As the CSEA News goes to press, things are moving so quickly that we can only say this is a snapshot of where things stand in early June.

After a long and difficult set of discussions, SEBAC has reached a framework, which may lead to a tentative agreement with the Malloy administration that will protect our benefits long term, provide job security for our members in difficult economic times, and guarantee wage increases in the later years of the agreement. At the same time, this framework provides significant savings to the state, but in such a way as to minimize the pain to our members to the greatest extent possible.

This framework is not ready to be voted upon because there are issues that still need to be resolved at the individual bargaining tables. We are currently working to resolve those issues. Assuming those outstanding bargaining unit issues are resolved, we will be conducting informational meetings and a ratification vote in mid-July. You can read more about the framework on page 6.

Shortly after the framework was announced, the General Assembly’s Republican Caucus came out against the framework for being too generous to workers. Then on May 31, Republican State Senators held a press conference to announce their revised budget proposal which would dramatically “reshape labor laws” to force significantly larger cuts to state wages and benefits than what had been proposed previously, without union consent. This proposal would mean the end of collective bargaining as we know it. The Senate Republican proposal would also:

- And triple all workers’ pension contributions in future years.
- “We have the power within the legislature to change statutes, prospectively and currently, to achieve savings,” said Senate Minority Leader Len Fasano. “This is the power we have. We don’t have to sit back and wait.”

Ending collective bargaining will not help our economic problems, just as it didn’t help the people of Wisconsin, Michigan or any of the other still struggling rust belt states that made the same mistake of blaming working families for their broader economic troubles. Without union contracts (negotiated through the collective bargaining process) to help set standards, wages and benefits for all workers in our state will fall. Without collective bargaining, an important safeguard against political cronyism will disappear and workers will no longer be able to speak out about important issues hurting the public without fear of retaliation by politicians.

State leaders have failed to finalize a state budget before the official close of the legislative session at midnight on June 7 and will have to finalize the budget during a special session.

Time for some real talk.

For better or worse, elections have consequences, and the 2016 election was a disaster for labor. We are now experiencing the results of a 50-year campaign against workers, unions, and collective bargaining. Look around at the rest of the country. Workers everywhere are suffering and the wealthy stand to benefit in a big way from the Trump administration’s recent appointment of right wing Justice Gorsuch to the Supreme Court, restoring the anti-worker majority. In Connecticut, we have fewer worker-friendly legislators in the General Assembly now than at any point in the last 30 years, and while Republicans have taken a hard ideological stance against the interests of labor and working families, many Democrats have also signed onto the lie that attacking unions is good for business.

In this context, we have been saying for months that we need to have more of a presence at the Capitol than ever before. To the members who responded by calling their legislators, coming to Hartford, and attending rallies I sincerely applaud you. We had a good turnout for our Council 400 Lobby Day on May 24, and those members did a fantastic job.

But every member of CSEA needs to do a serious gut check right now. Our union strength comes from our ability to spring into action and fight for issues that are important to us. If the anti-worker politicians in Hartford succeed in ending collective bargaining in Connecticut, we won’t need to worry about SEBAC frameworks or contract negotiations ever again because it will all go away. Ka-poo! Gone forever, and then we will have no say whatsoever in cuts to our wages/benefits this or future legislatures decide to unilaterally impose on state employees.

The only choice we have right now is to push for changes to the state’s tax structure and fight back against service cuts and when the 2018 election comes around we need to go vote for the most pro-worker candidates we can find because the picture at the Capitol is going to remain bleak if we don’t work to change it.

If you haven’t gotten our emails, it is likely because we do not have up-to-date contact information for you. Complete the information below and mail it to us either via email to emailupdate@csea760.com or mail the below form to:

**CSEA SEIU Local 2001**

760 Capitol Ave,

Hartford, CT 06106

Visit Our Union’s Website at **www.CSEA-CT.com**
Council 400 Summer Picnic

Join Us For Our Annual Outing

The Farmington Club’s 20-acre facility provides:
- Olympic sized swimming pool
- On-duty lifeguard
- Softball
- Basketball
- 6 Tennis courts
- Private dressing rooms
- Horseshoes
- Fishing
- Sand volleyball courts
- Showers
- Bocci ball court

Wednesday, August 30, 2017
11:00AM - 4:00PM, Rain Or Shine
Buffet from 12 noon - 2:30

At The Farmington Club
162 Town Farm Road Farmington, CT 06032

1-84 Exit 39, or Rte. 10 (to follow 1-84, exit 39) then Rte. 4 west to Farmington Center, proceed 1/2 mile west of center on Rte. 4, then right on Town Farm Road 1 1/2 miles.

Or, take Rte 9 north to I-84 west to Exit 39. Proceed as above on Rte. 4.

The Farmington Club
is handicap accessible.

Please complete this coupon
Council 400 Annual Outing: Wednesday August 30, 2017
Reservation Deadline: August 21st, 2017 (No refunds after this date).

Member: ___________________________ Spouse: ___________________________
Address _______________________________________________________________

Number of Guest(s): __________ Names: ____________________________________

$ Amount Enclosed: __________ Phone Number: __________ Chapter: __________

Mail this completed coupon and check (Payable to CSEA Council 400) to:
CSEA Council 400, 760 Capitol Ave., Hartford, CT 06106

You need only present your name at the entrance to obtain access to the Farmington Club.

