



AFSCME Employees

BENEFIT SUMMARY BOOKLET

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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 American Federation of State, County, and Municipal Employees (AFSCME) 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 AFSCME 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 union bank 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

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 (which 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 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
- 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 to 18 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 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 REHP Annuitant Health Care Program 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
- Prescription Drug Plan
- 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 the 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

Retired Employee Health Program (REHP) (Annuitants)

REHP Coverage

- Various benefit plans available to annuitants under age 65
- Various benefit plans available to annuitants age 65 and over
 - Medicare PPO
 - Medicare HMOs
 - REHP Prescription Drug Plan
- Plans to be determined by PEBTF Board of Trustees

REHP Eligibility

- If employee retires on or after July 1, 2008
 - at age 60 with at least 20 years of credited service **
 - at any age with at least 25 years of credited service **
 - on approved disability with at least 5 years of credited service **
 - Will receive the medical and prescription plan of benefits in effect for active employees
 - an employee who has at least 15 years of credited service ** as of June 30, 2008, or who has 13 years of service and is within one (1) year of superannuation age as of June 30, 2008, shall be eligible to elect REHP coverage upon reaching superannuation age with 15 years of credited service ** rather than 20 years.
- State System pays \$5 toward cost of coverage for annuitants not qualifying under above criteria

** Credited service earned on or after July 1, 2007 will be limited to service as a Commonwealth/State System employee which otherwise counts as credited service under State Employee Retirement System (SERS) and/or Public School Employee Retirement System (PSERS) and/or the PASSHE Alternative Retirement Plan (ARP) and/or other approved retirement systems' rules. Employees hired on or after July 1, 2007 who have earned credited service under SERS, PSERS or other approved retirement systems' rules in effect from time to time with another employer will not have that service counted for purposes of eligibility for REHP coverage unless they were employed by the Commonwealth/PASSHE prior to July 1, 2007. Credited service for military service, if determined to be eligible as service for SERS, PSERS or the PASSHE ARP, will be included in the determination of eligibility for REHP coverage.

REHP Contributions

For Majority Paid Coverage

- If employee retires on or after July 1, 2011
 - Will contribute based on final average salary as determined by the State Employees Retirement System and shall be 3.0% through June 30, 2015
 - Effective January 1, 2012, the annuitant contribution for those who become eligible for Medicare coverage shall be reduced from 3.0% to 1.5%

For Partially Paid Coverage (\$5 State Share)

- For 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, 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.

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).

Medical Reimbursement 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 \$40,000
- Coverage reduced at age 70 to 65%; coverage reduced at age 75 to 50%
- \$25,000 additional work-related accidental death
- Three-month waiting period
- Right to convert upon termination/retirement

Eligibility/Contribution

- 100% paid for permanent employees
- Other employees 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:

For employees hired before July 1, 2011:

Up to three years of service	7 days/yr. (2.70% of hrs. paid)
Over 3 years to 15 years of service	15 days/yr. (5.77% of hrs. paid)
Over 15 years to 25 years of service	20 days/yr. (7.70% of hrs. paid)
Over 25 years of service	26 days/yr. (10% of hrs. paid)

For employees hired on or after July 1, 2011:

Up to three years of service	7 days/yr. (2.70% of hrs. paid)
Over 3 years to 15 years of service	15 days/yr. (5.77% of hrs. paid)
Over 15 years of service	20 days/yr. (7.70% of hrs. paid)

- Unused leave may be carried from one year to the next
- 45 days' 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 4.24% of regular hours paid biweekly up to a maximum of 11 days per year
- Unused leave may be carried from one year to the next
- 300 days' accumulation
- 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; additional leave for sickness in immediate family may be used for a serious health condition after meeting certain criteria; additional leave is earned as follows:

Leave Service Credit

Over 1 year to 3 years
Over 3 years to 15 years
Over 15 years to 25 years
Over 25 years

Sick Family Allowance

Up to 52.5/56 additional hours (7 days)
Up to 112.5/120 additional hours (15 days)
Up to 150/160 additional hours (20 days)
Up to 195/208 additional hours (26 days)

- Payment in accordance with the following schedule for accumulated leave at retirement or death while in active service if certain eligibility is met:

<u>Days Accumulated</u>	<u>% Payout</u>	<u>Maximum Days Paid</u>
0 – 100	30%	30
101 – 200	40%	80
201 – 300	50%	150
Over 300 (in last year of employment)	100% of days over 300	11

- 100% of unused leave paid to survivor for work-related death

Effective with the beginning of the 2012 leave calendar year, employees who use no sick leave in a leave calendar year shall earn one additional personal leave day to be used in the following leave calendar year. Sick bereavement leave shall not count for purposes of this section; all other types of paid sick leave (personal sick leave, SPF sick leave, work-related injury sick leave, and sick family), unpaid sick leave used for SPF reasons, and paid and unpaid leave used for work-related injuries shall count for such purposes.

Personal Leave

- Paid leave earned as follows:
 - 1 day in first calendar year of employment
 - 1 day per half calendar year in second year of employment
 - 1 day per calendar quarter in third and subsequent years of employment
- 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
- Effective at the beginning of the 2012 leave calendar year, employee may use up to two personal leave days as extraordinary personal leave days per leave calendar year, to be used in full day increments (subject to operational consideration)
- Payment for unused accrued leave at termination/retirement

Leave Donation Program

- Permanent employees may donate maximum of 5 days annual and/or personal leave to management employees or union employees whose union has agreed to participate in the plan to be used for catastrophic or severe injury or illness of employee or family member
- Can donate within university or Office of the Chancellor
- Donations may not result in annual leave balances of less than 5 days
- Employees receiving donated leave must use 20 days for the catastrophic or severe illness/injury each year before utilizing donated leave and must use all accrued leave
- Employees may use up to 12 weeks donated leave per year, but donations may not be received in more than two consecutive leave calendar years

Holidays

- 11 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	Day after 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 at university where employed up to 128 undergraduate credits)
- Spouse and/or dependents (to age 25) (total waiver at university where employed up to first undergraduate degree)

REVISED MARCH 15, 2016