Welcome to the School District of Philadelphia

Benefits and Retirement Overview*

For

Commonwealth Association of School Administrators
(CASA)

Hired 7/1/2014 or later

Inside you will find a summary overview of the benefits for which you are eligible as a SDP CASA employee. Please visit our website often for updates, forms, and notifications.

Benefits Office, Suite G-10
Phone: 215-400-4630
Fax: 215-400-4631
Email: benefits@philasd.org

Retirement Office, Suite G-8
Phone: 215-400-4680
Fax: 215-400-4681
Email: retirement@philasd.org

Office Hours: Monday-Thursday, 9am-5pm. Fridays and after hours by advanced appointment only.
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Medical Health Plans*
CASA employees are eligible to enroll in either of the School District of Philadelphia’s Personal Choice plans: Modified Personal Choice 320 and Personal Choice 20/30/70%. However, employees represented by CASA for the first time must enroll in the Modified Personal Choice 320 plan. Employees who would like to switch to Personal Choice 20/30/70% plan may do so during the annual Open Enrollment period in May.

Modified Personal Choice 320: A PPO (preferred provider organization) plan, does not require referrals and gives you the ability to visit out of network doctors. It carries the following out-of-pocket costs:
- $300 individual/$900 family annual deductible on certain services,
- $1000 individual/$2000 family annual coinsurance on certain services,
- $20 co-payment for primary care physicians (PCP) and a $30 co-payment for specialists.
- A bi-weekly deduction of 8% of the monthly premium, as described below.

Personal Choice 20/30/70%: **Available during Open Enrollment Only** A PPO (preferred provider organization) plan, does not require referrals and gives you the ability to visit out of network doctors. It carries the following out-of-pocket costs:
- $0 deductible,
- $0 coinsurance,
- $20 co-payment for primary care physicians (PCP) and a $30 co-payment for specialists.
- A bi-weekly deduction of 8% of the monthly premium of the 320 plan, plus a 75% differential of the rates between the two plans, as described below.

<table>
<thead>
<tr>
<th>Tiers</th>
<th>Modified Personal Choice Mod PC 320</th>
<th>Personal Choice 20/30/70 with Buy-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$13.24</td>
<td>$50.00</td>
</tr>
<tr>
<td>Employee and Child</td>
<td>$18.54</td>
<td>$70.01</td>
</tr>
<tr>
<td>Employee and Children</td>
<td>$23.83</td>
<td>$90.01</td>
</tr>
<tr>
<td>Employee and Spouse/Life Partner *</td>
<td>$26.48</td>
<td>$100.02</td>
</tr>
<tr>
<td>Employee and Family *</td>
<td>$39.72</td>
<td>$150.02</td>
</tr>
</tbody>
</table>

* Plan is subject to an additional $40 spousal surcharge

Spousal Surcharge
CASA employees who cover a spouse or life partner as a dependent on their medical coverage incur a $40 per pay surcharge if your spouse or life partner is eligible for medical coverage through his/her employer.

Please Note: Beginning 9/1/2018, the spousal surcharge will increase to $75 per pay. This change will be effective the first pay in September 2018. Beginning 9/1/2020, the surcharge will increase to $100 per pay effective the first pay in September 2020.

**The surcharge is waived if you sign an attestation on the reverse side of the medical insurance application that your spouse is either not eligible for medical coverage through his/her own employer or your spouse is also an SDP employee**

Dental, Vision and Prescription Plans
School District of Philadelphia employees represented by CASA receive dental (United Concordia), optical (Independence Blue Cross), and prescription drug coverage (Independence Blue Cross Select Drug Program), all of which are provided at no cost to the employee.

Dental

United Concordia Flex Plan- Advantage Plus Network: This benefit is provided at no cost to the employee. With most plans, you pay a percentage of the cost for a procedure and your insurer pays a percentage. Using a network provider maximizes your benefit. How these percentages are determined depends on the types of dental services covered:
Coverage Limits: There is an annual deductible and coverage maximum for dental. The plan year is from December 1 - November 30.

