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, 2016. Take some time to review this newsletter – important benefit information appears on page 6.

**What’s Staying the Same for Plan Year 2016?**

- 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 2016?**

- **Aetna Medicare℠ 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.

- **Rates:** Rates for survivor spouses and billable members change each year. Survivor spouses and billable members should refer to the separate rate mailing they received.
What Changes Can I Make?

During Open Enrollment – for an effective date of January 1, 2016:

- **Change coverage:** You may select a different medical plan that will be effective January 1, 2016. Review the information in this newsletter.

- **Add a dependent:** You may add a dependent, including dependent children up to the age of 26, to REHP coverage for a January 1, 2016 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 or earlier than the date of the qualifying life event.

- **Remove a dependent:** During Open Enrollment, you may remove a dependent from coverage effective January 1, 2016 without a qualifying life event. Remember, throughout the year if you need to remove a dependent, it **must** be due to a qualifying life event and you **must** report it at the time of the qualifying life event. 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. You will be responsible for any claims incurred while your dependent was not eligible for benefits.**

Qualifying Life Events Include:

- Birth, adoption
- Marriage
- Divorce or termination of a domestic partnership
- Death of a spouse or child
- Your spouse’s or dependent’s loss of eligibility for other group health coverage
- Change of address makes you ineligible for your current plan

A complete list of qualifying life events may be found in the Retired Employees Health Program Benefits Handbook.

Your Retired Employees Health Program Medicare Plan Choices

There are no changes to the Medicare PPO and HMO plans being offered. The same plans that are available to you today are available in 2016.

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

The Medicare HMO plans vary by region:

- **Aetna MedicareSM 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 map of the Pennsylvania counties where each plan is offered.
<table>
<thead>
<tr>
<th></th>
<th>Medicare PPO</th>
<th>Medicare HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (based on the Medicare Part B Deductible)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Visit Network Providers Only</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>May Visit Non-Network Providers (at additional cost)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>You Must Choose a Primary Care Physician (PCP) from the Plan’s Network</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Referrals Needed for Specialist Care</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(some HMOs may not require; see comparison chart on <a href="http://www.pebtf.org">www.pebtf.org</a>)</td>
</tr>
<tr>
<td>$10 Copayment for Primary Care Physician (PCP) Office Visit</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>$15 Copayment for Specialist Office Visit</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>$50 Copayment for Emergency Room Visit (waived if admitted as an inpatient)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>You may Obtain Urgent and Emergency Care Anywhere in the United States</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Fitness Club Benefit</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>You Continue to pay the Monthly Medicare Part B Premium</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Prescription Drug Coverage Continues to be SilverScript® Insurance Company (no change)</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Refer to page 4 to compare plans. Visit www.pebtf.org for more information. You may download or order a copy of the REHP Benefits Handbook.
## How Do the Medicare HMO and Medicare PPO Options Compare?

<table>
<thead>
<tr>
<th></th>
<th><strong>Medicare HMO</strong></th>
<th><strong>Medicare PPO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Network Only</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None</td>
<td>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>
</tr>
<tr>
<td><strong>Primary Care Physician Office Visits</strong></td>
<td>$10 copay</td>
<td>$10 copay (after deductible) 80% plan payment* (after deductible)</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td>$15 copay</td>
<td>$15 copay (after deductible) 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>
</tr>
<tr>
<td><strong>Annual Physical</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</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>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</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>
</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% (100 days per benefit period) (after deductible)</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment/ Prosthetics</strong></td>
<td>Covered 100%</td>
<td>Covered 100% (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>
</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>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></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. Survivor spouses and billable members should refer to the rates that were mailed to them.

Summary only – for complete details, refer to your REHP Benefits Handbook.
Evaluating Your Medical Plan Choices

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

✓ If you want to save some money: You may want to consider a Medicare HMO. You do not have an annual deductible to satisfy. You only pay copayments for office visits, outpatient therapies, etc.

