ARTICLE 30

STATE-SPONSORED GROUP INSURANCE

Group Insurances.

Section A. Enrollment

New hires will be permitted to enroll in group insurance plans for which they are eligible during their first thirty-one (31) days of employment. Coverage under such plans is effective the first day of the bi-weekly pay period after enrollment.

Insurance elections made during the annual open enrollment process are effective the first day of the first full pay period in October, unless otherwise indicated.

Employee premium share for health, dental and vision insurance shall be as specified in the charts appended to this Agreement. Employees hired on or after January 1, 2000, who are appointed to a position with a regular work schedule consisting of 40 hours or less per bi-weekly pay period shall pay 50% of the premium for health, dental and vision insurance. This shall not apply to an employee appointed to a permanent-intermittent position. Eligibility for enrollment shall be in accordance with current contractual provisions. Employees who have a regular work schedule of 40 hours or less per biweekly pay period who are temporarily placed on a regular work schedule of more than 40 hours per biweekly pay period for a period expected to last six months or more shall be considered as working a regular work schedule of more than 40 hours for the period of the temporary schedule adjustment.

Financial incentives for selection of certain lower cost plans or for opting out of coverage will continue to be offered. The incentive amount and payment schedule will be determined in conjunction with the annual rate setting process administered by the Civil Service Commission and the State Personnel Director.

Group insurance plan provisions shall be effective at the beginning of the first full pay period in October, unless otherwise specified.

Section B. Health Insurance

The State agrees to continue to offer health plans that are compliant with the requirements of the Patient Protection and Affordable Care Act (PPACA) and its implementing regulations. No plan will be offered where the total aggregate cost when calculated in accordance with the Internal Revenue Service (IRS) regulations would exceed PPACA excise tax limits. Coverage details, including premium share, deductibles, co-pays and coinsurance and out-of-pocket maximum (OOPM) amounts and effective dates are described in Appendix F. Plans offered will include:

- The State Health Plan Preferred Provider Organization (SHP PPO)
- Health Maintenance Organization(s) (HMOs),
- A Catastrophic Health Plan

The aggregate cost for the SHP PPO and HMO's extending into 2020 must fall below the federal excise tax thresholds established by the IRS under PPACA. The aggregate cost which must be counted toward the applicable 2020 federal excise tax threshold will be calculated in accordance with IRS guidelines.

The employer agrees to provide notice as soon as administratively feasible, but not later than July 15, 2019, of the SHP PPO rates and HMO rates for FY 20. If the aggregate cost for any one of the health insurance plans offered by the State for enrollment (the SHP PPO or any HMO's) extending into 2020 exceeds federal excise tax thresholds established by the IRS, the parties agree that beginning with the Flexible Spending Account (FSA) enrollment for calendar year 2020, the medical spending account option will be reduced or eliminated to maintain aggregate cost below the applicable 2020 federal excise tax thresholds, unless prohibited by law, or if doing so would invalidate the plan in whole or in part resulting in additional costs to the employer and/or employees.

The SHP PPO shall include coverage for the following:

(1) Wellness and Preventive Coverage.

In-network Wellness and Preventive Coverage will continue to be provided as required by the PPACA and as outlined in Appendix F.

The SHP PPO will continue to offer voluntary care management services for high-risk, medically complex cases designed to work with the covered employee or enrolled dependent, provider and caregivers to ensure a clear understanding of the condition, prognosis and treatment options and help coordinate provider services.

(2) Prescription Drugs.

In order to promote the usage of generic prescription drugs to reduce costs while maintaining the quality of care, the Pharmacy Benefit Manager (PBM) will automatically substitute an approved generic drug for prescriptions written for multi-source brand name drugs, except for a list of narrow therapeutic index agents, e.g., Dilantin. In those instances when a physician prescribes a multi-source brand name drug and indicates on the prescription, “Dispense As Written” or DAW, the brand name drug will be dispensed and the enrollee will pay the applicable preferred or non-preferred brand name co-payment plus the difference in cost between the generic drug and the brand name drug. Brand name drugs are deemed to be non-preferred because of the availability of a generic equivalent or a therapeutically or chemically equivalent brand name drug. Maintenance drugs filled at a participating retail pharmacy will only be approved up to a 34-day supply.

