

Pennsylvania

Retired Employees Health Program (REHP)

Benefits Handbook

September 2026



Pennsylvania Employees Benefit Trust Fund (PEBTF)
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To all Eligible Retirees:

The Commonwealth of Pennsylvania provides Retirees and eligible Dependent(s) with financial protection in the case of illness or injury. The Commonwealth's Office of Administration ("Commonwealth") is pleased to offer you these benefits to maintain your health and well-being.

The Retired Employees Health Program (REHP) covers Retirees and their eligible Dependent(s) who are not eligible for coverage under Federal Medicare Programs. The REHP also provides a Medicare Open Access PPO and a Medicare Part D prescription drug plan to Retirees and Dependent(s) who are covered by Medicare.

This Handbook is designed to help you understand your health care benefits. Benefits are based on the date of retirement and are different for non-Medicare eligible Retirees and Medicare eligible Retirees.

The Handbook is written in plain, everyday language, and attempts have been made to avoid using medical and legal terminology. If you have questions about the terms used in this Handbook, please see the Glossary of Terms or contact the Pennsylvania Employees Benefit Trust Fund (PEBTF) at 1-800-522-7279.

This Handbook has been prepared to help you understand the main features of the medical coverage provided under the REHP. If there are any differences between this Handbook and the benefit contracts (other than differences relating to the Commonwealth's right to amend or modify benefits under the REHP), the contracts will control. If any questions arise that are not covered by this Handbook, the benefit contracts will determine how the question will be resolved.

The Commonwealth, as sponsor of the REHP, reserves the right at any time to amend or modify any and all benefits under the REHP, including, but not limited to, eligibility requirements, annuitant contribution rates, Least Expensive Plan provisions, and removal or replacement of service providers, in its sole discretion or as required by law, without prior notice or consent of Retirees or their Dependent(s). This Handbook (and any other documents you may receive describing the REHP) is not a contract for benefits, is not intended to create any contractual or vested rights in the benefits described and should in no way be considered a grant of any rights, privileges, or duties on the part of the Commonwealth, its agents or the PEBTF. The PEBTF administers the REHP on behalf of the Commonwealth and is empowered to establish administrative procedures under the REHP. Any such procedures may be applied to all Eligible Members, or to certain groups or classes of Eligible Members, as the Commonwealth may determine.

If, after reading your Handbook, you still have questions about your benefits or the rules for Dependent(s) eligibility, please contact the PEBTF.

To make the most of your benefits under the REHP, there are a few things you need to remember:

Non-Medicare Eligible Retirees

The REHP covers hospital or medical expenses for Retirees and their eligible Dependent(s) who are **not eligible** for Medicare.

If you are not eligible for Medicare and qualify for the REHP, you and your covered Dependents, who are not eligible for Medicare, are eligible for the PPO or HMO option in addition to the Prescription Drug Plan.

At the time you enroll in the REHP, you may change your coverage to any plan that is available in your geographic area.

If you or your eligible Dependent(s) is age 65 or over, but not eligible for Medicare, you will remain covered under one of the Non-Medicare Plan options and the REHP Prescription Drug Plan.

If you or a Dependent(s) becomes covered under Medicare, contact SERS or the PEBTF to let them know the date Medicare begins.

You must notify the PEBTF if you or one of your eligible Dependent(s) is receiving Medicare before age 65, for instance because of End Stage Renal Disease (ESRD) or other disability.

Medicare Eligible Retirees (Reaching Age 65 or disability/ESRD)

The REHP requires Medicare-eligible Retirees or Dependent(s) to enroll in both Medicare Part A and Part B as a condition of receiving medical and prescription drug coverage under any of the REHP plans.

The REHP does not cover and does not pay for hospital or medical expenses which are eligible under the Federal Medicare Program, Parts A and B. Therefore, it is important that you and your eligible Dependents find out if you/they are eligible for Medicare, through your own employment, a spouse's employment, or a disability. If you have questions about eligibility for Medicare Part A or Part B or if you want to apply for Medicare, contact your local Social Security Administration Office.

If an Eligible Member is eligible for Medicare due to age, disability or End-Stage Renal Disease (ESRD), they are eligible for the Medicare Open Access PPO and the REHP Medicare Part D Prescription Drug Plan.

Medicare Part A – Hospital Insurance

Persons enrolled in Social Security and age 65 automatically qualify for Medicare Part A. If you are not receiving Social Security and are age 65 you still qualify for Medicare, but you must actively enroll because enrollment is not automatic. You also may be eligible if you are under age 65 and you receive Social Security disability benefits or suffer from permanent kidney failure, also known as End Stage Renal Disease. The Social Security Administration can provide you with additional information.

Medicare Part B – Medical Insurance

If you or your Dependents are eligible for Medicare Part A, you also are eligible for Medicare Part B. If someone is eligible for Medicare Part B, they are automatically enrolled unless they are over 65 and not receiving Social Security benefits, have End Stage Renal Disease or they specifically decline the coverage.

Although enrollment in Medicare Part B is not mandated by federal law, and there is a monthly premium for Medicare Part B coverage, **Eligible Members should not decline Medicare Part B. You must enroll in Medicare Part B and continue your Part B premium if you want to receive medical and prescription drug benefits under the REHP**. **If given the option by Medicare to pay retroactive premiums to enroll**

retroactively in Part B, Retirees and Dependents must do so to retain REHP benefits.

If Eligible Members do not enroll in Medicare Part B, there may be a serious gap in your health insurance coverage, leaving you with large medical bills to pay. You will not have medical or prescription drug coverage through the REHP. In addition, Eligible Members who are given the option by Medicare to pay retroactive premiums to enroll retroactively in Medicare Part B must do so to retain REHP benefits. Because of this, you will want to give serious consideration to retaining coverage in Medicare Part A **and** Part B or to insuring your health care through some other form of insurance. (In rare cases, you or your Dependent(s) may have insufficient quarters of Social Security covered earnings to be eligible for Social Security benefits. If you or any of your Dependent(s) fall into this category, please contact the PEBTF for instructions.)

If you do not enroll in Medicare Part B you will not be eligible for the Part D prescription drug program offered through the REHP. If you have a coverage gap of 63 or more days when you are not enrolled in a Part D plan or do not have creditable coverage, you may have to pay a late enrollment penalty.

To apply for Medicare coverage or to find out if you are eligible, contact the nearest Social Security Administration Office. When an Eligible Member becomes eligible for Medicare or when your Medicare number changes, you must contact the PEBTF as soon as possible.

If your Dependent(s) becomes eligible for Social Security benefits because of reaching age 65 or becoming disabled, the Dependent(s) should contact the Social Security Administration at 1-800-772-1213 to discuss their eligibility for Medicare.

Medicare Part D – Prescription Drug

If an Eligible Member is eligible for Medicare Part A and B, they also are eligible for Medicare Part D. Because you are enrolled in the REHP Medicare Part D Prescription Drug Plan, **you should not enroll in a separate Medicare Part D plan.** If you enroll in another Medicare Part D plan, you will be disenrolled from REHP medical and prescription drug coverage. Low-income Medicare-eligible Members age 65 years old and older who qualify for Pennsylvania's PACE/PACENET Prescription Drug Program may be able to reduce their out-of-pocket expenses if they enroll in PACE/PACENET. Please call 1-800-225-7223 for more information.

All Retirees

It is your responsibility to contact the State Employees' Retirement System (SERS), or the PEBTF if you do not have a SERS pension, to:

- Change your address
- Add or remove Dependent(s) from the REHP
- Ask questions about your retirement check
- Change coverage (opt out or re-enroll)

The address and phone number for SERS are as follows:

State Employees' Retirement System Central Office
30 North Third Street, Suite 150
Harrisburg, PA 17101
Field Office Telephone: 1-800-633-5461

Disclaimer of Liability

It is important to keep in mind that the REHP is a plan of coverage for medical benefits and does not provide medical services; nor is the REHP responsible for the performance of medical services by the Providers of those services. These Providers include physicians and other medical professionals, hospitals, psychiatric and rehabilitation facilities, birthing centers, mental health, or substance use Providers and all other professionals, including pharmacies and the Providers of disease management services.

It is the responsibility of you and your physician to determine the best course of medical treatment for you. The REHP Plan option you have chosen may provide full or partial payment for such services, or an exclusion from coverage may apply. The Handbook explains the extent of such coverage, as well as relevant limitations and exclusions. Coverage may be provided under the PPO option or HMO option, Medicare Open Access PPO, Mental Health and Substance Use Program or the Prescription Drug Plan. In each case the PEBTF, as administrator of the REHP on behalf of the Commonwealth, has contracted with independent Claims Payors to administer claims for coverage and benefits under these plan options. These Claims Payors, as well as the physicians and other medical professionals and facilities who render medical services, are not Employees of the PEBTF, Commonwealth, or the REHP. They are all either independent contractors or have no contractual affiliation with the PEBTF, Commonwealth, or the REHP.

The PEBTF, Commonwealth, and REHP do not assume any legal or financial responsibility for the provision of medical services, including without limitation the making of medical decisions, or negligence in the performance or omission of medical services. The PEBTF, Commonwealth, and REHP do not assume any legal or financial responsibility for the maintenance of networks of physicians, pharmacies, or other medical Providers under any of the plan options that provide benefits based on the use of Network Providers. These networks are established and maintained by the Claims Payors which have contracted with the PEBTF with respect to the applicable plan options, and the Claims Payors are solely responsible for selecting and credentialing the members of those networks. Finally, the PEBTF, Commonwealth, and REHP do not assume any legal or financial responsibility for coverage and benefit decisions under the REHP made by the Claims Payor under each plan option, other than to pay coverage for benefits approved for payment by such Claims Payor, subject to the final right of appeal to the Commonwealth set forth in the claims procedures described in this Handbook.

Please read this Handbook carefully and share it with your family to ensure that you understand your benefits.

To obtain a quick overview of the benefits provided for non-Medicare eligible and Medicare eligible Retirees, please refer to the charts at the back of each respective health care benefits section.

THIS BENEFIT HANDBOOK IS AVAILABLE IN AN ALTERNATIVE FORMAT. PLEASE CONTACT THE PEBTF TO DISCUSS YOUR NEEDS.

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GLOSSARY OF TERMS

***Act 5 of 2017*.** The Pennsylvania law that amended the *State Employees' Retirement Code (Retirement Code), 71 Pa.C.S. §§ 5101-5958*, and mandated the establishment of new pension benefit tiers applicable to most Employees who became Members of the State Employees' Retirement System (SERS) on or after January 1, 2019, and the Public School Employees' Retirement system (PSERS) on or after July 1, 2019, and to any Employee who became a SERS/PSERS Member prior to those dates and elected a new pension benefit tier under *Act 5 of 2017*.

Active Employees Health Program (AEHP). The health insurance program provided by the Pennsylvania Employees Benefit Trust Fund (PEBTF) for eligible Commonwealth Employees who are in an Active Pay Status.

Active Pay Status. The condition in which an Employee is eligible for pay.

Acute: Rapid onset of severe symptoms and a short course; not Chronic

Approved Retirement System (ARS). A retirement program that is approved under Pennsylvania law as a valid retirement benefits program for Commonwealth employees, but in which the Retiree is not a Member of the State Employees' Retirement System (SERS) or a Member of the Public School Employees' Retirement System (PSERS). The term is inclusive of the Defined Contribution Plan established under the State Employees' Retirement Code, 71 Pa.C.S. § 5801, and the Defined Contribution Plan established under the Public School Employees' Retirement Code, 24 Pa.C.S § 8401.
ARS Participant. An Employee enrolled in an ARS.

Birthday Rule. A method to determine which health insurance plan is primary when a Dependent(s) child is covered by more than one plan. Unless a court decree states otherwise, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents have the same birthday, the plan that has covered the Dependent(s) child the longest is the primary plan.

Chronic. Slow onset and lasting for a long period of time.

Claims Payor. The PEBTF or other organization that adjudicates claims under the authority of the REHP, including but not limited to, Blue Cross, Blue Shield, various PPO, or HMO Network Providers or other third-party administrators selected by the Fund.

When the REHP selects a PPO, HMO, Prescription Benefit Manager or other third party administrator as the Claims Payor for an REHP plan option, that Claims Payor has the discretion and authority to render decisions on claims for benefits under the plan, to apply exclusions under the plan (for example, to determine whether a service is Experimental or Investigative), to determine whether a service is Medically Necessary and to determine the applicable Plan Allowance. The REHP or other Claims Payor has the authority and discretion to interpret and construe the terms of the plan and apply it to your factual situation.

Coinsurance. Your share of the costs of a covered health care service, calculated as a percent (for example, 30%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe.

Contribution Rate Coverage. REHP coverage where the Retiree must pay Retiree Contributions toward the cost of coverage; formerly known as "majority paid coverage."

Coordination of Benefits. A method by which two or more health insurance plans coordinate their respective benefits so that the total benefits paid does not exceed 100% of the total allowable expenses incurred.

Copayment. Pre-established payment that must be made by you under the particular plan (e.g., for a doctor's office visit, for Emergency Services or for a prescription).

Covered Service. Service or charge that is allowed under the plan, which is Medically Necessary, and which is rendered by an eligible Provider or supplier.

Curative Treatment. Having healing or remedial properties.

Deductible. Amount you must pay each plan year before the plan pays benefits.

Defined Benefit (DB) Plan. Commonwealth retirement plan in which the amount of the retirement benefit is determined by a formula set forth in the *Retirement Code*.

Defined Contribution (DC) Plan. Commonwealth retirement plan, created by *Act 5 of 2017*, in which the amount of the retirement benefit is determined by the value of the Employee's investment portfolio.

Dependent(s). The spouse or child of a Retiree Eligible Member who meets the eligibility requirements of the plan and has been enrolled by the Retiree Eligible Member as an eligible Dependent(s). (See Eligibility section)

Diagnostic Service. Procedures ordered by a physician or professional Provider because of specific symptoms to determine a definite condition or disease.

Disability/Disabled. As defined by *Section 5308I* of the *Retirement Code*: "An active member. . . shall . . . be entitled to a disability annuity if he becomes mentally or physically incapable of continuing to perform the duties for which he is emploI..." *71 Pa.C.S. § 5308(c)*. (Note: the definition of this term is not the same as the definition under the *Americans with Disabilities Act, 42 U.S.C. § 12102*):

Domiciliary Care. Home care providing mainly custodial and personal care for people who do not require medical or nursing supervision but mainly need assistance with activities of daily living because of a physical or mental disability.

Eligibility Points. Points which are used in the determination of eligibility for retirement benefits as defined in *Section 5307* of the *Retirement Code, 71 Pa.C.S. § 5307*. Eligibility Points are accrued by an Employee who is enrolled in SERS, PSERS, or ARS during active employment or an Employee who has been reemployed from *USERRA* leave or an Employee who dies while performing *USERRA* leave. Employment is limited to active employment with the executive, judicial, or legislative branches of the Commonwealth, and commissions, boards, departments, and authorities which are eligible to participate in the Group Life Insurance Program. For Employees participating in an ARS for which Eligibility Points are not calculated, Eligibility Points, for the purpose of this directive, will be determined by the Employee's agency in the same manner as SERS Members.

Eligible Member. An Eligible Member means a member enrolled in the REHP, whether as a Retiree member, a COBRA qualified member ("COBRA member"), a Survivor Spouse member, or the enrolled eligible Dependent(s) of a Retiree member or COBRA member. If you were previously enrolled for coverage but are not an Eligible Member, refer to the Handbook in effect when your coverage ended.

Emergency Medical Condition. A medical condition manifesting itself by Acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant individual, the health of the individual or their unborn child) in serious jeopardy, a serious impairment to bodily functions or a serious dysfunction of any bodily organ.

Emergency Services. Means, with respect to an Emergency Medical Condition, as required by the section 1867 of the Social Security Act (or as would be required by such section if it applied to independent, freestanding emergency departments: (i) a medical screening examination that is performed by and within the capabilities of an emergency department of a hospital or independent, freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; or (ii) such further medical examination of treatment that is within the capabilities of the staff and facilities of the hospital or independent, freestanding emergency department to stabilize the Eligible Member (and, if the services are performed at a hospital, regardless of the department of the hospital in which such examination or treatment is performed).Medical care performed to treat or stabilize an individual with an Emergency Medical Condition on account of that Emergency Medical Condition.

Employee. An individual employed by an agency that is eligible to participate in the REHP.

Experimental or Investigative. Services or supplies which the Claims Payor for the health plan option you have selected determines are:

- Not of proven benefit for the particular diagnosis or treatment of a particular condition; or
- Not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
- Provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Final Average Salary. For SERS Classes A, AA, A3, and A4 (PSERS Classes TC, TD, TE, and TF), the highest average compensation received during any three (3) non-overlapping periods of four (4) consecutive calendar quarters. For SERS Classes DC, A5, and A6 (PSERS Classes DC, TG and TH) the highest average compensation received during five (5) calendar years. For Members hired prior to January 1, 2019 who then elected the DC Plan, the highest average compensation received during any three (3) non-overlapping periods of four (4) consecutive calendar quarters as of June 30, 2019.

Final Gross Annual Base Salary. An Employee's final gross base pay rate expressed as an annual salary. Overtime and any other additional compensation or reimbursements are excluded from this calculation.

Group Life Insurance Program (GLIP). Term life insurance coverage that is available to permanent Commonwealth Employees pursuant to the *Act of July 17, 2007, P.L. 141, No. 42 (Act 42 of 2007), 72 P.S. §§ 1501-A—1508-A.*

HMO (Health Maintenance Organization). A health care option that uses a network of health care Providers, including physicians, hospitals, laboratories, rehabilitation, and nursing home facilities. HMO Network Providers have contracts with "health management companies" which bind them to certain rules, including fees. HMOs' rules also bind enrollees to obtaining care only by following specified procedures.

HIPAA. The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care. Equipment and services to the Eligible Member in the home for the purpose of restoring and maintaining Maximum levels of function and health of the Eligible Member.

In-Network. Care received from your Primary Care Physician or from a network specialist (PPO, HMO and Mental Health and Substance Use Program).

Least Expensive Plan (LEP). A health plan that is offered to Retirees who were hired on or after August 1, 2003, with no additional buy-up costs.

Maximum: The greatest quantity or amount payable to or for an Eligible Member or available to an Eligible Member, under the Covered Services section of the applicable plan option. The Maximum may be expressed in dollars, number of days or number of services, for a specified period of time.

Medically Necessary (or Medical Necessity). Services or supplies that are provided by a hospital or other facility Provider, or by a physician or other professional Provider that the Claims Payor for the health plan option you have selected determines are:

- Appropriate for the symptoms and diagnosis or treatment of the Eligible Member's condition, illness, disease, or injury; and
- Provided for the diagnosis, or the direct care and treatment of the Eligible Member's condition, illness, disease, or injury; and
- In accordance with standards of good medical practice; and
- Not primarily for the convenience of an Eligible Member or the Eligible Member's Provider; and
- The most appropriate supply or level of service that can safely be provided to the Eligible Member. When applied to hospitalization, this means that the Eligible Member requires Acute care as a bed patient due to the nature of the services rendered or the Eligible Member's condition, and the Eligible Member cannot receive safe or adequate care as an outpatient.

Medical Necessity does not override the Plan Exclusions. That is, if an item of care is listed as a Plan Exclusion, it will not be covered under the Plan, even if that care is Medically Necessary. Please see list of Plan Exclusions that are not covered under REHP benefits.

Medicare. Programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended. Medicare includes Hospital Insurance (Part A) and Medical Insurance (Part B), Medicare Advantage (Part C) and Prescription Drug (Part D).

Medicare Open Access PPO. A Medicare Advantage Plan offered by a private insurance company. Medicare pays a set amount of money every month to the Medicare Open Access PPO to arrange for health care coverage for Medicare Eligible Members enrolled in the plan.

Mental Health and Substance Use Program. This program provides independent, stand-alone, mental health and substance Use rehabilitation treatment services, whether inpatient or outpatient through a specialized network of professional Providers and treatment facilities.

Inpatient detoxification services will be provided through your medical plan option as appropriate.

Network Providers. Medical Providers, such as doctors and hospitals, who have a contractual agreement with PPO, HMO plans, or the Mental Health and Substance Use Plan to provide medical services or mental health services to enrolled Eligible Members.