- The annual deductible is $25.00 for the individual and $75.00 for a family.
- The coverage maximum is $2,000.00 per plan year.
- There is also a Lifetime orthodontic maximum of $1,200.00 per person.
- Cleaning services are not subject to a deductible.
- Diagnostic & preventive: This includes routine cleanings and exams. Services such as x-rays, sealants and fluoride treatments may be considered either preventive or basic. Our plan usually pays 100% of the cost for these procedures.
- Basic: Repair of fillings, crowns, inlays and simple extractions. Our plan pays up to 100% of these costs if you use a participating provider.
- Major: Root canals, crowns, bridges, surgery, implants and dentures are procedures that most dental insurers consider major. Our plans pay up to 80% of the costs for root canals and crowns. Bridges and dentures however, are covered up to 60%. You are responsible for the remainder of the bill.
- Orthodontics: Diagnostic, active and retention treatment is covered up to 50%. You are responsible for the remainder of the bill.
- Visit our website for a copy of the Summary of Benefits that explains exactly what and how much is covered by our plan: www.philasd.org/offices/benefits

Vision

This benefit is provided at no cost to the employee.

The Independence Blue Cross $100 Vision program is administered by Davis Vision. Members have access to comprehensive benefits, including routine eye care, a bi-annual ophthalmologist visit, frames and lenses. Benefits are maximized by using Davis Vision Providers that are conveniently located throughout the area. Paid-in-full benefits for eyeglasses with standard lenses are possible when you choose from a select grouping known as the Davis Collection of Frames.

Benefits of Vision Rider Program:
- Eye exam, including refraction, glaucoma screenings, and dilation, as professionally indicated, is covered.
- Eyeglasses, including spectacle lens and frames at non-participating providers. Maximum benefit of $100.
- Contact lenses (in lieu of eyeglasses) including standard, specialty and disposable lenses, evaluation and fitting. Maximum benefit of $100.

Value-added Services: In addition to comprehensive benefits, members with IBC’s Davis Vision Rider and Eyewear Benefit can take advantage of the following value-added services.

- Warranty – An unconditional one-year breakage warranty to repair or replace frames or lenses purchased at a participating provider for a period of one year. This warranty applies to all spectacle lenses, Davis Vision Collection of Frames and regional/national retailer frames, when the Collection is not available.
- Replacement Contact Lenses - Through Lens 123, a free mail order program, member may receive replacement contact lenses offered at guaranteed, discounted prices.
- Laser Vision Correction Services - Discount on Laser Vision Correction Services at Davis Vision Participating Laser Vision Correction Providers: Up to 25% off the participating provider’s usual and customary fees or 5% off any participating provider’s advertised specials, whichever is less.
- Additional Eyewear Discount - Members selecting non-covered materials (i.e., second pair of eyeglasses, sunglasses, etc.) will receive up to a 20% courtesy discount and up to a 10% discount on disposable contacts at most participating providers.

For answers to questions and details regarding your plan options, contact Independence Blue Cross at 1-800-ASK-BLUE, or visit them on the web at www.ibx.com and register your account.

Visit our website for a summary of benefits for the $100 vision plan and the Vision Rider Program: www.philasd.org/offices/benefits
Prescription

**FutureScripts:** The Select Drug Program is provided through Independence Blue Cross and is administered by FutureScripts. It is a comprehensive benefit that provides coverage for prescription drugs when prescribed by a licensed, practicing physician. The Select Drug Program is based on an incentive formulary that includes all generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. This benefit is provided at no cost to the employee.

**Retail Pharmacy**
Prescriptions are covered at participating pharmacies with the following member copayment:

<table>
<thead>
<tr>
<th>Formulary Type</th>
<th>Generic Formulary Copayment</th>
<th>Brand Formulary Copayment</th>
<th>Non-Formulary Brand Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Formulary</td>
<td>$10.00</td>
<td>$15.00</td>
<td>$25.00</td>
</tr>
<tr>
<td>Non-Formulary Brand</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mail Order Pharmacy**
Prescriptions are covered through mail-order for a 90 day supply with the following member copayment:

<table>
<thead>
<tr>
<th>Formulary Type</th>
<th>Generic Formulary Copayment</th>
<th>Brand Formulary Copayment</th>
<th>Non-Formulary Brand Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Formulary</td>
<td>$10.00</td>
<td>$15.00</td>
<td>$25.00</td>
</tr>
<tr>
<td>Non-Formulary Brand</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Information:**

Out of Network Reimbursement is available at 30% of the retail cost for the total amount dispensed. The member must submit a form for reimbursement.
Effective July 1, 2013, all contraceptive prescriptions and devices are covered for members at no cost.

