
# *SCUPA Employees*

## BENEFIT SUMMARY BOOKLET

REVISED MARCH 15, 2016

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This summary highlights the Employee Health Program, Retired Employee Health Program, Supplemental Benefits Program, and leave entitlements for Pennsylvania State System employees covered by the State College and University Professional Association (SCUPA) collective bargaining agreement. The benefits described are available to most employees; however, certain eligibility requirements must be met.

This summary is provided for general purposes only. Legal Plan Documents and the SCUPA collective bargaining agreement will govern any discrepancies that may arise. For additional information concerning health and supplemental benefits, contact the Pennsylvania Employees' Benefit Trust Fund (PEBTF) at (717) 561-4750 or toll-free at (800)522-7279, or at www.pebtf.org. Benefits, benefit levels, and eligibility rules are subject to change.

# General Information

## Who is the Pennsylvania Employees Benefit Trust Fund (PEBTF)

The Pennsylvania Employees Benefit Trust Fund (PEBTF), established in 1988, administers health care benefits to approximately 84,000 eligible Commonwealth of Pennsylvania employees and their dependents and 60,000 retirees and their dependents, as well as additional employer groups including the Pennsylvania State System of Higher Education. The PEBTF is governed by a Board of Trustees comprised of both Commonwealth and Union representatives.

## Who is Eligible for PEBTF Health Program Coverage

Eligibility for coverage is limited (Medical coverage only) for the first six months of employment as a new hire or re-hire. This six-month period is satisfied once your cumulative period that you are actively working as an employee reaches six months. Time that you may work in a temporary capacity will be credited toward the six-month requirement (although you must be a permanent full or part time employee to be eligible for PEBTF benefits). Time when you are furloughed or otherwise not actively working does not count toward the six-month requirement. If you leave employment and later return following a break in service of more than 180 calendar days, then you will be required to satisfy a new six month waiting period for full eligibility again.

**1. Eligible Person is defined as:**

a. Employees

To be eligible for medical and supplemental coverage under this plan, employee must be a permanent full-time employee or a permanent part-time employee (who works at least 50% of full-time hours).

b. Effective January 1, 2000, permanent part-time employees who work at least 50% of full-time hours' must
- Elect both medical and supplemental coverage, or
- Decline both medical and supplemental coverage.

**2. Eligible Dependent is defined as:**

The following Dependents are eligible to be enrolled:

a. Legal Spouse for whom the Human Resource Office has seen the original marriage certificate. Marriage certificates can be obtained from the courthouse in the county in which the marriage license was obtained. A list of Pennsylvania County Courthouses can be found at www.health.state.pa.us under Health Statistics.

b. Common Law Spouse for whom the Human Resource Office has collected information attesting that the marriage was in effect prior to September 17, 2003. The employee must present the Human Resource Office with two of the documents as outlined below, dated prior to September 17, 2003. The Human Resource Office will make a copy and forward to the PEBTF with the other necessary documentation:

i. Original deed to the employee's home, if owned jointly

ii. Original automobile title, if owned jointly

iii. Original statement of a current bank account that is held in joint name

iv. Original copy of the employee's Will, identifying the spouse

v. A copy of the coverage page (indicating filing status) and signature page (if a different page) of the employee's 2002 Federal Income Tax Return, which indicates marital status

vi. The Human Resource Office will not retain any copies of these documents

c. Domestic Partner for whom the Human Resource Office has collected information attesting to the Domestic Partnership. Same sex or opposite sex partners are eligible as dependents if the employee and his or her domestic partner meet specific criteria. (See PEBTF Summary Plan Description at https://www.pebtf.org/Active/Publications.aspx for more details). The employee must present the Human Resources Office with three of the documents as outlined below. All of the documents must be dated at least 6 months prior to the current date. The Human Resource Office will make a copy and forward to the PEBTF with the other necessary documentation.

i. A Domestic Partnership Agreement

ii. A deed or lease evidencing common ownership of real estate property or a common leasehold interest in property

iii. Evidence of joint title to a motor vehicle

iv. Driver's license listing a common address

v. Proof of joint bank accounts or credit accounts

vi. Proof of designation as a beneficiary for life insurance or retirement benefits or beneficiary designation under a partner's will

vii. Assignment of a durable power of attorney or health care power of attorney

viii. The Human Resource Office should not retain any copies of these documents

TAX IMPLICATIONS: Although employees who cover domestic partners will be charged the same applicable contribution rates as those who cover other dependents, the IRS requires that the contribution for the domestic partner's coverage be taken on a post-tax basis if the domestic partner is not the employee's tax-code dependent. In addition, employees must pay federal and FICA taxes on the value of the benefits provided to domestic partners (known as imputed income). The value of the benefits may change on an annual basis. Taxes will be withheld biweekly from your paycheck if you add a domestic partner. There are no additional taxes for employees who already have family coverage; for example, an employee who covers his or her own child will not incur additional charges if the employee adds a domestic partner.

d. Dependent child (under age 26): A child under age 26 may be covered as long as the child is not eligible for coverage (other than through a parent) under another eligible employer-sponsored health plan, including:

i. Your natural child

ii. Your legally-adopted child, including coverage during the adoption probationary period

iii. Your stepchild

iv. Child for whom you are the court-appointed legal guardian as demonstrated by the appropriate court order

v. A child for whom you are required to provide medical benefits by a Qualified Medical Child Support Order or National Medical Support Notice

vi. A foster child

vii. While a dependent can be enrolled at any time (with an effective date no more than 60 days retroactive), a newborn should be added to the employee's policy within 60 days of the date of the birth. If the newborn is not enrolled by that date and does not have other coverage, you will be responsible for claims for the period of time where the newborn is not covered.

viii. Natural child for whom you maintain parental rights

e. Disabled children – An employee's unmarried disabled dependent of any age may be covered if the child meets all of the following requirements:

i. Totally and permanently disabled, provided that the child became disabled prior to age 26 (total and permanent disability according to the PEBTF criteria must be documented by a physician on a Disabled Dependent Certification Form)

ii. Was a dependent of the employee before age 26

iii. Must depend on the employee for more than 50% support and is claimed as a dependent on the employee's Federal Income Tax Return

iv. The PEBTF will request recertification of disabled dependents every two years.

## Other Coverage

Dependent spouses or Domestic partners of employees hired prior to August 1, 2003 who are eligible for medical, prescription or supplemental benefits through their own employer or through retiree benefits (other than the Retired Employee Health Plan or Retired Pennsylvania State Police Plan) must take such coverage unless the spouse or domestic partner's employer charges an employee contribution or the spouse or domestic partner's employer offers an incentive to the spouse or domestic partner not to enroll. The spouse or domestic partner may also enroll in the PEBTF for medical and/or supplemental coverage, but the PEBTF will pay secondary.

Dependent spouses or Domestic partners of employees hired on or after August 1, 2003 who are eligible for medical, prescription or supplemental benefit coverage through their own employer or through retiree benefits (other than the Retired Employee Health Plan or Retired Pennsylvania State Police Plan) must take that coverage regardless of any employee contribution the spouse or domestic partner may pay and regardless of whether the spouse or domestic partner had been offered an incentive to decline such coverage(s).

