PEBTF BENEFIT NEWS for Retiree Members

Introducing PEBTF Health Advocate
Help is Just a Phone Call Away

HealthAdvocate℠

In late December, you received a mailing introducing PEBTF Health Advocate, a new service that is available to all members – retirees, spouses/domestic partners and dependents.

PEBTF Health Advocate offers personalized support to help you navigate the health care system by providing you and your family with confidential, one-on-one help. Their experts can answer all of your benefit questions and help with a wide range of health care and insurance-related issues – at no cost to you! Health Advocate is an added resource to you and your family, in addition to PEBTF Benefit Services and your health plan's member services.

Simply call PEBTF Health Advocate toll-free at 855-855-4238 to get started.

In addition to calling Health Advocate, you may access the secure member website and app. The PEBTF website, www.pebtf.org, offers a link from the home page to Health Advocate. The PEBTF website also includes a video about the services Health Advocate offers. Or, you may access the site directly at www.HealthAdvocate.com/PEBTF.

Why log in to the website?

- ✔ Get personalized help improving your health and saving on health care costs
- ✔ Send and receive secure messages from your Personal Health Advocate
- ✔ Set your communication preference
- ✔ Submit a billing or claims issue

Select ***Register Now*** and complete some information. You will create a user name, password and answer a security question. Make sure you enter your name exactly as you are enrolled in REHP benefits – you can find that on your medical plan ID card.

What's Inside

PEBTF Health Advocate makes health care easier

When you call PEBTF Health Advocate, you will be connected to an experienced Personal Health Advocate who can:

- Find and arrange appointments with the right doctors and specialists
- Locate and evaluate leading physicians and medical centers for second opinions
- Explain diagnoses and treatment options
- Coordinate care for complex medical issues
- Transfer medical records, lab results and X-rays
- Resolve insurance claims and billing issues
- And much more!

(continued on page 2)

(continued from page 1)

Mobile app offers convenience
The PEBTF Health Advocate app makes it easy to get in touch with a Personal Health Advocate and get help handling a wide variety of health care and insurance issues no matter where you are.

How to download the free mobile app
1. Go to the app store on your mobile device.
2. Search for "Health Advocate."
3. Tap INSTALL.

Once you've downloaded the app, be sure to register!
- Tap the Health Advocate app icon on your phone to open the app.
- Tap the **Member Login** button.
- Type the name of your organization – **PEBTF** – select it from the drop-down box and click "Continue."

HealthCost Estimator+
A feature of the website is the **HealthCost Estimator+**. You can compare costs for medical procedures and services by ZIP code.

One Member's Journey
Following a recent surgery, Steve needed help addressing an anesthesiology bill that should have been covered by his plan.
1. Steve called Health Advocate.
2. His Advocate asked Steve to send copies of all the paperwork, including phone numbers for his doctor and the surgery center.
3. His Advocate contacted Steve's health plan and determined they had, in fact, paid the anesthesiologist according to Steve's benefits.
4. His Advocate contacted the provider's office and forwarded copies of the payment, requesting they send Steve a written confirmation that he no longer owed them money.
5. Steve's Advocate contacted him with the good news.

Key features:
- Helps you shop around for medical procedures and services in your area
- Estimates costs for doctors, hospitals and other facilities nationwide (PPO members may visit facilities not in their area)
- Includes quality indicators, safety scores and patient reviews
- See real-time benefits information and estimated out-of-pocket costs
- Has complete mobile functionality (smartphone, tablet, PC)

PPO members may find the **HealthCost Estimator+** useful for services that are subject to the annual deductible. For example, your doctor may be sending you for an X-ray and may recommend a few network facilities in your area. You will be able to see which facility has a lower cost for the X-ray so that your out-of-pocket cost is lower.

Of course, you must always check if the provider/facility is in-network with your plan (Custom HMO members also need referrals). Your network doctor would handle any preauthorizations.

New Plan Year

January 1 marked the beginning of a new plan year. Some members chose to continue with the same medical plan they had last year, while others opted to make a plan change.

You should have received a new medical plan ID card in late December. All of the plans' ID cards include the 2018 copays. Present your medical ID card at the time you receive medical services.

Non-Medicare Eligible Members

As a reminder, both PPO options have changes to the annual deductibles, specialist and ER copays for 2018.