Visit our website for more information on the program: [www.philasd.org/offices/benefits](http://www.philasd.org/offices/benefits)

If you did not want to enroll in medical, dental, vision, AND prescription coverage, you may choose to enroll in:
- Medical only
- Vision and prescription only
- Dental Only
- Medical, Vision, and Prescription only
- Medical and dental only
- Dental, vision, and prescription only

Vision and Prescription coverage cannot be separated and dependent coverage must match employee coverage.
Life Events

A life event that impacts either you or your dependent(s)’s eligibility must be reported by submitting both a medical insurance application and proof of the life event within **thirty (30) calendar days to the SDP Benefits Department**. If these documents are not submitted to the Benefits office within 30 calendar days of the life event, the requested change(s) to add a dependent or change coverage will not be made. Failure to remove an ineligible dependent in a timely manner may result in charges for premiums and claims incurred by the ineligible dependent. You have the opportunity to submit changes during our annual Open Enrollment in May in which changes are effective July 1.

Life events include but are not limited to:
- Marriage or divorce of the employee
- An enrolled family member dies
- Loss of alternative health coverage
- Birth or adoption of a child by the employee
- Termination or commencement of employment of the employee’s spouse
- The employee or spouse/partner has a significant change in employment status (e.g. part-time to full-time or vice versa, spouse gains employment)
- The employee’s family member(s) loses coverage provided by other means

Open Enrollment

*Open Enrollment occurs annually in May.* Any changes to medical coverage or dependents, may be made during this time. Applications are accepted for the full month of May for an effective date of July 1. Please check your school district email daily as the benefits department may send emails requesting pertinent information regarding you or your dependent(s)’ medical coverage that may not be accepted after the close of Open Enrollment.

Life Insurance

As a new SDP employee represented by CASA, you are entitled to a term life insurance policy of up to $25,000, through Aetna U.S. Healthcare **at no cost to you**. You are not required to undergo a medical examination if you enroll within the first 31 days of your employment. However, if after such time you wish to elect life insurance or increase your coverage amount, you are required to complete an Evidence of Insurability form and approval for coverage is not guaranteed. All life insurance coverage becomes effective on the first day of the following month after 30 days of active service with the SDP.

If you pass away during active service at the District, your beneficiaries receive the full benefit, pending Aetna’s approval. If you have not designated a beneficiary(ies), the full benefit is assigned to your next of kin. Original, signed Beneficiary forms must be submitted in person or by mail.

All employees, who leave active service (retired or otherwise), have 31 days to convert all or part of the non-paid-up portion ($2,000 in the case of eligible retirees) of their active policies to a self-billing policy directly with The Aetna Life Insurance Company. All Life Insurance forms can be found on our website: [http://philasd.org/offices/benefits](http://philasd.org/offices/benefits)

Supplemental Term Life Insurance

In addition to the benefits we currently offer, you have the option to purchase additional term life insurance through convenient payroll deductions. The Aetna Supplemental Term Life Insurance plan is offered on a guaranteed issue basis up to $150,000 without proof of good health within 30 days of hire. A professional advisor from Benefit Harbor is available to assist with the enrollment process. The advisors ensure that you have a complete understanding of coverage and various features available to you.

If you want to enroll, call Benefit Harbor at 1-888-391-3841 and a counselor will guide you through the enrollment process. The call center hours are Mondays through Thursdays from 9:00 AM to 6:00 PM, and Fridays from 9:00 AM to 5:00 PM. You also have an option to enroll online at: [https://www.memberbenefitlogin.com/ees/psd.html](https://www.memberbenefitlogin.com/ees/psd.html)
**Wage Continuation (Short-Term Disability)**

As a CASA employee of the SDP, you may purchase Wage Continuation coverage to protect yourself from sustained salary loss due to an approved health related absence that extends beyond your sick time. During your initial eligibility as a new hire, you have a 30 day window from your start date, to enroll or waive Wage Continuation. Should you elect Wage Continuation coverage, **CASA new hires are not eligible for the program and are not charged wage continuation deductions until the conclusion of 90 days of service.** After the conclusion of 30 days from your start date as a new hire, you may only enroll or cancel coverage during the annual Open Enrollment period held May 1 to May 31.

