

the value of any concessions obtained by the state contained in the collective bargaining agreement used as justification by C82 to demand reopening.