New Child. A New Child means, with respect to any eligible Retiree or Dependent(s) of an eligible Retiree, a child who is newly born to, newly adopted by, or newly placed for adoption with the eligible Retiree or Dependent(s), as applicable.

Open Enrollment. Period of time specified by the REHP during which Eligible Members may, in accordance with the established eligibility rules, change the plan option in which they are enrolled.

Opt In. To enroll in the REHP.

Opt Out. To disenroll, either voluntarily or involuntarily, from the REHP.

Out-of-Network. Care provided by physicians or other medical professionals who have not contracted to provide services within the parameters established by a health or dental management company (PPO, HMO or Mental Health and Substance Use Plan). There is no Out-of-Network benefit for HMO enrollees other than for care for an Emergency Medical Condition.

Out-of-Pocket Maximum. The amount of eligible expenses you pay before the plan begins to pay at 100%.

Palliative. Relieves or alleviates without curing.

Part D. Medicare prescription drug coverage which is run by a Medicare approved private insurance company.

Pennsylvania Employees Benefit Trust Fund (PEBTF). The health and welfare fund that administers health care benefits to eligible Employees and Retirees.

PEBTF-Eligible Position. A position held by an Employee who is receiving or is eligible to receive health care benefits administered by the PEBTF.

Plan Allowance. Certain Claims Payors determine the Maximum covered expenses for a Covered Service by means of the Plan Allowance, rather than by determining the UCR charge. The Plan Allowance means the fee determined and payable by the Claims Payor for Covered Services as follows:

- For preferred Providers, the Plan Allowance is the lesser of the Provider's billed amount or the amount reflected in the Fee Schedule determined by the Claims Payor. The Fee Schedule is the document(s) that outlines predetermined fee Maximums that Participating and Out-of-Network Providers will be paid by the Claims Payor, as amended from time to time.
- For participating facility Providers, the Plan Allowance is the negotiated amount agreed to by the Provider and the Claims Payor. For Out-of-Network facility Providers, the Plan Allowance is the amount charged by the facility Provider to all its patients, but not more than the Fee Schedule or other Maximum payment amount, if any, established by the Claims Payor with respect to Out-of-Network facility Providers.

PPO (Preferred Provider Organization). Offers both In-Network and Out-of-Network benefits. Eligible Members do not have to choose a Primary Care Physician (PCP) to direct In-Network care. Medically Necessary care received by a PPO network Provider or facility is subject to a Copayment. Out-of-Network care is subject to an annual Deductible and Coinsurance.

Prescription Benefit Manager. The Claims Payor for the Prescription Drug Plan.

Preventive Care.

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/uspstf/;
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention https://www.cdc.gov/vaccines/hcp/imz-schedules/index.html;
- With respect to infants, children and adolescents, evidence-informed Preventive Care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") https://www.hrsa.gov/; and
- With respect to women, to the extent not described above in this definition, evidence informed Preventive Care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the HRSA https://www.hrsa.gov/
- Immunizations provided in accordance with treatment guidelines of the Pennsylvania State Board of Pharmacy, including guidelines of competent authorities that are so recognized by the Pennsylvania State Board of Pharmacy pursuant to 49 Pa. Code 403(e).
- For Members between age 50 and 70 who have prostates, PSA testing for prostate cancer every other year .
- For qualifying At Risk Members, a medically necessary and clinically appropriate examination of the breast using either standard or abbreviated magnetic resonance imaging or, where such imaging is not possible, ultrasound. The examination must be recommended by the Member's treating physician to screen for breast cancer when there is no abnormality seen or suspected in the breast. Coverage is limited to one examination each plan year.
- Genetic counseling and genetic testing provided by an individual who is appropriately licensed, certified or otherwise regulated for such counseling or testing. For purposes of this definition, the genetic testing must follow genetic counseling and is limited to a genetic laboratory test of the BRCA1 and BRCA2 genes for individuals assessed, based on a clinical risk assessment tool recognized by the applicable medical community, to be at increased risk of potentially harmful mutations in the BRCA1 or BRCA2 genes due to a personal or family history of breast or ovarian cancer.
- A drug, device or supply that is available over-the-counter for contraceptive purposes obtained with or without a prescription, provided that the drug, device or supply would be Preventive Care for such purpose if provided over-the-counter with a prescription.
- Magnetic resonance imaging or, where such imaging is not possible, ultrasound for the purpose of detecting, locating or otherwise observing breast cancer, or a colonoscopy, regardless of whether an abnormality for such test is seen or suspected, but for all such procedures, including biopsy and related pathology to complete the screening process, subject to the timeframe otherwise applicable under the rules set forth in this definition.

Apart from PSA testing for prostate cancer, items and services that constitute Preventive Care may be found at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

The REHP follows the broadest coverage recommendations based on the identified governing bodies.

An item or service shall be regarded as Preventive Care if it would be considered such under any of the subsections under this Section. Items and services that constitute preventive care under the first four bullets above may be found at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

In accordance with applicable law, coverage for certain services will be determined by an individual's anatomy and not by that individual's gender identity.

Primary Care Physician (PCP). The physician you choose to coordinate your care, including but not limited to family practice doctors, general practitioners, internists, or pediatricians.

Provider. Hospital facility other Provider, physician or professional other Provider licensed, where required, to render Covered Services.

Public School Employees' Retirement System (PSERS). The retirement system covering most retired public school Employees.

Qualifying Life Event. A Qualifying Life Event means, subject to any restriction under applicable law or any plan option, any of the following events:

- An eligible Retiree gains a new Dependent(s) through birth, adoption, or marriage.
- An eligible Retiree loses a Dependent(s) through divorce or death.
- A Retiree's Dependent(s) ceases to be eligible for coverage under the terms of the plan or a plan option.
- An Eligible Member experiences a termination or commencement of employment, strike or lockout, commencement of or a return from a leave of absence, change in worksite, or other change in employment status that causes the individual to become or cease to be eligible for coverage under a health plan maintained by their employer.
- An Eligible Member changes their residence and, as a result, becomes ineligible for a plan option in which they are enrolled.
- The cost of coverage under a plan option to an eligible Retiree significantly changes.
- An Eligible Member is enrolled in a plan option that ceases to be available to the Eligible Member because the plan option ceases to be offered under the plan or the plan option's service area is reduced or there is a substantial reduction in Providers in the plan option's network.
- An Eligible Member gains or loses group health coverage under another plan because of:
    - A change of election under another employer's plan that is made either during an annual enrollment period for a period of coverage that differs from the Plan Year or outside of an annual enrollment period pursuant to provisions under that employer's plan for reasons equivalent to a Qualifying Life Event.
    - A loss of coverage under a state children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government, the Indian Health Services, or a tribal organization; a state health benefits risk pool, a foreign government group health plan or similar program for group health coverage sponsored by a governmental or educational institution.
    - The plan receives a qualified medical child support order or other applicable judgment, decree or order resulting from divorce, legal separation, annulment, or change in legal custody that requires coverage of an eligible Retiree's child under the plan or a plan option or a child coverage order that requires a spouse, former spouse, or other individual to provide accident or health coverage to the eligible Retiree's child (and the coverage is actually provided).

- An Eligible Member becomes entitled to, or is entitled to and loses eligibility for, coverage under Part A or Part B of Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act, other than coverage solely related to the distribution of pediatric vaccines under section 1928 of such Act.
- An Eligible Member incurs a Special Enrollment Event.
- An Eligible Member's receipt of an order from a court or other authority directing the Eligible Member to disenroll the Eligible Member and/or Dependent(s).
- Spouse or other Eligible Member is enrolled in a high-Deductible plan with Health Savings Account (HSA) coverage through their employer. Spouse or other Eligible Members may be removed from REHP coverage to avoid any tax penalties.

Qualifying Payment Amount. For any item or service furnished by a Provider, the median of the contracted rates for the same or a similar item or service with Providers in the same or similar specialty in the geographic area in which the item or service was furnished. The median rate shall be determined based on the rates for all self-funded plans administered by the relevant Claims Payor unless the Plan Administrator chooses to make the determination based on all plans of the Plan Sponsor. In all events, the Qualifying Payment Amount shall be determined in accordance with and subject to the requirements set forth in applicable provisions of the Public Health Services Act and the regulations thereunder.

Recognized Amount. Means (i) for an item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount approved by the State under that system for the item or service; (ii) where no All-Payer Model Agreement applies, the amount determined under a method adopted by a State for determining the amount payable for an item or service, but only to the extent that such State law applies to the Plan; or (iii) where no such State law or All-Payer Model Agreement applies, the Qualifying Payment Amount.

Resignation. The voluntary termination of employment.

Respite Care. Services that provide a break for the caregiver of the chronically ill.

Retiree.

A former agency Employee, other than an enlisted member of the Pennsylvania State Police, who is:

(1) actively receiving pension benefits from the SERS; or

(2) actively receiving pension benefits from the PSERS; or

(3) actively receiving retirement benefits from an Approved Retirement System.

Retiree Contributions. Contributions toward REHP coverage based on a percentage of the retiring Employee's final gross base salary or Final Average Salary, or as otherwise determined by a collective bargaining agreement. Retirees who were hired on or after August 1, 2003, pay an additional buy-up cost to enroll themselves or an eligible Dependent(s) in a non-LEP plan.

Retired Employees Health Program (REHP). The health benefits plan covering eligible Retirees.

Retired Pennsylvania State Police Program (RPSPP). The health insurance plan covering eligible Retirees who were enlisted Employees of the Pennsylvania State Police.

SERS/PSERS Member. An Employee enrolled in the DB Plan either through SERS or PSERS.

Skilled Nursing Facility (SNF). Medicare-certified institution (or a distinct part of an institution) approved by the Claims Payor which is primarily engaged in providing skilled nursing and related services on an Inpatient basis to patients requiring 24 hour skilled nursing services but not requiring confinement in an acute care general Hospital. Such care is rendered by or under the supervision of physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- minimal care; Custodial Care, which is provided primarily for the maintenance of the member or is designed to assist the member in performing activities of daily living; Intermediate Care, which includes any such care ordered by and provided under the direction of a physician and is provided on a continuous 24-hour basis to Member who does not require the degree of care and treatment provided in a hospital or Skilled Nursing Facility; ambulatory care, or part-time care services; or
- care or treatment of Mental Illness, alcoholism or drug abuse.

Special Enrollment Event. Special Enrollment Event means a Special Enrollment Event within the meaning of HIPAA, with respect to which the plan is required to offer eligible Retirees and their Dependents an opportunity for coverage under plan options. A Special Enrollment Event is any of the following events:

- The marriage of an eligible Retiree
- The birth of a child of, adoption of a child by, or placement for adoption of a child with, an eligible Retiree
- An eligible Retiree's loss of eligibility coverage under another employer's plan, other than for a failure to pay premiums or other cause (for which purpose, for continuation of health coverage under COBRA, only the exhaustion of the Maximum continuation coverage period shall be regarded as a Special Enrollment Event)
- Another employer's termination of all employer contributions toward the cost of coverage (other than COBRA coverage)
- In the case of an eligible Retiree who is not enrolled for coverage under the plan or an Eligible Member's Dependent(s) either: (i) a loss of eligibility for coverage in a Medicaid plan under Title XIX of the Social Security Act or a state child health care plan under title XXI of the Social Security Act; or (ii) a commencement of eligibility for assistance with coverage under the plan provided by a Medicaid plan under title XIX of the Social Security Act or a state child health care plan under title XXI of the Social Security Act.

State Employees' Retirement System (SERS). The retirement system covering most retired Commonwealth Employees.

State Police Health Benefits Program (SPHBP). The health insurance plan covering active Pennsylvania State Police enlisted Employees.

Superannuation Age.

- For SERS Class A or AA, any age upon accrual of 35 Eligibility Points or age 60, except for an enforcement officer, a correction officer, a psychiatric security aide or a Delaware River Port Authority policeman, age 50.
- For SERS Classes G, H, I, J, K, L, M or N, age 55 upon accrual of 20 Eligibility Points.
- For SERS Class A3 and Class A4, any age upon attainment of a Superannuation Score of 92, provided the SERS Member has accrued 35 Eligibility Points, or age 65, or for park rangers or capitol police officers, age 55 with 20 years of service as a park ranger or capitol police officer, except for an enforcement officer, a correction officer, a psychiatric security aide or a Delaware River Port Authority policeman, age 55. A vestee with SERS Class A3 or Class A4 service credit attains Superannuation Age on the birthday the vestee attains the age resulting in a Superannuation Score of 92, provided

that the vestee has at least 35 Eligibility Points, or attains another applicable Superannuation Age, whichever occurs first.

- For SERS Class A5 or Class A6 at age 67 with three (3) Eligibility Points, 35 Eligibility Points upon attainment of a Superannuation Score of 97.
- For SERS and PSERS Class DC, at age 67.
- For PSERS Class TC or Class TD at age 62 or age 60 with 30 Eligibility Points or 35 Eligibility Points at any age.
- For PSERS Class TE or Class TF at age 65 with three (3) Eligibility Points or 35 Eligibility Points upon attainment of a Superannuation Score of 92.
- For PSERS Class TG at age 67 with three (3) Eligibility Points or 35 Eligibility Points upon attainment of a Superannuation Score of 97.
- For PSERS Class TH at age 67 with three (3) Eligibility Points.

Superannuation Score. A combined total of Superannuation Age plus Eligibility Points.

Survivor Spouse Coverage. Purchased coverage which is available to the spouse of a deceased Retiree, who had maintained the medical and prescription benefits at the time of death.

Therapy Service. The following services and supplies ordered by a Physician used for the treatment of an Illness or Injury, condition or disease, to promote the recovery of the Member. Therapy Services are covered to the extent specified in the Schedule of Benefits in the applicable Plan Option.

- Radiation Therapy - The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

- Chemotherapy - The treatment of malignant disease by chemical or biological antineoplastic agents.

- Dialysis Treatments - The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body including hemodialysis or peritoneal dialysis.

- Gene Therapy - Treatment of a specified condition (by provider in the applicable Gene Therapy network) through particular agents and processes that operate on genes that are damaged or functioning improperly in a way that causes the condition. The Plan recognizes only certain gene therapies as covered by the Plan. These Gene Therapies evolve with medical innovations and testing. A list for Gene Therapies may be obtained on the PEBTF website. All claims for Gene Therapies will be processed by Aetna, regardless of otherwise applicable Claims Payor.

- Physical Therapy - The treatment for a medical diagnosis by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, or prevent disability following Illness, Injury, or loss of body part.

- Respiration Therapy - Introduction of dry or moist gases into the lungs for treatment purposes.

- Occupational Therapy - Treatment for a medical diagnosis of a physically disabled person by means of constructive activities designed and adapted to promote the

restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

- Speech Therapy - Treatment for the correction of a medically diagnosed speech impairment resulting from Illness, surgery, Injury, congenital and developmental anomalies, or previous therapeutic processes or, regardless of cause, the correction of Childhood Stuttering, defined as a speech disorder characterized by repetition of sounds, syllables or words, prolongation of sounds and interruptions in speech developed between two and six years of age.

- Spinal Manipulation Therapy - Specific manipulation of vertebrae in order to reduce pain and restore function, also referred to as chiropractic care.

Treatment Plan. Projected series and sequence of treatment procedures based on an individualized evaluation of what is needed to restore or improve the health and function of a patient.

UCR (Usual, Customary, and Reasonable) Charge. The Maximum covered expense for a Covered Service in the service area. Expenses more than the UCR charge are the sole responsibility of the Eligible Member when non-participating Providers are used. The UCR charge is determined by the Claims Payor under the particular plan option you have selected (PPO, HMO, Mental Health and Substance Use Program) in accordance with the following factors:

- The usual fee which an individual Provider most frequently charges to most patients for the procedure performed.
- The customary fee determined by the Claims Payor based on charges made by Providers of similar training and experience in a given geographic area for the procedure performed.
- The reasonable fee (which differs from the usual or customary charge) determined by the Claims Payor by considering unusual clinical circumstances; the degree of professional involvement or the actual cost of equipment and facilities involved in providing the service.

The determination of the UCR charge made by the Claims Payor will be accepted by the REHP for purposes of determining the Maximum amount of expense eligible for coverage under the plan. Certain Claims Payors use the "Plan Allowance" in place of the UCR Allowance. Any reference to "UCR" or the "UCR Allowance" shall be deemed to refer to the "Plan Allowance" for those plan options which are administered by a Claims Payor that uses the Plan Allowance.

NOTE: Certain Claims Payors use the "Plan Allowance" instead of the UCR charge for determining the Maximum covered expense. Any reference hereunder to the "UCR" or the "UCR charge" shall be deemed to refer to the Plan Allowance for those plan options administered by a Claims Payor that uses the Plan Allowance.

***Uniformed Services Employment and Reemployment Rights Act (USERRA)*.** The federal law, *38 U.S.C. §§ 4301-4335*, that establishes employment and reemployment rights and responsibilities of uniformed service members and their employers.

$5 State-Paid-Coverage. REHP coverage where the Commonwealth pays $5 towards the cost of REHP coverage.

REHP BENEFITS AT A GLANCE …

Non-Medicare Eligible Retirees and Dependent(s)

- **Choice PPO:**
  - $20 Copayment for Primary Care Physician (PCP) In-Network office visit
  - $45 Copayment for In-Network specialist office visit
  - $50 Copayment for urgent care visit
  - $200 Copayment for Emergency Room visit (waived if the visit leads to an inpatient admission to the hospital)
  - In-Network annual Deductible of $400 single/$800 family
  - Out-of-Network: $800 annual Deductible/$1,600 family; 30% Coinsurance of the next $17,365 single/$34,731 family of eligible expenses after which the plan pays at 100% of eligible expenses

- **Basic PPO:**
  - $20 Copayment for Primary Care Physician (PCP) In-Network office visit
  - $45 Copayment for In-Network specialist office visit
  - $50 Copayment for urgent care visit
  - $200 Copayment for Emergency Room visit (waived if the visit leads to an inpatient admission to the hospital)
  - In-Network annual Deductible of $1,500 single/$3,000 family
  - Out-of-Network: $3,000 annual Deductible/$6,000 family; 30% Coinsurance of the next $17,365 single/$34,731 family of eligible expenses after which the plan pays at 100% of eligible expenses

- **Health Maintenance Organization (HMO) Option (requires residency in plan coverage area).**
  - This plan has a limited network of Providers and facilities
  - $5 Copayment for Primary Care Physician (PCP) office visit
  - $10 Copayment for specialist office visit
  - $50 Copayment for urgent care visit
  - $150 Copayment for Emergency Room (waived if the visit leads to an inpatient admission to the hospital)
  - No annual Deductible
  - No Out-of-Network benefit, except for Emergency Services.

- **Mental Health and Substance Use Program**
  - $20 Copayment for In-Network mental health office visit (PPO)
  - $5 Copayment for In-Network mental health office visit (HMO)
  - $20 Copayment for In-Network substance use office visit (PPO)
  - $5 Copayment for In-Network substance use office visit (HMO)
  - $150 Copayment for Emergency Room – HMO; $200 Copayment for Emergency Room - PPO (waived if the visit leads to an inpatient admission to the hospital)
  - Inpatient services covered 100% after annual Deductible for Eligible Members enrolled in the PPO; covered 100% under the HMO
  - Out-of-Network (Choice PPO Option): $800 single/$1,600 family annual Deductible; plan pays 70% of eligible expenses; Maximum out-of-pocket $10,600 single/$21,200 family; pre-authorization penalty of 20% reduction for non-notification

- Out-of-Network (Basic PPO Option): $3,000 single/$6,000 family annual Deductible; 30% Coinsurance of the next $17,365 single/$34,731 family of eligible expenses after which the plan pays at 100% of eligible expenses; pre-authorization penalty of 20% reduction for non-notification
- No Out-of-Network benefit if enrolled in the HMO

- **REHP Prescription Drug Plan**
  - Three-tier formulary Copayment structure

Medicare-Eligible Retirees and Dependent(s)

- **Medicare Open Access PPO**
  - Annual Deductible equal to Medicare Part B Deductible
  - $20 Copayment for Primary Care Physician (PCP) office visit and all outpatient therapy visits if you visit a Provider who is eligible to receive Medicare and accepts your plan
  - $30 Copayment for specialist office visit for a specialist who is eligible to receive Medicare payment and accepts your plan
  - $100 Copayment for Emergency Room Copayment (waived if the visit leads to an inpatient admission to the hospital)

- **REHP Prescription Drug Plan**
  - Three-tier formulary Copayment structure
  - Part D prescription drug plan

IMPORTANT NOTE: Under all options, benefits are limited to eligible expenses. Eligible expenses are expenses for Covered Services that do not exceed the Plan Allowance as determined by the Claims Payor with respect to the plan option you've selected. Charges for Covered Services by a network service Provider under the non-Medicare HMO and PPO options are always within UCR limits, but charges by Out-of-Network Providers may not be. You are responsible for all charges more than the Plan Allowance, if you receive services from an Out-of-Network Provider.