If you are unable to work because of an approved health related absence, you must exhaust all banked personal illness days, and at the conclusion of a short waiting period, you will be compensated a daily amount consistent with 75 percent of your salary for up to 6 months, pursuant to SDP approval.

The cost of this indemnity program is dependent upon your amount of accumulated sick leave, number of years of service, and salary.

<table>
<thead>
<tr>
<th>Accumulated Sick Leave</th>
<th>Waiting Period</th>
<th>Employee Premium per $100 of salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 days</td>
<td>7 work days</td>
<td>$2.95</td>
</tr>
<tr>
<td>10 but less than 30 days</td>
<td>6 work days</td>
<td>$1.47</td>
</tr>
<tr>
<td>30 but less than 90 days</td>
<td>5 work days</td>
<td>$0.13</td>
</tr>
<tr>
<td>90 or more days</td>
<td>5 work days</td>
<td>$0.04</td>
</tr>
</tbody>
</table>

*Rates are based upon every $100 gross per pay.

**Example:**

<table>
<thead>
<tr>
<th>Formula</th>
<th>Biweekly Gross pay (before taxes)</th>
<th>$</th>
<th>100</th>
<th>Rate listed in the chart above</th>
<th>=</th>
<th>Total biweekly premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 days</td>
<td>$2,200.00</td>
<td>$</td>
<td>100</td>
<td>× $2.95</td>
<td>=</td>
<td>$64.90 per pay</td>
</tr>
<tr>
<td>10 but less than 30 days</td>
<td>$2,200.00</td>
<td>$</td>
<td>100</td>
<td>× $1.47</td>
<td>=</td>
<td>$32.34 per pay</td>
</tr>
<tr>
<td>30 or more days</td>
<td>$2,200.00</td>
<td>$</td>
<td>100</td>
<td>× $0.31</td>
<td>=</td>
<td>$2.86 per pay</td>
</tr>
<tr>
<td>90 or more days</td>
<td>$2,200.00</td>
<td>$</td>
<td>100</td>
<td>× $0.04</td>
<td>=</td>
<td>$0.88 per pay</td>
</tr>
</tbody>
</table>

**Please note:** Enrollment in the Wage Continuation program does not guarantee eligibility of use. You must be approved by the Health Services Department for use of this program. Payments made towards Wage Continuation are not refundable whether it is cancelled, not used, or upon separation from the District.
Leave Policy

As an employee of the SDP, you are entitled to leave for personal reasons (personal leave), personal illness and for vacation consistent with the following:

**Personal Leave Days:** If you begin SDP employment at the beginning of the school year, you will receive three (3) days per year for emergencies and for matters that cannot be accomplished during non-working hours. You will receive a prorated number of days if you begin employment after the beginning of the school year. The prorated amount will not exceed 3 days. At the beginning of the following school year after your original appointment, you will receive 3 full personal days. Supportive Services Assistants are only entitled to 1 personal day per year.

Personal leave cannot be accumulated for use in another year. If you do not exhaust your personal days by the end of the school year, the unused time is placed in a frozen personal leave bank which you will be unable to utilize. If, however, a 10-month employee has accumulated 30 days or more in his or her personal leave bank, he or she is permitted to use up to a maximum of 2 additional personal leave days from that bank per year. Upon your separation from SDP employment, you will receive 100 percent compensation for all unused personal leave time, subject to taxes. There is no limit on the number of personal days you can accumulate over the course of your SDP service.

**Personal Illness Days:** If you begin SDP employment at the beginning of the school year, you receive ten (10) days per year for personal illness. You receive a prorated number of days for your first year if you begin employment after the start of the school year. The prorated amount will not exceed 10 days. At the beginning of the following school year after your original appointment, you receive 10 full personal illness days. There is no limit on the number of personal illness days you may accumulate. Upon your separation from SDP employment, you will receive 25 percent compensation for all unused personal illness days, subject to taxes.