COST:
(Includes a 2 1/2 hour lunch buffet (NOON-2:30PM) snacks and tax/gratuity)
- $15 Members
- $25 Member’s spouses
- $38 Members’ guests

Editors Note: June luncheon fliers were mailed to members’ homes. Council 400 does not hold regular meetings in July and August.
I am writing to express my deepest gratitude to you and the many SEIU staff and attorneys at Silver Golub & Teitell who worked tirelessly for 1.3 years to achieve justice for those of us who were unfairly laid off from state employment by Governor John Roland in 2002. I never dreamed that I would ever see the wages I lost during those very stressful eight months I was laid off.

Miraculously, I am thrilled to have just received a settlement check for my back pay, plus interest! I finally feel healed, thanks to the perseverance of SEIU and Silver Golub & Teitell. Please tell everyone involved how much I appreciate what they’ve done. I want you to know how thankful I am to be part of SEIU and to have had the union fighting relentlessly on my behalf (and others in the class action) for well over a decade! I can’t imagine what an arduous task this must’ve been, but all those who fought the battle should be proud that justice prevailed.

At the time of the layoffs, I was still in my working test period; I’d been with the department of education for only four months. It was so crushing to be pushed out the door, separated from friends and colleagues with more seniority. That was the worst financial struggle of my life, with my husband also laid off at the time, a mortgage and bills to pay, and both of us collecting unemployment. We had no health insurance and I couldn’t even afford to buy new clothes for job interviews.

After eight long months, I finally made it back to the education department, doing the science education work I loved for another 13 years. I retired one year ago, and this unanticipated compensation will enable me to make some dreams come true.

With deep appreciation,
Elizabeth Butter
CSEA Member Honored

On April 24th, the Connecticut Alliance for Retired Americans honored CSEA Council 400 member Amelia Smith with its “Activist of the Year” award. The event took place at the Connecticut Alliance’s 12th Annual Award Luncheon in Plantsville. Amelia is a delegate to our Retiree Council 400 and is President of her chapter, Chapter 410 in Suffield. She is also CSEA’s representative as a Vice-President to the Connecticut Alliance for Retired Americans.

More than a 100 delegates from various union retiree organizations attend the awards ceremony. CSEA had the largest contingency of delegates at the event. In addition to her CSEA family, her family and her church family were also in attendance.

The Connecticut Alliance for Retired Americans is one of thirty-five state chapters of the national organization, Alliance for Retired Americans. The long-term goal of the national Alliance is to engage in legislative battles to protect and preserve the health and economic security of older Americans.

State Retirees

By CSEA Retiree Coordinator Bernadette Conway

MEDICARE ADVANTAGE

As many people have heard by now, Comptroller Kevin Lembo put out a Request for Proposals for an insurance carrier to provide the State Employee Retiree Health Plan for Medicare covered retirees using a Medicare Advantage vehicle back in January. Finalizing this process is subject to approval by the State and by SEBAC. Because the results of the Request would produce substantial savings for the state, and improvements for Medicare Covered retirees, the RFP will go forward as part of the new Framework for an agreement between the State and SEBAC, assuming that Framework becomes a TA and is approved.

The State Health Care Cost Containment Committee, which is a body made up of both state labor leaders and state management, will be overseeing the implementation of the plan along with the Comptroller. Because there would be no loss of benefits for retirees, and the network would actually improve, combined with the cost effectiveness of the program, the target date for implementation will be January of 2018.

Many people have a negative association with Medicare Advantage based upon their experiences with INDIVIDUAL Medicare Advantage plans. Such plans have been notoriously plagued by limited doctor networks. The GROUP Medicare Advantage being proposed for post 65 retirees bears no resemblance to the individual plans. Our benefits and network coverage will actually expand as a result of moving to Medicare Advantage. We are not allowing any insurance carrier to set the terms of our plan. Our plan is set by the SEBAC Agreement, and its benefits are not changed by switching to Medicare Advantage as a vehicle for delivering those benefits to Medicare covered retirees – except to the extent we’ve actually been able to make some improvements. That means everything that you receive with your secondary insurance currently, you will continue to receive. And you will see improved benefits – this plan eliminates the out of network co-pay for Medicare covered services, and Silver Sneakers will be available to our members as some as some other improvements in podiatry and other services.

How will it work? You will receive a new insurance card that you will submit to your doctors and pharmacy. Doctors will see a benefit card that says the insurers name, not Medicare Advantage, along with State Employee Health Plan. Like all plans, it will produce by computer available to vendors its benefit mix which is ours plus improvements. It will have numbers to call to verify coverage for our plan, just like we do now.

Please see the Medicare Advantage Fact Sheets on page 9 to answer many questions you might have. As always, CSEA is committed to providing and preserving the benefits you worked hard for and deserve. More information will be provided in future CSEA Newsletters as well as be mailed to retirees.