REHP ELIGIBILITY REQUIREMENTS

When Do I Become Eligible?

Eligibility for the REHP is based on several factors includes years of service, age, date of hire and agency employment. Employees must meet the eligibility requirements outlined below and collect a pension to be eligible for the REHP. A SERS counselor will tell you if you are eligible at your retirement counseling session. If you are retiring under PSERS or an ARS, contact your agency's Human Resource Office for information about eligibility and enrolling in the REHP.

If you sign your retirement papers within 90 days of the termination of your employment and if you are eligible for REHP benefits, your health coverage can begin the day after your coverage as a Commonwealth Employee ends. Otherwise, you may enroll in the REHP at any time. However, the effective date of coverage cannot be more than 60 days prior to the date you file the Retiree Change Form with SERS for non-Medicare coverage. Your coverage will continue as long as you are considered a Retiree by SERS, PSERS, or ARS, unless you elect to cancel your coverage or fail to pay any applicable Retiree contributions. Coverage will be available to Retirees who do not enroll at retirement or who cancel their coverage because they are receiving health coverage as a Dependent(s) on their spouse's coverage with the Commonwealth or other employer. Retirees may either elect medical and prescription drug coverage or must opt out of both medical and prescription drug coverage. If you are enrolled in PACE/PACENET, TRICARE, or Veteran's Affairs Healthcare, you have an exception to enroll in medical only coverage.

Eligibility Point Requirements

When determining REHP eligibility, Eligibility Points earned on or after July 1, 2007, will be limited to service as a Commonwealth Employee with an agency eligible to participate in the Commonwealth's Group Life Insurance Program (See Appendix A). Employees hired on or after July 1, 2007, who earned Eligibility Points under SERS, PSERS, or ARS with another employer will not have those Eligibility Points counted for purposes of eligibility for REHP coverage, unless they had employment with the Commonwealth with an agency eligible to participate in the Commonwealth's Group Life Insurance Program prior to July 1, 2007. If it is determined by SERS, or the appropriate Human Resources (HR) office for PSERS or ARS Members, that a Commonwealth Employee with an agency eligible to participate in the Commonwealth's Group Life Insurance Program (See Appendix A) is eligible for additional Eligibility Points for military service, such Eligibility Points will be included in the determination of eligibility for REHP coverage.

For ARS Participants or PSERS Members, up to five (5) years of Non-Intervening Military Service should be counted in determining eligibility for the REHP.

For Employees in a DB Plan, up to five (5) years of Non-Intervening Military Service shall be counted in determining eligibility for the REHP; USERRA leave shall be counted in determining eligibility for the REHP if the service is purchased upon the end of military duty and within the timeframe provided by SERS.

Retiree Eligibility Requirements

A Retiree is eligible for the REHP if they meet the following criteria:

(1) Was a permanent full-time Employee or permanent part-time Employee (working 50% or more) in a PEBTF-eligible position for the 12 months preceding separation from Commonwealth employment. The Employee also must meet at least one of the following criteria:

- **(a)** Enrolled in the PEBTF, as either the enrollee or the spouse, on their last day in an Active Pay Status; or
- **(b)** Was eligible for enrollment in the PEBTF on their last date in an Active Pay Status. Employees with suspended benefits will not be eligible for REHP benefits until the debt or obligation is resolved and the suspension of benefits is removed. Employees who owe contributions from leave without pay with benefits must also make all payments to the PEBTF before being eligible for REHP benefits. The PEBTF will send a letter notifying you of any amounts owed.

(2) Was employed for three (3) years from their most recent date of hire, unless:

- **(a)** The Employee was furloughed and returned during the recall period; or
- **(b)** The Employee was previously eligible for Contribution Rate Coverage REHP, as described in Section 1 under the Requirements for Contribution Rate Coverage section of this document, other than through a Disability; or
- **(c)** The Employee was in a management position and was separated due to a lack of funds or the loss of an appointed position and they returned to Commonwealth employment within one (1) calendar year from the date of losing their most recent employment with the Commonwealth.

(3) All applicable REHP Retiree Contributions or monthly premiums must be made on time and in accordance with PEBTF billing and collection policies.

- **(a)** Termination of REHP benefits for delinquency for any Retiree, Dependent(s) or survivor spouse will be considered their one opportunity to opt out. All delinquent premiums, Retiree Contributions, or other payments due must be paid before they will be allowed to use the one-time Opt In.
- **(b)** Any Retiree, Dependent(s) or survivor spouse that is delinquent may choose to Opt Out before having benefits terminated. However, they also will be required to have all delinquent amounts repaid before being allowed to Opt In.

(4) Once a Retiree, Dependent(s) or survivor spouse becomes eligible for Medicare, whether due to: the receipt of Federal Disability benefits; end-stage renal disease; or reaching age 65, they **must** enroll in Medicare Part A and Part B to be eligible for medical and prescription benefits under the REHP. If given the option to enroll retroactively in Medicare, they **must** do so to be eligible for the REHP, or to remain eligible if already enrolled. Failure to enroll in Medicare retroactively will result in the termination of REHP benefits effective the date first eligible for Medicare until the date they have enrolled in both Medicare Part A and Part B.

(5) In determining eligibility for an Employee participating in an ARS, Eligibility Points earned as a Commonwealth Employee in an agency eligible to participate in the Commonwealth's Group Life Insurance Program should be considered in lieu of Eligibility Points in SERS or PSERS.

(6) For Employees who separated prior to July 1, 2003 and elected not to retire until a later date (i.e., vested their retirement benefit), eligibility and benefits (such as benefit levels and Retiree Contributions) will be based on the benefit levels and Retiree Contributions in force at the time of the separation.

(7) For Employees who separate(d) on or after July 1, 2003 and elect(ed) not to retire until a later date (i.e., vested their retirement benefit), benefits (such as benefit levels and Retiree Contributions) will be based on the benefit levels and Retiree Contributions in force on the date of retirement.

(8) If a Retiree who was eligible or enrolled in the REHP returns to Commonwealth employment, REHP eligibility upon subsequent retirement will be based on the rules applicable on the date of the latest retirement.

(9) Employees who are enrolled in SERS, PSERS or an ARS in an Age 60, 65 or 67 Superannuation Age group, who change to an Age 50 or 55 Superannuation Age group will be required to remain in the new position for one year before qualifying for the REHP at Age 50 or 55 Superannuation Age.

(10) Employees who are enrolled in SERS, PSERS or an ARS in an Age 50 or 55 Superannuation Age group who change to an Age 60, 65 or 67 Superannuation Age group and who qualified for Contribution Rate Coverage prior to the change do not lose eligibility they earned for Contribution Rate Coverage. Employees who have not qualified for Contribution Rate Coverage prior to the change must now qualify as the Age 60, 65 or 67 Superannuation Age group to which they changed.

(11) REHP coverage will not be available to any active Commonwealth Employee; including Employees receiving retirement/pension payments through SERS, PSERS or ARS and Employees who have received full distribution from their DC Plan.

(12) For any individual, whose pension or ARS is forfeited, REHP coverage will be retroactively terminated to the date of the pension or ARS forfeiture. The individual will also be held financially responsible for the repayment of any REHP benefits received by themselves and/or their Dependent(s) after the date of forfeiture.

Disability Retirements

Benefits available to an Employee with a Disability are authorized by collective bargaining agreements, memoranda of understanding, and Commonwealth policy.

Application for Disability Retirement

An Employee may apply for Disability retirement while on a paid or unpaid absence; however, the application must be received by a SERS Regional Counseling Center for SERS Members, or at the appropriate Human Resource (HR) office for PSERS or ARS Participants, or the BEB for ARS Participants in the DC Plan, **before** employment is terminated.

Once a disability retirement application has been submitted to the applicable office, the Employee must select one of the following options:

(1) An Employee may resign. The Resignation cannot be withdrawn without approval of the agency head; or

(2) An Employee may request to use paid or unpaid absence and resign later; however, the Resignation must be effective no later than the end of the pay period in which the applicable office gives notice of approval of disability retirement benefits. The Resignation cannot be withdrawn without approval of the agency head.

Disability Retirement Decision

For those who are eligible for a disability annuity, the effective date of Disability retirement benefits (i.e., monthly pension annuity) may not necessarily coincide with an Employee's Resignation. The applicable office, in concert with the HR Service Center (HRSC) and the Employee's agency HR office or HR Delivery Center, establishes the effective date for the disability retirement and resignation. For those who are eligible for a disability annuity, the Disability retirement benefits are effective the later of:

(1) The date the medical examiner determines the Employee became disabled based on the medical evidence submitted for review; or

(2) The first day the Employee is no longer eligible to receive pay (i.e., regular pay or paid absence).

If the Disability retirement is approved, whether permanent or temporary, while the Employee is on a paid or unpaid absence, the Employee's Resignation is to be effective no later than the end of the pay period in which the applicable office, as stated in the Responsibilities section below, gives notice of approval of the disability retirement. The Employee may not request an earlier Resignation date or delay the Resignation. All guaranteed rights of return expire.

If the Disability retirement is disapproved and the Employee is on paid or unpaid absence, the Employee may continue on approved absence or resign. If the Employee does not request additional leave, or additional leave is not approved, and the Employee does not return to work with a medical release in accordance with applicable policy, action may be initiated to terminate employment.

Disability Retirement REHP Effective Date

Provided the Retiree has met all of the eligibility requirements outlined in the Eligibility Requirements section, REHP coverage will be effective on the later of:

(1) For SERS or PSERS Members, the effective date of the Disability retirement (e.g., monthly pension annuity), or the date the SERS/PSERS Member is no longer covered under the AEHP, including leave without pay without benefits.

(2) For ARS participants, the effective date the participant received a full distribution from their DC Plan or the participant is no longer covered under the AEHP, including leave without pay without benefits.

If the effective date of the Disability retirement is retroactive more than one (1) year, REHP coverage can only be made effective retroactive one (1) year due to claims processing guidelines. Retirees who have purchased other medical or prescription coverage or had eligible medical or prescription claims during the time between the effective date of the Disability retirement and the effective date of REHP coverage will be eligible for reimbursement provided the Retiree is able to submit the necessary documentation.

When Retiree Coverage Begins

In most cases, you and your Dependents coverage begins the day after your PEBTF coverage as an active Employee ends; otherwise, it begins on the date you enroll. Employees with suspended benefits will not be eligible for REHP benefits until the debt or obligation is resolved and the suspension of benefits is removed. Employees who owe contributions from leave without pay with benefits must also make all payments to the PEBTF before being eligible for REHP benefits. The PEBTF will send a letter notifying you of any amounts owed.

If you elect to opt out of any part or all of your coverage, it **can be reinstated** one time only unless it was canceled because of re-employment by the Commonwealth and subsequent coverage under the Active Employees Health Program as either an Employee or spouse. Coverage will be available to Retirees who do not enroll at retirement or who cancel their coverage because they are receiving health coverage as a Dependent(s) on their spouse's coverage with the Commonwealth or other employer.

NOTE: Retirees who Declined coverage prior to June 1, 2007 are not eligible to enroll in the REHP.

If you marry, your spouse will be eligible for coverage as of the date of marriage; however, you must complete an enrollment form to add your spouse. The effective date may be the date of the marriage if you complete a form within 60 days of the marriage date. If you delay in adding your spouse, the effective date cannot be more than 60 days retroactive from the date the form is received by SERS (or the PEBTF for Retirees in PSERS, or ARS).

Non-Medicare Eligible Members, the effective date of coverage cannot be more than 60 days prior to the date you file the Retiree Change Form with SERS. Medicare Eligible Members will be enrolled the 1st of the month on a prospective basis (if retirement or the addition of a Medicare-eligible Dependent(s) is prior to the 1st of the month supplemental coverage will be in place until the Medicare Open Access PPO is active on the 1st of the month).

When Retiree Coverage Ends

Coverage continues for you and your eligible Dependents as long as you are considered a Retiree by SERS, PSERS, or ARS, you continue to pay any required premiums and as long as you are not an active Commonwealth Employee. If the PEBTF, on behalf of the REHP, demands repayment of amounts paid in error, and you do not repay the money or otherwise fail to cooperate with the PEBTF in its recoupment of monies owed, you and your Dependents will be ineligible for all future benefits until the money is repaid in full or until you make the first payment under a repayment plan agreed to between you and the PEBTF.

You may choose to opt out of REHP coverage if you have other coverage. You may opt out of REHP coverage one time only with the option to re-enroll at a later date. You have the following options for medical and/or prescription drug coverage offered by the REHP, as follows:

Non-Medicare eligible Retirees

- You are required to enroll in both medical and prescription drug coverage or to decline both.
- If you are enrolled in PACE/PACENET, TRICARE or VA health care, you have an exception to be enrolled in medical only coverage. A copy of the PACE/PACENET, TRICARE or VA ID card must be provided.
- Anyone who retired before January 1, 2013 and enrolled in a non-Medicare plan before January 1, 2013 will be able to remain in medical only or prescription drug only coverage until they become eligible for Medicare. If you opt out of medical only or prescription drug only REHP coverage, you may not enroll in medical only or prescription drug only REHP coverage upon opting back in to the REHP. Once you become eligible for Medicare you must enroll in both medical and prescription drug coverage or decline both.
- A Dependent(s) cannot maintain coverage that a Retiree opts out of or declines.

Medicare eligible Retirees

- You are required to enroll in both medical and prescription drug coverage or to decline both.
- If you are enrolled in PACE/PACENET, TRICARE or VA health care, you an exception to be enrolled in medical only coverage. A copy of the PACE/PACENET, TRICARE or VA ID card must be provided.

IMPORTANT: You may not be enrolled in more than one Medicare Advantage Plan. If you enroll in a Medicare Advantage Plan that is not one of the REHP options, your REHP medical and prescription drug coverage will be terminated.

You may not be enrolled in a private Part D Prescription Drug Plan. If you enroll in a private Part D plan, your REHP medical and prescription drug coverage will be terminated.

To "opt out" of REHP coverage: Please notify SERS. You will be required to complete a Retiree Change Form and attest to SERS that you have other coverage. You must then forward your completed Retiree Change Form to SERS, Central Office, Attn: Health Benefit Coordinator, 30 North Third Street, Suite 150, Harrisburg, PA 17101. PSERS or ARS Members must contact the PEBTF.

To re-enroll in REHP coverage: Please notify SERS. You will be required to complete a Retiree Change Form. Non-Medicare eligible Retirees: Mail your enrollment form to the PEBTF. Medicare-eligible Retirees: You will be enrolled in the Medicare Open Access PPO. Coverage will be effective the 1st of the month on a prospective basis. PSERS or ARS Members must contact the PEBTF.

No Duplication of Coverage

If your spouse is enrolled in the PEBTF's health program for Commonwealth Employees or the REHP, there can be no duplication of coverage. You may remain a Dependent(s) under your spouse's plan until your spouse retires. When your spouse retires, you can enroll in the REHP at that time.

If you are both retired Commonwealth Employees, you may enroll either as a Retiree or as a Dependent(s) of your spouse, but not as both. Your Dependent(s) child may be enrolled under your or your spouse's coverage, but not both. **An Employee who enrolls as the Dependent(s) of another Commonwealth Employee or Retiree will not have to pay the Retiree contribution, if applicable, until they enroll under their own REHP coverage.**

Dependent(s) Coverage

You may add an eligible Dependent(s) to benefits at any time. Effective date cannot be more than 60 days retroactive.

You must be enrolled in the REHP for your Dependents to be eligible under the REHP. Your Dependents must be enrolled to be covered under the REHP. You are responsible for any claim incurred by ineligible Dependents. You can enroll an eligible Dependent(s) at any time. However, the effective date cannot be more than 60 days retroactive from the date the form is received by SERS (or the PEBTF for Retirees in PSERS, or ARS). It is your responsibility to notify SERS when:

- Your Dependent(s) no longer qualifies as an eligible Dependent(s) as permitted under REHP rules
- You gain a Dependent(s) through birth, adoption, or marriage
- You lose a Dependent(s) through divorce, death, or ineligibility under the REHP
- Your spouse's employment ends, or your spouse loses coverage under another employer's plan, other than for failure to pay premiums or other cause
- Your Dependent(s) loses eligibility for coverage in a Medicare plan, a Medicaid plan or a state children's health insurance program

See the Glossary for a list of all Qualifying Life Events.

You are required to remove a Dependent(s) from coverage when your Dependent(s) is no longer eligible for REHP coverage, as indicated below.

- Your Dependent(s) no longer qualifies as an eligible Dependent(s) as permitted under REHP rules
- You lose a Dependent(s) through divorce, death, or ineligibility under the REHP

Termination of coverage is effective the date of the Qualifying Life Event so it is important that you notify SERS within 60 days of the Qualifying Life Event or your Dependent(s) will not be able to elect COBRA.

In the case of divorce, your ex-spouse and Dependent(s) children of your ex-spouse must be removed from REHP benefits effective the date of divorce. Any claims incurred after the date of divorce are your responsibility. The right to COBRA coverage depends on the timely notification of the divorce. In the case of divorce, you must notify SERS as soon as the divorce is final to

complete a Retiree Change Form. Do not wait until you receive the divorce decree to complete the Retiree Change Form. If the divorce is reported to SERS within 30 days of the effective date of the divorce, you will not be held liable for any benefit utilization by their ex-spouse or the ex-spouse's Dependent(s) children during the 30-day grace period.

In most instances, a spouse who is not eligible for REHP coverage because of their own Commonwealth employment but has REHP coverage through a spouse will become ineligible for REHP coverage on the effective date of divorce unless they elect COBRA Continuation Coverage. (See page 105 for more information about COBRA Continuation Coverage, including a description of when a spouse who is separated but not yet divorced from the Retiree might be eligible for such coverage.)

If your Qualifying Life Event is the addition of a New Child, the New Child is automatically covered for 31 days after birth, adoption or placement for adoption provided the PEBTF is notified. Coverage for the New Child will terminate at the end of the 31-day period unless the child is enrolled within 60 days of the birth, adoption, or placement of adoption by completing the appropriate form.

After your child is enrolled, you will have six months to provide the following for your New Child to continue to be enrolled for coverage under the Plan:

- Original birth certificate (or decree or another proof of adoption) and
- Social Security number

If you fail to provide the required documentation before the end of the six-month period, the PEBTF will notify you in writing of the expiration of the period for providing the documentation. You will have until the end of the seventh month to provide the documentation. You will have until the end of the seventh month to provide the documentation. If you have a child placed with you for adoption, you must provide a decree or proof of adoption. Proof of placement for adoption will not be sufficient to demonstrate that the placement of the child was, in fact, for the purpose of adoption.

If you fail to provide the New Child's Social Security number, the termination will be prospective. If you fail to provide the New Child's birth certificate or proof of adoption, the termination will be retroactive to the date of birth, adoption, or placement for adoption. You will be responsible for reimbursing the REHP for any claims paid for this child.

If you cannot provide appropriate documentation because of a delay in the legal process for obtaining the documentation and not because of a delay in your efforts to obtain the documentation, you may request an extension in writing from the PEBTF. The request must be received no later than 30 days after the date of the PEBTF's notice to you of the requirement to provide documentation of birth, adoption, or placement for adoption. You must include the reasons for the delay and the expected date when you will be able to provide the documentation. The PEBTF will decide whether to approve or reject the request and will notify you in writing of its determination. If the documentation (or request for an extension) is not provided within the appropriate time (or if the PEBTF rejects a request for an extension of time to provide the documentation), the New Child's coverage will be terminated.
The REHP covers the following eligible Dependents:

Spouse

If you were **hired as an active Employee prior to August 1, 2003** and your spouse is eligible for active or retiree (other than the REHP or RPSPP) medical or prescription drug benefit coverage through their own employer must take such coverage unless the spouse's

employer charges a contribution or offers an incentive not to enroll. The spouse may also enroll in the REHP, but the REHP will pay secondary.