**Vacation Days:** Appointed 12-month SDP employees accrue vacation days on a monthly basis. 10-month employees do not accrue vacation time; however, they are not required to work during winter, spring or summer breaks when schools are closed.

Eligible employees accrue vacation leave in accordance with the following schedule:

<table>
<thead>
<tr>
<th>Length of Uninterrupted Service to July 1</th>
<th>Vacation</th>
</tr>
</thead>
<tbody>
<tr>
<td>If appointed between January 1 and April 30</td>
<td>5 days</td>
</tr>
<tr>
<td>6 months to 4 years</td>
<td>10 days</td>
</tr>
<tr>
<td>4 years to 8 years</td>
<td>15 days</td>
</tr>
<tr>
<td>8 years to 15 years</td>
<td>20 days</td>
</tr>
<tr>
<td>More than 15 years</td>
<td>22 days</td>
</tr>
</tbody>
</table>

Vacation leave is accrued during the pay covering the 15th calendar day of the month. SDP employees may accumulate no more unused vacation days than an amount equal to twice their yearly allocation. Once you accumulate such an amount, you are not be permitted to accrue additional days that would exceed that amount. Upon your separation from SDP employment you will receive 100 percent compensation for all unused vacation, subject to taxes. 12-month represented employees may take 1 week of unpaid vacation time per year in addition to his or her vacation. Requests for such time should be submitted in the same manner as requests for vacation.

**Tracking your leave balances**

Please review the bottom portion of your paystub by logging into the SDP’s Employee Payroll Application to view your leave balance. If you have any questions, please contact the Payroll Department at 215-400-4490.
How do I check my leave balance?

You can view your leave balance through the Employee Payroll Information application or by checking your paycheck. Your School District of Philadelphia email name and password are used for access. If you do not know the name and password, call the Technology Help Desk at (215) 400-5555 for assistance. Please note that the balances shown are all subject to a post separation audit. Your paycheck references this.

From the School District of Philadelphia main website (http://www.philasd.org) go to the Employee Portal. In the Employee section, enter your email name and password. Your email user name should exclude the "@philasd.org" designation.

Launch the “Payroll Information” application. Enter the last four digits of your social security number when prompted. You can then select Leave Balances tab.

Leave balances are also posted on your paycheck:

<table>
<thead>
<tr>
<th>TYPE OF LEAVE</th>
<th>ACCRUAL</th>
<th>USAGE</th>
<th>BALANCE</th>
<th>TAXABLE BENEFITS</th>
<th>AMOUNT</th>
<th>YTD AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSONAL LV</td>
<td>3.00</td>
<td></td>
<td>3.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FROZEN PL</td>
<td>6.69</td>
<td></td>
<td>6.69</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VACATION</td>
<td>40.00</td>
<td>10.00</td>
<td>27.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEMS ILL</td>
<td>32.31</td>
<td>4.00</td>
<td>28.31</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
403(b) and 457(b) Retirement Savings Plans

A 403(b) or 457(b) plan are voluntary retirement plans offered to employees of the School District of Philadelphia. At any time during your employment you may contribute a portion of your salary on a pre-tax (traditional) or an after-tax (Roth) basis to an authorized SDP program-participating carrier.

All contributions are made by employees; there is no employer match or contribution to either 403(b) or 457(b) plan. While you are an active employee, you may be eligible to withdrawal from these accounts per the rules of section 403(b) and 457(b) of the IRS Code and the School District of Philadelphia Plan Documents.

CONTACT INFORMATION

Please contact any of these agents directly to determine which plan best meets your financial needs and to begin the enrollment process. The carrier of your choice will assist you with the necessary forms.