- The spouse or domestic partner's employer-sponsored plan is primary
- The spouse or domestic partner may also enroll in the PEBTF for medical, prescription and/or supplemental coverage, but the PEBTF will pay secondary
- If the spouse or domestic partner does not elect his/her own available coverage, he/she cannot be added to the PEBTF coverage

## No Duplication of Coverage

If you and your spouse/domestic partner both work for the commonwealth or a PEBTF-participating employer, you may not be enrolled as both an Employee Member and as a Dependent under your spouse's/domestic partner's coverage.

In addition, you cannot participate in both the PEBTF Plan for Active Employees and the Retired Employees Health Program (REHP) of the Commonwealth of Pennsylvania. Finally, your Dependent child may be enrolled under your or your spouse's/domestic partner's coverage, but not both.

## Health Program Coverage Effective Dates

### Health Insurance

Effective July 1, 2011, an employee can enroll for health benefits at any time or can enroll eligible dependents at any time. However, the effective date cannot be more than 60 days retroactive from the date the Human Resources Office receives the form.

### Prescription Drug Coverage

Your prescription drug coverage will begin on the day following the date you have worked six full months of employment as a new hire or re-hire.

You have the option of participating in a plan "buy-up" as of day one of employment to provide prescription drug coverage.

### Supplemental Benefit Coverage
### (includes Dental, Vision and Hearing coverage)

Your full PEBTF coverage, including coverage for Supplemental Benefits, will begin on the day following the date you have worked six full months of employment as a new hire or re-hire.

## Health Program Coverage Ending Dates

Your coverage will generally end on the date when:

- Your employment ends
- Your employment status changes to leave without pay without benefits
- Your employer no longer makes contributions on your behalf
- Your percent of time worked decreases to between 50% and 99%. Health coverage continues automatically at part-time employee rates unless you elect to terminate coverage
- Your percent of time worked decreases to less than 50%
- You are furloughed
- Your death
- You are suspended from PEBTF coverage for fraud and/or abuse and/or failure to provide requested information and/or failure to cooperate with the PEBTF in the exercise of its subrogation rights and/or failure to repay debt to the PEBTF
- You fail to remit any required premium contributions or buy-ups, including members who are on Leave Without Pay with Benefits
- Otherwise no longer eligible to participate

Dependent coverage will generally end on the date when:

- Your coverage ends
- Your Dependent no longer qualifies as an eligible Dependent under the rules of the Plan
- You voluntarily drop coverage for your Dependent as permitted under PEBTF rules
- You or your Dependent is suspended from PEBTF coverage for fraud and/or abuse and/or failure to provide requested information and/or failure to cooperate with the PEBTF in the exercise of its subrogation rights and/or failure to repay debt to the PEBTF
- The PEBTF determines an individual had been incorrectly enrolled as a Dependent (in such event, coverage may be canceled back to the date the individual was incorrectly enrolled)

Dependents need to have a qualifying event to be removed from coverage other than during open enrollment. Effective July 1, 2011, if the qualifying event results in the dependent no longer being eligible for coverage, the termination date will be the date of the qualifying event. The exception to this rule is where a dependent is no longer eligible for coverage (i.e. divorce). In this case, the termination must be requested within 60 days of the qualifying event.

If the qualifying event allows the dependent to be removed from coverage but does not make the dependent ineligible, the effective date can be retroactive up to 60 days from the date the form is submitted. However, in no event can the date be prior to the date of the qualifying event.

If your coverage ends in certain circumstances, you and your eligible Dependent(s) may qualify for continued coverage of health benefits. Please refer to the "COBRA Continuation Coverage" section for more details.

Upon an employee's death, eligible Dependent(s) may qualify for continued coverage. For further information, your Dependents may contact your local Human Resource Office or the PEBTF. If the employee's death is a result of a work-related accident, eligible Dependents may qualify for paid coverage.

## Continued Coverage as Provided by the PEBTF

**What is COBRA Continuation Coverage?**

A federal law passed in 1986, titled the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that employees and their families covered under most group health plans be offered the opportunity for temporary extension of health coverage (known as COBRA continuation coverage) in certain instances where coverage under the plan would otherwise end. This Notice summarizes your rights and obligations under COBRA law. Both you and your spouse/domestic partner (if you have a spouse/domestic partner on your coverage), should read this Notice carefully. For additional information about your rights and obligations under the PEBTF plan of benefits and under federal law, you should refer to your Summary Plan Description or contact the PEBTF at the address or telephone number shown above.

COBRA continuation coverage is temporary self-paid coverage available for active employees and their enrolled dependents through the PEBTF when one of the qualifying events listed below occurs which would result in a loss of coverage. Each individual entitled to COBRA continuation coverage because of a qualifying event is referred to as a qualified beneficiary. You do not have to show that you are insurable to elect COBRA continuation coverage.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed below. You can also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

There may be other coverage options for you and your family. You also may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

**When is COBRA Continuation Coverage Available?**

COBRA continuation coverage is available to qualified beneficiaries when a qualifying event occurs which would normally end coverage. Qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

**Employees** have a right to elect COBRA continuation coverage if coverage is lost because of:

1. A reduction in hours of employment, or
2. Termination of employment for reasons other than gross misconduct.

**A covered spouse/domestic partner of an employee** has a right to elect COBRA continuation coverage if coverage is lost because of:

1. Employee's death;
2. Employee's reduction in hours of employment or termination for reasons other than gross misconduct;

3. Divorce, legal separation from the employee in anticipation of divorce, or termination of a domestic partnership; or
4. Employee becomes entitled to Medicare benefits (Part A, Part B or both).

**A covered dependent of an employee** has a right to elect COBRA if coverage is lost because of:

1. Parent-employee's death;
2. Parent-employee's reduction in hours of employment or termination for reasons other than gross misconduct;
3. Parent-employee's divorce, legal separation from the employee in anticipation of divorce, or termination of domestic partnership;
4. Dependent's loss of dependent status (for example, over the eligible age) or
5. Parent-Employee becomes entitled to Medicare benefits (Part A, Part B or both).

**Who Notifies the PEBTF of a Qualifying Event?**

The employer is responsible for notifying the PEBTF if the qualifying event is a reduction in hours, termination of employment, or death of the employee. **For other qualifying events (divorce, termination of domestic partnership, dependent child's losing eligibility for coverage as a dependent) you must notify the PEBTF in writing (to the above address) within 60 days after the event occurs. If you do not notify the PEBTF within that time period any rights to COBRA continuation coverage will be permanently lost. Employees should also report the qualifying event to their local HR Office.**

**How is COBRA Continuation Coverage Provided?**

After the PEBTF receives proper notice of a qualifying event it will send you or your family member(s) an election notice explaining your rights and applicable premium rates for coverage. You have 60 days from the date of the election notice to notify the PEBTF that you wish to elect COBRA continuation coverage. A separate election may be made by each qualified beneficiary eligible for such coverage. Covered employees may elect coverage on behalf of their spouses/domestic partners and parents may elect coverage on behalf of their children. **If you do not timely elect COBRA continuation coverage your coverage under the PEBTF plan (whether PPO, HMO, CDHP or supplemental options) will end on the date of the qualifying event.**

If you elect COBRA continuation coverage you will be offered coverage which is the same as coverage provided under the plan to similarly situated employees or family members. Maximum coverage will be up to 36 months when the qualifying event is the death of the employee, divorce/termination of domestic partnership, or loss of a dependent child's eligibility. When coverage is lost because of a reduction in hours of employment or termination of employment (for reasons other than gross misconduct), coverage generally lasts for only up to 18 months.