HEARING AIDS

I am happy to report that hearing aids are still covered in your Healthcare Plan! As in the past, if you are in need of a hearing aid, call the Anthem Customer Service number, 1-800-922-2232, to ask them for participating physicians. Get more than one name, and make a few phone calls before making an appointment. Call to make sure they do not charge extra for the hearing test or the fitting.

Your basic hearing device will be covered 100 percent, but some physicians do not count the hearing test of fitting in the basic device, so you need to ask, otherwise you will be charged extra. Also, any “extras” or upgrades to the basic device will not be covered. You are entitled to one new device after 24 months.

PHONE FOR HEARING IMPAIRED

Phones with captioning for the hearing impaired are available at no cost for those that qualify. Title IV of the Americans with Disabilities Act (ADA) of 1990 mandated a nationwide system of telecommunications relay services to make the telephone network accessible to people who are deaf or hard of hearing or who have speech impairments. You can contact Wayne Simmons of ClearCaptions to find out how to get your free caption phone at 860-335-1140 or email him at wayne.simmons@clearcaptions.com.

COUNCIL 400 PICNIC

The Council 400 Picnic will be held on Wednesday, August 30th and will be at a new site, the Farmington Club, in Farmington, CT from 11am to 4pm, with a picnic buffet during lunchtime. The order form will be in next month’s edition of the CSEA News, but SAVE THE DATE!!!

TRIP TO THE CAPITOL

If you have ever wanted to take a see the history of our beautiful State Capitol, the CSEA Council 400 has set a date for a tour, Thursday, June 29th at 10:15 a.m. Please call or email me at 860-951-6614, ext. 112 or bconway@csea760.com if you are interested in attending.

ANTHEM IDENTITY PROTECTION

As you may remember, several years ago there was a security breach in the Anthem system. As long as you are an Anthem member, you are entitled to identity protection at no charge from All Clear ID, but it requires you to renew it every year. Normally, members are contacted by mail or email. If you are unsure if you renewed the protection, you can call them to find out at 1-855-227-9380 or 1-855-434-8077. When you call, you will need to tell them that you are a current Anthem member. If they tell you that you are not signed up for it, ask them to enroll you for the free protection.

Important numbers to have on hand:

• Retirement Division Payroll: 860-702-3480 or toll free 1-866-437-3586
• Retirement Division Life Insurance: 860-702-3537
• Retirement Division Health Insurance: 860-702-3533
• Questions regarding deferred compensation: 860-702-3543
• Anthem Blue Cross Blue Shield: 1-800-922-2232
• Oxford Health: 1-800-385-9055
• Caremark: 1-800-318-2572
• Silverscript: 1-866-693-4624
• Cigna: 1-800-244-6224
• HEP Care Management Solutions: 1-877-687-1448 or visit them at their CSEA Portal:
  • HEP Care Management Solutions: 1-877-687-1448 or visit them at their
  • Cigna: 1-800-318-2572
  • Silverscript: 1-866-693-4624
  • Caremark: 1-800-385-9055
  • Oxford Health: 1-800-385-9055
  • Anthem Blue Cross Blue Shield: 1-800-922-2232
  • Caremark: 1-800-318-2572
  • Silverscript: 1-866-693-4624
  • Cigna: 1-800-244-6224
  • HEP Care Management Solutions: 1-877-687-1448 or visit them at their portal:

Continued on page 5
Social Activities

All trips are open to everyone, including the general public. Here are some of the trips CSEA’s Social Activities Committee is working on for the coming year. Please use the RSVP form below if sending checks.

For All trips, mail checks with the RSVP Form (below) to CSEA Social Activities Committees 760 Capitol Ave, Hartford CT 06106  Questions?  Call 860-951-6614

NAME  
ADDRESS  
PHONE  
EMAIL  
TRIP  
TRAVEL COMPANION  
NAME  
COMPANION PHONE  
BUS PICK UP POINT

Boston Red Sox Vs. New York Yankees at Yankee Stadium (Bronx, NY)  
Sunday August 13, 2017. Game Time: 1PM. Price $135 per person. Includes Motor Coach Transportation, Game Ticket, possible complimentary food & beverages, call for more info. RSVP by 7/24/2017. Bus departs from Windsor Commuter Lot at 8:00am and the Southbury Commuter lot at 8:45am. Note: This trip is non-refundable.

Saratoga Horse Races, (Saratoga, NY) Very limited space  
Saturday, August 19, 2017. Price: $84  
Includes Motorcoach transportation, Admission Ticket, and reserved Grandstand seating for Saratoga Races. Bus departs from New Britain/West Hartford Commuter Lot Across from Target near Westfarms Mall at 8:15am and Manchester Commuter Parking Lot, Buckland Street and Pleasant Valley Road at 8:45am. RSVP by 8/1/2017. Note: This trip is non-refundable

Washington, DC AND George Washington’s MT. Vernon Estate and Garden  
Friday, September 29 - Monday, October 2. Price: $405 Per Person (double occupancy)  
Bus departs from Windsor Commuter lot at 8:00am and from the Southbury Commuter lot at 8:45am. RSVP by 7/27/2017

Other Upcoming Trips:

Kittery Shopping Outlets, Kittery, ME  
Saturday, October 7, 2017 Price TBD

9/11 Museum Trip  
Sept 2017 or October 2017. Price TBD

Retirees Continued

I want to thank all who participated in the CSEA Retiree Lobby Day on Wednesday, May 24th. Those who participated were able to contact their Legislators to send them the important message to protect their benefits. It was a great day! If you weren’t able to come to Hartford to participate, please contact your House Representative or Senator by email or phone.