The Employer shall continue to offer a mail order prescription drug option for maintenance drugs. At the employee's option, an employee may elect to purchase maintenance prescription drugs filled at up to a 90-day supply through the mail order option.

The employee co-pays for drugs at retail and through mail order are listed in Appendix F.

(3) Second Surgical Opinions

An individual will be entitled to a second surgical opinion. If that opinion conflicts with the first opinion the individual will be entitled to a voluntary third surgical opinion. Second and third

surgical opinions shall also be subject to applicable office visit co-pays and deductibles as provided in Appendix F.

(4) Home Health Care.

A program of home health care and home care services to reduce the length of hospital stay and admissions shall be available at the employee's option. The service must be prescribed by an attending physician who must certify that the home health care services are being used instead of inpatient hospital care, and that the patient is confined to the home due to illness. Services shall be covered to the extent that they would have been covered if the individual had remained or been confined in the hospital.

Home infusion therapy shall be covered as part of the home health care benefit or covered by its separate components (e.g. durable medical equipment and prescription drugs), however a patient shall not be required to be homebound.

(5) Hospice Care.

Hospice care shall be available to terminally ill enrollees. Services must be provided by a participating hospice program, and written statements of prognosis may be required. Covered hospice benefits include physical, occupational and speech language therapy, Home Health Aid services, medical supplies and nursing care. See Appendix F for deductible and co-pay amounts.

(6) Birthing Centers.

Birthing center care shall be available to employees at their option in lieu of hospitalization. Birthing center care is covered under the delivery and nursery care benefits set forth in Appendix F.

(7) Hearing Care Program.

The hearing care program will include audiometric exams, hearing aid evaluation tests, hearing aids and fitting subject

to the applicable office call fee for the examination and shall be available once every thirty-six (36) months unless significant hearing loss occurs earlier and is certified by a physician. When medically appropriate, binaural hearing aids are a covered benefit. See Appendix F.

(8) Weight Reduction

Employees and covered dependents enrolled in the SHP PPO will be eligible for a lifetime maximum reimbursement of $300 for non-medical, weight reduction if they meet the following conditions:

(a) The employee or covered dependent is obese as defined by being more than one hundred (100) pounds overweight or more than fifty percent (50%) over ideal weight and weight loss clinic attendance is prescribed by a licensed physician, or

(b) The employee or covered dependent is more than fifty (50) pounds overweight or more than twenty-five percent (25%) over ideal weight, has a diagnosed disease for which excess weight is a complicating factor, and weight loss clinic attendance is prescribed by a licensed physician.

The $300 amount will not apply to the SHP PPO deductibles.

(9) Durable Medical Equipment.

Durable medical equipment (DME) and prosthetic and orthotics appliances are covered benefits as outlined in Appendix F, Medically necessary orthopedic inserts prescribed by a licensed physician are included as a covered benefit.

(10) Dependent and Long Term Nursing Care.

The parties agree to work cooperatively to provide assistance in identifying and referring employees and dependents to appropriate custodial care facilities and to agencies for custodial care at home.

(11) Smoking Cessation

The SHP PPO shall include a smoking cessation program which shall include smoking cessation counseling.

(12) In-and-out-of-network process. An employee may be eligible to receive a waiver to allow in-network coverage by out-of-network providers if in-network providers are not available within a standard distance below, or based on the type of services required.

Waivers will be available if the Third Party Administrator (TPA) determines access to network providers is not within the standard distance. The standards for the waiver are as follows:

- Where there are not two (2) primary care physicians within fifteen (15) miles;
- Where there are not two (2) specialists within twenty (20) miles;
- Where there is not one (1) hospital within twenty-five (25) miles.

Failure to seek services from a PPO provider will result in a Plan member being treated as out-of-network unless the covered member was seeking services as the result of an emergency. If there is not adequate access to a PPO provider, exceptions will be handled on a per case basis. A member is considered to have access to the network based on the type of services required, except as provided above.

If a member does not have access to the network, the member will be treated as in-network for all benefits. The member will be responsible for the applicable in-network deductibles, co-payments and coinsurance.

