Nonrepresented Employees

(Managers)

BENEFIT SUMMARY BOOKLET

REVISED MARCH 15, 2016

TABLE OF CONTENTS

This summary highlights the Pennsylvania State System of Higher Education Health Program, Supplemental Benefits Program, Annuitant Health Care Program, and leave entitlements for System managers (Non-Represented employees). The benefits described are available to most employees; however, certain eligibility requirements must be met.

Information is provided for general purposes only. Legal Plan Documents will govern any discrepancies that may arise. For additional information concerning these benefits, contact your human resource office. Additional information is also available at http://www.passhe.edu/inside/hr/syshr/Pages/unit_info.aspx?q=managers Benefits, benefit levels, and eligibility rules are subject to change.

General Information

Who is Eligible for PASSHE Health Program Coverage (Active Employees)?

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

   a. Employees

      To be eligible for coverage under this plan, employee must be a permanent, full-time employee (including temporary, full-time faculty with at least an academic year contract) or a permanent, part-time employee (including temporary, part-time faculty with at least an academic year contract) who is scheduled to work every pay period for at least 50 percent of full-time.

   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 eligibility requirements on page 4)

      Same-Sex Domestic Partners (SSDP) and children of 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.

   b. Children under 26 years of age and who meet one of the following requirements:

      - A natural child of your own;
      - A legally adopted child (including a child living with the employee during the probation period);
      - A stepchild;
      - A minor child for whom the employee 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 employee was the child's court or agency appointed legal guardian prior to the child's 18th birthday;
      - 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 System university 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 your 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.

   c. Unmarried Dependent child 26 years of age or older who is incapable of self-support because of a physical or mental disability that commenced before the age of 26. Periodic certification of continued disability will be required to maintain eligibility.

d. 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 the employee's coverage terminates.

Dependent Eligibility Verification

The Pennsylvania State System of Higher Education (PASSHE) requires verification of health care program eligibility both for dependents of newly hired employees and for dependents newly added to current employees' and annuitants' coverage as a result of a life event change (i.e., marriage, birth or adoption of a child, etc.) or during open enrollment. This is to ensure that dependents covered under the PASSHE Active Health Care Programs and the Supplemental Benefits Program meet the eligibility requirements for coverage.

- All new employees will have 60 days from their date of hire to provide satisfactory documentation to verify dependent eligibility.
- All current employees 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 current employees will have until the end of open enrollment for dependents added during the annual open enrollment, (unless specified differently in the open enrollment communication) to provide satisfactory documentation to verify dependent eligibility.
- All documentation must be provided to the university human resources 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 document or a certified copy to your university human resources office when verifying your dependent(s). The university human resources office will review the documentation provided to determine dependent eligibility. You will retain the original documents and copies **will not** be maintained in the human resources office.

If satisfactory documentation for enrolled dependent(s) is not provided to your university human resources office within 60 days of your date of hire or 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 your university human resources office.

DOCUMENTATION REQUIREMENTS FOR ACTIVE EMPLOYEES

DEPENDENT	REQUIRED DOCUMENTATION	POSSIBLE RESOURCES TO OBTAIN DOCUMENTATION
Spouse	• Marriage Certificate (this is not the certificate provided from the official conducting the ceremony) • Spouse Health Care Enrollment Attestation Form (for employees hired on/after July 1, 2013) • Affidavit attesting to the existence of marriage performed outside of the United States if a foreign marriage	• County courthouse that issued original marriage certificate or a certified copy. A list of Pennsylvania County Courthouses can be found at www.health.state.pa.us under Health Statistics and Vital Records. • Spouse Health Care Attestation Form available under forms on the State System website or from the university human resources office • Foreign Marriages Affidavit available from university human resources office
Child(ren) by birth	• Birth certificate ❖ ❖ If document was generated outside of US and is not in English, it must be translated and certified by translator.	• 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. • 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
Child(ren) by adoption	• Court approved adoption order **OR** • Placement letter from court/adoption agency for pending adoptions	• County courthouse that issued final adoption order • County court/adoption agency that issued placement letter
Child(ren) by legal guardianship	• Court or agency order establishing guardianship **AND** • Affidavit of Residence and/or Dependency for Other Children Form	• County courthouse/agency that issued guardianship order • Affidavit of Residence and/or Dependency for Other Children Form available from university human resources office
Stepchildren	• Birth certificate ❖ **AND** • Marriage certificate ❖ If document was generated outside of US and is not in English, it must be translated and certified by translator.	• 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. • 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 • 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
Disabled dependent	• Will be verified by health plan vendor	• Health Plan Vendor

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 employee and dependents may be enrolled on each other's policies for the purpose of coordination of benefits.