HOW TO FIND YOUR LEGISLATORS:

Online: go to www.cga.ct.gov/asp/menu/cgafindleg.asp  
This will bring you to the site where you type in your address, and it tells you who your Legislators are. Click on their name and it will give you their contact information. Or call:

• Senate Republicans: 860.240.8800, Toll free - 800.842.1421
• House Republicans: 860.240.8700, Toll free - 800.842.1423
• Senate Democrats: 860.240.8600, Toll free - 800.842.1420
• House Democrats: 860-240-8500, Toll free - 800.842.1902

Please call CSEA at 860-951-6614 to check trip availability or for more information

Please call for trip availability. No refunds on cancellations on or after deadline. Travel insurance (cancellation waivers) available on some trips (see flyer) due with initial reservation. Reservations accepted on a first-come, first-served basis.
As the CSEA News goes to press, bargaining units are working to finalize their unit agreements within the framework outlined below. This framework is the result of several months of difficult discussions, but we believe it is a fair agreement that will protect our benefits long term, provide job security for our members in difficult economic times, and guarantee wage increases in the later years of the agreement. At the same time, this framework provides significant savings to the state, but in such a way as to minimize the pain to our members to the greatest extent possible.

The full SEBAC framework and all other documents referenced on the subsequent Q&A’s can be viewed on the CSEA webpage www.csea-ct.com and on the SEBAC website www.CTStateEmployees.com

### SEBAC Framework

SEBAC 2017: Pre-7/1/22 Financial Impacts to Members

<table>
<thead>
<tr>
<th>Contract Item</th>
<th>Contract Year (July 1-June 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16-17</td>
</tr>
<tr>
<td>GWI</td>
<td>0</td>
</tr>
<tr>
<td>AI</td>
<td>0</td>
</tr>
<tr>
<td>Lump Sum</td>
<td>No</td>
</tr>
<tr>
<td>Longevity</td>
<td>Yes, on time</td>
</tr>
<tr>
<td>Active employee health care premium share</td>
<td>Current rate</td>
</tr>
<tr>
<td>Furlough Days</td>
<td>No</td>
</tr>
<tr>
<td>Pension Contributions</td>
<td>Current contribution</td>
</tr>
<tr>
<td>Retiree health premium share</td>
<td>None</td>
</tr>
<tr>
<td>Drug co-pays</td>
<td>$5/20/35</td>
</tr>
<tr>
<td>ER co-pay for Unnecessary visit</td>
<td>$35</td>
</tr>
<tr>
<td>Site of Service Labs/Diagnostics</td>
<td>None</td>
</tr>
<tr>
<td>Treatment choice incentives</td>
<td>Not available</td>
</tr>
<tr>
<td>Medicare advantage</td>
<td>Not available</td>
</tr>
<tr>
<td>Job security</td>
<td>Expired 6/30/15</td>
</tr>
</tbody>
</table>

Post 6/30/22 – SEBAC health & pension agreement will be extended to 6/30/27. Health & pension benefits stay the same (except for those hired on or after 7/1/17 - subject to new Tier 4) but COLA formula changes per SEBAC 2017, and a 30 month delay is put in place before receiving first COLA, in addition to some less significant changes (see TA for details).

* - Note that unit agreements expire on 6/30/21; this year is shown only for highlighting last year of premium share increase.
### Q&A On the SEBAC Framework

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is it true that SEBAC leaders signed a tentative agreement with the governor’s administration?</td>
<td>No – what coalition leaders authorized on Tuesday, May 23 was a framework document that is specifically <strong>not</strong> a tentative agreement (TA). You can see a copy of it here: Framework Document. To become a tentative agreement, local bargaining unit contracts will need to be completed through local bargaining committees; a formal tentative agreement will then need to be created, and a vote taken by SEBAC leaders to approve it as a TA.</td>
</tr>
<tr>
<td>2. When do the members get to vote?</td>
<td>As is always the case, tentative agreements go to the membership for ratification. Since the framework concerns both local issues and SEBAC Coalition issues, bargaining unit members will vote on two questions: Whether to approve their local agreement, and whether to support the SEBAC Agreement.</td>
</tr>
<tr>
<td>3. When will all of that occur?</td>
<td>We hope to conclude bargaining unit agreements as quickly as we can, but it will take some time as there are 33 units now bargaining. Once that is completed, and a tentative SEBAC agreement can then be reached, it will take some time for each union to follow its membership ratification procedure.</td>
</tr>
<tr>
<td>4. Is that the last step?</td>
<td>No. The final step is approval by the General Assembly, but that doesn’t happen until after all members of coalition unions in good standing complete their voting process.</td>
</tr>
<tr>
<td>5. When should I retire if I want to do so before changes in the framework would apply to me?</td>
<td>No pension changes affect anyone who retires before 7/1/22, other than the pension contribution changes which of course end when you retire. To see the effective dates when health care changes effect new or current retirees, please refer to the Health Care Q&amp;A, or to the Medicare Advantage Q&amp;A. For Health Care you may also want to refer specifically to the Framework Document at the bottom of page 1 and the top half of page 2.</td>
</tr>
<tr>
<td>6. Where can I find out more information?</td>
<td>The best place is through your elected union leadership or through your union’s website. You can also find helpful links here: <a href="http://www.CTStateEmployees.com">www.CTStateEmployees.com</a></td>
</tr>
</tbody>
</table>