If you were **hired as an active Employee on or after August 1, 2003**, your spouse who is eligible for active or retiree (other than the REHP or RPSPP) medical or prescription drug benefit coverage through their own employer must take that coverage regardless of any contribution the spouse must pay and regardless of whether the spouse had been offered an incentive to decline such coverage(s). Coverage for such spouse in the REHP is limited to **secondary** coverage. This rule does not apply for those spouses who are self-employed. Retirees must complete an annual spouse attestation. The attestation will be completed for any spouse who is non-Medicare eligible. It is not required for a Medicare eligible spouse. The PEBTF will notify you of the attestation deadlines.

Common Law Spouse

If you and your spouse were married as common law, the REHP will permit you to enroll your common law spouse as a Dependent(s), provided you complete a Common Law Marriage Affidavit and provide any additional information requested by the PEBTF to demonstrate the validity of your common law marriage.

Your common law marriage must be recognized as such by the state in which it was contracted. The REHP will only recognize a Pennsylvania common law marriage entered into prior to September 17, 2003. Most states do not recognize common law marriage and while some states still recognize common law marriage, there is no such thing as a common law divorce. If you list an individual as your common law spouse and subsequently remove them from coverage, you will not be permitted to subsequently add someone else as your spouse, common law or otherwise, without first producing a valid divorce decree from a court of competent jurisdiction certifying your divorce from your prior common law spouse.

For common law marriage entered into in Pennsylvania, you will be required to present documents dated prior to September 17, 2003, such as a deed to a house indicating joint ownership, joint bank accounts, a copy of the cover page (indicating filing status) and signature page (if different) of your federal income tax return indicating marital status as of 2002. Figures reflecting income and deductions may be redacted (i.e., blacked out). Additional documentation may be required as well.

Spousal Support Orders

A court spousal support order which directs that a Retiree provide medical coverage for their former spouse does not and cannot require that the REHP do anything other than comply with the terms of the benefit plan, including the plan's provisions and procedures for continuation coverage under COBRA. Therefore, spouse must duly elect, and timely pay for, COBRA coverage in accordance with the plan's COBRA requirements to fulfill the Retiree's obligation under the court order. Such a court order for spousal support relates only to the Retiree's obligations, as the REHP and PEBTF are not subject to the court's jurisdiction in such a legal action.

Dependent(s) Children to Age 26

As a Retiree, you may cover your child to age 26. Marriage, residency, tax support and student status are not considered in determining eligibility for children under age 26. Coverage for an eligible child ends on the last day of the month in which the child turns 26 unless the child qualifies as a Disabled Dependent(s). Child under age 26, include the following:

- Your natural child (original birth certificate required)
- Legally adopted child; includes coverage during the probationary period (Court Adoption Decree is required)

- Stepchild for whom you have shown an original marriage certificate and a birth certificate indicating that your spouse is the parent of the child
- Child who is under age 18 and for whom you are the legal guardian or legal custodian as demonstrated by an appropriate court order
- Eligible foster child (until age 18 unless child is required to stay in the foster care system due to special needs or continuing education which will require annual court recertification)
- Child for whom you are required to provide medical benefits by a Qualified Medical Child Support Order or National Medical Support Notice

NOTE: You must reside in the service area to enroll in an HMO. The HMO plan offered by the REHP is a Custom HMO and offers a limited network of Providers and facilities. Emergency Services only are covered outside of the service area. Seek Emergency Services and contact the plan. If you have a Dependent(s) who resides outside of the HMO's service area, they will have Emergency Services coverage only and would have to return to the service area for all other medical care; therefore, you may want to enroll in a PPO.

The necessary documentation must be presented to SERS when adding a new spouse (original marriage certificate or child (original birth certificate, Court Adoption Papers, etc.). SERS will notify you of the documentation needed. Contact the PEBTF for instructions if you are covered under PSERS, or ARS.

Adult Dependent(s) Coverage

The REHP provides coverage for Dependents age 26 to age 30 on a self-paid basis under certain conditions. Your Dependent(s) must meet all of the following criteria:

- Is not married
- Has no Dependents
- Is a resident of Pennsylvania or is enrolled as a full-time student at an accredited educational institution of higher education
- Is not eligible for coverage under any other group or individual health insurance
- Is not enrolled in or entitled to benefits under any government health care benefits program (for example, Medicare or Medicaid)

The adult Dependent(s) must enroll in the same REHP medical and prescription drug benefits that the Retiree has and must pay a monthly premium directly to the PEBTF for coverage to continue. If the Retiree is eligible for Medicare, the non-Medicare eligible Dependents will remain in the non-Medicare plan selected by the Retiree. The Dependent(s) does not have the option of enrolling in REHP coverage that the Retiree does not have nor dropping REHP coverage in which the Retiree is enrolled. Coverage ends when the Retiree's coverage ends.

You may contact the PEBTF for information on Adult Dependent(s) Coverage and the monthly premium amounts.

Disabled Dependents

Your unmarried disabled Dependent(s) of any age may be covered if all of the following requirements are met:

- Is totally and permanently disabled, provided that the Dependent(s) became disabled prior to age 26
- Was your or your spouse's Dependent(s) before age 26
- Depends on you or your spouse for more than 50% support

- Is claimed as a Dependent(s) on your or your spouse's federal income tax return (In the event of a divorce, your child may be eligible for coverage if the child is claimed as a Dependent(s) by you every other year pursuant to a divorce decree or similar judgement)
- Completes a Disabled Dependent(s) Certification Form (must be completed by Retiree Eligible Member)

A Dependent(s) shall be considered "totally and permanently disabled" if they are unable to perform any substantial, gainful activity because of physical or mental impairment that has been diagnosed and is expected to last indefinitely or result in death. The determination whether an individual is totally and permanently disabled will be made by the Commonwealth (or its delegate) in reliance upon medical opinion and/or other documentation (e.g., evidence of gainful employment) and shall be made independently without regard to whether the individual may or may not be considered disabled by any other entity or agency, including without limitation, the Social Security Administration. Accordingly, the Commonwealth (or its delegate) may require an individual to submit to an examination by a physician of the Commonwealth's own choosing, to determine whether the individual is, or continues to be totally and permanently disabled. Failure to cooperate in this regard is grounds for the Commonwealth to determine, without more, that the individual is not, or is no longer, totally and permanently disabled.

NOTE: A disabled Dependent(s) child will not automatically be excluded from coverage if they live outside your home, but the child's living situation and its ramifications will be considered in determining whether the child meets the support requirements. For example, a disabled adult child who lives in a group home or other facility and whose care and expenses are subsidized significantly by the government may no longer be deemed to receive more than half of their support from you or your spouse.

Important: It is your responsibility to advise the PEBTF of any events that would cause your disabled Dependent(s) to no longer be eligible for coverage. If you fail to advise the PEBTF of any such event **within 60 days of the event**, your Dependent(s) will not be able to elect COBRA continuation coverage. You will be responsible for any claims incurred while your Dependent(s) was not eligible for benefits.

If a Dependent(s) Certification Form is needed, the PEBTF will advise you. You will receive a recertification form (PEBTF-6RC) every two years. The form must be returned within 45 days of the mailing. Based on the responses on the recertification form (PEBTF-6RC) the Dependent(s) status will be continued or ended.

When Dependent(s) Coverage Begins

A New Child will be covered under the plan for 31 days following birth, adoption, or placement for adoption. Coverage will not continue if the child is not enrolled within 60 days of birth. You are required to present the necessary documentation to SERS when adding a spouse or Dependent(s) child to REHP coverage. PSERS or ARS Members must contact the PEBTF.

Report changes in your marital or family status to SERS, or to the PEBTF for PSERS or ARS Members. You can enroll an eligible Dependent(s) at any time. However, the effective date cannot be more than 60 days retroactive. Medical expenses incurred for Dependents who are not enrolled in the plan will not be paid.

If you or any eligible Dependents are an inpatient in a facility on the date your REHP coverage would normally begin, coverage will not begin until the date of discharge or until the hospital stay is extended as the result of another cause.

When Dependent(s) Coverage Ends

Dependent(s) coverage will generally end on the date when:

- Your coverage ends.
- Your Dependent(s) no longer qualifies as an eligible Dependent(s) under the rules of the Plan (for example, divorce, etc.).*
- You voluntarily drop coverage for your Dependent(s) as permitted under REHP rules.
- You or your Dependent(s) is suspended from REHP coverage for fraud and/or abuse and/or intentional misrepresentation of a material fact and/or failure to cooperate with the PEBTF in the exercise of its subrogation rights and/or failure to provide requested information and/or failure to repay debt to the REHP.
- Your Dependent Child turns 26 (if not disabled) – Coverage terminates the last day of the month in which the Dependent(s) turns 26.
- Your Dependent Child is determined to no longer be totally and permanently disabled, if age 26 or older.
- The PEBTF determines an individual had been incorrectly enrolled as a Dependent(s) (in such event, coverage may be canceled back to the date the individual was incorrectly enrolled)
- Your Medicare-eligible Dependent(s) enrolls in an individual Medicare Advantage Plan or Medicare Part D Prescription Drug Plan

You may only remove a Dependent(s) during Open Enrollment or due to a Qualifying Life Event.

*See the Glossary for a list of all Qualifying Life Events.

Important: You (or your Dependent(s)) must advise the PEBTF within 60 days of an event which causes a child to no longer be an eligible Dependent(s). If the REHP pays benefits for an individual who was covered as your Dependent(s) when benefits are incurred after that individual ceases to be eligible for coverage, you will be required to repay the REHP the full amount of such benefits within 60 days of the date that you are notified of the amount due, unless alternative repayment arrangements are made with the PEBTF. Your Dependent(s) or ex-spouse may also lose the right to elect COBRA continuation coverage if you do not notify the PEBTF within 60 days of the date the Dependent(s) or ex-spouse no longer qualifies for coverage.

*In the case of divorce, you must notify SERS or the PEBTF for PSERS or ARS members, as soon as the divorce is final to complete a Retiree Change Form. Your ex-spouse's REHP coverage will be terminated on the actual date of divorce. To give you time to receive notice of the date of divorce, you will have 30 days from the date of the divorce to contact SERS. The effective date of the ex-spouse's termination of benefits will be the actual date of divorce. If the divorce is reported within 30 days of the effective of divorce, you will not be held liable for any benefit utilization by the ex-spouse during the 30-day grace period. Do not wait until you receive the divorce decree to contact SERS or the PEBTF (for PSERS and ARS members) and complete the Retiree Change Form. If you delay notifying SERS or the PEBTF (for PSERS and ARS members), you will be responsible for any claims incurred by your ex-spouse after the date of the divorce until the time the PEBTF was notified.

Notify SERS as soon as your divorce is final.

You may wish to contact SERS (for PSERS and ARS members) to request the appropriate forms to remove your spouse so that they are readily available. If you delay past the 30-day grace period, you may be responsible to repay the REHP for any benefits provided to your ex-spouse when ineligible for coverage under the PEBTF. Your ex-spouse may also lose the right to elect

COBRA continuation coverage if notification is not within 60 days of the date of divorce. Your ex-spouse's REHP coverage will be terminated on the actual date of divorce.

If your coverage ends, in certain circumstances, you and your eligible Dependent(s)(s) may qualify for continued coverage of health benefits. Please refer to the "COBRA Continuation Coverage" section for more details.

NOTE: If you chose to opt out of coverage, your Dependent(s) must also be opted out of coverage.

RETIREE CONTRIBUTIONS

Contribution Rate Coverage

Requirements

The Commonwealth shall pay a portion of the cost of coverage for Retirees who retire meeting the Eligibility Requirements of this handbook and who have elected coverage and meet the requirements for Contribution Rate Coverage.

(1) Eligibility for Contribution Rate Coverage for Employees requires one of the following:

- **(a)** 25 or more Eligibility Points; or
- **(b)** An Employee who leaves Commonwealth employment prior to, at or after Superannuation Age and is subsequently rehired and then retires at or after Superannuation Age must have at least 20 Eligibility Points in SERS, PSERS or ARS; or
- **(c)** A combination of 20 Eligibility Points and Superannuation Age; or
- **(d)** Disability retirement.
  - **1** If an Employee who had previously qualified for Disability retirement returns to Commonwealth employment, and later retires under other than a Disability retirement, they must meet the qualifications that apply to non-Disability retirements.
  - **2** ARS Participants seeking Disability retirement should contact the Office of Administration, Human Resources and Management, Office of Employee Relations and Workforce Support, Bureau of Employee Benefits (BEB). SERS or PSERS Members should contact SERS or PSERS, as appropriate, for specific details and instructions.
  - **3** An Employee must have five (5) or more Eligibility Points at the time the application is submitted.

(2) For Employees who transfer from an agency that participates in the REHP to an agency that is eligible to participate in the Commonwealth's Group Life Insurance Program, but does not participate in the REHP (See Appendix A: if the Employee met the eligibility requirements under Sections 1 and 2 of Eligibility Requirements and Section 1 under Requirements for Contribution Rate Coverage at the time of the transfer, the Employee will be eligible for Contribution Rate Coverage upon retirement.

(3) For Employees who transfer from an agency that is eligible to participate in the Commonwealth's Group Life Insurance Program, but does not participate in the REHP, to an agency that participates in the REHP: the Employee must be employed for three (3) years from their most recent date of transfer and meet the requirements under Sections 1 and 2 of Eligibility Requirements and Section 1 under Requirements for Contribution Rate Coverage.

(4) For Employees who transfer from an agency that participates in the REHP to an employer that does not participate in the REHP or is not eligible to participate in the Group Life Insurance Program: if the Employee met the applicable eligibility requirements under Sections 1 and 2 of Eligibility Requirements and Section 1 under Requirements for Contribution Rate Coverage at the time of transfer, the Employee will be eligible for Contribution Rate Coverage upon retirement.

(5) For Employees hired before January 1, 2019, who elected Class A5, A6, TG, TH, or DC and met the applicable eligibility requirements under Sections 1 and 2 of Eligibility Requirements and Section 1 under Requirements for Contribution Rate Coverage prior to July 1, 2019, the Employee will be eligible for Contribution Rate Coverage upon retirement.

(6) For Employees hired before January 1, 2019, who elected Class A5, A6, TG, TH, or DC Plan and had not met the applicable eligibility requirements under Sections 1 and 2 of Eligibility Requirements and Section 1 under Requirements for Contribution Rate Coverage prior to July 1, 2019, Superannuation Age will be determined by the Class the Employee elected.

Retiree Contributions

Retired prior to July 1, 2005. For most employees who retired prior to July 1, 2005, and qualified for Contribution Rate Coverage, there is no contribution rate.

Retired July 1, 2005 through June 30, 2007. For most employees who retired on or after July 1, 2005, through June 30, 2007, and qualify for Contribution Rate Coverage, the annual cost is 1% of final average gross salary.

Retired July 1, 2007, through June 30, 2011. Non-Medicare eligible Retirees who qualify for Contribution Rate Coverage contribute three (3) percent of the lesser of the Employee's Final Average Salary or Final Gross Annual Base Salary. Medicare eligible Retirees contribute a percentage equal to 1.5 percent of the lesser of the Employee's Final Average Salary or Final Gross Annual Base Salary.

If an Employee, whose Contribution Rate Coverage is based on final annual salary, voluntarily transferred to a lower paid position, or decreased the number of hours worked less than one (1) year prior to retirement, the Employee's Final Annual Gross Base Salary shall be based on the Employee's gross annual base salary prior to them decrease in pay or decrease in hour.

Retired on or after July 1, 2011. Non-Medicare eligible Retirees who qualify for Contribution Rate Coverage contribute three (3) percent of the Employee's Final Average Salary. Medicare eligible Retirees contribute 1.5 percent of the Employees Final Average Salary.

Hired on or after August 1, 2003. Non-Medicare eligible Retirees who are enrolled in a plan other than a LEP, are subject to a monthly LEP premium in addition to the Retiree Contributions. Retirees subject to the LEP provision and enrolled in family coverage will continue under the LEP premium for as long as one or more Dependent(s) are not covered under Medicare.

Hired Prior to January 1, 2019. For Employees who voluntarily switched to Class A5, A6, TG, or TH, the Final Average Salary calculation will be based on the class of service in which the Employee earned the majority of their service. For Employees who voluntarily switch to the DC Plan, the Final Average Salary calculation determined on June 30, 2019, will be the Final Average Salary used to calculate the DB benefit attained as a DB Plan Member.

Employees covered under a collective bargaining agreement at the time of retirement should refer to the applicable collective bargaining agreement to determine the specific parameters that control their Contribution Rate Coverage.

$5 State-Paid Coverage

Requirements

Employees who entered SERS or an ARS *prior to January 1, 2011 (PSERS prior to July 1, 2011)*, must have at least five (5) Eligibility Points when retiring prior to Superannuation Age or at least three (3) Eligibility Points when retiring at or after Superannuation Age.

Employees who entered SERS or an ARS *on or after January 1, 2011* (PSERS on or after July 1, 2011), must have at least ten (10) Eligibility Points when retiring prior to Superannuation Age or at least three (3) Eligibility Points when retiring at or after Superannuation Age.

Retiree Costs

For any Retiree who does not meet the requirements for Contribution Rate Coverage, the Commonwealth will contribute $5.00 per month toward the cost of the coverage and the Retiree is responsible for the remaining cost of the coverage

Decline/Opt Out Requirements

Retirees may decline REHP coverage under the following circumstances:

(1) Retirees who retire on or after June 1, 2007, may Decline REHP coverage. A Retiree must attest that they have other healthcare coverage and complete the applicable enrollment/change forms. The Retiree will be permitted to enroll at a later date. There is no time limit on this later enrollment.

(2) The initial declination of REHP coverage does not count toward the limit on reenrollments in the REHP.

(3) Retirees who Declined REHP coverage prior to June 1, 2007, do not have the option of enrolling at a later date.

Retirees, Dependent(s), and survivor spouses may Opt Out of REHP coverage under the following circumstances:

(1) Retirees, Dependent(s), and survivor spouses who chose to Opt Out must Opt Out of both medical and prescription coverage. Retirees, Dependent(s), and survivor spouses who /are enrolled in PACE/PACENET, TRICARE or VA coverage may only Opt Out of prescription coverage. A Retiree, Dependent(s) or survivor spouse must attest that they have other healthcare coverage and complete the applicable enrollment/change forms. The Retiree, Dependent(s) or survivor spouse has one opportunity to Opt In. There is no time limit on the one-time Opt In.

(2) Retirees and survivor spouses who opted out of REHP coverage prior to June 1, 2007 do not have the option of opting in at a later date.

(3) Once a Retiree or survivor spouse has opted out and then elected to Opt In, the Retiree or survivor spouse may Opt Out again but **cannot** Opt In for a second time, unless either Opt Out is due to, or in conjunction with, the Retiree's or survivor spouse's enrollment for coverage under the PEBTF, RPSPP or SPHBP as an Employee or Dependent(s) or the REHP as a Dependent(s).

(4) Retirees and survivor spouses who choose to Opt Out from REHP coverage are subject to the following requirements:

- **(a)** Dependent(s) may not be enrolled in any coverage under which the Retiree is not enrolled (this does not apply to a survivor spouse who receives single coverage only).

(b) The effective date of the Opt Out is the later of the date on the Retiree Change Form or the end of the month in which the requested Opt Out date occurs if the survivor spouse or Retiree or any Dependent(s) is enrolled in Medicare.

Dual Enrollments

If a Retiree is eligible for enrollment in the REHP and the Retiree's spouse is enrolled in the AEHP, there shall not be a duplication of medical coverage. A Retiree who elects to be enrolled under their spouse's AEHP plan for medical and supplemental must Decline REHP coverage.

A Retiree may be covered as a Dependent(s) under the AEHP until their spouse is no longer covered under the AEHP. When the spouse is no longer covered under the AEHP, the Retiree may enroll in the REHP, either under their own contract or as a Dependent(s) under the spouse's REHP contract.