The approved providers for the School District’s 403(b) and 457(b) Plans are:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Phone/Access Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>AXA Advisors</td>
<td>(888) 660-4108</td>
</tr>
<tr>
<td>Lincoln Investment Planning</td>
<td>(800) 242-1421 x1321</td>
</tr>
<tr>
<td>MetLife Resources</td>
<td>(800) 543-2520 or (610) 325-6100 x1417</td>
</tr>
</tbody>
</table>
| TIAA-CREF                    | (800) 842-2888<br>Online Enrollment: [www.TIAA-CREF.ORG](http://www.tiaa-cref.org)  
  ● 403(b) Access Code: 500644  
  ● 457(b) Access Code: 500645 |
| VALIC                        | (877) 889-1589            |

More information on the program, the benefits of participating and a comparison of the programs can be found on our website, [http://philasd.org/offices/benefits](http://philasd.org/offices/benefits). You may also call the tax shelter line at 215-400-2248 or visit the Employee Benefits office.
Public School Employees' Retirement System (PSERS)-Mandatory Pension Plan

PSERS is one of the largest public pension plans in the nation. This defined benefit plan guarantees you a monthly lifetime benefit based on your age, final average salary and the number of credited service after you reach a certain combination of age and/or service, provided you are vested.

Effective 7/1/11, all new PSERS’ members are automatically enrolled in a “shared risk” program Class T-E with a mandatory contribution base rate of 7.5 percent of gross salary deducted on a pre-tax basis. Employees have a one-time opportunity to elect Class T-F within 45 days of receiving written notifications from PSERS.

- Class T-E has a pension multiplier of 2%, with a “shared risk” contribution levels that could never go below 7.5% or above 9.5%
- Class T-F has a pension multiplier of 2.5%, with a “shared risk” contribution levels that could never go below 10.3% or above 12.3%
- Member contribution rates could increase or decrease by 0.5% every three years starting on 7/1/2015. Both memberships require 10 service credit (10 years of full-time employment) for vesting.

Purchasing Service Credit

Purchasing service credit is when you add additional service to your PSERS account by paying contributions and interest for previous service rendered. You must be an active contributing member of PSERS to purchase service credit.

New members of PSERS who begin employment on or after July 1, 2011, have a one year window to apply to purchase Non Qualifying Part Time (NQPT) service. Multiple service members who are actively contributing with the State Employees’ Retirement System (SERS) must apply to purchase prior PSERS service credit through SERS.

Purchasing Service Credit for Class T-E and Class T-F Members

To purchase service credit, contact PSERS directly at 888-773-7748; however, please consider the following: The cost to purchase NQPT service and most types of non-school or non-state service credit is the full actuarial cost. In other words, when you purchase service credit, you are paying an amount for the purchase that will result with you self-funding your future PSERS retirement benefit. You would pay an amount that would be based on your projected total credited service, projected final average salary, your projected contributions, the projected school contributions, the projected state contributions, all projected interest, plus the projected amount of funds needed to cover the appropriate corresponding portion of your lifetime benefit. The only exception to funding the full cost of the purchase is when you purchase military service.

What Members Should Consider Before Applying to Purchase Service

Questions to ask yourself to help you decide if purchasing will be worth it to you:

- **Will you work until normal retirement?** The cost to you is determined by a formula that assumes you retire on the day you reach superannuation (normal retirement). If you retire sooner than normal retirement, you could pay more for the benefit than the added value of the purchase.

- **Will your salary increase an average of 5.5% each year?** If over the course of your career you experience a salary increase less than 5.5% per year, it is possible that you could pay more to purchase the service than you would receive in benefits as a result of the purchase. However, if over the course of your career you experience a salary increase greater than 5.5% per year, it is possible that the benefits you would receive as a result of purchasing the service could be greater than the cost to you.

You may visit the PSERS web site at [www.psers.state.pa.us](http://www.psers.state.pa.us) for more information.

Resigning/Retiring

Upon your intent to resign/retire from the SDP, you will need to notify the Retirement Department. Notification of Retirement/Resignation forms are located on the SDP’s website under Retirement or available in the Retirement Department.
Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside money on a pre-tax basis through payroll deductions to pay for eligible health care, dependent care, and/or commuter/parking expenses. This provides a tax break to cover out-of-pocket health and dependent care expenses. When employees purchase benefits on a pre-tax basis, their compensation is reduced for purposes of calculating wages subject to federal and F.I.C.A. taxes and, in most states, state income tax. For residents of Pennsylvania, state taxes are saved on Health Care FSA elections, but not Dependent Care FSA elections.