If a member does not have access to the network but then additional providers join the network so that the member would now be considered in-network, the member will be notified and given a reasonable amount of time in which to seek care from and in-network provider. Care received from a non-network provider after that grace period will be considered out-of-network and the out-of-network

deductibles, co-payments, coinsurance and out-of-pocket maximums will apply. If a member is undergoing a course of treatment at the time he or she becomes in-network, the in-network rules will continue for that course of treatment only pursuant to the PPO Standard Transition Policy. Once the course of treatment has been finished, the member must use an in-network provider or be governed by the out-of-network rules.

(13) Subrogation.

In the event that a Plan member receives services that are paid by the SHP PPO, or is eligible to receive future services under the SHP PPO, the SHP PPO shall be subrogated to the participant's rights of recovery against and is entitled to receive all sums recovered from, any third party who is or may be liable to the participant, whether by suit, settlement, or otherwise, to the extent of recovery for health related expenses. A participant shall take such action, furnish such information and assistance, and execute such documents as the SHP may request to facilitate enforcement of the rights of the SHP and shall take no action prejudicing the rights and interests of the SHP.

(14) Telemedicine

An optional telemedicine program will be available for health and mental health services, subject to applicable office visit co-pays and deductibles. See Appendix F.

2. Health Maintenance Organization (HMO).

As an alternative to the State Health Plan, enrollment in HMOs may be offered to those employees residing in areas where qualified licensed HMOs are in operation. HMO Coverage information is provided in Appendix F.

Section C. Dental Expense Plan.

(a) The State agrees to continue to offer dental plans. Coverage details, including premium share, co-pays, annual maximum and

separate lifetime orthodontic maximum and effective dates are described in Appendix G. Plans offered will include:

- The State Dental Plan Preferred Provider Organization
- A Dental Maintenance Organization (More Dental Maintenance Organizations shall be explored)
- A Preventive Dental Plan

(b) Covered Dental Expenses: The Dental Expense Plan will pay for incurred claims for employee and/or enrolled dependents at the applicable percentage of either the actual fee or the usual, customary and reasonable fee, whichever is lower, for the dental benefits covered under the Dental Expense Plan.

Coverage for the following services under each plan is listed in Appendix G:

(1) Diagnostic Services:

Oral examinations and consultations twice in a fiscal year.

(2) Preventive Services:

Prophylaxis - teeth cleaning three (3) times in a fiscal year, four (4) times when medically necessary;

Topical application of fluoride for children up to age 19, twice in a fiscal year;

Space maintainers for children up to age 14.

Oral exfoliate cytology (brush biopsy) will be covered when warranted from a visual and tactile examination.

(3) Radiographs:

Bite-wing x-rays once in a fiscal year, unless special need is shown;

Full mouth x-rays once in a five (5) year period, unless special need is shown.

(4) Minor Restorative Services (fillings):

Amalgam, silicate, acrylic, porcelain, plastic and composite restorations;

Gold inlay and outlay restorations.

(5) Major Restorative Services:

Onlays and crowns when the teeth cannot be restored with another filling material.

(6) Oral Surgery:

Extractions, including those provided in conjunction with orthodontic services;

Cutting procedures; Treatment of fractures and dislocations of the jaw.

(7) Endodontic Services:

Root canal therapy;

Pulpotomy and pulpectomy services for partial and complete removal of the pulp of the tooth;

Periapical services to treat the root of the tooth.

(8) Periodontic Services:

Periodontal surgery to remove diseased gum tissue surrounding the tooth;

Adjunctive periodontal services, including provisional splinting to stabilize teeth, occlusal adjustments to correct the biting surface of a tooth and periodontal scaling to remove tartar from the root of the tooth;

Treatment of gingivitis and periodontitis-diseases of the gums and gum tissue.

(9) Bonding:

The dental plan covers cosmetic bonding for the eight (8) front teeth of children between the ages of 8-19 years of age. Cosmetic bonding is a covered benefit when it is required because of severe tetracycline staining, severe fluorosis, hereditary opalescent dentin, or ameleogenesis imperfecta.