Married Retirees may enroll as a Retiree or as a Dependent(s) of the spouse, but not as both. Other eligible Dependent(s) may be covered as the Dependent(s) of one of the Retirees, but not both. The Birthday Rule is used to determine primary coverage for Coordination of Benefits but does not apply when determining on which Retiree's contract to enroll Dependent(s) children.

BENEFITS UNDER ALL NON-MEDICARE HEALTH PLAN OPTIONS

See PPO and HMO Option sections for summary information

The REHP offers the following non-Medicare medical plan options: PPO and HMO. You choose the option that best fits your needs. In addition, the REHP offers Mental Health and Substance Use Program benefits, as well as a Prescription Drug Plan. In each case, the REHP has contracted with one or more outside professional Claims Payors to administer benefits under the options.

There are two PPO plans – the Choice PPO and the Basic PPO. Both PPO plans have annual In-Network Deductibles that apply to the following: Hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), imaging, Skilled Nursing Facility care and Home Health Care. Preventive Care and Gene Therapy are covered at 100% and are not subject to the Deductible and Copayments. The Gene Therapy program is administered by Aetna regardless of which medical plan you are enrolled in.

To understand the benefits available to you, you should read this section, which describes information which applies under all non-Medicare health plan options, as well as the description in this handbook of the particular health benefit option that covers you (or Prescription Drug Plan, as the case may be). In addition, you should read the section "Services Excluded from All Benefit Options" for a description of limitations applicable to all options.

As you read this handbook, please keep the following in mind:

- This handbook is a summary only. In the event of a conflict between the REHP Benefits Handbook and the health plan contract, the contract will control.
- The Claims Payor with respect to your health benefit option or Prescription Drug Plan has the authority to interpret and construe the Plan and apply its terms and conditions with respect to your fact situation. In doing so, the Claims Payor may rely on its medical policies which are consistent with the terms of the Plan.
- No benefits are paid unless a service or supply is Medically Necessary (see the "Glossary of Terms"). The Claims Payor is empowered to make this determination, in accordance with its medical polices.
- With respect to certain options, if you use an Out-of-Network Provider, the Claims Payor pays a percentage of the "Usual, Customary and Reasonable" or "UCR" charge. Certain Claims Payors do not determine a UCR charge and instead pay a percentage of the Plan Allowance (see the "Glossary of Terms"). You are responsible for paying the full amount of the charge above the UCR charge or Plan Allowance. The Claims Payor is empowered to determine the UCR charge or Plan Allowance, in accordance with its own procedures and policies consistent with the terms of the Plan.
- The Claims Payor is also empowered to determine any limitation on benefits under the terms of the contract. These determinations may include, among others, whether a service or supply is Experimental or Investigative.

Ambulance Services

Ambulance and Advanced Life Support (ALS) services from the home or the scene of an accident or medical emergency to a hospital are fully covered if Medically Necessary. Ambulance services and EMS care are also covered even when a patient is not transported to the hospital. The Medical Necessity for this benefit is determined by the Claims Payor. Ambulance service between hospitals or from a hospital or Skilled Nursing Facility to your home is covered **if Medically Necessary. Medically necessary ambulance service generally means that the use of other means of transportation could endanger the person's health. Coverage for ambulance service is provided only if you have utilized a vehicle that is specially designed and equipped and used only for transporting the sick and injured.** Benefits for ambulance service are not available if the Claims Payor determines that there was no medical need for ambulance transportation.

Ambulance service is not provided for a vehicle which is not specifically designed and equipped and used for transporting the sick and injured. Ambulance service is not covered for your convenience or the facility and is limited to those emergency and other situations where the use of ambulance service is Medically Necessary. If non-emergency transport can be safely effected by means of a non-ambulance vehicle (e.g., a van equipped to accommodate a wheelchair or litter), ambulance service will not be considered Medically Necessary. Air or sea ambulance transportation benefits are payable only if the Claims Payor determines that the patient's condition, and the distance to the nearest facility able to treat the patient's condition, justify the use of air or sea transport instead of another means of transportation.

Wheelchair van or litter van transportation is not covered.

For PPO option: Failure to precertify Out-of-Network, non-Emergency Services may result in a 20% reduction in benefits payable for non-emergency ambulance services. Also, you will be reimbursed at the Out-of-Network rate for eligible Medically Necessary, non-emergency ambulance transports if you use an Out-of-Network Provider.

Case Management

Case Management is a standardized medical assessment process that focuses on providing you with the appropriate types of health care services in a cost-effective manner when you are experiencing a high cost or specialized episode of care. Typically, this is a catastrophic illness. Your needs are assessed by a case manager, who then coordinates your overall medical needs. This could involve such things as arranging for services to be provided in your home or setting other than the hospital. The review procedures are provided to you at no additional cost.

Centers of Care

Notwithstanding anything in this Plan to the contrary, the REHP may determine that a service, supply or charge that would otherwise be a Covered Expense shall be a Covered Expense only if the service, supply or charge is furnished by a Hospital or other Provider specifically designated by the REHP as a "Center of Care" for such expense. If the REHP makes such a determination, the Plan shall cover the reasonable costs that you incur in connection with such Covered Expense for transportation, food and lodging, subject to such limitations as the REHP may prescribe.

Chiropractic Care/Spinal Manipulations

PPO Option	HMO Option
▪ 12 Medically Necessary visits per year; then a Treatment Plan must be submitted for additional visits ▪ $20 Copayment for In-Network chiropractic care ▪ Out-of-Network care is subject to annual Deductible and is reimbursed at 70% plan payment ▪ You should choose a network chiropractor for the highest level of benefits ▪ Payments are based on Plan Allowance. You may be billed for amounts in excess of the Plan Allowance if visit an Out-of-Network chiropractor	▪ All outpatient therapies have a combined maximum of 60 visits per year – therapies subject to the maximum include chiropractic/spinal manipulation, physical, occupational, speech, pulmonary rehabilitation and respiratory. Cardiac rehabilitation is limited to 72 visits in a rolling three-year period ▪ $5 Copayment for network chiropractic care ▪ Each HMO has its own review procedures. The chiropractic benefit does not cover visits or treatment for the maintenance of a condition. Some of the HMOs may only allow two weeks of treatment for an Acute condition ▪ Benefits are payable only if you use an In-Network chiropractor

Continuity of Care

If you, with respect to a Participating Provider are: (i) undergoing a course of treatment for a serious and complex medical condition; (ii) undergoing a course of institutional or inpatient care; (iii) scheduled to undergo surgery (or post-operative care); (iv) undergoing a course of treatment for an actual pregnancy; or (v) receiving treatment for a terminal illness; at a time when the Participating Provider's participation is terminated or similarly disrupted, as determined by the Claims Payor, you shall be provided notice of the opportunity to elect to continue care with such Provider under a transitional care program. If you make such election, the Plan shall continue to cover such care as if the Provider remained a Participating Provider for a period of 90 days from the date the notice of the transitional care opportunity is provided.

Determination on Limitations to Benefits

Benefits under the various plan options may be limited in a number of ways:

- Coverage is limited to Medically Necessary Covered Services or supplies.
- Coverage is not provided for charges in excess of the UCR (Usual, Customary and Reasonable) charge or the Plan Allowance, as applicable.
- Coverage is not provided for services or supplies that are Experimental or Investigative in nature.
- Certain services and supplies are excluded from coverage or are covered subject to limitations, restrictions or pre-conditions (such as pre-authorization or case management procedures). See, for example, Services Excluded From All Benefit Options.

The REHP authorizes the Claims Payor with respect to each plan option to determine whether a service or supply is Medically Necessary, exceeds the UCR charge/Plan Allowance, is Experimental or Investigative in nature, or is otherwise subject to an exclusion, limitation, or pre-condition. Such decisions may be made pursuant to the Claims Payor's medical policies and procedures, consistent with the terms of the contract. The Commonwealth will generally not overturn on appeal a decision made by the Claims Payor which is made within its authority to do so under the terms of the contract.

Durable Medical Equipment (DME), Prosthetics, Orthotics, Medical Supplies and Diabetic Supplies

DME, prosthetics, orthotics, medical supply and diabetic supply services are provided by the medical plans.

- DME includes equipment such as wheelchairs, oxygen, hospital beds, walkers, crutches and braces, breast pumps and supplies for post-partum individuals, etc.
- Prosthetics and Orthotics (P&O) include artificial limbs, braces (such as leg and back braces), breast prostheses and Medically Necessary shoe inserts for diabetics
- Medical supplies include urological and ostomy supplies
- Diabetic supplies include syringes, needles, lancets, test strips, pumps, and glucometers (you should obtain insulin under the Prescription Drug Plan)
- Medically Necessary cranial prosthetics (wigs) for conditions specified by the Claims Payor are subject to a maximum reimbursement of $1,000 per year. Limited to one per calendar year

For Custom HMO Eligible Members: You must obtain your DME items and supplies from a network supplier. You have no coverage if you go to a supplier that does not participate with your Custom HMO.

For PPO Eligible Members: You have both a Network and an Out-of-Network benefit.

Covered Medically Necessary equipment and supplies obtained from a network supplier, as determined by your medical plan, are paid at 100% of the eligible covered expense.

Covered Medically Necessary equipment and supplies obtained from an Out-of-Network supplier, as determined by your medical plan, are paid at 70% of the UCR allowance up to the Out-of-Pocket Maximum for Out-of-Network services. You may also be responsible for the difference between the actual amount billed by the Out-of-Network supplier and the plan's allowed amount.

NOTE: Equipment or supplies dispensed in a physician's office or emergency room setting, provided as part of Home Health Care, Skilled Nursing Facility care or Hospice services; or as part of covered dialysis and home dialysis will be paid by your PPO at 100% after Deductible if it is billed by the Provider and not by a DME supplier. Your Provider may dispense the equipment and will bill your PPO. For example, if you receive a knee brace or crutches at the emergency room, it is paid at 100% after Deductible. If your doctor writes a prescription for a DME item, you should obtain it from a Network supplier to get the highest level of benefits.

Your medical plan will provide coverage for the rental or purchase of DME and Prosthetics exceeding a rental or purchase price of $100 (or other dollar threshold as may be established by your medical plan in accordance with its DME policy). Preauthorization is required for the rental of any DME item and the purchase of all DME and P&O devices.

Emergency Medical Services

The plan covers emergency medical care as a result of an accident or severe illness as follows:

Emergency Accident Care: Services and supplies for the treatment of traumatic bodily injuries resulting from an accident. The PPO and HMO Copayment is waived if you are admitted as an inpatient.

Emergency Medical Care: Emergency Services shall be covered: (i) without terms or conditions, including any otherwise applicable requirement for prior authorization (but not including exclusions from coverage, Coordination of Benefits, waiting periods, or cost-sharing requirements under the Plan); and (ii) without regard to whether services are rendered by a Network Provider. In accordance with applicable legal requirements, no administrative requirements or limitations shall apply to Emergency Services rendered by a Provider that does not participate in the Network that are more restrictive than the administrative requirements and limitations that apply to Emergency Services rendered by a Provider that does participate in the Network, and the cost-sharing requirement for such Emergency Services shall not be higher than the cost-sharing requirement that would apply if the Emergency Services were rendered by a Network Provider. However, the cost-sharing requirement shall be calculated as if the total amount charged is the Recognized Amount. Amounts paid pursuant to such cost-sharing requirements shall count toward your satisfaction of any Deductible or Out-of-Pocket Maximum applicable to benefits for services provided by a Provider in the Network as if such services were rendered by such a Network Provider.

Coverage for any and all follow-up services (that are not Emergency Services) will be provided only if such services are provided in a doctor's office or, if available and appropriate, through a telehealth visit, and such coverage will otherwise be subject to the terms under the Plan that apply to such (non-emergency) services. Your Copayment is waived if you are admitted as an Inpatient.

Examples of an Emergency Medical Condition include, but are not limited to:

- Broken bone
- Chest pain
- Seizures or convulsions
- Severe or unusual bleeding
- Severe burns
- Suspected poisoning
- Trouble breathing
- Vaginal bleeding during pregnancy

The HMO Emergency Room Copayment is $150, and the PPO Emergency Room Copayment is $200, which is waived if the visit leads to an inpatient admission to the hospital. If you are admitted to the hospital as a result of an emergency, contact your health plan within 48 hours. If you are unable to contact the health plan, a relative or friend may do so for you. The phone number appears on your health plan ID card.

There may be instances where you are placed in a hospital room, but it is considered to be "observation care," which is considered outpatient and not an admittance to the hospital.

Observation services are defined as the use of a bed and periodic monitoring by the hospital's nursing or other ancillary staff, which are reasonable and necessary to evaluate an outpatient's medical condition or determine the need for possible inpatient admission.

Therefore, if you are in observation care from an ER visit, you will be required to pay your $150 ER Copayment (HMO) or $200 ER Copayment (PPO).

All follow-up care should be scheduled in a doctor's office.

Emergency Services. In accordance with applicable legal requirements and subject to the terms and conditions set forth elsewhere in this paragraph Emergency Services shall be covered: (i) without terms or conditions, including any otherwise applicable requirement for prior authorization; and (ii) without regard to whether services are rendered by a Network Provider. In accordance with applicable legal requirements, no administrative requirements or limitations shall apply to Emergency Services rendered by a Provider that does not participate in the Network that are more restrictive than the administrative requirements and limitations that apply to Emergency Services rendered by a Provider that does participate in the Network, and the cost-sharing requirement for such Emergency Services shall not be higher than the cost-sharing requirement that would apply if the Emergency Services were rendered by a Network Provider. However, the cost-sharing requirement shall be calculated as if the total amount charged is the Recognized Amount. Amounts paid pursuant to such cost-sharing requirements shall count toward your satisfaction of any Deductible or Out-of-Pocket Maximum applicable to benefits for services provided by a Provider in the Network as if such services were rendered by such a Network Provider. For purposes of clarity, the foregoing provisions of this paragraph shall apply only with respect to professional Providers in an independent, freestanding emergency department, in the emergency department of a hospital, or, to the extent further medical examination or treatment is needed to stabilize you, in another department of a hospital.

Coverage for all follow-up services (that are not Emergency Services) will be provided only if such services are provided in a doctor's office or, if available and appropriate, through a telehealth visit, and such coverage will otherwise be subject to the terms under the Plan that apply to such (non-emergency) services. Your Copayment is waived if you are admitted as an Inpatient.

Rabies Vaccine After An Exposure: The rabies vaccine, including Rabies Immune Globulin (when Medically Necessary), is covered by the plan after an exposure to an animal bite and not as a preventive immunization. You will be charged the applicable Copayment for each visit to the Provider or facility. Doctors' offices may not stock the rabies vaccine. Therefore, you may return to the Emergency Room for additional vaccine injections. A $150 Copayment (HMO)/$200 Copayment (PPO) will be charged for each return visit to the Emergency Room. If you receive additional vaccine injections at your PCP's office, you will be charged the $20 Copayment under the Choice PPO or Basic PPO and a $5 Copayment under the HMO for the office visit. The vaccine injections are subject to the annual Deductible under the Choice PPO and Basic PPO.

Dental Services Related to Accidental Injury: Emergency hospital services which are required as a result of an accidental injury to the jaw, sound natural teeth, mouth or face. Injury as a result of chewing, biting or teeth grinding is not considered an emergency or accidental injury.

Facility Services

Covered inpatient services at a participating network hospital include the following. PPO option: Services are covered 100% after an annual Deductible. HMO option: Services are covered 100%. See the summary benefit charts in each medical plan section.

- Unlimited days in a semiprivate room, or in a private room if determined to be Medically Necessary by the Claims Payor

- Intensive care
- Coronary care
- Maternity care admissions
- Services of your network physician or specialist
- Anesthesia and the use of operating, recovery, and treatment rooms
- Diagnostic Services
- Drugs and intravenous injections and solutions, including chemotherapy and radiation therapy (**NOTE:** Drugs dispensed to the patient on discharge from a Hospital are not covered under the medical plan – use your Prescription Drug Plan; see the section on Specialty Medications)
- Oxygen and administration of oxygen
- Therapy services
- Administration of blood and blood plasma

The following outpatient services also are covered at a participating network facility. PPO option: Services are covered 100% after an annual Deductible. HMO option: Services are covered 100%. See the summary benefit charts in Section 3:

- Emergency Services – $150 Copayment (HMO)/$200 Copayment (PPO), which is waived if admitted as an inpatient
- Pre-admission testing
- Surgery
- Anesthesia and the use of operating, recovery, and treatment rooms (anesthesia may not be administered by a surgeon or assistant at surgery); however, anesthesia and anesthesia supplies rendered in connection with oral surgery will not be excluded from coverage solely because they are rendered by the oral surgeon or assistant at oral surgery. The medical plans may provide coverage for anesthesia services for dental care rendered to a patient who is seven years of age or younger or developmentally disabled for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia
- Services of your network physician or specialist
- Diagnostic Services
- Drugs, dressing, splints, and casts
- Chemotherapy, radiation, and dialysis services, physical, respiratory, occupational, speech, cardiac and pulmonary rehabilitation therapies, including spinal manipulation therapies (see charts for the annual maximums); subject to Copayments; Gene Therapy (no Deductible or Copayment)

Medically necessary services also are covered Out-of-Network (PPO option) but they are subject to an annual Deductible and Coinsurance. Also, any changes in excess of the Plan Allowance as determined by the Claims Payor are non-eligible expenses and are entirely your responsibility.

Home Health Care

PPO Option	HMO Option
▪ Covered 100% In-Network after annual Deductible ▪ No day limit for In-Network care. You must precertify for both In-Network and Out-of-Network Home Health Care services. ▪ **Out-of-Network**: 70% plan payment after Deductible. Out-of-Network Providers may balance bill for the difference between Plan Allowance and actual charge. ▪ Failure to precertify Out-of-Network services may result in a reduction in benefits payable for Home Health Care services in accordance with the preauthorization policies of the PPO.	▪ Covered 100% In-Network ▪ You may receive 60 Medically Necessary visits in a 90-day period. The benefit is renewed when 90 days without Home Health Care have elapsed. Benefits may be renewed at the option of the HMO. Benefits also are provided for certain other medical services and supplies when provided along with a primary service

Benefit Limits Under all Plan Options:

Medically necessary Home Health Care benefits will be provided for the following services when provided and billed by a licensed Home Health Care agency:

- Professional services of appropriately licensed and certified individuals
- Physical, occupational, speech and respiratory therapy
- Medical or surgical supplies and equipment
- Certain prescription drugs and medications
- Oxygen and its administration
- Dietitian services
- Hemodialysis
- Laboratory services
- Medical social services consulting
- Antibiotic intravenous drug treatment
- Durable Medical Equipment (DME)
- Well mother/well baby care following release from an inpatient maternity stay (the mother does not have to be essentially homebound)

You must be essentially homebound. Benefits are also provided for certain other medical services and supplies when provided along with a written Treatment Plan to the Claims Payor. The Claims Payor will review from time to time the Treatment Plan and the continued Medical Necessity of Home Health Care visits.

The Claims Payor requires preauthorization for payment for Home Health Care services.

Benefits are only provided for Medically Necessary Home Health Care Covered Services that relate to the improvement of a medical condition. Custodial services and services with respect to the maintenance of a condition are not covered.

You **do not** have to be essentially homebound for Medically Necessary infused medicine therapy billed by a medical supplier, Home Health Care agency or infusion company.

No Home Health Care benefits will be provided for homemaker services, maintenance therapy, food or home delivered meals and home health aide services.

A patient who needs skilled nursing services for more than 8 hours in a 24-hour period would normally be admitted to or remain in a Skilled Nursing Facility or hospital. Custodial care, such as assistance with bathing or eating, and intermediate care is not covered.

Hospice Care

Hospice care offers a coordinated program of home care, inpatient hospice facility and inpatient Respite Care for a terminally ill Eligible Member and your family. The program provides supportive care to meet the special physical, psychological, spiritual, social, and economic stresses often experienced during the final stages of an illness. The plan pays 100% of Covered Services. You may contact your health plan for a list of participating hospices. This benefit is not renewable.

PPO option Eligible Members: You may use an Out-of-Network hospice, but you will be responsible for the Deductible, Coinsurance, and any charges in excess of the Plan Allowance as determined by the Claims Payor.