When the qualifying event is the end of employment or a reduction in hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the Medicare entitlement. (For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse/domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event, since 36 minus 8 equals 28 months.)

There are two ways in which the 18-month period of COBRA continuation coverage can be extended: (1) a disability extension of the 18-month period to a maximum of 29 months, or (2) a second qualifying event extension of the 18-month period up to a maximum of 36 months.

**Disability Extension**

The 18 months may be extended to 29 months if a qualified beneficiary (including a covered employee or any dependent who is a qualified beneficiary) is determined by the Social Security Administration to be disabled and the PEBTF is so notified within 60 days of the determination and before the end of the 18-month COBRA continuation coverage period. The disability would have to

have started before the 60th day of COBRA continuation coverage and must last until the end of the 18-month period of coverage. The affected individual must also notify the PEBTF within 30 days of any subsequent determination that the individual is no longer disabled.

**Second Qualifying Event Extension**

If your family experiences another qualifying event (if the second event would have caused the spouse/domestic partner or dependent child to lose coverage under the benefit plan had the first qualifying event not occurred) during the 18 months of COBRA continuation coverage, the spouse/domestic partner and dependent children can get up to18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the PEBTF. This extension may be available to the spouse/domestic partner and any dependent children if the employee or former employee dies, becomes entitled to Medicare benefits, or gets divorced or terminates domestic partnership or if the dependent child ceases being eligible under the plan.

**Payment of COBRA Premiums**

The amount of the applicable COBRA premium and due date for payment will be explained in the Election form sent to you. The premium may change during the COBRA period of coverage. You do not have to send any payment for continuation coverage with the Election Form. However, **you must make your first payment for COBRA continuation coverage within 45 days after the date of your first invoice**. The PEBTF will send you coupons (which are sent the first week of the month), and the first coupon will be retroactive to the qualifying event date. This initial invoiced amount will include:

1. The period of coverage from the time your coverage under the Plan would have otherwise terminated up to the time of the billing month after COBRA was elected, and
2. Any regularly scheduled monthly premium that becomes due between your election and the end of the 45-day period. (If a regular monthly premium is received by the PEBTF prior to payment of this initial invoice amount, and during the 45-day period, the monthly premium will be applied to the initial invoice.)

**If you do not make your first payment for COBRA continuation coverage within 45 days of the date of your first invoice, you will lose all continuation coverage rights under the Plan of Benefits.**

**Premium Due Dates and Grace Period**

All monthly premiums are due by the first of each month. If you fail to pay the initial premium or any subsequent monthly premium in a timely manner, your coverage will terminate **and cannot be reinstated.** After you make your first payment for coverage you will be required to pay for coverage for each subsequent month of coverage and will be given a maximum grace period of 30 days to make each periodic monthly payment. If you fail to make a monthly payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the Plan of Benefits.

**Can COBRA Continuation Coverage be Terminated Early?**

Yes. The law provides that COBRA continuation coverage may be terminated prior to the end of the maximum coverage period for any of the following reasons:

1. The Employer no longer provides group health coverage to any of its employees;
2. The premium for your coverage is not paid timely;
3. You first become covered under another group health plan after the date of election; or
4. You become entitled to Medicare after the date of election; or
5. Coverage was extended for up to 29 months due to disability and subsequent determination finds that you are no longer disabled.

If you remain covered at the end of the COBRA period and are not Medicare eligible you may be allowed to convert to an individual health plan.

If you have any questions about COBRA consult your Summary Plan Description or contact the PEBTF at one of the telephone numbers listed on this notice. **If you change your address you must promptly notify your local Human Resources Office and the PEBTF.** You should also keep a copy of any notices you send to the PEBTF.

## Your Responsibilities as an Active Employee:

| Event | Medical and/or Supplemental Coverage | Group Life Insurance |
|---|---|---|
| When you become eligible for benefits as a new employee or become eligible due to an organizational change | Contact your Human Resources Office within 30 days to complete enrollment for benefits through Employee Self Service (ESS) or by hard copy form | Enrollment completed automatically through the SAP system – you will need to go online at www.metlife.com/mybenefits to complete the beneficiary designation. |
| When you acquire a Dependent (birth, adoption, or marriage) | Contact your Human Resources Office to add your new Dependent | Contact Metropolitan Life Insurance Company (MetLife) at 1-855-972-5433 or go online at www.metlife.com/mybenefits if you wish to change your beneficiary designation. |
| When you lose a Dependent (divorce, or Dependent loss of eligibility for any reason) | Contact your Human Resources Office to remove the Dependent(s). If your Dependent is interested in COBRA continuous coverage, you or your Dependent must inform your Human Resources Office within 60 days of loss. | Contact Metropolitan Life Insurance Company (MetLife) at 1-855-972-5433 or go online at www.metlife.com/mybenefits if you wish to change your beneficiary designation. |
| When your spouse or domestic partner obtains coverage through his/her employer | Contact your Human Resources Office within 60 days to complete a hard copy form for coordination of benefits (refer to Other Coverage Information on page 3) | No action required. |
| When you or your spouse turns age 65 or otherwise becomes eligible for Medicare. | Contact your Human Resources Office and the Social Security Administration about Medicare and other benefits at least 60 days prior to turning 65. | No action required. |
| When your Domestic Partner turns age 65 or otherwise becomes eligible for Medicare | Domestic Partner may remain on active coverage; however, they are encouraged to also enroll in Medicare Part A and Part B to avoid penalty for not enrolling when eligible. | No action required. |
| When you turn age 70 or 75. | No action required. | MetLife will inform you if your amount of insurance is affected. |
| When you retire. | Contact your Human Resources Office to enroll in the Pennsylvania State System of Higher Education Annuitant Health Care Program (AHCP) and to discuss COBRA continuation coverage. | Your coverage ends. Contact MetLife at 1-855-972-5433 if you wish to apply for conversion of coverage. |
| If you or your spouse are eligible for Medicare | Enrollment in Medicare Part A and/or Part B as required by Medicare rules. | No action required. |
| If you become disabled. | Contact your Human Resources Office to find out how your coverage will be affected. | If you are permanently and totally disabled and losing active status, contact MetLife at 1-855-972-5433 to file for disability life insurance. |
| In case of your death. | Your Dependents should contact your Human Resources Office to discuss health insurance continuation provisions. | Your beneficiary should provide MetLife with a death certificate. |

# Basic Health Care and Supplemental Benefits (Active Employees)
## Administered by the PEBTF

## *Coverage*

### Employee Health Program

- Employees may choose from:
  - Preferred Provider Organization (PPO) Option
  - Health Maintenance Organization (HMO) Option – Employee must reside within an eligible county (check availability of coverage by county)
  - Consumer Driven Health Plan (CDHP) – If the contract includes a domestic partner, enrollment in the CDHP is not permitted
- Survivor benefits for dependents of employees who die as a result of a work-related injury
- Benefits determined by PEBTF Board of Trustees

