Open Enrollment is your annual opportunity to review your health plan choices. If you are happy with your current plan, you do not need to do anything during this Open Enrollment. If you decide to make a change, your new plan will be effective January 1, 2014. Take some time to review this newsletter – important benefit information appears on page 6.

What’s Staying the Same for Plan Year 2014?

✔ No change in the Plan of Benefits
✔ Copayments and coinsurance remain the same
✔ Medical plan offerings remain the same

What’s Changing for Plan Year 2014?

Aetna MedicareSM Plan (PPO) annual deductibles may change: The annual deductibles are based on the Medicare Part B deductible and are subject to change each year. As of the date of this mailing, Medicare has not released those deductible amounts.

UPMC for Life HMO Fitness Benefit: The fitness benefit changes for 2014. See page 4 of this newsletter.

Rates: Rates for survivor spouses and billable members change each year. Please refer to the separate rate mailing survivor spouses and billable members will receive.

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All Medicare eligible members are receiving the newsletter. If you are turning 65 between now and April 30, 2014, you also are receiving this newsletter so that you can read about the medical plans offered to you as a Medicare-eligible member.
What can I do during Open Enrollment?

**Change coverage:** You may elect a new medical plan that will be effective January 1, 2014. Review the following pages for more information.

**Add a Dependent:** In addition to making a medical plan change, you may add a dependent to PEBTF coverage with a January 1, 2014 effective date. Or, you may add a dependent at any time throughout the year. If you add a dependent throughout the year, the effective date of the enrollment cannot be more than 60 days retroactive.

**Dependents to Age 26:** You may add a dependent between the ages of 19 and 26. For 2014, the requirement, “Is the dependent eligible for other employer-sponsored health coverage (other than through a parent),” has been removed. Therefore, you may cover an eligible dependent provided he or she is under age 26.

**Remove a Dependent:** You may remove a dependent from coverage effective January 1, 2014 during Open Enrollment without a qualifying life event. Remember, throughout the year you must remove a dependent due to a qualifying life event and you must report it at the time of the qualifying life event. For example, if you get divorced, your spouse must be removed effective the date of divorce. You must provide notice of a qualifying life event within 60 days of the event to the State Employees’ Retirement System (SERS), if you receive a SERS pension. Otherwise, contact the PEBTF. If you wait more than 60 days to report your event, your dependent will lose the right to continue coverage under COBRA and you will also be responsible for any claims incurred while your dependent was not eligible for benefits.

**Your Retired Employees Health Program Medicare Plan Choices**

There are no changes to the Medicare HMO and PPO plans being offered. The same plans that are available to you today are available in 2014.

- **Aetna Medicare℠ Plan (PPO) – 800-307-4830; www.aetna.com**
  Available throughout Pennsylvania and nationally

  The Medicare HMO plans vary by region:

  - **Aetna Medicare℠ Plan (HMO) – 800-307-4830; www.aetna.com**
    Available in Southeastern Pennsylvania region and in some areas outside Pennsylvania.

  - **Geisinger Gold Classic (HMO) – 800-540-8653; www.thehealthplan.com**
    Available in Central and Northeastern Pennsylvania regions.

  - **UPMC for Life Medicare HMO – 866-517-2803; www.upmchealthplan.com**
    Available in Western Pennsylvania region.

  Refer to page 8 for a list of the counties where each plan is offered.
Medicare PPO
The annual in-network and out-of-network deductibles are subject to change each year. This is based on the Medicare Part B deductible and, as of this date, the information has not been published by Medicare. The Medicare PPO offers greater provider flexibility but out-of-pocket costs are generally higher than with a Medicare HMO.

If you choose the Medicare PPO:
- You may visit both network and out-of-network providers – Aetna MedicareSM Plan (PPO) offers a national network.
- You have an annual in-network deductible before the plan pays for any services.
- You have an out-of-network benefit that is subject to an annual deductible and coinsurance.
- You are not required to choose a primary care physician (PCP) from the plan’s network, but you are strongly encouraged to have a relationship with a physician who coordinates all of your medical care.
- You do not have to obtain referrals to specialists.
- You have a low network office visit copayment and a low network specialist office visit copayment.
- You may obtain urgent and emergency care anywhere in the United States.
- You have a fitness club benefit.
- You continue to pay the Part B premium.
- Your prescription drug coverage continues to be a Medicare Part D prescription drug plan provided by SilverScript® Insurance Company – there are no benefit changes. As always, there can be changes to the prescription drug formulary that could affect your copayment.

Medicare HMO
The Medicare HMO may be the lowest cost option. You pay a copayment when you visit network providers.