### Q&A On Health Care

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Will the State Employee Health Care Plan Change for Actives and Future Non-Medicare Retirees</td>
<td>There will be some changes designed to save money and improve health. But the basic plan choices between “POS Plans” and “POE Plans” will continue, with both types of plans having the same network, POS plans allowing out of network coverage, and “POE plans” allowing coverage only in network. All of those choices remain exactly as described in the Health Care Planner that was mailed to employee’s homes, and has been on the Comptroller’s website since late April, except for the changes explained below.</td>
</tr>
<tr>
<td>2. So what does change?</td>
<td>There are some changes in pharmacy benefits, and some changes in medical benefits. We’ll take them separately.</td>
</tr>
</tbody>
</table>
| 3. Okay, let’s start with medical. What changes?                       | 1. We have provided significant positive incentives for members to use the most high value, cost effective providers. These incentives come from Tiered Provider Networks and Smart Shopper, which are explained in more detail below.  
2. We have a new network structure for outpatient laboratory services and diagnostic imaging called Site of Service (also explained below).  
3. The co-pay for unnecessary emergency room visits is raised much higher – to $250. However, we continue to use the current definition of “unnecessary”, which waives the co-pay if the patient is admitted to the hospital, or if the patient had no reasonable alternative to using the ER. (A link to the current waiver request form is here: ER Copay Waiver)  
4. Finally, the Plan already requires medical necessity for physical or occupational therapy (PT/OT) but the vendors have had not had a clear and consistent structure of utilization management to review medical necessity. A consistent utilization standard will now be applied. |
| 4. How do Tiered Provider Networks and Smart Shopper work?             | Tiered Provider Networks waive the current $15 co-pay for a set of primary care providers, and specialists, who have been found to provide high quality, cost effective care. About 70% of primary care providers will be in the preferred Tier. Tiering of specialists will begin with 10 specialties for which there is currently good quality data, but may be expanded. Within these 10 specialties, about 60% of the doctors are in the preferred Tier. Finally, under the Smart Shopper Program, there are currently 9 medical procedures for which rebates will be made available to members based on data showing these procedures are provided in a way that is cost effective, and reduces secondary risks like hospital readmission, hospital acquired infection, etc. In each of these cases, if a member chooses a non-preferred provider, or not to use a Smart Shopper provider, the benefit remains precisely what it is now. These upsides to members may be expanded over time as more data becomes available with respect to other specialties and procedures. |
| 5. How do these positive changes for members actually save the Plan money? | By encouraging members to use high quality, cost effective providers who have good results (e.g. avoid hospital readmission, have fewer complications, etc), the savings far exceed the cost of rebates or waivers. |
Q&A On Health Care (continued from Page 7)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| 6. Which specialties are going to be Tiered? | So far:  
- Allergy & Immunology  
- Cardiology  
- Endocrinology  
- ENT  
- Gastroenterology  
- OB/GYN  
- Ophthalmology  
- Ortho/Surgery  
- Rheumatology  
- Urology |
<p>| 7. Which procedures will provide rebates to patients through Smart Shopper? | Site of Service is the name for the new network structure for outpatient laboratory services and diagnostic imaging (blood work, urine tests, stool tests, x-rays, MRIs, CT scans, etc.). Plan data has shown tremendous variation in the amount the Plan is charged for outpatient diagnostic tests such as blood tests, MRI, and CAT scans, even though the reading of those results is by the same doctors. The labs themselves charge prices that may vary by as much as 300% for exactly the same test. To encourage the use of the reasonably priced labs, about 60% of labs and imaging centers will be designated preferred labs and will continue to be 100% covered by the Plan. Of the remaining labs, most will be deemed “in network” and will have 80% coverage. The remainder will be deemed “out of network” and will be 60% covered. This a new restriction in the plan, but it is required that members always have convenient options of 100% covered facilities throughout the state. The Plan’s savings comes from encouraging members to avoid the high price facilities which provide the same services as the reasonably priced ones. |
| 8. How does Site of Service work? | Site of Service is the name for the new network structure for outpatient laboratory services and diagnostic imaging (blood work, urine tests, stool tests, x-rays, MRIs, CT scans, etc.). Plan data has shown tremendous variation in the amount the Plan is charged for outpatient diagnostic tests such as blood tests, MRI, and CAT scans, even though the reading of those results is by the same doctors. The labs themselves charge prices that may vary by as much as 300% for exactly the same test. To encourage the use of the reasonably priced labs, about 60% of labs and imaging centers will be designated preferred labs and will continue to be 100% covered by the Plan. Of the remaining labs, most will be deemed “in network” and will have 80% coverage. The remainder will be deemed “out of network” and will be 60% covered. This a new restriction in the plan, but it is required that members always have convenient options of 100% covered facilities throughout the state. The Plan’s savings comes from encouraging members to avoid the high price facilities which provide the same services as the reasonably priced ones. |
| 9. What are the pharmacy changes? | There are two changes in pharmacy which save money mostly by encouraging members to use more cost effective pharmaceutical drugs. One is a change in co-pays, the second is a change in formulary. They are described separately below: |
| 10. What is the change in pharmacy co-pays? | For drugs prescribed under the Health Enhancement program, pharmacy co-pays move from the current structure of $5/15/25 to a new structure of $5/10/25/40. The current structure has three prices: Generics are $5, Preferred Brand Names $10, and non-preferred are $25. The new structure has two Generic Prices -- $5 and $10 -- to encourage members to use lower price generics. This is because recent consolidation in the generic drug industry has allowed some manufacturers to price gouge while much more reasonably priced clinically equivalent generics are available elsewhere. The increase in the brand name pricing further incents members to use generics. Co-pays for drugs prescribed to treat chronic condition under the Health Enhancement Program (like insulin for Diabetes, or statins for High Blood pressure) will not change. |