Covered Palliative and Supportive Services

- Professional services of an RN or LPN
- Physician fees (if affiliated with the hospice)
- Therapy services (except for Gene Therapy and dialysis treatment)
- Medical and surgical supplies and Durable Medical Equipment (DME)
- Prescription drugs and medications
- Oxygen and its administration
- Medical social services counseling
- Dietitian services
- Home health aide services
- Family counseling services

Special Exclusions and Limitations

The hospice care program must deliver hospice care in accordance with a Treatment Plan approved by and periodically reviewed by the health plan.

No hospice benefits will be provided for:

- Medical care rendered by your physician
- Volunteers, including family and friends who do not regularly charge for services
- Pastoral services
- Homemaker services
- Food or home delivered meals
- Hospice inpatient care in a facility that exceeds a total of 12 months

Respite Care is limited to a maximum of ten days of facility care or 240 hours of in-home care throughout the treatment period.

If you or your responsible party elects to institute Curative Treatment or extraordinary measures to sustain life, you will not be eligible to receive further hospice care benefits.

Human Organ and Tissue Transplant

If a human organ or tissue transplant is provided from a living donor to a human transplant recipient, the facility and professional Provider services described previously are covered, subject to the following:

- When both the recipient and the donor are Eligible Members, each is entitled to the benefits of the plan.
- When only the recipient is an Eligible Member, both the donor and the recipient are entitled to the benefits of this plan provided the treatment is directly related to the organ donation. The non-Eligible Member donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance or health plan coverage, or any government program. Benefits provided to the non-Eligible Member donor will be charged against the recipient's coverage under this plan.
- When only the donor is an Eligible Member, the donor is entitled to the benefits of this plan. The benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance or health plan coverage, or any government program available to the recipient. No benefits will be provided to the non-Eligible Member transplant recipient.
- If any organ or tissue is sold rather than donated to the Eligible Member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered as authorized by the Claims Payor.
- Coverage under this plan for the non-Member donor will not continue indefinitely. Coverage is limited to the transplant and any immediate follow-up care.
- The reasonable cost of transportation and lodging for a Member who is receiving a transplant, one companion, and the donor shall be a Covered Expense if the Member receives those transplant services at the Center of Excellence, as designated by the Claims Payor, and such Center of Excellence is more than 100 miles from the Member's residence, subject to the following limits: (1) the maximum amount reimbursable for the combined transportation and lodging expenses of the Member, companion, and donor is $10,000 per type of procedure as determined by the Claims Payor; and (ii) lodging expenses are limited to $50 per night per person and $100 per night for all persons.

PPO option: Services are covered 100% after the annual Deductible. HMO option: Services are covered 100%.

Mastectomy and Breast Reconstruction

Mastectomies are covered if Medically Necessary, including post-surgery inpatient care for the length of stay that the treating physician determines is necessary to meet generally accepted criteria for safe discharge, and cannot be performed on an outpatient basis. PPO option: Services are covered 100% after an annual Deductible. HMO option: Services are covered 100%. The REHP will provide coverage for one Medically Necessary Home Health Care visit within 48 hours after discharge, when the discharge occurs within 48 hours following admission for the mastectomy. Coverage for reconstructive surgery, including surgery to re-establish symmetry between the breasts after the mastectomy, is provided. Prosthetic devices related to mastectomies are covered under the plan. The REHP also covers physical complications at all stages of the mastectomy, including lymphedemas.

Maternity Services

Childbirth services including pre-and post-natal care, are covered. PPO Option: Hospital and newborn care are covered 100% after an annual Deductible. HMO option: Services are covered 100%. Maternity services must be coordinated by a network OB/GYN or your PCP (HMO option). The network OB/GYN will obtain proper authorization from the Claims Payor. The approval will cover maternity services. Federal law allows mothers and infants to remain in the hospital for 48 hours after a normal delivery or 96 hours after a cesarean.

The plan also covers complications of pregnancy and medical costs due to miscarriage.

Abortion services are only covered in the following cases:

- The abortion is necessary to preserve the life or health of the Eligible Member, as certified by the Eligible Member's treating physician; or
- The abortion is performed in the case of pregnancy caused by rape reported within 72 hours to a law enforcement agent, or by incest which is reported to a law enforcement agent within 72 hours from the date when the Member first learns they are pregnant.

Where the certifying physician will perform the abortion or has a pecuniary or proprietary interest in the abortion there shall be a separate certification from a physician who has no such interest.

Elective abortions are not covered by the plan. Facility services rendered to treat illness or injury resulting from an elective abortion are covered if approved by the claims payor.

Mental Health and Substance Use Rehabilitation Services (Outpatient)

Mental health and substance use treatment and services are not covered by your medical plan except as described below. Please see the section on the Mental Health and Substance Use Program. Medical providers may treat mental health conditions within the scope of their license. Nothing in this section shall limit coverage for a non-mental health and substance use professional's administration of a specialty drug that is prescribed to prevent a Member from relapsing into addiction to a controlled substance and that the FDA requires to be administered under the oversight of a doctor of medicine (M.D).

Mental health and substance use services are covered by a separate plan. See that section of this Handbook for more information.

Medical Detoxification Treatment for Substance Use: The medical plan covers detoxification services as an inpatient or outpatient whichever is determined to be Medically Necessary by your plan. The Mental Health & Substance Use Program covers ambulatory detoxification In-Network only.

Special Medical/Behavioral Health Care Benefits: Both your medical plan and the Mental Health and Substance Use Program provide outpatient benefits for the diagnosis and medical management of the following conditions: Attention Deficit Disorder (ADD), Attention Deficit/Hyperactive Disorder (ADHD), Anorexia, Bulimia and Tourette's Syndrome.

Under the medical plan, physicians may diagnose any of these conditions, and prescribe and monitor medications. No counseling benefits are available under the medical plan. For more information, see the section on Mental Health and Substance Use Program.

Coverage for Autism Spectrum Disorders: Benefits for autism spectrum disorders will be provided by the REHP medical plans, the Mental Health and Substance Use Program and the REHP Prescription Drug Plan. There is no annual maximum benefit.

Coverage is provided for Members who have a diagnosis of autism spectrum disorder. The coverage is in accordance with Pennsylvania's Autism Insurance Act (Act 62 of 2008 – HR 1150). Autism spectrum disorders include: Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Development Disorder (Not Otherwise Specified).

Subject to the Deductibles, Copayments, and Coinsurance applicable under your medical plan option, coverage is provided for behavioral therapy, including intensive behavioral therapy such as applied behavioral analysis (ABA), provided that the therapy is:

- Focused on the treatment of core deficits of the Eligible Member's autism spectrum disorder and maladaptive/stereotypic behaviors that are posing a danger to the Eligible Member themself, to others, or to property or that impair the Eligible Member's daily functioning.

- Provided by a Board Certified Applied Behavioral Analyst or other qualified Provider, acting in accordance with an appropriate Treatment Plan prescribed by the Eligible Member's physician.

Prior authorization is required for ABA and other forms of intensive behavioral therapy. To comply with Federal rules about mental health parity, ABA services are now considered "outpatient, other" services (rather than office visits). You will not pay a copayment as copayments do not apply to "outpatient, other" services but these services are subject to your annual Deductible under the PPO plan. ABA services are covered at 100% for HMO members and for PPO members, after your deductible is met.

Medical treatment of the autism spectrum disorder, apart from this behavioral treatment, shall be covered in accordance with the terms of your medical plan option.

Other Covered Medical Services

Your health plan also covers the following services when ordered by a network physician and authorized by your health plan. Services where you do not pay a Copayment are subject to an annual Deductible under the PPO option.

- Sterilization – PPO and HMO Eligible Members no Copayment for the surgery
- Bariatric surgery (subject to restrictions – see Section 7 and the Claims Payor's medical policy)
- Sex reassignment surgery (subject to the Claims Payor's medical policy)
- Dental Services – Removal of fully and partially bony-impacted teeth is covered – PPO Eligible Members have a $45 specialist Copayment and HMO Eligible Members have a $10 specialist Copayment and must use a health plan network dentist or oral surgeon
- Podiatric care for treatment of disease or injury – PPO Eligible Members have a $45 specialist Copayment and HMO Eligible Members have a $10 specialist Copayment
- Diabetic education and diabetic foot care. Routine diabetic foot care with a diagnosis of diabetes (including individuals with gestational diabetes). Coverage is provided up to one time per calendar year for gestational diabetes and four times per calendar year for diabetic foot care. Diabetic supplies covered under the DME carve-out for Retirees – see the Durable Medical Equipment section).
- Durable Medical Equipment (rental or purchase) if not obtained from a DME supplier – see the Durable Medical Equipment section
- Coverage for approved clinical trials – coverage for routine patient costs associated with items and services furnished as part of a clinical trial are covered under your plan. These

include physician charges, labs, X-rays, professional fees and other routine medical costs. The coverage does not apply for the actual device, equipment or drug that is typically given to the patients free of charge by the company sponsoring the clinical trial.

Preventive Care Services

Covered Preventive Care services are provided at no cost to you.

The Patient Protection and Affordable Care Act requires plans to cover In-Network Preventive Care services according to guidelines established by various sources. The REHP provides coverage for the following preventive services under all of its medical plans at 100% for In-Network Preventive Care.

Preventive Care: As of the Preventive Care effective date, the full cost of an item or service that is Preventive Care and that is provided In-Network shall be covered without any cost-sharing by you. The Preventive Care effective date shall be the first day of the Plan year that follows the date on which the item or service becomes Preventive Care by at least one year or such earlier date required by law. If the Preventive Care item or service is not available In-Network, the full cost of the item or service shall be covered without any cost-sharing Out-of-Network. With regard to contraception, if your attending physician prescribes a particular Preventive Care contraceptive based on Medical Necessity, the full cost of that contraceptive will be covered provided that the contraceptive has been approved by the Food and Drug Administration for the applicable situation. Except as expressly provided in this Section or as otherwise required by law, medical management that is otherwise applicable with regard to a Preventive Care item or service under the Plan shall apply to such item and service.

On the following pages, you will see three charts that outline the Preventive Care services. Present your medical ID card at your network physician's office and you will not have to pay a copay for Preventive Care services.

Preventive Care follows:

USPSTF: Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). https://www.uspreventiveservicestaskforce.org/uspstf/

ACIP (CDC): Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For more information, visit: https://www.cdc.gov/vaccines/schedules/index.html

HRSA: With respect to infants, children and adolescents, evidence-informed Preventive Care and screenings provided for in comprehensive guidelines support by the Health Resources and Services Administration (HRSA) https://www.hrsa.gov/

HRSA: With respect to women, to the extent not described above, evidence informed Preventive Care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the HRSA. https://www.hrsa.gov/

PA State Board of Pharmacy: Immunizations provided in accordance with treatment guidelines of the Pennsylvania State Board of Pharmacy, including guidelines of competent authorities that are so recognized by the Pennsylvania State Board of Pharmacy pursuant to 49 Pa. Code 403(e).

Apart from PSA testing for prostate cancer, items and services that constitute preventive care may be found at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

The REHP will follow the broadest coverage recommendations based on the identified governing bodies.

In accordance with applicable law, coverage for certain services will be determined by an individual's anatomy and not by that individual's gender identity.

The below preventive care items are not all inclusive; the PEBTF follows the guidelines as set forth above. These guidelines are subject to change.

Preventive Care Services	Frequency/Comments
Adults	
Abdominal aortic aneurysm screening	One time screening for men ages 65 to 75 years who have ever smoked
Adult routine physical exams and Preventive Care (age 19 and over)	One per calendar year
Alcohol screening and counseling (unhealthy alcohol use)	One per calendar year; screening in accordance with the USPSTF guidelines; any future treatment must be obtained under the mental health and substance use benefit
Blood pressure screening /screening for hypertension(includes pregnant and postpartum persons)	Screening in accordance with the USPSTF guidelines
Anxiety disorder screening	Adults 64 years or younger, including pregnant and postpartum persons
Cholesterol screening	One per calendar year
Colorectal cancer screening – for adults 45 years and older	Fecal occult blood testing or fecal immunochemical test (FIT) – annually Cologuard – every 3 years CT colonography – every 5 years Sigmoidoscopy – every 5 years Screening colonoscopy – every 10 years, regardless of whether an abnormality for such test is seen or suspected, subject to the same timeframe listed above
Depression and suicide risk screening (includes pregnant and postpartum persons)	One per calendar year; in accordance with USPSTF guidelines; any future treatment must be obtained under the mental health and substance use benefit
Diabetes screening (prediabetes and Type 2)	One per calendar year; screening in accordance with the USPSTF guidelines
Falls prevention in community-dwelling older adults	Exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk of falls
Healthy Diet Counseling and Physical Activity for Cardiovascular Disease Prevention – for adults with known risk factors for cardiovascular disease, in accordance with USPSTF guidelines	Covered according to your plan's medical policy
Hepatitis B virus (HBV) infection screening	In adults at high risk of infection
Hepatitis C virus (HCV) infection screening	In adults ages 18-79 years; screening in accordance with the USPSTF guidelines

Preventive Care Services	Frequency/Comments
Immunizations • COVID-19 • Haemophilus influenza type b (Hib) • Hepatitis A • Hepatitis B • Human Papillomavirus (HPV) – through age 45 • Influenza (flu) • Measles, Mumps, Rubella (MMR) • Meningococcal • Mpox (for those at risk for Mpox infection) • Pneumococcal • Polio • Respiratory Syncytial Virus (RSV) – age 50 and older • Tetanus, diphtheria, pertussis (Td/Tdap) • Varicella (chickenpox) • Zoster (shingles) - Shingrix – age 50 and older • Immunizations that combine two or more component immunizations to the extent the component immunizations are covered under the Plan	Doses, recommended ages and recommended populations vary. All recommended routine immunizations are covered at no cost to the Member. Vaccines are recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP)
Intimate partner violence and caregiver abuse of older or vulnerable adults: Screening persons of reproductive age, including pregnant and postpartum persons	Included in physical exam; screening in accordance with the USPSTF guidelines
Latent tuberculosis infection (LTBI) screening in asymptomatic adults at increased risk (age 18 and older)	One per calendar year; screening in accordance with the USPSTF guidelines
Lung cancer screening	Annual screening with low-dose computed tomography (LDCT) in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years
Medical nutritional counseling	Covered according to your plan's medical policy when provided and billed by a professional licensed nutritionist or dietitian
Prostate Specific Antigen (PSA) testing for prostate cancer screening	Between ages 50 and 70 years; every other year
Sexually transmitted infections (STIs) screening and prevention counseling	Counseling is one per calendar year; screenings are in accordance with USPSTF guidelines
Skin cancer prevention: behavioral counseling	Counseling about minimizing exposure to ultraviolet (UV) radiation for persons to age 24 years with fair skin types to reduce their risk of cancer
Syphilis infection in nonpregnant adults	Screening in accordance with the USPSTF guidelines for adults who are at increased risk of syphilis infection
Tobacco smoking cessation in adults (including pregnant persons)	Screening in accordance with the USPSTF guidelines; prescription tobacco cessation products are covered under the Prescription Drug Plan

Preventive Care Services	Frequency/Comments
Unhealthy drug use: Screening adults age 18 years or older (including pregnant persons)	Screening in accordance with the USPSTF guidelines; any future treatment must be obtained under the mental health and substance use benefit
Weight loss to prevent obesity-related morbidity and mortality in adults: Behavioral Interventions	Clinicians should offer or refer adults with a body mass index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions
Adults	
Well visits	Annual, though 2 OB/GYN and 2 physical exams may be needed to obtain all necessary recommended preventive services, depending on an individual's health status, health needs and other risk factors
Breast cancer chemoprevention counseling	For members at higher risk; includes chemoprevention medications under the Prescription Drug Plan
Breast cancer genetic test counseling (BRCA)	For members at higher risk
Breast cancer mammography screenings	One per calendar year for members age 40 and older (includes coverage for 3-D mammograms); includes MRI or ultrasound for purpose of detecting, locating or otherwise observing breast cancer, regardless of whether an abnormality for such test is seen or suspected but for all such procedures, including biopsy and related pathology to complete the screening process, subject to the same timeframe listed above
Breast cancer screenings for at-risk members	See the section on page 53
Cervical cancer screenings	Cytology (pap smear) one per calendar year
Contraception methods counseling All Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures and patient education and counseling for all individuals with reproductive capacity.	Counseling is included in physical exam Prescription drugs and OTC products (sponges, spermicides) are covered under the Prescription Drug Plan. OTC contraceptives are covered with or without a prescription
Osteoporosis screening – bone mineral density screening	Age 65 years and older and postmenopausal women younger than 65 years who are at increased risk for an osteoporotic fracture as estimated by clinical risk assessment
STIs counseling and screening	Counseling is two per calendar year; screenings are in accordance with USPSTF guidelines
Pregnant Members	
Prenatal care	First visit to determine pregnancy
Anemia screening	Screening in accordance with the USPSTF guidelines
Blood pressure screening	

Preventive Care Services	Frequency/Comments
Breastfeeding support, supplies and counseling by a trained Provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment. Certain breast pumps and supplies are covered for post-partum individuals	You must obtain the breast pumps under the Durable Medical Equipment benefit provided by your medical preplan
Gestational diabetes screening	Screening in accordance with the USPSTF guidelines
Healthy weight and weight gain in pregnancy: Behavioral counseling interventions	Screening guidelines in accordance with the USPSTF guidelines
Hepatitis B (HBV) screening	Screening in accordance with the USPSTF guidelines
HIV screening	Screening in accordance with the USPSTF guidelines
Preeclampsia screening	Screened throughout pregnancy with blood pressure checks at each prenatal visit
Rh(D) Incompatibility screening	Screening in accordance with the USPSTF guidelines
Respiratory Syncytial Virus (RSV) immunization	At 32 weeks to 36 weeks and 6 days gestation
Screening for diabetes after pregnancy	Screenings are in accordance with HRSA guidelines
Syphilis infection during pregnancy	Screening in accordance with the USPSTF guidelines
Urinary tract or other infection screening (asymptomatic bacteriuria)	At 12 to 16 weeks gestation or at first prenatal visit, if later
Children	
Well child visits	Unlimited for children under age 3; one per calendar year for ages 3 to 18 years
Alcohol screening and counseling (unhealthy alcohol use)	Screening in accordance with the USPSTF guidelines; any future treatment must be obtained under the mental health and substance use benefit
Anxiety screening	Screening for anxiety in children and adolescents aged 8 to 18 years
Autism spectrum disorder screening in early childhood	Screenings are in accordance with HRSA guidelines (Bright Futures)
Blood pressure screening	Included in well child visits
Cervical cancer screening	For sexually active individuals
Cholesterol screening	One per calendar year for children ages 2 through 18
Congenital heart defect in infants	Screenings are in accordance with HRSA guidelines (Bright Futures)
Depression and suicide risk screening	Recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years; one per calendar year; any future treatment must be obtained under the mental health and substance use benefit
Developmental/Behavioral screening	One per calendar year
Glucose screening	One per calendar year for children ages 2 through 18
Hearing screening	Screening in accordance with the USPSTF guidelines
Height, weight and body mass index measurements	Included in well child visits

Preventive Care Services	Frequency/Comments
Hematocrit or hemoglobin screening	One per calendar year
Hepatitis B virus (HBV) infection screening	In adolescents at high risk of infection
HIV screening	Adolescents aged 15 and older; screening in accordance with the USPSTF guidelines
High Body Mass Index (BMI)/Obesity in Children and Adolescents	For children and adolescents 6 years or older; screening in accordance with USPSTF guidelines
Immunizations • COVID-19 • Dengue (Dengvaxia) • Diphtheria/Tetanus/Pertussis (DTaP), Tetanus/Diphtheria/Pertussis (Tdap) or Tetanus/Diphtheria (Td) • Haemophilus influenza type b (Hib) • Hepatitis A • Hepatitis B • Human Papillomavirus (HPV) – ages 9 to 21 • Influenza (Members age 18 and older may also receive the vaccine under the Prescription Drug Plan – see the Prescription Drug Plan section for more information • Measles/Mumps/Rubella (MMR) • Meningococcal (MCV4) • Pneumococcal (PCV) • Polio (IVP) • Respiratory Syncytial Virus (RSV) • Rotavirus • Varicella (Chickenpox) • Immunizations that combine two or more component immunizations to the extent the component immunizations are covered under the Plan	Pediatric immunizations are covered for Members and Dependents up to age 21 at no cost Vaccines are recommended by the Centers for Disease Control and Prevention (CDC)
Lead screening	Two per calendar year
Medical nutritional counseling	Covered according to your plan's medical policy when provided and billed by a professional licensed nutritionist or dietitian
Medical history	Included in well child visits
Newborn blood and bilirubin	Screenings are in accordance with HRSA guidelines (Bright Futures)
Ocular prophylaxis for gonococcal ophthalmia neonatorum	Prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum
Oral fluoride varnish	Screening in accordance with the USPSTF guidelines
Sexually transmitted infections (STIs) prevention counseling and screening	One per calendar year; screenings are in accordance with USPSTF guidelines
Skin cancer prevention: behavioral counseling	Counseling young adults, adolescents, children and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months and older with fair skin types to reduce their risk of cancer
Syphilis infection in nonpregnant adolescents	Screening in accordance with the USPSTF guidelines for adolescents who are at increased risk of syphilis infection

Preventive Care Services	Frequency/Comments
Tobacco use in children and adolescents: Primary care interventions in school-aged children and adolescents who have not started to use tobacco	Screening in accordance with the USPSTF guidelines
Tuberculin test	
Vision screening in children aged 3 to 5 years	Screening in accordance with the USPSTF guidelines

NOTE: The above preventive care items are not all inclusive; the PEBTF follows the guidelines as set forth above. These guidelines are subject to change.

