DOWNSTATE
HEALTH SCIENCES UNIVERSITY

Department of Human Resources
Benefits Department
Downstate Health Sciences University
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MEMORANDUM

November 3, 2023

To: Management/Confidential and UUP- Represented Employees

From: Doriel Forde
Benefits Manager

SUBJECT: PRODUCTIVITY ENHANCEMENT PROGRAM (PEP)

The Productivity Enhancement Program (PEP) for 2024 allows eligible SUNY Management Confidential (M/C) and UUP represented employees to exchange up to **eight** previously accrued annual leave in return for a biweekly credit that reduces the employee's share of the New York State health Insurance Program (NYSHIP) premium.

The enrollment period for the 2024 calendar year began on November 1, 2023 and will end at the close of business Monday, December 11, 2023. Employees who participated in the program in previous years and are interested in participating in 2024 calendar year, must re-enroll each year.

The credit of $800 or $1,600 is based on the employee's salary, and whether the employee has an individual or family contract. The credited funds will be divided over twenty-six pay periods. For $800, the credit will be $30.76 biweekly and for $1600, the credit will be $61.53 biweekly.

The credit of $750 or $1,500 is based on the employee's salary, and whether the employee has an individual or family contract. The credited funds will be divided over twenty-six pay periods. For $750, the credit will be $28.85 biweekly and for $1500, the credit will be $57.69 biweekly.

Eligible full-time employees with a salary of **$76,028** or less, and eligible part-time employees whose salary is **within the same range** may exchange four (4) or eight (8) annual leave days

for an annual credit of up to $800 or $1600, respectively. Additionally, eligible full-time and eligible part-time employees whose earnings are **more than $76,028 and below $108,646 may** exchange two and half (2.5) or five (5) annual leave days for a credit of up to $750 or $1500 respectively.

Employees participating must meet **all** of the following criteria:

- Must be covered by the 2022-2026 New York State/UUP Collective Bargaining Agreement or be a SUNY M/C employee;
- Must be a full-time employee with an annual salary below $108,646 OR be part-time whose bi-weekly salary is **within the salary range at the time of enrollment;**
- Must be in an active status and be paid on a Calendar Year or College Year basis;
- Must be a NYSHIP enrollee (contract holder) in the Empire Plan or an HMO;
- Must be eligible to receive an employer contribution toward NYSHIP premiums (or be on leave without pay from a position in which the employee is normally eligible for an employer share contribution toward NYSHIP premiums, FMLA and PFL, PPL); and
- Must have a **leave balance** of at least **eight (8)** vacation days if full-time, or **four (4)** days if part-time remaining after the election of PEP.

Once an employee enrolls for **2024**, he/she will continue to participate in the program for the duration of the plan year unless he/she separates from State services or cease to be a NYSHIP contract holder. **Note** that an employee who moves between individual and family coverage under the NYSHIP rules will have his/her health insurance contributions adjusted upward or downward as appropriate.

As the decision to participate in PEP is a personal one, an employee should consider several factors before making the decision. Such factors include his/her daily rate of pay versus the annual cost of the NYSHIP premium, his/her leave balances, his/her normal annual accrual rate, his/her anticipated need to use annual leave, and his/her ability to forfeit two and a half or more days of annual vacation time during the calendar year.

Employees should also keep in mind that at the time of retirement, he/she is eligible to receive payment for up to thirty (30) days of accrued annual leave. **Note that any disputes arising from this program are not subject to the grievance procedures contained in the 2022-2026 State/UUP collective bargaining agreement.**

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.

If you wish to enroll in PEP for **2024**, please complete the attached form and return it to the Benefits Office at Box #1191 by the **close of business Monday, December 11, 2023**.

The Benefits Office is located in the Basement of the Library at 395 Lenox Rd. or the forms can be emailed to **benefits@downstate.edu**

Should you have any questions or need additional information, you may contact the Benefits Office at Extension 3015.

UUP & SUNY M/C Productivity Enhancement Program for 2024 – Enrollment Form

Name_____ Last 4 digits of SS#_____

Health Insurance Plan _____ Individual ☐ or Family Coverage ☐ (CHECK ONE)

By signing this document, I elect to participate in the 2024 portion of the Productivity Enhancement Program (PEP) and agree to the provisions contained in the Productivity Enhancement Program Description (hereafter Program Description) that is available in my campus Human Resources Office. I understand that I must meet the eligibility criteria explained in the Program Description in order to participate.

I understand that full-time employees earning up to $76,028 will surrender either 4 days or 8 days of annual leave in return for a credit of up to $800 or $1,600 to be applied toward the employee share of NYSHIP premiums deducted from biweekly paychecks issued in 2024, and full-time employees earning more than $76,028 and up to $108,646 will surrender either 2.5 or 5 days of annual leave in return for a credit of up to $750 or $1,500 to be applied toward the employee share of NYSHIP premiums deducted from biweekly paychecks issued in 2024. I understand that part-time employees will forfeit annual leave on a prorated basis in accordance with their payroll/employment percentage in return for a prorated credit. I understand that ALL of these leave credits will be deducted from my leave balances at the time my enrollment is processed. I understand that no portion of this leave will be returned to me under any circumstances.

I wish to surrender ___ day(s) of annual leave. In exchange for surrendering this accrued leave I will receive a health insurance contribution credit (hereafter "credit") to be applied against the employee share cost of NYSHIP health insurance premiums deducted from biweekly paychecks issued in 2024. The maximum possible amount of this credit for full-time employees is $1,600. The maximum credit for part-time employees will be prorated based upon the employee's payroll/employment percentage. Pursuant to the program description, the amount of this credit will be established at the time of enrollment and will be adjusted only upon movement between individual and family coverage. I understand that I will not receive any amount of credit that exceeds the cost of the employee share of my NYSHIP premiums paid during this period.

I understand that this enrollment form only applies to the 2024 NYSHIP plan year. I understand that in order to participate, this completed election form must be filed with my campus Human Resources Office by the close of business on Monday, **December 11, 2023**.

Signature_____ Date_____

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

This information is being requested pursuant to New York State Civil Service Law section 161-a for the principal purpose of determining eligibility for the Productivity Enhancement Program for 2022. This information will be used in accordance with Public Officers Law section 96(1). Failure to provide this information may result in a denial of eligibility to participate in the Productivity Enhancement Program for 2022. This information will be maintained by the employee's Agency Personnel Office. For further information relating only to the Personal Privacy Protection Law, contact pio@cs.state.ny.us.

For Agency Human Resources Office Only:

Full-time_____ Part-time_____ (check one)

Days of annual leave deducted from employee's balance: _____ Date_____

Verification of eligibility: I certify that this applicant meets the eligibility criteria necessary for participation in this program.

Name_____ Title_____

Signature_____ Date_____

For Health Benefits Administrators Only:

Date Processed_____

Biweekly Health Insurance Contribution Credit_____

Name_____ Title_____

Signature_____ Date_____