(10) Prosthodontic Services:

Repair or rebasing of an existing full or partial denture;

Initial installation of fixed bridgework;

Implants;

Initial installation of partial or full removable dentures (including adjustments for six [6] months following installation);

Construction and replacement of dentures and bridges (replacement of existing dentures or bridges is payable when five [5] years or more have elapsed since the date of the initial installation).

(11) Sealants:

Coverage for sealants on permanent molars that are free of any restorations or decay. Sealant treatment is payable on a per tooth basis. Dependents up to age 14 are eligible for the sealant application. The benefit is payable for only one application per tooth within a three (3) year period.

(12) Orthodontic Services:

Minor treatment for tooth guidance;

Minor treatment to control harmful habits;

Interceptive orthodontic treatment;

Comprehensive orthodontic treatment;

Treatment of an atypical or extended skeletal case;

Post-treatment stabilization;

Separate lifetime maximum of $1,500 per each enrollee; Orthodontic services for dependents up to age 19; for enrolled employee and spouse, no maximum age. Orthodontic coverage shall be extended to each dependent up to age 25 if the dependent is a full-time student at an accredited institution.

(d) Dental At-Point-of-Service PPO

Employees and dependents enrolled in the State Dental Plan may access the improved benefit levels specified in Appendix G by utilizing dental care providers that are members of the Point-of-Service PPO.

Section D. Vision Care Insurance.

a. The State agrees to continue to offer a vision plan. Coverage details for participating and non-participating providers, are described in Appendix H. Except for employees appointed to a position with a regular work schedule consisting of 40 hours or less per bi-weekly pay period as provided above, the Employer shall pay one hundred percent (100%) of the applicable premium for employees covered by this Agreement for the Group Vision Plan.

b. Benefits payable for participating providers under the Plan will be as follows:

(1) Examination: Payable once in any twelve (12) month period with an employee co-payment identified in Appendix H.

(2) Suitability Exam: A contact lens suitability exam determines whether you can wear contact lenses. The fee for this exam is included in the allowance for the contact lenses.

(3) Replacement Frequency: The Plan will cover eyeglass lenses, frames or contact lenses once every twelve (12) months if there is a prescription change.

(4) Eyeglass Lenses: Lenses are payable once every twelve (24) months with an employee co-payment identified in Appendix H for eyeglass lenses and frames. The standard lens size definition is 60 millimeters in diameter. If a larger lens is selected, the employee must pay for the additional expense attributable to lens size greater than 60 millimeters in diameter.

(5) Special Lenses: The Plan will cover slab off prism and prism lenses with no additional charge to the employee. Lenticular lenses are payable as defined in item 3 above.

(6) Contact Lenses

Medically Necessary: The Plan will cover medically necessary contact lenses once every twelve (12) months with an employee co-payment identified in Appendix H. Medically necessary means (a) must correct the member's

acuity to 20/70 or better in the better eye or (b) the member has one of the following visual conditions: keratoconus, irregular astigmatism, or irregular corneal curvature.

Not Medically Necessary: The Plan will pay a maximum allowance identified in Appendix H and the employee shall pay any additional charge of the provider for such contact lenses. The contact lens evaluation is included in the cost of the contact lens allowance.

(7) Frames: The maximum frame allowance is identified in Appendix H and the employee shall pay any additional charge from the provider for the frames.

(8) Lens Options: The Plan will cover Rose Tint 1 and Rose Tint 2 or Photochromatic tint at no additional charge to the employee

c. Plan payments for out of network providers are identified in Appendix H.

d. Computer Glasses: Employees who are required to use computers and other digital devices or microfiche readers on a full-time basis shall be eligible for reimbursement for an initial Vision Testing Examination at rates provided herein on regardless of when they were last examined, or on an annual basis in conjunction with a routine eye exam.

Such employees who require prescription corrective lenses which are different than those normally used, are eligible for an additional pair of glasses at the benefit level described in Appendix H. These lenses and frames are in addition to those provided under the Vision Care Insurance. An employee obtaining glasses for working who does not otherwise wear glasses would not be covered by this provision.

e. Safety Glasses: Employees who are required to use safety glasses on a full-time basis, as determined by the departmental employer, and who use prescription eyeglasses shall be eligible for a pair of prescription safety glasses at the benefit level described in Appendix H. These lenses and frames are in addition to those provided under the Vision Care Insurance.