If you enrolled in: Choice PPO (Aetna)

Your costs for in-network care are:

- $20 copay for your primary care physician (PCP) office visit
- $45 copay for a network specialist office visit
- $20 copay visit for outpatient therapies (such as physical and occupational therapy, manipulation therapy, etc.)
- $50 copay for urgent care visit
- $200 ER copay (waived if admitted)

Certain services are subject to the annual in-network deductible of $350 per year for single coverage/$700 for family coverage and then the plan pays 100% of the service:

- Hospital expenses (inpatient and outpatient)
- Imaging such as X-rays, MRIs, CT scans
- Skilled nursing facility care and home health care

If you were hired on or after 8/1/03, you pay $58.74 per month for single coverage or $117.48 for family coverage.

If you enrolled in: Basic PPO (Highmark)

Your costs for in-network care are:

- $20 copay for your primary care physician (PCP) office visit
- $45 copay for a network specialist office visit
- $20 copay visit for outpatient therapies (such as physical and occupational therapy, manipulation therapy, etc.)
- $50 copay for urgent care visit
- $200 ER copay (waived if admitted)

Certain services are subject to the annual in-network deductible of $1,200 per year for single coverage/$2,400 for family coverage and then the plan pays 100% of the service:

- Hospital expenses (inpatient and outpatient)
- Imaging such as X-rays, MRIs, CT scans
- Skilled nursing facility care and home health care

If you enrolled in: Custom HMO (Aetna or Geisinger – depending on region where you live)

- $5 copay for your primary care physician (PCP) office visit
- $10 copay for a network specialist office visit (referral required)
- $5 copay visit for outpatient therapies (such as physical and occupational therapy, manipulation therapy, etc. – referral required)
- $50 copay for urgent care visit
- $150 ER copay (waived if admitted)

You **must** visit a provider/facility that is part of the Custom HMO network – if you don't, the service will not be covered under your plan and you will pay the entire charge

Blood Work Under the PPO Option

If you use Quest Diagnostics or LabCorp, you pay $0 for covered tests. ***New for 2018***, if you go to another facility, such as a hospital outpatient center, you pay a $30 lab copayment.

Medicare Eligible Members

The Medicare PPO and HMO plans copays changed for 2018:

	2018 Copay (Medicare PPO & HMO)
PCP Office Visit	$20
Specialist Office Visit	$30
Outpatient Therapies	$20
Outpatient Mental Health Care	$20
Emergency Room	$100

Medicare Part B Premium

For 2018, there is no increase in the Medicare Part B premium. If you are enrolling in Medicare Part B for the first time, you will pay a monthly Part B premium of $134.

Aetna Medicare PPO Deductible

The Aetna Medicare PPO deductible is based on the Medicare Part B deductible. For 2018, your annual deductible remains at $183. The annual out-of-network deductible is $366. After you meet the annual deductible, you pay your copayments.

Changes to Your Prescription Drug Copays – All Retirees

Prescription drug copay changes were effective January 1, 2018. To save money, ask your doctor about generic drugs.

	Copay 1/1/2018
Prescriptions at a Network Pharmacy Up to a 30 Day Supply	
Tier 1: Generic drug	$12
Tier 2: Preferred brand-name drug	$30*
Tier 3: Non-Preferred brand-name drug	$60*
Mail Order or Retail Maintenance at a CVS Pharmacy Up to 90 Day Supply	
Tier 1: Generic drug	$18
Tier 2: Preferred brand-name drug	$45*
Tier 3: Non-Preferred brand-name drug	$90*
Retail Maintenance at a Rite Aid Pharmacy (Non-Medicare)Preferred or Non-Preferred Network Retail Pharmacy (Medicare) Up to 90 Day Supply	
Tier 1: Generic drug	$24
Tier 2: Preferred brand-name drug	$60*
Tier 3: Non-Preferred brand-name drug	$120*

*plus the cost difference between the brand and the generic, if one exists

There may be some formulary changes for 2018. Some medications may have moved from preferred to non-preferred, which would result in a higher cost to you. Visit www.pebtf.org > Publications & Forms to view the formulary.

Additional Benefits

Non-Medicare Eligible Members

Mental Health & Substance Abuse Benefit: Optum continues to administer the mental health and substance abuse benefit.