| 11. What is the change in pharmacy formulary? | Our plan will move to using the standard CVS/Caremark formulary which fights price gouging in the pharmacy industry by removing certain drugs from the standard prescription list where their price has become excessively high, and there are equally clinically effective alternatives available. If a doctor feels a non-formulary drug is medically necessary, a member may appeal any CVS/Caremark denial, and the ultimate determination will be made by the patient’s doctor, not CVS/Caremark. |
| 12. Why do all of these changes make sense? | In total, they save a lot of money, which is good for the plan, but also good for members who through their premium share currently pay an average of 12% of plan costs. Just as important, though, they save money primarily by keeping members healthier, or by encouraging members to avoid unnecessary costs rather than simply making members pay more. We think these kinds of changes are the best way to “bend the curve” of health care costs for the state and for the members. |
| 13. When do these changes take effect? | For actives they should start around 7/1/17 or upon legislative approval of the agreement if that’s after 7/1. The benefit enhancements that save money (Tiered Networks and Smart Shopper) or which are purely procedural (PT/OT) will apply to retirees on around the same date. The other changes (increased ER co-pay, the laboratory/imaging network change, and pharmacy changes) will apply only to new retirees who retire on or after October 2, 2017, or the 2nd of the month at least 60 days after legislative approval, whichever is later. |
| 14. Are there any changes in the Health Enhancement Program (HEP)? | There are no new HEP requirements. However, the parties did agree to explore adding new HEP opportunities for members to choose to sign up for, or not sign up for, on a totally voluntary basis (choosing not to sign up would have no impact on whether a member can remain in the HEP). If new voluntary opportunities are created, they will be studied for cost-effectiveness to see if they should remain an option for members who choose them. |
| 15. We heard something about a new Medicare Advantage plan. Why isn’t that discussed here? | This Q&amp;A is about Active and Future Retirees under 65. Medicare Advantage, which pertains to retiree healthcare for Medicare covered retirees, is describe in the Medicare Advantage Q&amp;A on page 9. |</p>
<table>
<thead>
<tr>
<th><strong>Question</strong></th>
<th><strong>Answer</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Is it true that Medicare-eligible Retirees Will be Moving from the State Employee Health Plan to a new Medicare Advantage Plan?</td>
<td>No – Medicare eligible retirees will remain on the State Employee Health Plan. What will change is the vehicle by which Plan benefits are delivered.</td>
</tr>
<tr>
<td><strong>2</strong> What does that change to Medicare Advantage mean for how Plan Benefits are delivered to Medicare-covered retirees?</td>
<td>Currently when those retirees get Medicare covered services, Medicare pays first, and the State Plan through its insurance vendor pays the part Medicare doesn’t pay (subject to plan co-pays and deductibles). Some services are not Medicare covered (like Naturopaths) and those services are covered only through the Health Plan. Under Medicare Advantage, for Medicare covered services the insurance vendor pays both the part Medicare pays, and the part the State Plans pays, and then is reimbursed by the federal government. As before, non-Medicare covered services will continue to be paid by the Plan without federal reimbursement.</td>
</tr>
<tr>
<td><strong>3</strong> Will my benefits change?</td>
<td>Yes, but only positively. Every single benefit currently covered under the State Employee Health Plan will continue to be covered. Some new benefits will be provided – for instance “Silver Sneaker” coverage is added at no cost.</td>
</tr>
<tr>
<td><strong>4</strong> But won’t more doctors be out of Network?</td>
<td>Actually it’s the opposite. The plan currently has a wide network of providers, but there are a substantial number who will be out of Network. Using Medicare Advantage to provide Medicare covered services, the Plan will treat all doctors who accept Medicare in any way as in Network. That’s over 99% of doctors who provide Medicare covered services. The Network for non-Medicare covered services won’t change.</td>
</tr>
<tr>
<td><strong>5</strong> This sounds too good to be true? How can this change possibly save money?</td>
<td>The answer is in how the federal government reimburses for Medicare covered services. Under the current structure for delivering those services, Medicare pays pre-set amounts for specific services, regardless of the particular patient involved. Under the new Medicare Advantage vehicle, the federal government accepts that patients have various risk factors that make services more likely to be needed. Medicare reimburses more for those patients, and the State shares some of those savings. In addition, Medicare provides incentives for keeping riskier patients healthier, and the State share part of those savings as well.</td>
</tr>
<tr>
<td><strong>6</strong> Isn’t the State self-insured? How do we know the Insurance vendor isn’t making savings promises it can’t keep</td>
<td>The contract with a Medicare Insurance provider is insured. That is, the provider must provide the benefits at the cost to the State it quoted during the contract period.</td>
</tr>
<tr>
<td><strong>7</strong> One of my parents was on an individual Medicare Advantage plan years ago? Is this the same kind of vehicle?</td>
<td>Not at all. Individual Medicare Advantage Plans provide benefits set by the Carrier. We Have GROUP Medicare Advantage with benefits set by the group, in this case our SEBAC agreement, NOT the carrier; and so the carrier must provide all the services covered by the State Employee Health Plan. In addition, years ago Medicare Advantage plans made their money by using narrow networks which allowed them to lower provider reimbursement rates. Currently, group Medicare Advantage makes money (and shares savings) by maximizing federal reimbursement rather than negotiating low provider rates.</td>
</tr>
<tr>
<td><strong>8</strong> What do we hope will happen as a result of the Medicare Advantage vehicle?</td>
<td>We hope not only to save money due to the higher federal reimbursements, but in the long run save even more money by keeping seniors healthier. The federal reimbursement structure is designed to encourage things like home visits for at risk seniors, 24 hour telephone availability for seniors with questions or concerns, and wellness incentives like Silver Sneakers. If we work together, we will save money, improve health, and improve the quality of life for our Medicare Covered retirees.</td>
</tr>
<tr>
<td><strong>9</strong> Can the Insurance Vendor Change Our Coverage or Benefits Over Time?</td>
<td>Absolutely not. The benefits and coverage rules are set by the SEBAC Agreement. The vendor must provide the State Employee Health Plan using the Medicare Advantage vehicle.</td>
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Q&A For Future Retirees