### Prescription Drug Benefits Program

- 6 month waiting period
- Employee may elect to enroll in prescription drug benefit program as of day one of eligibility and contribute through plan "buy-up" for coverage
- Survivor benefits for dependents of employees who die as a result of a work-related injury
- Benefits determined by PEBTF Board of Trustees

### Supplemental Benefits Program

- 6 month waiting period
- Vision Plan
- Dental Plan
  - United Concordia Dental PPO (fee for service) – uses Advantage Plus dental network
- Hearing Aid Plan
- Survivor benefits for dependents of employees who die as a result of a work-related injury
- Benefits determined by PEBTF Board of Trustees

### Waiver of Medical and/or Supplemental Benefits

- Employees may elect to waive enrollment in medical, prescription and/or supplemental coverage for themselves and family members
- Employee contributions will not occur while Waiver of medical, prescription and supplemental coverage is in effect
  - If employee chooses to waive only medical and remain enrolled in prescription and/or supplemental benefits, the employee contribution would continue
  - If employee chooses to waive only prescription and remain enrolled in medical and/or supplemental benefits, the employee contribution would continue
  - If employee chooses to waive only supplemental benefits and remain enrolled in the medical and/or prescription coverage, the employee contribution would continue

## *Eligibility/Contribution*

- For permanent employees who elect health care coverage – you will contribute a percentage of bi-weekly gross salary towards cost of coverage (see chart below)

| | Employee Contribution for non-participation in Get Healthy (not receiving waiver) | Employee Contribution for participation in Get Healthy (receiving waiver) |
|---|---|---|
| July 2014 to present | 5.0% | 2.0% |

- New employees or newly eligible employees must complete the Wellness Screening within 45 days of the date of the communication letter from the PEBTF to qualify for participation in Get Healthy and the waiver for the lower contribution rate, and will be required to meet continued participation requirements annually.
- For permanent full-time employees hired on or after August 1, 2003 who elect coverage:
  - First 6 Months of Employment
    - Single coverage only in the least costly plans in their county of residence
    - May purchase a more expensive plan; must pay cost difference (Plan Buy-Up) in addition to the employee contribution (Get Healthy)
    - May purchase health benefits for eligible dependents (Dependent Buy-Up)– in same health plan as employee enrolled
    - May purchase prescription drug coverage; must pay cost of plan for the first six months (Prescription Buy-Up)
    - No supplemental benefits
  - Beginning with 7th Month of Employment
    - Employee and eligible dependents covered for medical benefits under least expensive plans
    - Employee and eligible dependents receive prescription and supplemental benefits
    - Continue to contribute a percentage of bi-weekly gross salary
    - May purchase a more expensive plan; must pay cost difference (Plan Buy-Up) in addition to the employee contribution (Get Healthy)
- For eligible permanent part-time employees – employees contribute 50% plus employee contribution at the same percentage rate as permanent full-time employees

## Flexible Spending Accounts

Reduces the amount of taxes paid by designating a portion of salary to an account for eventual reimbursement of certain medical and dependent care expenses. Except for the medical reimbursement carry-over provision described below, account balances not used are forfeited.

Employees do NOT need to re-enroll in an FSA the following year in order to access their carryover funds If employees do not elect an account and they have money to be rolled over, a new account will be created. Please note, a new account will not be created until the carryover has occurred (typically around the end of April).

### Health Care Account

- Maximum annual contribution is $2,500
- Eligible expenses for reimbursement include co-insurances, deductibles and amounts in excess of plan allowances or maximums, prescription drug co-payments, PPO, and HMO doctor office visit charges, lasik eye surgery, chiropractic services, etc. Certain over-the-counter drugs and medicines will only be eligible for reimbursement if you have and can provide a prescription from your physician.

### Dependent Care Reimbursement

- Maximum annual contribution is $5,000 ($2,500 if you are married and filing a separate income tax return)
- Dependent care must be necessary so that you, and if you are married, your spouse can work or look for work
- Eligible expenses for reimbursement include child care centers that care for six or more children and that meet the IRS definition of a qualified day care center, caregivers for a disabled spouse or dependent who lives with you, babysitters, nursery schools, household expenses provided that a portion of these expenses are incurred to ensure a dependent's well-being and protection

### *Eligibility/Contribution*

- Permanent full-time employees
- Permanent part-time employees working at least 50% time
- 100% employee-paid

## Premium Conversion Plan

Allows employees who are contributing to the cost of health care to pay those contributions on a pre-tax basis, resulting in higher take-home pay

### *Eligibility/Contribution*

All employees enrolled in a health care plan and contributing toward the cost of that plan

## Group Life Insurance

### *Coverage*

- Term life insurance equal to nearest $1,000 of annual salary
- Minimum coverage $2,500; maximum coverage $50,000
- Coverage reduced at age 70 to 65%; coverage reduced at age 75 to 50%
- $20,000 additional work-related accidental death benefit
- Three-month waiting period
- Right to convert upon termination/retirement

### *Eligibility/Contribution*

- State System pays 100% for permanent employees
- Dependents ineligible

## Voluntary Group Life and Personal Accident Insurance

### *Coverage*

- Employee term life and personal accident insurance in increments of $10,000; maximum coverage $500,000 (if application for Voluntary Group Life for employee is made within 31 days of employment, guaranteed amount of coverage is $150,000 or five times annual salary (whichever is less) without medical underwriting)
- Spouse term life and personal accident insurance in increments of $5,000; maximum coverage $100,000 (if application for Voluntary Group Life for spouse is made within 31 days of employment or date of eligibility, i.e., new marriage, guaranteed amount of coverage is $25,000 without medical underwriting)
- Children term life and personal accident insurance in amounts of $5,000 or $10,000

### *Eligibility/Contribution*

- Permanent full-time employees and dependents
- Permanent part-time employees and dependents, if employee works at least 50% time
- 100% employee-paid

## Voluntary Long-Term Disability Insurance

### *Coverage*

- Income protection equal up to 60% of gross annual base salary to a maximum of $5,000 monthly benefit
- Amount offset by retirement benefits, workers' compensation, social security, and paid leave with a guarantee of 10% of long-term disability benefit amount or $100/month, whichever is greater
- Employee may elect either a 90-day or 180-day elimination period
- Cost of living adjustments

### *Eligibility/Contribution*

- Permanent full-time employees
- Permanent part-time employees working at least 50% time
- 100% employee-paid

## Annual, Sick, and Personal Leaves

### Annual Leave

- Paid leave earned based on percentage of regular hours paid biweekly and years of service as follows:

| | |
|---|---|
| Up to one year of service | 10.4 days/yr. (4% of hrs. paid) |
| Over 1 year to 15 years of service inclusive | 15.6 days/yr. (6% of hrs. paid) |
| Over 15 years to 25 years of service inclusive | 20.8 days/yr. (8% of hrs. paid) |
| Over 25 years of service | 26.0 days/yr. (10% of hrs. paid) |

- Unused leave may be carried from one year to the next
- 45-day maximum accumulation
- Leave in excess of 45 days not used within the first seven pay periods of the new leave calendar year will be converted to sick leave up to the maximum accumulation
- Payment for unused leave at termination/retirement