The “Use It or Lose It” Rule:
If you do not use all the money you have contributed to any FSA account, you will lose any remaining balance in the account at the end of the eligible claims period. This rule exists under the IRS guidelines for tax-advantaged plans; it applies to the medical and dependent care FSA only. The plan year runs from January 1 through December 31. You have two and a half month carryover period to use all deposited contributions. In summary, you have until March 15 of the next year to use up your balance from the previous year.

If you resign, retire or separate from the District any time during the year, you have 90 days to submit any claims from the beginning of the plan year to your separation date. Below are the tax-advantaged FSA accounts we offer through AmeriFlex, our third party administrator. You can learn more about the products at www.flex125.com

Enrollment:
Enrollment is different for each program:
- Employees may enroll for the Commuter Reimbursement Accounts at any time throughout the year.
- Enrollment in the Dependent Care FSA can be completed during the Open Enrollment period, held by AmeriFlex. Open Enrollment is held in November, effective January 1.
- The Medical Flexible Spending Account is available to newly eligible employees after completing one full year of service. Employees can enroll during the Open Enrollment period, held by AmeriFlex. Open Enrollment is held in November, effective January 1.

Elections are made per calendar year (January through December) during the voluntary benefits open enrollment held each November.

Medical Flexible Spending Account (FSA)
Also known as Health FSA, you can use your pre-tax contributions to pay for eligible health care costs such as:
- medical and dental out-of-pocket expenses and co-pays
- eye exams, contact lenses/solutions and glasses
- prescription drugs
- orthodontia and dental care
- medical devices such as hearing aids and diabetic testing supplies

Please be aware that if you pay for a visit with a provider who does not accept our insurance and later get reimbursed by the insurance company, only the out-of-pocket expense is eligible for the FSA reimbursement. Example: You visit the dentist and write a check for the full charge of $150. United Concordia then sends you a reimbursement check for $100. You can submit a claim to AmeriFlex for your out-of-pocket cost of $50.

Dependent Care Account (DCA)
A DCA allows you to get reimbursed for eligible childcare expenses that enable you and your spouse to be employed. Typical eligible expenses are:
- The costs of babysitter, daycare, after-school care, Pre-K program, and day camp for dependents under 12 years old, the dependent must be your dependent under federal tax rules.
- Services must be for the physical care of the child, not for education, meals, etc.
- Expenses for overnight camps and kindergarten are not eligible for reimbursement.
Commuter and Parking Reimbursement Accounts (CRA)
A CRA allows you to use pre-tax contributions to pay for eligible mass transit, parking, and van-pooling expenses.

- Transit Account – to be used for public transportation such as costs for SEPTA monthly passes, tokens, and regional rails.
- Parking Account – to be used for parking costs at or near your work location, or the parking costs at a train station where you get transportation to work.

The IRS sets a monthly reimbursement limit annually, please refer to the below above for the current plan year. You have to pay out of pocket (post tax) for any amount over the IRS monthly limits. You have the ability to adjust future contributions to avoid excess or shortage by completing a form to change your payroll deductions.

Visit the AmeriFlex website at www.Myameriflex.com and select “Employees” for more information about the FSA plans, a list of eligible expenses, and forms.

**Contribution Limits:**
Note: Annual elections will be spread over 20 pay periods, excluding the summer months. See below for the contribution limit and eligible expenses for each plan type.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Maximum Election Limits (as of 1/1/2017)</th>
<th>Examples of Eligible Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>$2,600 Annually</td>
<td>Co-pays for office visits and prescriptions, deductibles, amounts above plan limits, eye exams and glasses, contact lenses, orthodontia, not covered medical and dental expenses</td>
</tr>
<tr>
<td>Dependent Care</td>
<td>$5,000 annually</td>
<td>Day care, day camp, preschool, pre-kindergarten</td>
</tr>
<tr>
<td>Transit CRA</td>
<td>$255 per month</td>
<td>Subway or bus passes, van or car-pooling costs</td>
</tr>
<tr>
<td>Parking CRA</td>
<td>$255 per month</td>
<td>Parking expenses incurred to park your vehicle near your employer or near mass transit/commuter facilities</td>
</tr>
</tbody>
</table>
Continuation Coverage Rights Under COBRA

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 doesn’t 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.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

***For all 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), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the SDP’s COBRA third party Administrator, Discovery Benefits.***

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**How is COBRA continuation coverage provided?**

Once the Plan 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Retirees with 30 or more years of service will also be entitled to continue medical health insurance under the Pennsylvania Law Acts 110/43 (COBRA) until age 65, after coverage is terminated by the District.