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<tbody>
<tr>
<td>1</td>
<td>I’m confused about how the changes in the SEBAC Framework might affect me when I retire. I know the Pension and Health care agreement is extended and would now expire 6/30/27, but there are some changes. Can you explain how this work?</td>
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<td>Sure. There are a few changes that would affect both current and future retirees – changes that improve benefits while at the same time producing savings. For under 65 retirees these include co-pay waivers and rebates for certain preferred providers, and for over 65 this includes using the Medicare Advantage vehicle to provide our plan benefits, which allows us to expand our network and improve benefits. You can read about those at <a href="#">Health Care Q&amp;A</a> and <a href="#">Med. Adv. Q&amp;A</a>. This Q&amp;A will focus on pension and retiree health care changes that affect only future retirees.</td>
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<td>2</td>
<td>What are the pension benefit changes that might affect me when I retire?</td>
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<td>If you retire before the current agreement would have expired (6/30/22), there are no changes that affect you. You retire under the current pension plan as is. If you retire after 6/30/22, the only pension benefit change that affects you is a change to the Cost of Living Adjustment, or “COLA”.</td>
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<td>3</td>
<td>What does happen to the COLA effective for people retiring after 6/30/22?</td>
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<td>There are two changes. One affects the COLA formula, the other affects the first date you receive a COLA. They are explained below.</td>
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<td>4</td>
<td>Can you start with the COLA formula change? What happens that affects 7/1/22 and later retirees?</td>
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<td>Since 1997, our COLA has been computed as a percentage of the increase in the most common consumer price index, called CPI-W. Currently our COLA is 60% of the increase in the CPI-W up to 6%, and 75% of the increase above 6%, with a minimum COLA of 2%, and a maximum of 7.5%. The new formula will provide the same COLA as the current formula except in years where the CPI-W goes up less than 2%. In those cases, while the current formula produces a COLA of 2% even if the CPI-W increase is less than 2%, the new COLA would provide an increase equal to the CPI-W increase.</td>
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<td>5</td>
<td>What change affects the first date I receive a COLA?</td>
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<td>Currently, depending upon the exact month you retire, the delay between retirement and your first COLA is 9 to 15 months, averaging 12 months. Starting with 7/1/22 retirees, your first COLA would be on the 30th month following the date of your retirement – so 18 months later than it is now – and then every 12 months thereafter. However, there may also be an additional COLA paid with your first annual COLA that provides some protection if the cost of living increase is unusually high during the first 18 months following your retirement.</td>
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<td>6</td>
<td>How does the additional COLA work?</td>
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<td>Effective the 30th month after retirement, in addition to your normal annual COLA, you will receive an additional COLA if during your first 18 months of retirement, the CPI-W goes up more than an annualized 5.5%. If so, the additional COLA is above formula, minus 2.5%, multiplied by 1.5 (because it’s 18 months). This sounds complicated, but what it comes down to is if your 18-month delay happens to be in a very high cost of living increase year, you will get the same annualized COLA you would have received without that delay, minus 2.5%. So the delay still affects you, but it’s effect is more limited.</td>
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<td>7</td>
<td>What about Retiree Health Care (“RHC”) Premium Shares? What happens there?</td>
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<td>Two things affect the cost of retiree health care. They are the cost of the retiree’s share of the health care premium, and for over 65 retirees, the State’s reimbursement of the Medicare Part B premium, which is paid by the retiree to the Federal Government through their Social Security checks. We will cover the changes and effective dates of those changes below.</td>
</tr>
<tr>
<td>8</td>
<td>First, what is the earliest date of retirement that is affected by any of the premium share increases?</td>
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<td>For under 65 retirees there are premium share changes depending on the effective date of their retirement. If you retire before the “RHC Effective Date”, which is the later of October 2, 2017 or the second of the month 60 days after legislative approval of the agreement, your retiree premium share is unchanged from the current rule. That is, you pay 1.5% of the premium if you choose a POS plan (by far the most common choice), and pay 0% of the premium if you chose a POE Plan. Over 65 retirees on Medicare pay no premium shares no matter what date they retire.</td>
</tr>
<tr>
<td>9</td>
<td>What happens if I retire after the RHC Effective Date?</td>
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<td>Again, nothing changes in over 65 Medicare retiree premium shares – they remain zero. If you are under 65 and retire on or after the RHC Effective date, but before 7/1/22, here’s what happens. Hazardous Duty Retirees, and other Retirees with 25 years or more of service, no change. Non-hazardous duty retirees with fewer than 25 years of service pay an increase of 1.5%. That is, the POE plan goes to a 1.5% premium share, and the POS plan goes to 3%.</td>
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</table>
What happens if I retire before 7/1/22? While you are under 65, you will pay a premium share of 3% hazardous duty, and 5% for non-hazardous duty retirees. Once you go on Medicare at age 65, your premium goes to zero as is current practice.