### Sick Leave (Includes Bereavement and Sick Family Leave)

- Paid leave earned at 6% of regular hours paid biweekly which equates to 15.6 days/yr.
- Unused leave may be carried from one year to the next
- 300 days accumulation
- Must contribute 2.6 days annually to sick leave bank
- 3-5 days of leave may be used for death of relative, depending on relationship
- 5 days of leave may be used for sickness in immediate family
- Effective for retirement on or after October 12, 2006 - Payment in accordance with the following schedule for accumulated leave at retirement if certain eligibility is met

| Days Accumulated | % Payout | Maximum Days Paid |
|---|---|---|
| 0 – 100 | 30% | 30 |
| 101 – 200 | 40% | 80 |
| 201 – 300 | 50% | 150 |
| Over 300 (in last year of employment) | 100% of days over 300 | 13 |

### Personal Leave

- 12-month employees earn 5 days per year
- 9-month employees earn 4 days per year
- Personal leave not used within the leave calendar year in which it was earned may be carried over for seven pay periods
- Personal leave not used within the first seven pay periods of the new leave calendar year will be lost
- Payment for unused accrued leave at termination/retirement

## Sick Leave Bank Program

- Mandatory benefit program which requires employees to contribute earned sick leave in the amount equal to 1% of regular hours paid each biweekly pay period
- Employees receiving donated leave must use all accumulated sick leave before they are eligible for any Sick Leave Bank hours
- Employees may be granted up to a maximum of 225 hours per individual request from the Sick Leave Bank; additional time would need to be requested and approved by the Sick Leave Bank Committee and could be granted in increments of up to 225 hours

## Holidays

- 10 paid holidays per year

| | |
|---|---|
| New Year's Day | Martin Luther King Jr., Day |
| President's Day * | Memorial Day |
| Fourth of July | Labor Day |
| Columbus Day * | Veteran's Day* |
| Thanksgiving | Christmas |

- Observation of holidays may vary by university (*minor holiday)

## Retirement

Employees can choose from a Defined Benefit Plan or a Defined Contribution Plan.

Defined Benefit Plan – State Employees' Retirement System (SERS)*
Retirement income is based on a fixed formula that considers your years of service, age, and final average salary. The retirement benefit amount for vested participants is guaranteed and not affected by the investment earnings of the plan. Participants are 100% vested after 10 years of service (5 years if enrolled prior to January 1st, 2011). Visit the SERS website for more information.

Defined Contribution Plan – Alternative Retirement Plan (ARP)
Retirement income from the ARP plan is determined by your account balance at the time of retirement, which is comprised of your employee contributions (5% of salary), the State System contributions (9.29% of salary) and any investment earnings based on the performance of the investments you choose. Participants are 100% vested from date of enrollment. Employees may enroll in any of the three available vendors, Fidelity, TIAA-CREF or VALIC.

*The Public School Employees' Retirement System (PSERS) is a defined benefit plan for Pennsylvania's public school employees. If you are a current member of PSERS, the State System is able to continue your enrollment in PSERS or you may elect SERS and opt for multiple service which combines service in both SERS and PSERS to receive a single retirement benefit, or you may enroll in the ARP plan.

- Contribution rates and benefits vary by plan, view the Retirement Comparison Chart by visiting the State System's website at http://www.passhe.edu/inside/hr/syshr/Retirement_Docs/Retirement_Plan_Comparison.pdf

- Employees have 30 days from the first date of eligibility to select enrollment in either the Defined Benefit Plan or the Defined Contribution Plan. **Failure to select a plan within 30 days will result in automatic enrollment in SERS**, the Defined Benefit Plan for Pennsylvania public employees.

- Regardless of the plan you choose, you are required to contribute a percentage of your salary to the retirement plan. Employee contributions are tax deferred. Once you have elected a plan, your election is final and binding and you cannot change retirement plans.

## Tax Sheltered Annuity (TSA) Plans

- A supplemental retirement savings program authorized under Section 403(b) of the Internal Revenue Code
- All Pennsylvania State System of Higher Education employees are eligible to participate
- Eligible employees can enroll at any time
- Employee contributes a portion of salary for retirement on a pre-tax basis
- Participation is voluntary
- Employee makes entire contribution and there is no employer match
- Account with approved TSA vendor must be established and proof of account provided prior to completing the PASSHE Tax Sheltered Annuity Salary Reduction Agreement for bi-weekly payroll deductions
    - For a comparison of the TSA and Deferred Compensation Plans, please refer to the Pennsylvania State System of Higher Education website at: http://www.passhe.edu/inside/hr/syshr/Retirement_Docs/403b-457PlanComparison.pdf

## Deferred Compensation Plan

A governmental 457(b) plan. The Program was established by the State Employees' Retirement System (SERS), which contracts with Empower Retirement, the retirement business of Great West Financial, to serve as the administrator. All State System employees are eligible to participate and can enroll at any time.

Employees have the flexibility to choose traditional or Roth contributions. Traditional 457 contributions are made on a before-tax basis, and you pay income taxes only when you take a distribution. All Roth contributions are made with after-tax dollars. Employees make the entire contribution, there is no employer match. Meet with an Empower Retirement Plan Counselor to get started by enrolling in 457 plan.

Comparison of the TSA 403(b) and Deferred Compensation Plans, can be found at:
http://www.passhe.edu/inside/hr/syshr/Retirement_Docs/403b-457PlanComparison.pdf

## State Employee Assistance Program

The State Employee Assistance Program (SEAP) is a confidential assistance program that provides a wide range of confidential, no-cost services to treat a broad range of problems. Examples of the type of counseling services are listed below. The SEAP is administered by the Commonwealth's Office of Administration, who has contracted with United Behavioral Health (UBH) to provide SEAP services.

To obtain a brochure describing the services provided by the SEAP, you may contact your human resources office. Each university has a designated SEAP coordinator in the human resources office who can also answer questions about the program. Services provided by the SEAP are strictly confidential – the State System will not be notified if you use the services unless you give written consent.

### Eligibility

All employees of the State System, their spouses (including "significant others"), children (regardless of age), and other members of the employee's household are eligible to receive the SEAP services. Coverage is effective the date your employment begins and terminates the date you go on a leave without pay without benefits or the date your employment ends, unless you retire. SEAP services are also available to annuitants and their family members. Individual family members, at their own initiative, may call the SEAP directly.