Preventive Care Covered Medications – No Copayment

The following medications are covered at no cost under your Prescription Drug Plan with a prescription from your doctor.

- Aspirin to help prevent illness and death from preeclampsia in individuals age 12 and older after 12 weeks of pregnancy who are at high risk for the condition
- Bowel preparation medications for screening colorectal cancer for adults age 45 through 74
- Contraceptives including emergency contraceptives and over-the-counter contraceptive products (condoms, sponges, spermicides, oral contraceptives), with or without a prescription
- Diabetes prevention medicine – Metformin 850 mg – for preventing or delaying diabetes for adults age 35 to 70 who have overweight or obesity
- Folic acid daily supplement for individuals age 55 or younger who are planning to become pregnant or are able to become pregnant
- Medications for risk reduction of primary breast cancer in individuals age 35 and older who are at risk
- Oral fluoride for preschool children older than six months to five years of age without fluoride in their water
- Tobacco cessation and nicotine replacement products – prescription drug coverage is for the generic form of Zyban or Chantix and nicotine replacement products (limited to a Maximum of 168-day supply)
- Statins to help prevent serious heart and blood vessel problems (cardiovascular disease) in adults age 40 – 75 who are at risk. This covers generic low to moderate intensity statins only.
- Antiretroviral therapy for pre-exposure prevention of Human Immunodeficiency Virus (HIV) infection in people who are at an increased risk
- Vaccines and immunizations to prevent certain illnesses in infants, children and adults

Remember that a prescription is required for you to obtain reimbursement for any of these preventive prescription drugs, even those that are available over the counter.

NOTE: The list of covered preventive drugs is subject to change.

Preventive Breast Cancer Screenings – For Qualifying At-Risk Members

Additional Testing: In addition to your annual preventive mammogram, the plan covers a medically necessary and clinically appropriate examination of the breast using either standard or abbreviated magnetic resonance imaging (MRI) or, where such imaging is not possible, ultrasound. The additional testing is covered at no cost to you. The examination must be recommended by your treating physician to screen for breast cancer when there is no abnormality seen or suspected in the breast, but for all procedures, including biopsy and

related pathology to complete the screening process. Coverage is limited to one examination each plan year.

Genetic Testing: Genetic counseling and genetic testing provided by an individual who is appropriately licensed, certified, or otherwise regulated for such counseling or testing and is covered at no cost to you. For purposes of this definition, the genetic testing must follow genetic counseling and is limited to a genetic laboratory test of the BRCA1 and BRCA2 genes for individuals assessed, based on a clinical risk assessment tool recognized by the applicable medical community, to be at increased risk of potentially harmful mutations in the BRCA1 or BRCA2 genes due to a personal or family history of breast or ovarian cancer.

A Qualifying At-Risk Member, based on the opinion of your treating physician, is at increased risk for breast cancer because of:

- Personal history of atypical breast histologies
- Personal history or family history of breast cancer
- Genetic predisposition for breast cancer
- Prior therapeutic thoracic radiation therapy
- Heterogeneously dense breast tissue based on breast composition categories with any one of the following risk factors:
  - Lifetime risk of breast cancer of greater than 20% according to risk assessment tools based on family history
  - Personal history of BRCA1 or BRCA2 gene mutations
  - Not having had genetic testing, but a first-degree relative with a BRCA1 or BRCA 2 gene mutation
  - Prior therapeutic thoracic radiation therapy between 10 and 30 years of age; or
  - Personal history of Li-Fraumeni syndrome, Cowden syndrome, or Bannyan-Riley-Ruvalcaba syndrome or
  - Extremely dense breast tissue based on breast composition

Private Duty Nursing

Outpatient private duty nursing services are covered under the PPO option only under limited conditions when ordered by a physician and deemed Medically Necessary for the improvement of a medical condition. Private duty nursing is not covered under the HMO plan. Private duty nursing is covered 100% after the annual Deductible for the PPO. Private duty nursing that is primarily for the maintenance of a condition or for the convenience of a family member is not covered. You may receive up to 240 hours a year of Medically Necessary, private duty nursing care as defined by the plan that can only be provided by a Registered Nurse or Licensed Practical Nurse (Respite Care and services provided by Home Health Aides are not covered). In no event will benefits be paid for private duty nursing in excess of eight hours in a day (or other 24-hour period as administered by the Claims Payor in accordance with its medical policies).

A facility's daily charge includes payment for nursing services provided by its staff. Services provided by a nurse who ordinarily resides in your home or is a member of your immediate family are not covered. Private duty nursing will be case managed.

Provider Services

Medically necessary Covered Services in a doctor's office include:

- Diagnosis and treatment of injury or illness (includes Diagnostic Services)
- Periodic health evaluation and routine check-up
- Immunizations (see Preventive Benefits section)
- Allergy diagnosis and treatment (including allergy serum)
- Gynecological care and services
- Maternity/obstetrical care (HMO and PPO – no charge for all visits)
- Family planning consultation
- Diagnosis and treatment for mental health or substance use treatment
- Emergency Services in your physician's office
- Routine diabetic foot care with a diagnosis of diabetes (including individuals with gestational diabetes). Coverage is provided up to one time per calendar year for gestational diabetes and up to four times per calendar year for diabetic foot care
- Medically necessary nutritional counseling (subject to your plan's medical policy), including diabetic educational training when provided and billed by a professional licensed nutritionist or dietitian
- Enteral formula when administered under the direction of a physician. Oral administration is limited to the treatment of the following metabolic disorders: phenylketonuria, branched chain ketonuria, galactosemia and homocystinuria
- Replacement of cataract lenses for adults and Dependent(s) children following surgery is covered only when new cataract lenses are needed because of a prescription change and you have not previously received lenses within the 24-month period of the current prescription change
- Acupuncture when used to treat pain and nausea. Must meet the Claims Payor's Medical Policy for coverage

PPO option: Services are covered 100% after applicable Copayment or annual Deductible.
HMO option: Services are covered 100% after applicable Copayment.

Skilled Nursing Facility (SNF)

PPO Option	HMO Option
▪ Covered 100% In-Network after annual Deductible ▪ You may receive 240 days at a participating facility. You must precertify for both In-Network and Out-of-Network services. Failure to precertify may result in a reduction of benefits ▪ Benefit renews 12 consecutive months from the first date of admission to a SNF	▪ Covered 100% In-Network ▪ You may receive 180 days per year at a participating facility. ▪ Benefit renews 12 consecutive months from the first date of admission to a SNF

▪ Out-of-Network: 70% plan payment after Deductible, up to 240 days. Out-of-network Providers may balance bill for the difference between Plan Allowance and actual charge	

Benefits are provided for Skilled Nursing Facility (SNF) care, when Medically Necessary, if:
- The physician must certify that you need skilled care and the Claims Payor agrees that skilled services were Medically Necessary on a daily basis
- You must require and receive skilled nursing or skilled rehabilitation services, or both, on a daily basis. Skilled nursing and skilled rehabilitation services are those that require the skills of technical or professional personnel such as registered nurses, physical therapists and occupational therapists. In order to be deemed skilled, the services must be so inherently complex that they can be safely and effectively performed only by, or under the supervision of, professional or technical personnel

Examples of Skilled Nursing or Skilled Rehabilitation Services include:
- Development, management, and evaluation of a patient's care plan
- Observation and assessment of the patient's changing condition
- Enteral feedings that comprise at least 26 percent of daily caloric requirements and provide at least 501 milliliters per day
- Nasopharyngeal and tracheostomy aspiration (suctioning)
- Insertion and sterile irrigation and replacement of suprapubic catheters
- Applications of dressings involving prescription medications and aseptic (sterile) technique
- Treatment of extensive decubitus/pressure ulcers or other widespread skin disorder
- Ongoing assessment of rehabilitation needs and potential
- Therapeutic exercises
- Gait evaluation and training
- Patient education services to teach a patient self-maintenance
- Initial phases of regimen involving administration of medical gases, such as oxygen
- Intravenous or intramuscular injection and intravenous feedings

Examples of Non-Skilled Services, which are considered Personal Care, Intermediate or Custodial Care, are not covered by the Plan:
- Administration of routine oral medications, eye drops and ointments
- General maintenance care of colostomy or ileostomy
- Routine services to maintain satisfactory functioning of indwelling bladder catheters
- Changes of dressings for non-infected postoperative or Chronic conditions
- Prophylactic or Palliative skin care, including bathing and application of creams, or treatment of minor skin problems
- Routine care of the incontinent patient. The mere presence of a urethral catheter does not justify a need for skilled care
- Rehabilitation services provided less than five days per week
- General maintenance care in connection with plaster casts, braces, or similar devices
- Use of heat as Palliative or comfort measure
- Routine administration of medical gases, such as oxygen, after a regimen of therapy has been established
- Assistance with activities of daily living, including help in walking, getting in and out of bed, bathing, dressing, eating, and taking medications
- Periodic turning and positioning in bed
- General supervision of exercises which have been taught to the patient, including the actual carrying out of a maintenance program

No benefits are paid in the following instances:

- After you have reached the Maximum level of recovery possible for your particular condition, and you no longer require definitive treatment other than routine supportive care
- When confinement in a SNF is intended solely to assist you with the activities of daily living or to provide an institutional environment for convenience
- Other than incidentally for treatment of alcoholism, drug addiction or mental illness
- For intermediate care or custodial care

The Claims Payor may periodically, at its own initiative or at the request of the PEBTF, re-evaluate the Medical Necessity (or other criteria for eligibility) of a SNF stay.

Wellness Benefit

The managed care plans offer a variety of wellness programs designed to assist you in attaining a healthy lifestyle. Wellness benefits may include health club membership discount programs, health education, smoking cessation, and weight loss programs. Benefits vary among plans. Please contact your health plan for specific wellness benefits.

For additional information please see the various medical plan sections.

PREFERRED PROVIDER ORGANIZATION (PPO) OPTION

Non-Medicare Eligible Members

Summary

There are two PPO plans available – the Choice PPO and the Basic PPO. Each plan covers the same medically-necessary services as set forth by the REHP. The difference is in the annual Deductible.

- Deductibles differ between Choice PPO and the Basic PPO
- PPO offers both an In-Network and an Out-of-Network benefit
- In order to receive the highest level of benefits, you must choose one of the In-Network physicians or facilities
- You may self-refer for Medically Necessary care, as defined by the plan
- $20 Copayment for PCP office visits (for general practitioners, family practitioners, internists and pediatricians)
- $20 Copayment for telehealth visit (through Teladoc™)
- $45 Copayment for specialist office visit
- $50 Copayment for urgent care visit
- $200 Copayment for Emergency Room visit (waived if the visit leads to an inpatient admission to the hospital)
- Plan coverage for services rendered by Out-of-Network Providers is based on the Usual, Customary and Reasonable (UCR) charge or Plan Allowance, as determined by the Claims Payor. Payment of amounts in excess of the UCR charge or Plan Allowance are your responsibility
- The PPO must authorize any non-emergency inpatient hospitalizations. Penalties may be applied if you do not obtain prior authorization from your health plan.
- If you elect to receive treatment from a network Provider, you must present the ID card to obtain services.
- If you elect to receive treatment from an Out-of-Network Provider, you may be asked to present your ID card to obtain services or you may need to provide a copy of your ID card when you submit the claim form requesting reimbursement. Check with your plan on how to submit Out-of-Network claims.

Benefit Highlights - Choice PPO Option

	Network Providers	Out-of-Network Providers *
DEDUCTIBLE (per calendar year) Annual In-Network Deductible must be paid first for the following services (other than Preventive Care and Gene Therapy): Hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), imaging, Skilled Nursing Facility care and Home Health Care.	$400 single $800 family	$800 single $1,600 family

	Network Providers	Out-of-Network Providers *
MEDICAL OUT-OF-POCKET MAXIMUM (per calendar year)	$400 single $800 family Plus Copayments	Deductible $800 single/ $1,600 family 30% Coinsurance of the next $17,365 single/$34,731 family after which the plan pays at 100%
COMBINED OUT-OF-POCKET MAXIMUM (per calendar year) When the Out-of-Pocket Maximum is reached, the PPO pays at 100% until the end of the benefit period.	$10,600 single $21,200 family ***Includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes Deductibles, Coinsurance, Copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.	$10,600 single $21,200 family ***Includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes Deductibles, Coinsurance and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Out-of-Network Providers, but it does include Out-of-Network cost sharing.
PREVENTIVE CARE		
See ***Benefits Under All Non-Medicare Health Plan Options*** section for a list of Preventive Care services	Covered 100%	70% plan payment; Eligible Member pays 30% If not available In-Network, full cost shall be covered without any cost sharing
MATERNITY SERVICES		
▪ Office visits	Covered 100% including first prenatal visit	70% plan payment; Eligible Member pays 30%
▪ Hospital and newborn care	Covered 100% after Deductible	70% plan payment; Eligible Member pays 30%

	Network Providers	Out-of-Network Providers *
PHYSICIAN VISITS		
▪ Office visits (family practice, general practice, internal medicine, and pediatrics)	$20 Copayment per office visit	70% plan payment; Eligible Member pays 30%
▪ Specialist office visits	$45 Copayment per office visit	70% plan payment; Eligible Member pays 30%
▪ Diagnostic tests (imaging, X-ray, MRI, etc.), inpatient visits, surgery and anesthesia	Covered 100% after Deductible	70% plan payment; Eligible Member pays 30%
▪ Diagnostic tests (lab and pathology)	Covered 100%	70% plan payment; Eligible Member pays 30%
OUTPATIENT THERAPIES		
▪ Outpatient physical & occupational therapy ▪ Speech therapy ▪ Cardiac rehabilitation (72 visits/3 years, rolling) ▪ Pulmonary rehabilitation (12 visits per year) ▪ Respiratory therapy ▪ Manipulation therapy (restorative, chiropractic – 12 Medically Necessary visits, then Treatment Plan submitted; not for maintenance of a condition)	$20 Copayment per visit	70% plan payment; Eligible Member pay 30%
OTHER PROVIDER SERVICES		
▪ Radiation therapy, chemotherapy, kidney dialysis (not covered at an Out-of-Network freestanding dialysis center) ▪ Gene Therapy (in network not subject to Deductible and Copayment) ▪ Home Health Care ▪ Outpatient Private Duty Nursing (240 hours per year/8 hours per day) ▪ Skilled Nursing Facility (240 days per year)	Covered 100% after Deductible	70% plan payment; Eligible Member pays 30%
▪ Hospice (outpatient– see page 43 for more information)	Covered 100%	70% plan payment; Eligible Member pays 30%
▪ Hospice (inpatient)	Covered 100% (365 days per admission)	Not covered

	Network Providers	Out-of-Network Providers *
OUTPATIENT HOSPITAL FACILITIES		
▪ Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis (not covered if provided in a n freestanding dialysis center – is covered at an Out-of-Network rate if it is an Out-of-Network hospital), anesthesia & surgery	Covered 100% after Deductible	70% plan payment; Eligible Member pays 30%
▪ Outpatient Diabetic Education	Covered 100%	Not covered
INPATIENT HOSPITAL SERVICES		
Professional fees & facility services including: room & board & other Covered Services (preauthorization is required for most services)	Covered 100% after Deductible (365 days per benefit period)	70% plan payment; Eligible Member pays 30% Out-of-Network: 70 days per calendar year
EMERGENCY SERVICES		
▪ Urgent care	$50 Copayment	70% plan payment; Eligible Member pays 30%
▪ Emergency treatment for accident or medical emergency	$200 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital); Deductible waived	$200 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital); Deductible waived
▪ Ambulance services for Emergency Services	Covered 100%; Deductible waived	Covered 100%; Deductible waived

	Network Providers	Out-of-Network Providers *
DURABLE MEDICAL EQUIPMENT		
▪ Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics in accordance with the medical plan's DME policy	Covered 100% if obtained by a Network supplier; Deductible waived **NOTE**: Equipment or supplies dispensed in a physician's office or emergency room setting, provided as part of Home Health Care, Skilled Nursing Facility care or Hospice services; or as part of covered dialysis and home dialysis will be paid by your PPO at 100% after Deductible, if it is billed by the Provider and not by a DME supplier. Your Provider may dispense the equipment and will bill your PPO. For example, if you receive a knee brace or crutches at the emergency room, it is paid at 100% after Deductible. If your doctor writes a prescription for a DME item, you should obtain it from a Network supplier to get the highest level of benefits.	70% plan payment; Eligible Member pays 30%; Deductible waived if obtained by an Out-of-Network supplier
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited

*Network providers agree to accept the PPO plan allowance as payment in full, often less than their normal charge. If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the provider's charges and the plan allowance.

NOTE: All benefits are limited to Covered Services that are determined by the PPO to be Medically Necessary.

See the section on Mental Health and Substance Use Program provided under the Choice PPO.