Section E. Long Term Disability Insurance.

The Employer shall maintain the existing Long Term Disability Insurance coverage, except that effective October 1, 2005, the eligibility period for Plan II claimants who remain totally disabled shall be reduced from age 70 to age 65, or for a period of 12-months, whichever is greater. Additionally, the benefit period for "mental/nervous" claims shall be limited to 24 months from the beginning of the time a claimant is eligible to receive benefits. This limitation does not apply to mental health claims where the claimant is under in-patient care. These changes shall only apply to new claims made after September 30, 2005.

The Employer shall continue to provide a rider to the existing LTD Insurance program. All employees who are enrolled in the LTD insurance program shall automatically be covered by this rider. The rider shall provide a waiver of 100% of the health insurance (or HMO) premium while the enrolled employee is receiving LTD insurance benefits for a maximum of six months. The Employer shall pay the entire cost of such rider. To thereafter continue health insurance (or HMO) coverage during the LTD-compensable period, the employee shall be responsible for remitting his/her share of the premium (if applicable). If not prohibited by the IRS, an employee whose LTD rider has expired may transfer immediately to a state-employee spouse's health plan.

The LTD benefit shall be payable twice monthly for the first six months of disability; after six months, benefits shall be paid monthly.

An employee may "freeze" any sick leave accrued during the period when he/she is using up sick leave because of the disability which leads directly to receiving LTD benefits.

The monthly maximum benefit will be $5000 for disabilities beginning after September 30, 2002.

Section F. Life Insurance.

a. **Employee Life:** The Employer shall provide a State-sponsored group life insurance plan which has a death benefit equal to two (2) times annual salary rounded up to the nearest $1,000, with a minimum $10,000 benefit. The Employer shall pay one hundred percent (100%) of the premium for this benefit. Less than full-time employees who are working 40% or more of full time shall

have their benefit level determined as if they were working full-time in a full-time position. Employee life insurance coverage is effective on the first day of employment.

b. Dependent Life: An employee may enroll legal spouse and/or eligible children in a dependent life insurance plan. Dependent children must be unmarried and between the ages of 14 days and 23 years. The age ceiling under the optional life insurance plan shall not apply to dependents who are documented as being incapacitated by a physical or mental impairment, provided coverage does not terminate for any other reason.

(1) Employee pays one hundred percent (100%) of premium for optional dependent coverage via payroll deduction.

(2) Employee may choose between seven (7) levels of dependent coverage:

(a) Level one insures spouse for $1,500 and children from age 15 days to 23 years for $1,000**.**

(b) Level two insures spouse for $5,000 and children from age 15 days to 23 years for $2,500.

(c) Level three insures spouse for $10,000 and children from age 15 days to 23 years for $5,000.

(d) Level four insures spouse for $25,000 and children from age 15 days to 23 years for $10,000.

(e) Level five insures children only from age 15 days to 23 years for $10,000.

(f) Level six insures spouse for $50,000 and children from age 15 days to 23 years for $15,000.

(g) Level seven insures children from age 15 days to 23 years for $15,000.

9. Accidental Death Insurance.

The State shall provide a State-sponsored Accidental Death Insurance Plan which has a benefit of $100,000 in case of an employee's accidental death in line of duty.

Section G. Continuation of Group Insurances.

a. Upon Layoff.

(1) Employees who are laid off, at the time of layoff, may elect to continue enrollment in the SHP PPO (or alternative plan) and life insurance plan by paying the full amount (100%) of the premium. Such enrollment may continue until the employee is recalled or for a period of three (3) years, whichever occurs first. Such employees may also elect to continue enrollment in the Group Dental (or alternative plan) and/or Group Vision Plans by paying the full amount (100%) of the premium. Such enrollment may continue until the employee is recalled or for a period of eighteen (18) months, whichever occurs first. In accordance with Paragraph (2) of this Section, the Employer shall pay the Employer's share of such premiums for two (2) pay periods for employees selecting these options.