Medicare Eligible Members:
Mental Health and DME benefits are part of your Medicare PPO or HMO plan.

PPO Members: Your outpatient mental health office visit copay is $20. Inpatient services are subject to the PPO medical deductible. You may visit out-of-network providers at higher out-of-pocket costs.

Custom HMO Members: Your outpatient mental health office visit copay is $5. You must visit an Optum network provider. If you go out-of-network, you will not have coverage.

Durable Medical Equipment (DME), Prosthetics, Orthotic, Medical and Diabetic Supplies: DMEnsion continues to administer the durable medical equipment (DME), prosthetics, orthotics, medical and diabetic supply benefit. There are no changes to this benefit.

Help for Diabetics Coming in Spring 2018

Non-Medicare Eligible Members

The REHP will offer the Livongo for Diabetes Program, which makes living with diabetes easier by providing you with a connected meter, personalized tips and coaching.

Who is eligible for this program?
All REHP non-Medicare eligible members with insulin-dependent diabetes or who are taking hypoglycemic drugs will be able to enroll in this free program.

How does it work?
You will be provided a connected meter and as many strips and lancets as you need shipped to your door with no hidden costs or copays. Your readings are automatically sent to Livongo via the connected meter you will receive. When your readings are out of range (either high or low), the meter will ask questions to help troubleshoot why the reading would be out of range. If your reading is severely out of range, a Diabetes Response Specialist will call or text you within minutes, 24/7. You will also be able to share your blood sugar readings with your family and physicians to alert them when you are out of range.

Additional Support
Diabetes Educators are standing by to advise you on nutrition, lifestyle and diabetes management anytime you have questions.

If you qualify for the ***Livongo for Diabetes Program***, you will receive additional information in the coming months. We hope you consider taking advantage of this added benefit – having a support system to help you manage your condition is invaluable.

Coverage for Autism Spectrum Disorder Annual Amount Increased to $39,668 per Year – Effective January 1, 2018

Important Information Needed to File Your 2017 Federal Taxes
Non-Medicare Eligible Members

Watch your mail for important tax information. The Affordable Care Act (ACA) requires the PEBTF to provide you with an annual notice summarizing your and your dependents' enrollment in the PEBTF health coverage.

You will receive a Form 1095-B from the PEBTF. The Form 1095-B is the Health Coverage Form. It has information you'll need to report on your tax return. The information basically shows whether or not you've had qualifying health insurance coverage.

Your tax preparer should be familiar with these forms. Please refer to your IRS Form 1040 (2017) line 61 Healthcare: individual responsibility. On IRS Form 1040EZ (2017), see line 11. You may also want to refer to IRS Form 8962 Premium Tax Credit as well as Form 8965 Healthcare Exemptions.

Medicare to Issue New Cards

You may have seen the television commercials about the new Medicare cards. The Centers for Medicare & Medicaid Services (CMS) will begin mailing new cards in April 2018 with completion expected April 2019.

Medicare is removing Social Security numbers from the cards. The new Medicare card has a new "Medicare number" that is unique to you. This change will help to protect your identity.

When you receive your new Medicare card, destroy the old one. Because REHP Medicare members are enrolled in a Medicare PPO or Medicare HMO, you do not have to present your Medicare card at the doctor's office; you will continue to use your ID card from the medical plan.

Make sure your mailing address is up to date with both Medicare and SERS. If your address needs to be corrected, contact Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. You may contact SERS at 1-800-633-5461.

Important Information for Members Receiving Social Security Disability Benefits

If you are receiving Social Security Disability benefits, normally you will get Medicare coverage after you've received disability benefits for two years. However, in some cases, Medicare will give you an "option" to pay retroactive Medicare premiums in order to have a retroactive Part B date. Regardless of whether you are the retiree or the dependent, you **MUST** accept the offer to pay the retroactive premiums and enroll in Part B retroactively. Failure to do so will result in the loss of REHP eligibility for the time period in which you could have been enrolled in Part B. In addition, the retiree will be responsible for any REHP benefits utilized during the time period when not enrolled in the REHP.

Reminder – Notify SERS of a Divorce

If you get a divorce, you **MUST** remove your spouse from your PEBTF benefits. Your spouse will be terminated from benefits effective the date of divorce. You will be responsible for any claims incurred after the date of divorce. Don't delay!