If your spouse is eligible for employer coverage through his/her employer, the following rules apply based on your date of employment:

For Employees Hired PRIOR to July 1, 2013
Spouses added to coverage after July 1, 2001 who are eligible for fully-paid employer coverage (e.g., no employee contribution for coverage) through his/her employer must be enrolled in their employer's coverage and PASSHE health coverage will provide benefits as secondary payer only.

For Employee Hired ON OR AFTER July 1, 2013
If an employee enrolls a spouse in the PASSHE health plan and that person is eligible for coverage under their own employer's plan, the spouse shall be required to enroll in their own employer's plan for their primary coverage as a condition for eligibility for secondary coverage under the PASSHE health plan regardless of the cost to the spouse for that coverage.

Health Program Coverage Effective Dates

Coverage for you and your Dependents begins on your date of employment or on the date you become eligible. You have 30 days from the date your employment begins or the date you become eligible for benefits to complete the enrollment for benefits.

If you enroll during an open enrollment period, coverage will begin the following July 1. In the case of employees 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 your human resources 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 terminate employment or are furloughed;
- You regularly work less than 50 percent of full-time;
- You retire, or
- You die.

Eligibility may end when you take a long term unpaid leave of absence.

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 employee.

When a Dependent child reaches age 26, coverage will end on the last day of that month.

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.

COBRA Continuation of Coverage (for Active Employees and Annuitants)

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

This continuation coverage is available for employees, annuitants, and dependents covered under the following programs:

1. State System of Higher Education Group Health Program (medical/hospital/prescription drug/hearing);
2. State System of Higher Education Annuitant Health Care Program (medical/hospital/prescription drug);
3. State System of Higher Education Supplemental Benefits Program (dental and vision); or
4. State System of Higher Education Medical Reimbursement Account through the Flexible Spending Account.

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a covered employee or annuitant, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare Benefits (under Part A, Part B, or both); or
5. You become divorced (or legally separated from your spouse in anticipation of divorce).*

Dependent children of covered employees and annuitants will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare Benefits (Under Part A, Part B or both);
5. The parents become divorced or legally separated*; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

Employees enrolled in the State System of Higher Education's Medical Reimbursement Account through the Flexible Spending Account Plan may continue after-tax contributions through the end of the calendar year in which eligibility was lost, so long as there was a positive account balance at that time.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, or the employee is becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event.–

You Must Give Notice of Some Qualifying Events

The State System of Higher Education has the responsibility to notify the COBRA Administrator of the employee's or annuitant's death, termination of employment or reduction in hours. For the other qualifying events (divorce or legal separation* of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the employee, annuitant, or family member must notify the State System of Higher Education within 60 days after the qualifying event occurs. You must provide this notice to your university's human resources office (see address below). *If notice is not given within the 60 days required by law, the individual losing their group coverage forfeits all rights to COBRA continuation coverage*.

When the COBRA Administrator is notified that one of these events has happened, it will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date the COBRA Administrator mails you a notice or, if later, the date you would lose coverage to inform the administrator that you want continuation coverage. Your first payment is due within 45 days of your election. A separate election may be made by each person.

How is COBRA Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare Benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's 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 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 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 (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family 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 Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated*, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your university human resources office at the address or phone number listed below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. The information for Regional Office for Pennsylvania is Philadelphia Regional Office, 170 S. Independence Mall West, Suite 870 West, Philadelphia, PA 19106-3317, (215) 861-5300. For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your university human resources office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your university human resources office. Any notification, which is your responsibility under law, will not be considered adequate unless it is made to the human resources office.

**Under Federal law a "legal separation" is a qualifying event if it causes loss of coverage. For Pennsylvania residents, there is no "legal separation" recognized in the law. Therefore, separation would not be a qualifying event entitling the spouse and children to COBRA coverage. The "qualifying event" is the date of the divorce since separation is not recognized in Pennsylvania*

Conversion of Coverage

If you do not wish to continue coverage through the State System of Higher Education's program, you will be able to enroll in a direct payment program for your medical coverage. Also, conversion is available to anyone who has elected continued coverage through COBRA and the term of that coverage has expired. If your coverage through the State System is discontinued for any reason, except as specified below, you may convert to a direct payment program. The conversion opportunity is not available if either of the following applies:

- You are eligible for another group health care benefits program through your place of employment; or
- When your employer's program is terminated and replaced by another health care benefits program.

Your Responsibilities as an Active Employee:

Event	PPO	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 within 60 days 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 within 60 days to remove the Dependent(s). Failure to notify your Human Resources Office within 60 days will result in your dependent losing election rights for COBRA benefits.	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 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 4 – Rules for spouse eligibility)	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.	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 SSHE 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.

State System of Higher Education Group Health Program (SSHEGHP) and Supplemental Benefits

Coverage

Nonrepresented employees who are eligible for health care will have the opportunity to enroll in the Preferred Provider Organization (PPO) plan and to enroll in the Supplemental Benefits plan.