(2) Employees laid off as a result of a reduction in force may elect to pre-pay their share of premiums, if any, for the SHP PPO (or alternative plan), Group Dental Plan (or alternative plan), Group Vision Plan, and life insurance for two (2) additional pay periods after layoff by having such premiums deducted from their last pay check. The Employer shall pay the Employer's share of premiums for the SHP PPO (or alternative plan), Group Dental Plan (or alternative plan), Group Vision Plan, and life insurance for two (2) pay periods for employees selecting this option. Coverage for the State Health Plan (or alternative plan), Group Dental Plan (or alternative plan), Group Vision Plan, and life insurance shall thereafter continue for these two (2) pay periods. Election of this option shall not affect the laid off employee's eligibility for continued coverage as outlined in Paragraph (1) of this Section.

b. Upon Leave.

Employees who are granted a leave of absence may elect to continue enrollment in the SHP PPO (or alternative plan) at the time the leave begins. Except as may be otherwise

provided in the Federal Family and Medical Leave Act, for continuation of health plan benefits, such employees shall be eligible for continued enrollment during the leave of absence by paying the full amount (100%) of the premium. Such employees may also elect, at the time the leave begins, to continue enrollment in the life insurance plan for up to twelve (12) months by paying the full amount (100%) of the premium. Such employees may likewise elect to continue enrollment in the Group Dental Plan (or alternative plan) and/or Group Vision Plan for up to eighteen (18) months by paying the full amount (100%) of the premium.

c. Continuation of Life Insurance Coverage in the Event of Total Disability.

Upon presentation of satisfactory evidence of total disability to Civil Service, which is defined as receiving benefits from one of the following:

(1) The State's Long Term Disability Plan,

(2) Social Security Disability coverage,

(3) Workers' Compensation Insurance, or

(4) The State's Duty or Nonduty Disability Retirement Plan,

The employee shall receive life insurance coverage fully paid by the Employer for as long as the employee is totally disabled. All premium payments made by the employee prior to establishing Total Disability shall be reimbursed to the employee. The benefit level is the amount in force on the day the employee becomes totally disabled; however, if the employee is totally disabled on his/her 65th birthday, the employee shall be considered retired and the life insurance coverage shall be the same as if the employee had retired.

d. Group Insurance Enrollment Upon Limited Term Recall.

All employees covered by this Agreement who accept limited term recall into positions in these Bargaining Units are eligible for enrollment in all group insurance plans in which they were enrolled at the time of layoff. Coverages in such plans shall be

the same as the coverage at the time of layoff. Such employees shall not be considered as temporary (less than 720 hours) employees.

e. Health Plan coverage for enrolled dependents will cease the 30th day after a Bargaining Unit member's death unless the covered Bargaining Unit member is eligible for an immediate pension benefit from the State Employees' Retirement System, or unless the dependents elect continued plan coverage in accordance with provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Section H. Group Auto and Homeowners Plan.

Employees in these Bargaining Units shall, upon completion of a successful bidding process, be eligible for enrollment in a group auto and homeowners plan with the employee to pay the entire cost of any premiums.

Section I. Voluntary Benefits

Employees in these Bargaining Units shall be eligible to enroll in a Voluntary Benefits plan established by the Employer. The entire cost of any premiums shall be paid by the employee through payroll deduction or by direct bill as permitted by the specific plan. Benefits offered may include home and auto insurance, voluntary group term life insurance, universal life insurance, and a pre-paid legal plan. Plan offerings will be announced through an annual open enrollment process, and in the event any optional coverage plan is cancelled or withdrawn, employees enrolled in the plan will be sent written notice at least 30 calendar days in advance of the coverage end date.

Section J. Flexible Spending Accounts (FSAs).

The Employer shall maintain a flexible compensation plan for employees in these Bargaining Units, and employees are eligible to participate in Dependent Care and Medical Spending Accounts authorized in accordance with Section 125 of the Internal Revenue Service (IRS) Code except as provided in the 2015 Letter of Understanding titled “Federal Excise Tax Implications”.

Section K. Labor Management Healthcare Committee

The Union shall be entitled to continue to participate in statewide Labor Management Healthcare Committee meetings.