Contact the State Employees Retirement System (SERS) immediately at the time of divorce to complete the necessary paper work.

Resources to Help You Stay Healthy

Help to Quit Smoking

Non-Medicare Eligible Members: We all make resolutions and your resolution may be to quit smoking in 2018. The Quit For Life® Program can help. It is offered free of charge to REHP non-Medicare eligible retirees and covered dependents (age 19 and older). Call 1-866-QUIT-4-LIFE (1-866-784-8454) today or visit www.quitnow.net/PEBTF to enroll or find more information.

Medicare Eligible Members: Contact your Medicare PPO or HMO for information about smoking cessation programs.

Discount Programs

Non-Medicare Eligible Members: Your medical plan offers discounts on gym memberships, nutrition counseling, alternative medicines and other services. Visit www.pebtf.org and click on Get Healthy Discount Programs. Then select your medical plan for more information. It's a great way to save money!!

Medicare-Eligible Members: Your Medicare HMO or PPO offers a fitness benefit which includes a free gym membership to gyms and health clubs in your plan's network. Contact your plan for more information.

February is American Heart Month

February is American Heart Month. Heart disease is the leading cause of death for American women and men, accounting for 1 in 4 deaths in the United States. Nearly half of Americans have at least one risk factor for heart disease, such as high blood pressure, high cholesterol, obesity, physical inactivity or an unhealthy diet. Risk also increases with age.

Some of the risk factors for heart disease cannot be controlled, such as your age or family history. But you can take steps to lower your risk by changing the factors you can control.

Your lifestyle choices can increase your risk for heart disease and heart attack. To reduce your risk, your doctor may recommend changes to your lifestyle. The good news is that healthy behaviors can lower your risk for heart disease:

- Limit or avoid foods high in saturated fats, trans fat, and cholesterol. Also, too much salt (sodium) in the diet can raise blood pressure levels.
- Increase regular physical activity to lower your risk for heart disease and other chronic conditions.
- Take steps to lose weight. Obesity is linked to higher "bad" cholesterol and triglyceride levels and to lower "good" cholesterol levels. In addition to heart disease, obesity can also lead to high blood pressure and diabetes. Talk to your health care team about a plan to reduce your weight to a healthy level.
- Limit alcohol. Drinking too much alcohol can raise blood pressure levels and the risk for heart disease. It also increases levels of triglycerides, a form of cholesterol, which can harden your arteries. Women should have no more than one drink a day; men should have no more than two drinks a day.
- Stop smoking. Tobacco use increases the risk for heart disease and heart attack. Cigarette smoking can damage the heart and blood vessels, which increases your risk for heart conditions such as atherosclerosis and heart attack. Also, nicotine raises blood pressure and carbon monoxide reduces the amount of oxygen that your blood can carry. Exposure to secondhand smoke can increase the risk for heart disease even for nonsmokers.

Source: Centers for Disease and Prevention

PEBTF
Pennsylvania Employees
Benefit Trust Fund
150 South 43rd St., Suite 1
Harrisburg, PA 17111-5700

Local: 717-561-4750
Toll Free: 800-522-7279

PEBTF telephone hours:
8 a.m. – 5 p.m. Tuesday - Friday
8 a.m. – 6 p.m. Monday (or 1st day following a holiday weekend)

PEBTF Benefit News is available in an alternative format. Please contact the PEBTF to discuss your needs.

93

This newsletter may contain a general description of the Plan. It is provided for informational purposes only and should not be viewed as a contract, offer of coverage, confirmation of eligibility or investment, tax, medical or other advice. In the event of a conflict between this newsletter and the official plan document, the official plan document will control however, to the extent expressly stated, an article may modify the provisions of the REHP Benefits Handbook. The commonwealth reserves the right to amend, modify or terminate the terms of the Plan, including any options available under the Plan, at any time and for any reason, with or without prior notice.

IMPORTANT BENEFIT INFORMATION

Let us Know About our Service

We randomly select members who have spoken to a PEBTF Benefit Services Representative to participate in a customer service survey. If you are selected, you will receive a letter with instructions on completing the survey. You can even access the survey via our website.

We hope you will consider completing the survey. Your comments are important to us and will help us to continue to improve our member services.

The 2018 Retired Employees Health Program (REHP) Benefits Handbook is now available and may be found on www.pebtf.org.