## Benefits

The SEAP provides confidential, no-cost counseling services for a broad range of personal and work-related problems. By calling the SEAP as soon as you feel a problem is getting too difficult to handle alone, you will be able to speak to a SEAP intake counselor – a skilled professional with a clinical master's degree and at least four years clinical experience. The SEAP intake counselor will ask you a few questions to help you find the right resource to address your issues and concerns. Unlimited telephone consultations and up to three (3) counseling sessions are provided at no charge. The following SEAP hotlines are available 24 hours per day, 7 days per week:

**SEAP HOTLINES**
**(AVAILABLE 24 HOURS A DAY)**
**1-800-692-7459**
**1-800-824-4306 (TDD)**

The SEAP can help you deal with any of the following concerns or other problems that may be troubling you or a family member:

Parent/Child Conflict
Work-Related Problems
Marital and Relationship Problems
Financial or Legal Concerns
Alcohol or Drug Problems
Death and Dying
Job Burnout
Stress
Physical Abuse
Stress and Anxiety
Depression
Aging Parents
HIV and AIDS
Compulsive Disorders

## Tuition Waiver

- Employee – Total waiver of tuition applicable to undergraduate credits not to exceed 128 undergraduate credits or 60 graduate credits at any State System university
- Spouse/Same sex domestic partner
  - Total waiver of tuition for spouse/same sex domestic partner at the university where employed
  - 50% waiver of tuition at State System universities other than university where professional employee is employed
- Children of employee up to age 25
  - Total waiver of tuition (up to first undergraduate degree) at university where employed
  - 50% waiver of tuition (up to first undergraduate degree) at State System universities other than university where professional employee is employed
- Does not include children of same sex domestic partner

# General Information

## Who is Eligible for PASSHE Annuitant Health Care Program (AHCP) Coverage?

1. **Eligible Person is defined as**:

   a. Annuitants, who as an active employee had a current hire date prior to January 16, 2016.

      State System annuitants and eligible Dependents may enroll in the State System of Higher Education Annuitant Health Care Program ("SSHEAHCP") if they meet eligibility requirements on the last day actively at work. Employees must retire and begin drawing a qualifying annuity from one of the State System's retirement plans in order to receive SSHEAHCP benefits. **Verification of an annuity must occur prior to enrollment in the AHCP.** If vesting retirement, enrollment in the SSHEAHCP can be postponed until the monthly annuity begins. Annuitants who continue coverage under the State System's active or annuitant health care programs as a Dependent under a spouse's contract or who have documented other coverage, will be permitted to delay enrollment in the SSHEAHCP until the spouse's contract or other coverage ceases. Please note employees retiring must begin drawing an annuity in order to qualify for a sick leave payout. If the spouse of the annuitant is also a State System of Higher Education employee eligible to participate in the State System of Higher Education Group Health Program (SSHEGHP) or State System of Higher Education Annuitant Health Care Program (SSHEAHCP), he or she may enroll as a single Member or as a Dependent under the Member's coverage, but not both. Likewise, Dependents may only be covered under one SSHEGHP or SSHEAHCP Plan.

   b. The Group may not discriminate in enrollment or contribution based on the health status, as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), of an Eligible Person. If the Group does discriminate in enrollment or contribution based on health status, the Group shall be solely liable for any claims or expenses, including medical claims or expenses, incurred by the Eligible Person against whom the discrimination has occurred.

2. **Eligible Dependent is defined as**:

   The following Dependents are eligible to be enrolled:

   a. Legal Spouse (See other coverage requirements on page 4. This only applies to spouses added to health coverage after July 1, 2001.)

      Same-Sex Domestic Partners (SSDP) who were enrolled for coverage prior to January 1, 2016 are grandfathered for continued health coverage. No new SSDP enrollment will be permitted as of January 1, 2016.

   c. Children under 19 years of age who meets one of the following requirements:

      - A natural child of your own;
      - A legally adopted child (including a child living with the annuitant during the probation period);
      - A stepchild living with you;
      - A minor child for whom the annuitant is the court or agency appointed legal guardian, as evidenced by the court or agency order establishing guardianship;
      - A child over the age of 18, for whom the annuitant was the child's court or agency appointed legal guardian prior to the child's 18th birthday; or

- A newborn child of an employee from the moment of birth to a maximum of 31 days from date of birth. To be covered as a Dependent beyond the 31-day period, the newborn child must be added as a Dependent through the Central Benefits Office within 60 days from date of birth. In the event that a newborn child is not eligible for continuing coverage as a Dependent under this Contract, the parent may convert such child's coverage to individual coverage with the health care provider, provided an application for conversion is made within thirty-one (31) days of the child's birth and the appropriate premium is received within such period.

d. Unmarried Dependent child 19 to 25 years of age who meets all of the following requirements:

   - Enrolled in and attending as a full-time student at a recognized course of study or training;
   - Not employed on a regular full-time basis; and
   - Not covered under any group insurance plan or prepayment plan through the student's employer.

e. Unmarried Dependent child 19 years of age or older who is incapable of self-support because of a physical or mental disability that commenced before the age of 19. Periodic certification of continued disability will be required to maintain eligibility.

f. Unless otherwise set forth in this Section, a dependent's coverage automatically terminates and all benefits hereunder cease, whether or not notice to terminate is received by the Plan on the day following the date in which such employee's coverage terminates.

## Dependent Eligibility Verification

The Pennsylvania State System of Higher Education (PASSHE) requires verification of health care program eligibility for dependents newly added to current annuitants' coverage as a result of a life event change (i.e., marriage, birth or adoption of a child, etc.) This is to ensure that dependents covered under the PASSHE Annuitant Health Care Programs meet the eligibility requirements for coverage. All annuitants will have 60 days from the date they add a new dependent as a result of a life event change to provide satisfactory documentation to verify dependent eligibility. All documentation must be provided to the System Central Benefits office.

The following chart has been prepared to provide you with types of documentation that are acceptable for dependent verification and possible resources for documentation. You must provide an original or certified copy of the original document to the System Central Benefits office when verifying your dependent(s). The System Central Benefits office will review the documentation provided to determine dependent eligibility. You will retain the original documents and copies **will not** be maintained in the System Central Benefits office.

If satisfactory documentation for enrolled dependent(s) is not provided to the System Central Benefits office within 60 days of adding a dependent as a result of a life event change, the dependent's health plan coverage will be terminated retroactively to the date on which the dependent was enrolled. If claims were paid for ineligible dependents, restitution will be required and you will be billed for any ineligible claims.

Questions concerning this dependent verification process should be referred to the System Central Benefits office at (717) 720-4153.