Preferred Provider Organization (PPO) Plan

PPO Plan Feature		
	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	70% after deductible

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

Preventive Care

There are **no member costs** for preventive care at in-network providers–the plan pays 100% of the costs for qualifying preventive services. By following the recommendations in the preventive schedule, you may be able to either prevent certain medical conditions, or detect them before they become more serious.
Take a moment to review the preventive schedule and, if needed, contact your medical provider to obtain any recommended services.

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 services, 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 are 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. • 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., x-ray, MRI, nonpreventive lab/pathology). • Inpatient and outpatient surgery. • Hospitalization. • Durable medical equipment. • Chemotherapy, dialysis and infusion therapy. • Home health care, skilled nursing facility care and hospice care.
Not a comprehensive list of services, click here for more details	

Prescription Drug Plan

Enrolled in conjunction with Medical Coverage

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")

Hearing Aid Plan

Benefits currently administered by Highmark Blue Shield (for employees enrolled in health coverage)

- 100% of the plan allowance for services up to $350/36-month period

Waiver of Medical Coverage

- Employees may elect to waive enrollment in medical coverage for themselves and family members
- Employee contributions will not occur while Waiver of medical coverage is in effect
- Re-enrollment for medical coverage will only be permitted during open enrollment or upon occurrence of a life event (i.e., loss of other coverage, divorce, marriage, etc.)

Supplemental Benefits Program

Dental Plan - Benefits currently administered by United Concordia (UCCI)
$1,250 maximum benefit per calendar year per person (Orthodontics has a separate maximum)

- 100% of the plan allowance for
  - Diagnostic services
  - Preventive services
  - Basic restorative services
  - Periodontal services
  - Oral surgery services

- 70% of the plan allowance for
  - Major restorations
  - Prosthetics
- 60% of the plan allowance for
  - Orthodontics
  - $3,000 lifetime maximum benefit per person

Vision Plan – Benefits currently administered by National Vision Administrators (NVA)
- NVA Participating Providers
- Routine exam, standard lenses, and progressive lenses paid in full
- Frames - $50 allowance towards wholesale price
- Contact lenses and low vision aids based on a schedule of allowances
- NVA Non-Participating Providers
- Routine exam - $40 for optometrists and $45 for ophthalmologists
- Frames, standard lenses, contact lenses and low vision aids based on a schedule of allowances towards retail price
- No additional allowance for progressive lenses

Eligibility/Contribution for Active Employees

PPO Plan
(Includes Prescription Drug Plan)

Full-time employees:
- Permanent full-time employees contribute a percentage of premiums (see chart below) for medical and prescription plan on a pre-tax basis
- Effective July 1, 2008, employees who are enrolled in the PPO Plan are required to participate in the Health Care Management Program (Wellness Program) to receive a reduced premium contribution (see chart below.) Failure to participate and/or complete the requirements of the Wellness Program on a timely basis results in premium contributions at the higher non-participant level.
- Contributions are based on selected plan and contract size (single, two-party or family)

Full-Time Employees Percent of Premium Contribution	
Participant in Wellness Program	Non-participant in Wellness Program *
18%	28%

*** New hires receive wellness participation rate until new plan year (July 1) – more detailed information can be found under Healthy U section**

- Wellness Program participation requirements are provided upon health plan enrollment.

Part-time employees:
- Permanent part-time employees who work at least 50% time, contribute a percentage of premium (see chart below) for medical and prescription plan on a pre-tax basis
- Effective July 1, 2008, employees who are enrolled in the PPO Plan are required to participate in the Health Care Management Program (Wellness Program) to receive a reduced premium contribution (see chart below.) Failure to participate and/or complete the requirements of the Wellness Program on a timely basis results in premium contributions at the higher non-participant level.

- Contributions are based on selected plan and contract size (single, two-party or family)

Part-Time Employees Percent of Premium Contribution	
Participant in Wellness Program	Non-participant in Wellness Program *
57.5%	62.5%

*** New hires receive wellness participation rate until new plan year (July 1) – more detailed information can be found under Healthy U section**

- Wellness Program participation requirements are provided upon health plan enrollment.

Supplemental Benefits Program (Dental and Vision)

- State System pays 100% for permanent full-time employees and dependents and for permanent part-time employees and dependents, if the employee works at least 50% time.

Healthy U
PASSHE Health Care Management Program

The Pennsylvania State System of Higher Education (PASSHE) Health Care Management Program, Healthy U, is a Wellness Program designed to help you improve your well-being and become more engaged in every aspect of your health. Healthy U was developed by PASSHE for management, faculty, non-faculty coaches, police and security personnel and nurses. If you are enrolled in the State System of Higher Education Group Health Program's PPO health care plan, you and your covered spouse are strongly encouraged to participate in Healthy U.