What about the State’s reimbursement of the Medicare Part B premium, does that ever change? In part. Medicare-covered retirees who retire(d) on or before 6/30/22 have no change at all. The State continues to reimburse the full Part B premium paid to the federal government by the retiree. For retirees who retire on or after 7/1/22, when they get Medicare covered, the State will continue to reimburse the full standard Medicare Part B premium charged by the feds. However, there is an additional premium charged by the feds for wealthier retirees, and a small number of our retirees are charged some of that extra premium. Starting with people retiring 7/1/22 or later, the State will split the extra cost the feds charge to wealthier retirees. In other words, the State will pay the full standard premium, plus half of any extra. The definition of “wealthy” is set by the federal government, and the extra Part B premium varies by the amount of a retiree’s income, and all the numbers are indexed for inflation. You can read the current numbers here, although of course they will be different by 7/1/22 when the first retirees (those retiring on or after that date) could be affected. Medicare Part B Premiums. There is also a table at the end of this Q&A showing the impact using 2017 figures since we have no figures for 2022.

Are there any other changes affecting future retirees? Retirees get the same benefits when they retire as they did when they are active (except for benefit improvements the parties decide to add). Benefits improvements which are part of the Framework will affect all retirees. Other changes in active health care that are part of the Framework will affect future retirees beginning with people who retire on or after the RHC Effective date (see # 8). These changes are designed to save money by incenting health enhancing and cost-effective choices by employees, while having little or no effect on member’s pockets. They are described in detail in our Health Care Q&A, which can be found at Health Care Q&A.

Where can I get more information? The best place is through your elected union leadership, staff, or through your union’s website. You can also find helpful links on www.CTStateEmployees.com

If your yearly income in 2015 (for what you pay in 2017) was

<table>
<thead>
<tr>
<th>File individual tax return</th>
<th>File joint tax return</th>
<th>File married &amp; separate tax return</th>
<th>Part B Monthly Premium (in 2017)</th>
<th>State Reimburse (for 7/1/22 Retirees or Later)</th>
<th>Retiree’s Net Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
<td>$85,000 or less</td>
<td>$134.00</td>
<td>$134.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>above $85,000 up to $107,000</td>
<td>above $170,000 up to $214,000</td>
<td>Not applicable</td>
<td>$187.50</td>
<td>$160.75</td>
<td>$26.75</td>
</tr>
<tr>
<td>above $107,000 up to $160,000</td>
<td>above $214,000 up to $320,000</td>
<td>Not applicable</td>
<td>$267.90</td>
<td>$200.95</td>
<td>$66.95</td>
</tr>
<tr>
<td>above $160,000 up to $214,000</td>
<td>above $320,000 up to $428,000</td>
<td>above $85,000 and up to $129,000</td>
<td>$348.30</td>
<td>$241.15</td>
<td>$107.15</td>
</tr>
<tr>
<td>above $214,000</td>
<td>above $428,000</td>
<td>above $129,000</td>
<td>$428.60</td>
<td>$281.30</td>
<td>$147.30</td>
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