# DOCUMENTATION REQUIREMENTS FOR ANNUITANTS

| DEPENDENT | REQUIRED DOCUMENTATION | POSSIBLE RESOURCES TO OBTAIN DOCUMENTATION |
|---|---|---|
| Spouse | • Marriage Certificate (this is not the certificate provided from the official conducting the ceremony)<br>• Affidavit attesting to the existence of marriage performed outside of the United States if a foreign marriage | • County courthouse that issued original or certified copy of the marriage certificate. A list of Pennsylvania County Courthouses can be found at www.health.state.pa.us under Health Statistics and Vital Records.<br>• Foreign Marriages Affidavit available from the System Central Benefits office |
| Child(ren) by birth | • Birth certificate ❖<br><br>If dependent child is a full-time student over age 19, you also must complete a Student Certification Form signed by the registrar's office ***or accompanied by an Enrollment Verification Certificate from the National Student Clearinghouse*** | • For Pennsylvania births, birth certificates are available from the PA Department of Health, Division of Vital Records and can be requested by fax, mail, or online at www.health.state.pa.us. Fee is $10.<br>• Many states allow you to order a new birth certificate from their website. Access to other state websites can be linked through http://www.cdc.gov/nchs/w2w.htm<br>• Student Certification Form available from the System Central Benefits office |
| Child(ren) by adoption | • Court approved adoption order **OR**<br>• Placement letter from court/adoption agency for pending adoptions<br><br>If dependent child is a full-time student over age 19, you also must complete a Student Certification Form signed by the registrar's office ***or accompanied by an Enrollment Verification Certificate from the National Student Clearinghouse*** | • County courthouse that issued final adoption order<br>• County court/adoption agency that issued placement letter<br>• Student Certification Form available from the System Central Benefits office |
| Child(ren) by legal guardianship | • Court or agency order establishing guardianship **AND**<br>• Affidavit of Residence and/or Dependency for Other Children Form<br><br>If dependent child is a full-time student over age 19, you also must complete a Student Certification Form signed by the registrar's office ***or accompanied by an Enrollment Verification Certificate from the National Student Clearinghouse*** | • County courthouse/agency that issued guardianship order<br>• Affidavit of Residence and/or Dependency for Other Children Form available from the System Central Benefits office<br>• Student Certification Form available from the System Central Benefits office |
| Stepchildren | • Birth certificate ❖ **AND**<br>• Marriage certificate<br><br>If dependent child is a full-time student over age 19, you also must complete a Student Certification Form signed by the registrar's office ***or accompanied by an Enrollment Verification Certificate from the National Student Clearinghouse*** | • For Pennsylvania births, birth certificates are available from the PA Department of Health, Division of Vital Records and can be requested by fax, mail, or online at www.health.state.pa.us. Fee is $10.<br>• Many states allow you to order a new birth certificate from their website. Access to other state websites can be linked through http://www.cdc.gov/nchs/w2w.htm<br>• County courthouse that issued original marriage certificate. A list of Pennsylvania County Courthouses can be found at www.health.state.pa.us under Health Statistics and Vital Records.<br>• Student Certification Form available from the System Central Benefits Office |
| Disabled dependent | • Will be verified by health plan vendor | • Health Plan Vendor |

❖ If document was generated outside of US and is not in English, it must be translated and certified by translator

## Other Coverage Information

If your spouse is also a PASSHE employee or annuitant eligible to participate in either the active coverage or the Annuitant Health Care Program (AHCP), he or she may enroll as a single subscriber under his/her own plan, or as a dependent under the active employee's coverage, but not both. Likewise, dependents may only be covered under one PASSHE active group plan or PASSHE-AHCP plan.

If your spouse is covered under the Pennsylvania Employees Benefit Trust Fund (PEBTF) through another Commonwealth agency (not PASSHE), the annuitant and dependents may be enrolled on each other's policies for the purpose of coordination of benefits.

Spouses eligible for fully-paid employer coverage through his/her employer must be enrolled in their employer's coverage and State System health coverage will provide minimal benefits as secondary payer only. (This only applies to spouses added to health coverage after July 1, 2001)

## Health Program Coverage Effective Dates

Coverage for you and your Dependents begins on the date of retirement or on the date you become eligible and enroll. If you enroll during an open enrollment period, coverage will begin the following July 1. In the case of annuitants who have declined coverage due to enrollment in another health care program, coverage may be made effective as of the date the other coverage ceases upon timely submission (within 60 days) of evidence that the other coverage has ended. Otherwise, you may only enroll during the next open enrollment.

If you marry, your spouse will have coverage as of the date of marriage; however, you must complete an enrollment form to add your spouse within 60 days of the marriage date before claims will be paid. A newborn child will be covered under the plan for 31 days following birth. Coverage will not continue beyond 31 days unless an enrollment form is completed within 60 days.

Changes in your marital or family status must be reported to the System Central Benefits office as soon as possible. If eligible Dependents are not added to your contract within 60 days of acquisition or within 60 days from the date that eligibility under other coverage ended, those Dependents may not enroll until the next open enrollment period for an effective date of July 1.

## Health Program Coverage Ending Dates

Eligibility ends when:

- You voluntarily terminate coverage;
- You fail to make premium contribution payments (if applicable); or
- You die.

Your coverage ends on the date your eligibility ends.

The coverage for a Dependent spouse will end on the day prior to the effective date in which the spouse is divorced from the annuitant.

If a Dependent child reaches age 19, takes a full-time job, or marries, coverage will end on the last day of that month. If a full-time student reaches age 25, takes a full-time job, marries, or ceases to be a full-time student, coverage will end on the last day of the month. If a medical condition causes a full-time student Dependent to become less than full-time, coverage may be extended, upon certification, for up to one year from the date that the Dependent is unable to attend school full-time.

Coverage also ends if you fail to make any required premium contribution.

**ON THE DAY YOUR COVERAGE ENDS, IT IS ILLEGAL TO USE YOUR IDENTIFICATION CARDS.**
**PLEASE DESTROY THEM IMMEDIATELY.**
**IF YOU OR A DEPENDENT DO USE YOUR CARDS, YOU WILL BE CHARGED.**

## Your Responsibilities as an Annuitant:

| Event | Action to Take |
|---|---|
| When you acquire a Dependent (birth, adoption, or marriage) | Contact the System Central Benefits Office within 60 days to add your new Dependent |
| When you lose a Dependent (divorce, or Dependent loss of eligibility for any reason) | Contact the System Central Benefits Office to remove the Dependent(s). If your Dependent is interested in COBRA coverage, you or your Dependent must inform the System Central Benefits Office within 60 days of loss. |
| When you or your spouse turns age 65 or otherwise becomes eligible for Medicare. | Contact the System Central Benefits Office and the Social Security Administration about Medicare and other benefits. Enrollment in Medicare Part A and Part B is required. |
| When your child is between ages 19 and 25 and becomes a full-time student. | Contact the System Central Benefits Office to complete the enrollment and Student Certification forms. |
| In the case of your death. | Your Dependents should contact the System Central Benefits Office to discuss health insurance continuation provisions. |

# Annuitant/Retiree Health Care Program (AHCP)

## *Eligibility*

***For Majority Paid Coverage***

- For eligible employees with current hire date prior to July 1, 1997, when covered employees retire
    - at age 60 with at least 10 years of credited service (may include purchased service)
    - at any age with at least 25 years of credited service (may include purchased service)
    - on approved disability with at least 5 years of credited service (may include purchased service)
- For eligible employees with current hire date July 1, 1997 to June 30, 2004, when covered employees retire
    - at age 60 with at least 15 years of Commonwealth/State System service only
    - at any age with at least 25 years of Commonwealth/State System service only
    - on approved disability with at least 5 years of Commonwealth/State System service only
- For eligible employees with current hire date on or after July 1, 2004 but before January 16, 2016 when covered employees retire
    - at age 60 with at least 20 years of Commonwealth/State System service only
    - at any age with at least 25 years of Commonwealth/State System service only
    - on approved disability with at least 5 years of Commonwealth/State System service only
- For employees hired on or after January 16, 2016
    - no retiree health coverage is available

***For Partially Paid Coverage ($5 State Share)***

- For eligible employees enrolled in the State Employee' Retirement System (SERS), Public School Employees' Retirement System (PSERS) or the Alternative Retirement Plan (ARP) who do not meet the requirements of majority paid coverage and were hired prior to January 16, 2016, the State System will contribute $5.00 per month toward the cost of coverage and the retiree is responsible for the remaining cost of the coverage.

To qualify, employees who retire prior to superannuation age must have five years of credited service if they entered SERS or ARP prior to January 1, 2011 (PSERS prior to July 1, 2011). Employees who entered SERS or ARP after January 1, 2011 (PSERS after July 1, 2011) must have ten years of credited service. Employees who retire at or after superannuation age must have three years of credited service. Superannuation age is different depending on the retirement plan and the Class.