Participation in the Wellness Program carries with it many rewards in addition to the financial incentives of paying substantially lower health care contribution rates. In the long run, the payback in terms of your improved well-being will likely be far more significant than the contributions you saved since good health is the single most important quality in our lives and the basis for enjoying all other aspects of life.

Just as our universities are the source of educational inspiration for thousands of students every year, PASSHE hopes that Healthy U will inspire you and your family to become more educated about your own health and to take advantage of the information, resources and programs for a healthier you!

Why Should I Participate In Healthy U?
Participation in Healthy U will entitle you to pay the lowest health plan contribution rates. This is an obviously considerable financial incentive for you and your covered spouse to participate in Healthy U. However, both management and union are hopeful that employees will be interested in participation in order to become more involved in improving their own health or maintaining their current good health into the future.

How Do I Ensure I Will Pay the Lowest Health Plan Contribution Rate?
Participation in Healthy U by both you and your covered spouse will entitle you to pay the lowest health plan contribution rates. If either you or your spouse do not meet the participation requirements, you will not be eligible for the lowest health plan contribution rates.

How Do I Participate in Healthy U?
Please refer to the Pennsylvania State System of Higher Education website at http://www.passhe.edu/inside/hr/syshr/Pages/healthy-u.aspx for more information on participation and requirements of the program.

As a New Employee, When Can I Participate in Healthy U?
As a new employee, when you enroll in healthcare benefits initially you will pay the lowest health plan contribution rates. In order to continue paying the lowest premium rates in the following plan year, you and your covered spouse will need to complete the Healthy U participation requirements prior to the end of the wellness plan year (generally May 31).

What Preventive Services are Covered Under My Benefits Plan?
As a State System manager (non-represented employee), your plan includes a full routine preventive schedule of benefits for adults. This schedule includes coverage for the routine physical exam itself, as well as various other tests and screenings that may be included with the exam. Please be aware that your physician may recommend tests and screenings that are not covered as part of your preventive schedule of benefits. You are responsible for verifying that tests and screenings will be covered (by contacting Highmark Member Services at 1-888-745-3212) and if they are not, you are responsible for paying for any services not covered.

Will the Personal Information that I Supply to Highmark Be Kept Confidential and Will the State System View the Health Information I Submit?
Highmark and their wellness partner fully comply with all Health Insurance Portability and Accountability Act (HIPAA) regulations. Protected health information (PHI) is kept completely confidential and all web transactions occur on a secure site and secure link.

The information you enter is kept completely confidential and will not be shared with PASSHE. All personal health information is protected by HIPAA and may not be divulged without your permission. All reports provided to PASSHE contain aggregate data only, and contain no individual PHI.

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 a 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 deductibles and amounts in excess of plan allowances or maximums, prescription drug co-payments, PPO 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 to pay health care contributions on pre-tax basis, resulting in higher take-home pay. Post-tax contributions will be taken in certain circumstances as required by IRS guidelines.

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
- $20,000 additional work-related accidental death
- 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 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	15.6 days/yr. (6% of hrs. paid)
Over 15 years to 25 years of service	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
- Unlimited 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
- Payment in accordance with the following schedule for accumulated leave at retirement or death while in active service 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	100% of days over 300	15

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

Personal Leave

- 6 days earned 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

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 illness/injury 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 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 not more than 2 consecutive calendar years

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

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 or refer to the Pennsylvania State System of Higher Education website at: http://www.passhe.edu/inside/hr/syshr/Pages/seap.aspx . 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. 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

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.

   b. 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.

c. 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.

d. 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.

e. 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) • 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. • Foreign Marriages Affidavit available from the System Central Benefits office
Child(ren) by birth	• Birth certificate ❖ 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. • 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 • Student Certification Form available from the System Central Benefits office
Child(ren) by adoption	• Court approved adoption order **OR** • Placement letter from court/adoption agency for pending adoptions 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 • County court/adoption agency that issued placement letter • Student Certification Form available from the System Central Benefits office
Child(ren) by legal guardianship	• Court or agency order establishing guardianship **AND** • Affidavit of Residence and/or Dependency for Other Children Form 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 • Affidavit of Residence and/or Dependency for Other Children Form available from the System Central Benefits office • Student Certification Form available from the System Central Benefits office
Stepchildren	• Birth certificate ❖ **AND** • Marriage certificate 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. • 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 • 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. • 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: • January 1, 2016 = 18% • With future increases 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: • January 1, 2016 = 18% • With future increases 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		
	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. • 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). • Inpatient and outpatient surgery. • Hospitalization. • Durable medical equipment. • Chemotherapy, dialysis and infusion therapy. • 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