When the qualifying event is the end of employment or reduction of the employee’s hour 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 enrollment, 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 also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability extension of 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

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

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); 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.

**Special Enrollment Notice**

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself and/or your dependents in this plan in the future, provided that you request enrollment within 30 days after your other coverage terminates. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

**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 the contact or contacts identified 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. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

**Keep your Plan informed of address changes**-To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Other information**: All employees are covered by Independence Blue Cross Family of Companies. The monthly cost to continue coverage under these plans depends on the type of coverage and family status. Other available health insurance plans include dental, vision, and prescription coverage. Please note: if you are represented by the Philadelphia Federation of Teachers (CASA), Local 1201, or Local 634 bargaining units, you must purchase COBRA for dental, vision and prescription plans through the Health and Welfare Office of your respective union. Non-Represented, CASA, and SPAP employees should contact the District’s Third Party Administrator, Discovery Benefits directly (see below).

**Plan contact information**-It is not necessary to contact the School District at the time of your separation from employment for information on COBRA. A notification of the COBRA election will be mailed to the employee’s home address by the District’s Third Party Administrator, Discovery Benefits, prior to the termination of benefits. If notice is not received within a timely manner, please free to call Discovery Benefits for more information:

Discovery Benefits
P.O. Box 2079
Omaha, NE 68103
866-451-3399
EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child’s birth or placement);
- To care for the employee’s spouse, child, or parent who has a qualifying serious health condition;
- For the employee’s own qualifying serious health condition that makes the employee unable to perform the employee’s job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee’s spouse, child, or parent.

An eligible employee who is a covered servicemember’s spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer’s normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual’s FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,200 hours of service in the 12 months before taking leave; and
- Work at a location where the employer has at least 50 employees within 70 miles of the employee’s worksite.

“Special hours of service” requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days’ advance notice of the need for FMLA leave. If it is not possible to give 30-days’ notice, an employee must notify the employer as soon as possible and, generally, follow the employer’s usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee’s need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-899-5627

www.dol.gov/whd
U.S. Department of Labor | Wage and Hour Division
PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.
How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact:

**EMPLOYEE BENEFITS**
www.philasd.org/offices/benefits
440 N. Broad Street-Suite G10, Philadelphia, PA 19130  
Phone: 215-400-4630

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer Name</th>
<th>School District of Philadelphia (SDP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Employer Identification Number (EIN)</td>
<td></td>
</tr>
<tr>
<td>23-6004102</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer Address</th>
<th>Employee Benefits 440 North Broad St, Suite G10</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Employer Phone Number</td>
<td></td>
</tr>
<tr>
<td>215-400-4630</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>Philadelphia</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. State</td>
<td>PA</td>
</tr>
<tr>
<td>9. Zip Code</td>
<td></td>
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<tr>
<td>19130</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Who can we contact about employee health coverage at this job?</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYEE BENEFITS</td>
</tr>
<tr>
<td>11. Phone Number (if different from above)</td>
</tr>
<tr>
<td>215-400-4630</td>
</tr>
</tbody>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [ ] All employees.
  - [v] Some employees. Eligible employees are: Determined pursuant to employee job classification and the Collective Bargaining Agreements in which the School District of Philadelphia participates.
• With respect to dependents:

☑ We do offer coverage. Eligible dependents are: As defined in the policies and Collective Bargaining Agreements referenced above.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

EXPLANATION OF HEALTH INSURANCE MARKETPLACE NOTIFICATION
Effective January 1, 2014 the Affordable Care Act (also known as Healthcare Reform) requires all individuals to have health insurance or incur a financial penalty. To assist all individuals in purchasing this required insurance, Health Insurance Marketplaces are being put in place.