If you choose a Medicare HMO:
- You will not pay an annual deductible.
- You must choose a primary care physician (PCP) from the plan’s network.
- Your PCP refers you to a network specialist when necessary.
- You have a low office visit copayment and a low specialist office visit copayment.
- You must obtain medically-necessary services from a network physician; there are no out-of-network benefits.
- You may obtain urgent and emergency care anywhere in the United States.
- You have a fitness club benefit.
- You continue to pay the monthly Medicare Part B premium.
- Your prescription drug coverage continues to be a Medicare Part D prescription drug plan provided by SilverScript® Insurance Company – there are no benefit changes. As always, there can be changes to the prescription drug formulary that could affect your copayment.

Refer to page 5 to compare plans.

To request information from the Medicare HMO or PPO plans, contact the plan directly. The phone numbers appear on page 2. Visit www.pebtf.org and click on 2013 Medicare Open Enrollment for more information.
UPMC for Life Medicare HMO Offers a New Fitness Benefit for 2014

You can work out where you please

UPMC for Life members will have a new fitness benefit called Fit for Life. You can go to any fitness facility you like and get reimbursed up to a maximum annual amount.

This reimbursement amount does not count toward your annual out-of-pocket maximum. Some restrictions may apply.

Current members: See the Evidence of Coverage for details. New members: You will receive a reimbursement form in your welcome kit once you become a UPMC for Life member.

If you have questions about the fitness benefit, you may contact UPMC for Life Medicare HMO at 866-517-2803.

Making a Medical Plan Change

If you are happy with your current Medicare HMO or PPO: You don’t have to do anything during this Open Enrollment. You will remain in your current plan.

If you want to change to the Aetna Medicare℠ Plan (PPO): Call the PEBTF at 1-800-522-7279 and a Benefit Services Representative can take your enrollment information. You must call the PEBTF by Friday, November 8, 2013.

If you want to change to a Medicare HMO: Contact the Medicare HMO in your area to request an enrollment packet. The Medicare HMO telephone numbers appear on page 2. The Medicare HMO enrollment form will be included in the packet. Complete the enrollment form and mail it to the Medicare HMO postmarked by Friday, November 8, 2013. The Medicare HMO also can take your enrollment information over the telephone.

You, your spouse and any Medicare eligible dependents should each complete a separate enrollment form if each person wants to change to a Medicare HMO. You, your spouse and Medicare eligible dependent do not have to be enrolled in the same option – you may each choose your own plan.

The Medicare HMO will notify the PEBTF and SERS on your enrollment.

If you change plans: You will receive your new medical ID card in late December. Present your new ID card to your physician after January 1, 2014.

Do not destroy your red, white and blue Medicare ID card. While you do not need to present this ID card for medical care, you should keep this card in case it is needed in the future.
### How Do the Medicare HMO and Medicare PPO Options Compare?

<table>
<thead>
<tr>
<th></th>
<th>Medicare HMO Network Only</th>
<th>Medicare PPO In-Network</th>
<th>Medicare PPO Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None</td>
<td>Annual Medicare Part B deductible, which is subject to change each year</td>
<td>2 times the annual Medicare Part B deductible, which is subject to change each year</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$2,500</td>
<td>$2,500 per year – for all network and out-of-network costs (includes the deductible)</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Physician Office Visits</strong></td>
<td>$10 copay</td>
<td>$10 copay (after deductible)</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td>$15 copay</td>
<td>$15 copay (after deductible)</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Preventive Care (as outlined by Medicare)</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Annual Physical</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Mental Health Care</strong></td>
<td>Covered 100%; outpatient visits - $15 copay</td>
<td>Covered 100%; outpatient visits - $15 copay (after deductible)</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care</strong></td>
<td>Covered 100% (100 days per benefit period)</td>
<td>Covered 100% (100 days per benefit period) (after deductible)</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>Covered 100% after $50 copay (waived if the visit leads to an inpatient admission to the hospital)</td>
<td>Covered 100% after $50 copay (after deductible)</td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment/ Prosthetics</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Diabetic Supplies</strong></td>
<td>Covered 100% for test strips, lancets and glucometer</td>
<td>Covered 100% for test strips, lancets and glucometer</td>
<td>80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Fitness</strong></td>
<td>Fitness club benefit (check with health plan for specific information)</td>
<td>Fitness club benefit (check with health plan for specific information)</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>No lifetime maximum</td>
<td>No lifetime maximum</td>
<td>No lifetime maximum</td>
</tr>
</tbody>
</table>

* Member pays 20%

You continue to pay the Part B premium no matter which option you choose. Billable members and survivor spouses should refer to the rates that were mailed to you.

Summary only – for complete details, refer to your REHP Benefits Handbook.
Important Benefit Information
Changes to the REHP Notice of Privacy Practices

In accordance with the requirements of HIPAA, the REHP previously has provided you with its Notice of Privacy Practices. This notice provides information about how the REHP handles your personal medical information (otherwise known as “Protected Health Information” or “PHI”). As the notice describes, the REHP may use or disclose Protected Health Information for purposes of treatment, payment, health care operations, and certain other specified activities in accordance with HIPAA’s rules.