## *Contribution*

- Annuitants who are eligible for majority-paid coverage shall contribute to the cost of the AHCP at the same dollar amount for the type of contract and choice of plan as that in effect on the date of their retirement.
- Throughout the annuitant's lifetime while enrolled in the AHCP, the dollar amount paid by the annuitant will be adjusted whenever the percentage of contribution paid by active employees for the same type of contract and choice of plan is adjusted.
- The new percentage will be applied to the dollar amount for the type of contract and choice of plan that was in effect on the day of the annuitant's retirement to determine the new annuitant contribution.
- Annuitant benefits continue to include coverage for dependents
- The Wellness Program and non-participant contribution increases do not apply to annuitants
- State System pays $5 toward cost of coverage for annuitants who qualify for partially-paid coverage under eligibility requirements listed above
- If the annuitant, subsequent to retirement, changes plans or adds or deletes dependents, the dollar amount of their contribution will change to conform to the dollar amount of contributions for the most comparable plan and size of contract that was in effect on the date the annuitant retired. The wellness program non-participant contributions do not apply to annuitants.

| Plan Choices | Annuitant Contributions |
|---|---|
| PPO (not Medicare Eligible –Pre 65 years old) | Pays percent paid by active employees:<br>• January 1, 2016 = 18%<br>• With future increases<br>Applies to cost of plan in effect at retirement |
| Medicare Eligible - Medicare supplement with Rx under Major Medical ($500 deductible – covered services paid at 80% after deductible has been satisfied on an annual basis) and Rx discount card | Pays percent paid by active employees:<br>• January 1, 2016 = 18%<br>• With future increases<br>Applies to cost of plan in effect at retirement |

## *Coverage*

**Annuitants not Medicare eligible/pre-65 years old who retire prior to December 31, 2015**

- PPO coverage in effect at time of retirement with prescription drug card

**Annuitants not Medicare eligible/pre-65 years old who retire on or after December 31, 2015**

- PPO plan design effective January 1, 2016 as follows:

| PPO Plan Feature | REMOVED | |
|---|---|---|
| | **In-network** | **Out-of-network** |
| **Deductible** | $250 per person, $500 per family | $500 per person, $1,000 per family |
| **Member Coinsurance** | 10% | 30% |
| **Out-of-Pocket Maximum** (Applicable to coinsurance only; does not include deductible and copays) | $1,000 per person, $2,000 per family | $2,000 per person, $4,000 per family |
| **Primary Care Physician Office Visit** | $15 copay (not subject to deductible or coinsurance) | 70% after deductible |
| **Specialist Office Visit** | $25 copay (not subject to deductible or coinsurance) | 70% after deductible |
| **Preventive Care** | Plan pays 100% - no deductible or coinsurance | 70% after deductible |

**Deductibles and coinsurance do not apply to in-network preventive care or to services for which a copay applies.**

### Definition of Plan Terms

- **Deductible** – The amount you will pay for the applicable health care services before the health plan begins to pay.
- **Coinsurance** – Your share of the cost of the applicable health care service, after the deductible is met.
- **Out-of-Pocket Maximum** – The maximum amount you will be required to pay in a calendar year in coinsurance payments. After this amount has been satisfied, the health plan will pay 100% of the applicable covered health care costs for the remainder of the calendar year. (Members will continue to be responsible for copays for office visits and prescription drugs).
- **Copay** – A fixed, upfront dollar amount that you pay each time you receive certain health care services (such as an office visit or a prescription). The deductible/coinsurance do not apply to services subject to a copay.

### Important – the deductible and coinsurance only apply to certain types of health care expenses.

| *Here are some areas where the deductible and coinsurance **do not** apply.* | *Here ae some common medical services where the deductible and coinsurance **will apply.*** |
|---|---|
| • In-Network Preventive Care-Preventive services (such as annual physicals, well baby visits, immunizations and mammograms) will continue to be covered at 100% by the health plan; there will be no member cost associated with these services.<br><br>• Services to which a copay applies-If a copay applies to the service you are obtaining, then that service is not subject to the deductible or coinsurance. This includes primary care and specialist office visits, emergency room visits, and prescription drugs. For these services, your cost is the associated member copay amount. | • Diagnostic/Imaging Services (e.g.-ray, MRI, nonpreventive lab/pathology).<br>• Inpatient and outpatient surgery.<br>• Hospitalization.<br>• Durable medical equipment.<br>• Chemotherapy, dialysis and infusion therapy.<br>• Home health care, skilled nursing facility care and hospice care. |
| *Not a comprehensive list of services, click here for more details.* | |

**Prescription – not Medicare eligible/pre-65 years old**

| **Prescription Drug Tier** | **Retail Copay** (30-day supply) | **Mail-Order Copay** (90-day supply) |
|---|---|---|
| Generic | $10 | $ 20 |
| Brand Drugs, Formulary | $30 | $ 60 |
| Brand Drugs, Nonformulary | $50 | $100 |

- No deductible for prescriptions

- If brand drug that has a generic equivalent is dispensed, employee responsible for brand drug copayment plus difference in cost between generic and brand drug unless physician requests brand drug be dispensed ("No Substitution")

**Prescription - Annuitants Medicare eligible (age 65 and over)**

- Signature-65 and Major Medical coverage to supplement Medicare Parts A and B.
- Enrollment in Medicare Parts A and B is required.
- Annual Major Medical deductible of $500 individual
- Major Medical member 20% coinsurance (plan pays 80%) after deductible until out pocket maximum limit of $350 per person is met in calendar year.
- Major medical will reimburse at 100% after out of pocket limit is met

**Pharmacy Discount Program for Medicare Eligible Annuitants**

Highmark has made arrangements with a network of pharmacies to offer you discounted prices for many prescription drugs. **You will pay less when you use a pharmacy that participates in this network.** Your Highmark member ID card will have a special symbol printed on it that tells the pharmacist to give you a discount on most prescription drugs. To receive your discount, you must show your ID card to the pharmacist when you have your prescriptions filled. The amount you pay for most prescription drugs will reflect this discount. To locate a network pharmacy, call the Highmark toll-free Member Services telephone number printed on the back of your ID card or visit the website at www.highmarkblueshield.com.

**Prescription drug costs incurred at either a retail pharmacy or through mail order may be submitted to Major Medical for reimbursement.**

Prescription Drug Discount Process

1. Present your prescription(s) to a retail pharmacist or through mail order.
2. The pharmacist will advise you of the discounted prescription price.
3. The member pays the discounted price for the prescription at the time of purchase and get a detailed receipt.
4. The member submits the receipt and completed major medical claim for to Highmark for processing and payment. (**The annual member deductible for retirements on or after July 1, 2004, is $500.)**
5. Once the deductible is satisfied for the calendar year, Major Medical will reimburse you directly at 80% of the allowed cost.

## Continuation of Coverage (for Active Employees and Annuitants)

See pages 5 – 8 **CONTINUATION OF COVERAGE (COBRA) FOR ACTIVE EMPLOYEES AND ANNUITANTS** for detailed information.

REVISED MARCH 15, 2016