✓ If you want flexibility: You may want to consider the Medicare PPO. You have both a network and out-of-network benefit with the Medicare PPO. If you see doctors that are not part of the plan’s network, you still receive benefits but at a higher out-of-pocket cost.

✓ If some of your doctors are not in your current plan’s network: Take a look at the other plan available in your county of residence. You may contact the plan to request a provider directory or visit www.pebtf.org to link to the health plans’ websites to view online directories. Click on 2015 Medicare Open Enrollment.

Making a Medical Plan Change

If you are happy with your current Medicare PPO or HMO: 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 13, 2015.

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 enrollment form will be included in the packet. Complete the enrollment form and mail it to the Medicare HMO postmarked by Friday, November 13, 2015. 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 dependents 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, 2016.

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.
Important Benefit Information

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.

Other Covered Preventive Immunizations

Your Medicare HMO and PPO plans cover the following preventive immunizations. Visit your doctor for these vaccines.

- Pneumonia
- Hepatitis B

Your SilverScript Prescription Drug Plan covers the shingles immunization according to Medicare guidelines. Present your prescription drug ID card at a network pharmacy and pay the copay.

PEBTF Offers Secure Website Area

The PEBTF website, www.pebtf.org, has a secure area that allows you to check eligibility and the benefits in which you are enrolled. It also contains links to other secure documents. Retirees are able to see their own information as well as any dependent children under age 21. Covered spouses/domestic partners are able to see their own information as well as any dependent children under age 21 who are on the retiree’s contract.

This secure area is also used for completing member surveys – members who contact PEBTF Benefit Services may be randomly selected to complete an online survey.

To register for this secure area, you will be asked to set up a new username and password, provide an email address and answer three security questions. After you register, you will use the unique username and password that you created each time you return to the site. The process also includes self-service capabilities to change or reset your password.

2016 Medicare HMO and PPO Plan Materials

The Centers for Medicare and Medicaid Services (CMS) requires that information about your Medicare PPO or HMO plan be mailed to you each year. You may keep these documents with your important papers and dispose of any old materials when you receive the 2016 updates. The documents are for informational purposes only.
SilverScript Prescription Drug Plan Members
What is the Medicare Part D IRMAA?

The Income-Related Monthly Adjustment amount or “IRMAA” applies to Medicare beneficiaries with high incomes. For example, if your 2015 reported yearly income as a single taxpayer is greater than $85,000 (greater than $170,000 filing jointly), you will be responsible for paying an additional $12.30 (2016 amounts have not been released by CMS). This is in addition to your monthly premium. The IRMAA will be further adjusted as income levels increase. Important points about the Part D IRMAA to keep in mind:

- If you owe an IRMAA, Social Security will send you a letter notifying you that the extra amount you owe will be added to your Medicare Part D premium. 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. The Part D IRMAA is billed directly by the Centers for Medicare and Medicaid Services (CMS). You pay your Part D IRMAA payment to Medicare, not to the REHP or the PEBTF or to your prescription drug plan.

- If you do not pay your IRMAA, you risk disenrollment from your Medicare Part D plan.

- **If you have questions about your Part D-IRMAA bill**, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. To learn more about Part D-IRMAA visit Social Security’s website at http://ssa.gov/pubs/10536.html.

Source: www.silverscript.com

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.

For More Information About Help in Paying for Your Health Insurance Coverage
Medicaid and the Children’s Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

The Retired Employees Health Program (REHP) Benefits Handbook includes information about help in paying for your health insurance coverage. It may be found on page 143 of the Handbook. Go to www.pebtf.org and click on the box, **REHP Benefits Handbook for Retiree Members, July 2014**. You may contact the PEBTF to order a paper copy if you don’t have access to a computer. An updated Benefits Handbook will be done for 2016 and a future newsletter will notify you when it’s available.
Health Plans Across the State
Contact the PEBTF to find out what plans are available in your county of residence.

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.