The REHP has made changes to its Notice of Privacy Practices, effective September 23, 2013. Information in the Notice has been reorganized for precision and clarity and to reflect changes in the HIPAA Privacy and Security regulations. This document describes the most important changes to the Notice.

The REHP is required by applicable federal and state laws to maintain the privacy of your Protected Health Information and to notify you in the event of a breach of any unsecured PHI.

We are permitted to use and disclose PHI for a variety of purposes that include setting premium rates and other underwriting activities. We may not, however, use or disclose genetic testing, counseling, or education information or family medical history for underwriting purposes, even if you were to authorize us to do so. Except with regard to long term care plans, the regulations strictly prohibit the use and disclosure of genetic PHI for underwriting purposes.

By law, we are prohibited from using or disclosing PHI for activities not described in the Notice without your authorization. Certain activities are specifically identified. For example, in the unlikely event that we obtain psychotherapy notes, we would be required to obtain authorization for almost every type of use or disclosure that we might make of those notes. We would also need authorization to use or disclose PHI for marketing purposes (other than in face-to-face meetings or in providing a nominal promotional gift) or for any disclosure that is regarded as a sale of PHI.

Your right to access your own PHI has been expanded in certain respects. If you request to receive a copy of PHI that is included in your “designated record set” in a particular format and we can readily produce PHI in that format, we will meet your request. You may also request us to send the information to another person directly. To make these requests, you should obtain the applicable form prescribed by the REHP.

The Notice will be available in the new REHP Handbook. To request a copy of the Notice, you may contact our Benefit Services Department at (717) 561-4750 or (800) 522-7279. The Notice is also available on our website, www.pebtf.org.

REHP May Cancel Your Coverage for Fraud or Intentional Misrepresentation

IMPORTANT: If you intentionally provide false or misleading information about eligibility for coverage under the REHP Plan (or about a claim) or you fail to make a required contribution on time, your coverage may be terminated retroactively. This may occur, for example, if you file a false claim, fail to notify us promptly of a divorce or fail to submit timely proof of birth or adoption that verifies your relationship with a new child whom you have added as a dependent.
Important Reminder from the REHP and Medicare

If you get a bill from Medicare for Part D-IRMAA, pay the full amount of the Part D-IRMAA right away

In 2013, you were enrolled in the SilverScript Medicare Part D prescription drug plan as part of your REHP coverage. We are happy to provide this coverage to you as part of your benefit package. Depending on the amount of your income, you may get a letter from Social Security telling you that you have to pay Part D-IRMAA. The Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) is an additional amount you have to pay, by law, for Medicare Part D drug coverage. If you do not have the Part D-IRMAA taken out of any Social Security checks you may get, Medicare will bill you the Part D-IRMAA amount you have to pay.

The REHP can only pay your Part D plan premiums. **You have to pay the Part D-IRMAA to Medicare** in order to keep your REHP prescription drug coverage. You pay your Part D-IRMAA directly to Medicare, not to the REHP or the PEBTF.

If you have to pay the Part D-IRMAA, you should have received a bill from Medicare telling you how much you owe for Part D-IRMAA and where to send the payment. Pay the Part D-IRMAA in full as soon as you get it. Medicare must get your full payment by the bill’s DUE DATE, which is always around the 25th of the month. If you don’t pay your bill in full by the due date, you will be disenrolled from your SilverScript Part D prescription drug coverage and Medicare Advantage (MA) plan and you and your eligible dependents will have no REHP medical and prescription drug coverage.

Take these important steps to make sure you keep your coverage:

1. Even if you don’t get a Social Security check, report any residence changes to Social Security and to the State Employees’ Retirement System (SERS) if you receive a pension from SERS. If you do not receive a pension from SERS, contact Social Security and the PEBTF. Medicare uses the address on file at Social Security to mail bills and other important information.

2. Pay the total amount on the bill as soon as you get it. Make sure the payment arrives to Medicare by the bill’s due date.

3. Sign up for Medicare Easy-Pay to have your Part D-IRMAA paid automatically each month.


**Flu Season is Right Around the Corner and it’s Time to Get Your Flu Shot**

It is soon that time of year when we begin to think about the flu and protecting our family by getting a flu shot. The REHP provides you with this important preventive care benefit as part of the benefits you receive from your Medicare health plan.

You are able to get your flu shot from your doctor. Some of the Medicare plans may offer other alternatives such as getting your flu shot at certain pharmacy chains. For more information, contact your medical plan by calling the number that appears on your medical ID card.

Your Medicare PPO or HMO also provides coverage for the following preventive immunizations:

- Pneumonia
- Hepatitis B
- Shingles (for members age 60 and older)
IMPORTANT OPEN ENROLLMENT AND BENEFIT INFORMATION

Health Plans Across the State
To be eligible for a plan: You must reside in the county in which the plan is offered

Aetna Medicare℠ Plan (HMO) also is offered in select areas nationally. Please contact the PEBTF at 1-800-522-7279 for more information on the availability of this plan.