Benefit Highlights - Basic PPO Option

	Network Providers	Out-of-Network Providers *
DEDUCTIBLE (per calendar year) Annual In-Network Deductible must be paid first for the following services: Hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), imaging, Skilled Nursing Facility care and Home Health Care.	$1,500 single $3,000 family	$3,000 single $6,000 family
MEDICAL OUT-OF-POCKET MAXIMUM (per calendar year)	$1,500 single $3,000 family Plus Copayments	Deductible $3,000 single/$6,000 family 30% Coinsurance of the next $17,365 single/ $34,731 family after which the plan pays at 100%
COMBINED OUT-OF-POCKET MAXIMUM (per calendar year) When the Out-of-Pocket Maximum is reached, the PPO pays at 100% until the end of the benefit period.	$10,600 single $21,200 family ***Includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes Deductibles, Coinsurance, Copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.	$10,600 single $21,200 family ***Includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes Deductibles, Coinsurance and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Out-of-Network Providers but it does include Out-of-Network cost sharing.
PREVENTIVE CARE		
See ***Benefits Under All Non-Medicare Health Plan Options*** section for a list of Preventive Care services	Covered 100%	70% plan payment; Eligible Member pays 30% If not available In-Network, full cost shall

	Network Providers	Out-of-Network Providers *
		be covered without any cost sharing
MATERNITY SERVICES		
▪ Office visits	Covered 100% including first prenatal visit	70% plan payment; Eligible Member pays 30%
▪ Hospital and newborn care	Covered 100% after Deductible	70% plan payment; Eligible Member pays 30%
PHYSICIAN VISITS		
▪ Office visits (family practice, general practice, internal medicine, and pediatrics)	$20 Copayment per office visit	70% plan payment; Eligible Member pays 30%
▪ Specialist office visits	$45 Copayment per office visit	70% plan payment; Eligible Member pays 30%
▪ Diagnostic tests (imaging, X-ray, MRI, etc.), inpatient visits, surgery, and anesthesia	Covered 100% after Deductible	70% plan payment; Eligible Member pays 30%
▪ Diagnostic tests (lab and pathology)	Covered 100%	70% plan payment; Eligible Member pays 30%
OUTPATIENT THERAPIES		
▪ Outpatient physical & occupational therapy ▪ Speech therapy ▪ Cardiac rehabilitation (72 visits/3 years, rolling) ▪ Pulmonary rehabilitation (12 visits per year) ▪ Respiratory therapy ▪ Manipulation therapy (restorative, chiropractic – 12 Medically Necessary visits, then Treatment Plan submitted; not for maintenance of a condition)	$20 Copayment per visit	70% plan payment; Eligible Member pays 30%
OTHER PROVIDER SERVICES		
▪ Radiation therapy, chemotherapy, kidney dialysis (not covered at an Out-of-Network freestanding dialysis center) ▪ Gene Therapy (in network not subject to Deductible and Copayment – the Gene Therapy benefit will be administered by Aetna regardless of which medical plan you are enrolled in ▪ Home Health Care ▪ Outpatient Private Duty Nursing (240 hours per year/8 hours per day) ▪ Skilled Nursing Facility (240 days per year)	Covered 100% after Deductible	70% plan payment; Eligible Member pays 30%

	Network Providers	Out-of-Network Providers *
▪ Hospice (outpatient– see page 43 for more information)	Covered 100%	70% plan payment; Eligible Member pays 30%
▪ Hospice (inpatient)	Covered 100% (365 days per admission)	Not covered
OUTPATIENT HOSPITAL FACILITIES		
▪ Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis (not covered if provided in an Out-of-Network freestanding dialysis center – is covered at an Out-of-Network rate if it is an Out-of-Network hospital), anesthesia & surgery	Covered 100% after Deductible	70% plan payment; Eligible Member pays 30%
▪ Outpatient Diabetic Education	Covered 100%	Not covered
INPATIENT HOSPITAL SERVICES		
▪ Professional fees & facility services including: room & board & other Covered Services (preauthorization is required for most services)	Covered 100% after Deductible (365 days per benefit period)	70% plan payment; Eligible Member pays 30% Out-of-Network: 70 days per calendar year
EMERGENCY SERVICES		
▪ Urgent care	$50 Copayment	70% plan payment; Eligible Member pays 30%
▪ Emergency treatment for accident or medical emergency	$200 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital); Deductible waived	$200 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital); Deductible waived
▪ Ambulance services for Emergency Services	Covered 100%; Deductible waived	Covered 100%; Deductible waived

	Network Providers	Out-of-Network Providers *
DURABLE MEDICAL EQUIPMENT		
▪ Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics in accordance with the medical plan's DME policy	Covered 100% if obtained by a Network supplier; Deductible waived **NOTE**: Equipment or supplies dispensed in a physician's office or emergency room setting, provided as part of Home Health Care, Skilled Nursing Facility care or Hospice services; or as part of covered dialysis and home dialysis will be paid by your PPO at 100% after Deductible, if it is billed by the Provider and not by a DME supplier. Your Provider may dispense the equipment and will bill your PPO. For example, if you receive a knee brace or crutches at the emergency room, it is paid at 100% after Deductible. If your doctor writes a prescription for a DME item, you should obtain it from a Network supplier to get the highest level of benefits.	70% plan payment; Eligible Member pays 30%; Deductible waived if obtained by an Out-of-Network supplier
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited

*Network providers agree to accept the PPO plan allowance as payment in full, often less than their normal charge. If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the provider's charges and the plan allowance.

NOTE: All benefits are limited to Covered Services that are determined by the PPO to be Medically Necessary.

See the section on Mental Health and Substance Use Program provided under the Choice PPO.

If you or your Dependents receive or plan to receive services from an Out-of-Network Provider who recommends services, it is your responsibility to obtain preauthorization from your plan. See the section below on Care or Treatment Requiring Preauthorization. You must call the plan and provide the following information:

- Your name and the name of the person for whom the services will be rendered
- Your PPO ID number

- Your physician's name
- Diagnosis of your illness, injury, or condition
- Name of the facility in which you will receive treatment
- Medical/surgical treatment you will receive or reason for your admission to the facility

IMPORTANT NOTE: In the chart that appears on the preceding pages, all benefit payment percentages are based on "eligible expenses." Eligible expenses are expenses for Covered Services that do not exceed the Plan Allowance for the service as determined by the PPO (the "Claims Payor"). You are responsible for all costs in excess of the Plan Allowance.

You can save money by using a PPO network Provider. Network Providers, sometimes called participating Providers have agreed to accept the PPO's allowance as payment in full - often less than their normal charge. Since Network Providers charge no more than the Plan Allowance, by using these Providers you can avoid the possibility of unexpected charges more than the Plan Allowance. If you use an Out-of-Network Provider, you are responsible for the Deductible, applicable Coinsurance and all amounts in excess of the Plan Allowance.

Out-of-Network (or Non-Network) Services

Choice PPO: Each year, you pay the first $800 (the deducible) of covered Out-of-Network expenses for each covered person/$1,600 for family.

Basic PPO: Each year, you pay the first $3,000 (the Deductible) of covered Out-of-Network expenses for each person/$6,000 for family.

After the Deductible, the PPO plan will pay 70% of the next $17,365 single/$34,731 family of most Out-of-Network covered expenses. Once you reach the Out-of-Pocket Maximum, the plan pays 100% of covered expenses for the rest of the year. The combined Out-of-Pocket Maximum is $10,600 single/$21,200 family. This includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between the brand and generic does not apply). Please refer to the above summary chart for more information.

NOTE: Covered expenses do not include charges in excess of the Plan Allowance for a service or supply as determined by the PPO. The percentage reimbursement described in the Benefit Highlights Chart for Out-of-Network Providers is based on the Plan Allowance. For example, a "70% plan payment" for Out-of-Network Providers means 70% of the Plan Allowance. You are responsible for paying the entire amount of the charge in excess of the Plan Allowance (as applicable), in addition to any Deductible or Coinsurance.

For Out-of-Network care, there is an unlimited lifetime Maximum benefit.

All claims for Out-of-Network services must be filed on forms provided by the PPO. All claims must be filed with the PPO and postmarked no later than one year from the date of service. Please contact the PPO's phone number on your ID card for more information.

Care or Treatment Requiring Preauthorization

Preauthorization is an advance review of your proposed treatment to ensure it is Medically Necessary. **Preauthorization does not verify that you are covered by the plan nor does it guarantee payment**. All inpatient admissions and certain outpatient procedures require prior approval before they are performed.

Preauthorization requirements do not apply to services provided by a hospital Emergency Room Provider. If an inpatient admission results from an Emergency Room visit, notification must occur within 48 hours or two business days of the admission. If the hospital is a network

Provider, the hospital is responsible for performing the notification. If the hospital is an Out-of-Network Provider, you or your responsible party acting on your behalf are responsible for the notification.

The telephone number for preauthorization appears on your PPO ID card. Present your ID card to your health care Provider. A network Provider will obtain preauthorization. If you use an Out-of-Network Provider, it is your responsibility to obtain preauthorization.

If the network Provider fails to obtain or follow the preauthorization requirement, the Plan Allowance will not be subject to reduction. If you use an Out-of-Network Provider and preauthorization is not obtained, the amount that would be paid for the Medically Necessary service is subject to a reduction of 20 percent as a penalty for failure to preauthorize. The penalty is in addition to your Out-of-Network Deductible and Coinsurance.

Care Outside of the Plan's Network Area/Student Benefits

The PPO provides an out-of-area benefit for you and your eligible Dependents.

Members who are traveling outside the local area covered by the PPO Network are eligible for Aetna's national PPO provider network. Contact Aetna for information about providers outside of your area.

Care Outside of the Country

Coverage is available out of the country for urgent/Emergency Services. Also, coverage for follow-up care for the condition treated during the emergency/urgent visit will be covered. You should seek care at the nearest facility and contact Aetna as soon as possible. If the Provider requires payment up front, you may submit any claims to Aetna for processing.

Obtaining preauthorization, where required, is your responsibility (the preauthorization telephone number is on the back of your medical ID card).

You should ask for an itemized billing statement that includes your diagnosis and is translated into U.S. dollars.

Filing an Out-of Network Claim

All claims for Out-of-Network services must be filed on forms provided by the PPO. The claims must be filed with the PPO and postmarked no later than one year from the date of service. Please contact the PPO's phone number on your ID card for more information.

If your claim for benefits is denied, see page 113 for a description of the appeals process.

For additional information, please refer to the following sections: Benefits under all Non-Medicare Health Plan Options and Services Excluded From all Medical Benefit Options.

HEALTH MAINTENANCE ORGANIZATION (HMO) OPTION

Non-Medicare Eligible Members

Summary

You must visit a Network Provider if enrolled in the Custom HMO. The network is limited and not all Providers in your area participate. Review the Provider directory by visiting www.pebtf.org.

- The HMO is a Custom HMO which offers a limited network of Providers and facilities. Only Emergency Services are covered outside of the service area.
- HMOs cover medical services as set for by the REHP.
- You must choose a Primary Care Physician (PCP) from the network of HMO doctors
- You may self refer for Medically Necessary care to an HMO-network specialist, as defined by the plan
- $5 Copayment for PCP office visits during regular hours (for general practitioners, family practitioners, internists, and pediatricians)
- $10 Copayment for telehealth visit (through Teladoc™)
- $10 Copayment for specialist office visit (referral from you PSP is required)
- $50 Copayment for urgent care visit
- $150 Copayment for Emergency Room visit (waived if the visit leads to an inpatient admission to the hospital)
- You must present the HMO's ID card to obtain services.

HMO Provider Networks

HMOs have contracts with certain physicians and licensed medical professionals. HMOs also have contracts with certain hospitals and medical facilities. These groups form HMO networks from which you receive medical services. Each HMO has its own network of doctors and hospitals.

HMOs pay for services only if the services are rendered by a Provider or facility which is in the HMO network. There is no coverage for services received outside of the network.

Primary Care Physician

You must choose a Primary Care Physician (PCP) from the network of HMO doctors. Your PCP acts as your personal physician. Care provided or coordinated by your PCP is considered In-Network.

For your PCP, you may choose a general or family practitioner, internist, or pediatrician. Each Eligible Member of your family may have a different PCP.

If your PCP is not available or refuses to provide care, you should contact the Member Services Department of your HMO. You may request to change your PCP by calling or writing your HMO's Member Services Department. The effective date of the change will depend on the date you notify Member Services.

Failure to receive authorization for services from the HMO will result in non-payment of those services.

Benefit Highlights – HMO Option

	Network Providers
DEDUCTIBLE (per calendar year)	None
OUT-OF-POCKET MAXIMUM ***Includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between brand and generic does not apply).***	$10,600 single $21,200 family Includes Deductibles, Coinsurance, Copayments, and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Out-of-Network Providers and other Out-of-Network cost sharing
PREVENTIVE CARE	
See ***Benefits Under All Non-Medicare Health Plan Options*** section for a list of Preventive Care services	Covered in full If not available In-Network, full cost shall be covered without any cost sharing
MATERNITY SERVICES	
▪ Office visits	Covered in full including first prenatal visit
▪ Hospital and newborn care	Covered in full
PHYSICIAN VISITS	
▪ Office visits (PCPs include family practice, general practice, internal medicine, and pediatrics)	$5 Copayment per office visit;
▪ Specialist office visits	$10 Copayment per office visit
▪ Lab and pathology tests, X-rays, inpatient visits, surgery and anesthesia	Covered in full
OUTPATIENT THERAPIES	
▪ Outpatient physical & occupational therapy ▪ Speech therapy ▪ Cardiac Rehabilitation ▪ Pulmonary Rehabilitation ▪ Respiratory therapy ▪ Manipulation therapy (restorative, chiropractic Medically Necessary visits; not for maintenance of a condition)	$5 Copayment per visit Combined Maximum of 60 visits per year for all outpatient therapies, except cardiac rehabilitation which is limited to 72 visits in a rolling three-year period (Therapy services are considered "visits;" however, if the same provider performs more than one physical medicine session or different types of therapies on the same day, on a Member, it only counts as one visit)

	Network Providers
OTHER PROVIDER SERVICES	
▪ Radiation therapy, chemotherapy, kidney dialysis ▪ Gene Therapy (no Copayment) – the Gene Therapy benefit will be administered by Aetna regardless of which medical plan you are enrolled in ▪ Home Health Care (60 visits in 90 days) ▪ Hospice (outpatient and inpatient; inpatient covered 365 days per admission) – see page 43 for more information) ▪ Skilled Nursing Facility (180 days per calendar year)	Covered in full
OUTPATIENT HOSPITAL SERVICES	
▪ Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis, anesthesia & surgery ▪ Outpatient Diabetic Education	Covered in full
INPATIENT HOSPITAL SERVICES	
▪ Professional fees & facility services including: room & board & other Covered Services	Covered in full (365 days per calendar year)
EMERGENCY SERVICES	
• Urgent care (may visit any HMO contracted urgent care facility both in and outside of Pennsylvania) Go to www.aetna.com/dse/custom/pebtf ▪ Traveling? You can change your location after you select the Custom HMO to find an urgent care facility	$50 Copayment
▪ Emergency treatment for accident or medical emergency	$150 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital)
▪ Ambulance services for Emergency Services	Covered in full
DURABLE MEDICAL EQUIPMENT	
▪ Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics in accordance with the medical plan's DME policy	Covered in full
LIFETIME MAXIMUM BENEFIT	Unlimited

NOTE: All benefits are limited to Covered Services that are determined by the HMO (the "Claims Payor") to be Medically Necessary.

Care or Treatment Requiring Preauthorization

Preauthorization is an advance review of your proposed treatment to ensure it is Medically Necessary**. Preauthorization does not verify that you are covered by the health plan or guarantee payment.** All inpatient admissions and certain outpatient procedures require approval before they are performed.

Care Outside of the HMO Area

You must reside in the service area to enroll in an HMO. The HMO plan offered by the REHP is a Custom HMO and offers a limited network of Providers and facilities. Emergency Services only are covered outside of the service area. Seek Emergency Services and contact the plan. For urgent care, you may visit any HMO contracted urgent care facility both in and outside of Pennsylvania). Go to www.aetna.com/dse/custom/pebtf. Traveling? You can change your location after you select the Custom HMO to find an urgent care facility

If you have a Dependent(s) who resides outside of the HMO's service area, they will have Emergency Services and urgent care coverage only and would have to return to the service area for all other medical care; therefore, you may want to enroll in a PPO.

Care Outside of the Country – Emergency Services

If you are traveling outside of the United States, you should remember to always carry your HMO identification card. There may be instances where a medical facility in a foreign country will recognize the HMO as providing payment for services. If the out-of-country medical facility does not recognize your HMO, you will probably be required to pay for medical services. You may then submit your claims to the HMO when you return home. You should ask for an invoice that includes your diagnosis and is translated into American dollars. Under the HMO option, benefits for services obtained Out-of-Network are generally limited to emergency situations.

Filing an Out-of-Network Claim

All claims for benefits under the HMO option must be filed with the HMO and postmarked no later than one year from the date of service.

If your claim for benefits is denied, see page 113 for a description of the appeals process.

For additional information, please refer to the following sections: Benefits under all Non-Medicare Health Plan Options and Services Excluded From all Medical Benefit Options.

MENTAL HEALTH AND SUBSTANCE USE PROGRAM

Non-Medicare Eligible Members

The Mental Health and Substance Use Program applies to non-Medicare eligible Retirees and eligible Dependents regardless of when they retired.

Summary

The Mental Health and Substance Use Program will provide Mental Health and Substance Use Program rehabilitation treatment services, whether inpatient or outpatient. (**Inpatient detoxification services will be coordinated by the plan but services are covered under the PPO, HMO options, when clinically necessary**.)

Your Mental Health and Substance Use Program is provided by Optum and is separate from your medical plan. Optum's phone number is on your medical ID card. To view the benefits, see the chart below that corresponds to your medical plan.

The Mental Health and Substance Use Program provides a specialized network of professional Providers and treatment facilities which have been evaluated according to comprehensive guidelines established by the Mental Health and Substance Use Program. The Claims Payor's Network Providers have not only fulfilled its specific selection and credentialing criteria but are committed to your health and well-being.

You should experience lower out-of-pocket expenses and no claim forms if you use Mental Health and Substance Use Program In-Network Providers. However, PPO Eligible Members have the freedom to receive eligible Mental Health and Substance Use Program services from Out-of-Network Providers, but at a lower level of benefit coverage.

Under mental health parity, psychological conditions must be treated the same as physical illnesses. There are no visit limits under the Mental Health and Substance Use Program. Out-of-pocket costs are not higher under the Mental Health and Substance Use Program and there are no separate Deductibles. The Mental Health and Substance Use Program will work with your specific medical plan option to track any Deductibles that may apply to both medical and Mental Health and Substance Use Program treatment. You will not have two Deductibles to satisfy under the PPO option. Medical and Mental Health and Substance Use Program benefits will both apply to the Deductibles.

The Mental Health and Substance Use Program benefit will continue to be separate from your medical plan, but the Mental Health and Substance Use Program will be structured the same as your medical plan option. The following pages detail the Mental Health and Substance Use Program benefits for Eligible Members under all medical plan options. Please refer to the applicable chart that highlights the Mental Health and Substance Use Program benefits for the medical plan option in which you are enrolled.

Under the Mental Health and Substance Use Program, you must call a toll-free number and speak with a trained counselor who will gather information and refer you to a mental health or substance use professional. After an initial appointment, the mental health or substance use professional will discuss your situation with the mental health Provider's professional staff and an individual Treatment Plan will be developed.

Benefit Highlights – Mental Health and Substance Use Program

For Eligible Members Enrolled in the Choice PPO Option

Service	Network	Out-of-Network
DEDUCTIBLE (per calendar year)	$400 single $800 family	$800 single $1,600 family
OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the plan pays at 100% until the end of the benefit period	$10,600 single $21,200 family ***Includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes Deductibles, Coinsurance, Copayments, and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.	$10,600 single $21,200 family ***Includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes Deductibles, Coinsurance, Copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Out-of-Network Providers, but it does include Out-of-Network cost sharing
MENTAL HEALTH		
Office Visits	100% after $20 Copayment For telehealth visits, the Copayment is waived	70% plan payment; Eligible Member pays 30% after Deductible Limited to licensed psychiatrists, psychologists, social workers and nurses Subject to retrospective review
Outpatient (all other) – includes Applied Behavior Analysis (ABA) treatment	100% after Deductible	70% plan payment; Eligible Member pays 30% after Deductible Limited to licensed psychiatrists, psychologists, social workers and nurses Subject to retrospective review

Service	Network	Out-of-Network
Inpatient & Intermediate*	100% after Deductible	70% plan payment; Eligible Member pays 30% after Deductible Subject to retrospective review
SUBSTANCE USE		
Office Visits	100% after $20 Copayment For telehealth visits, the Copayment is waived	70% plan payment; Eligible Member pays 30% after Deductible
Outpatient (all other)	100% after Deductible	70% plan payment; Eligible Member pays 30% after Deductible
Inpatient	100% after Deductible	70% plan payment; Eligible Member pays 30% after Deductible
Ambulatory Detoxification	100% after Deductible	70% plan payment; Eligible Member pays 30% after Deductible
Medical Detoxification	Covered by medical plan	
EMERGENCY ROOM	$200 Copayment, waived if the visit leads to an inpatient admission	
* Intermediate care includes partial hospitalization, day treatment and intensive outpatient		

Benefit Highlights – Mental Health and Substance Use Program

For Eligible Members Enrolled in the Basic PPO Option

Service	Network	Out-of-Network
DEDUCTIBLE (per calendar year)	$1,500 single $3,000 family	$3,000 single $6,000 family
OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the plan pays at 100% until the end of the benefit period	$10,600 single $21,200 family ***Includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes Deductibles, Coinsurance, Copayments, and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.	$10,600 single $21,200 family ***Includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes Deductibles, Coinsurance, Copayments, and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Out-of-Network Providers, but it does include Out-of-Network cost sharing
MENTAL HEALTH		
Office Visits	100% after $20 Copayment For telehealth visits, the Copayment is waived	70% plan payment; Eligible Member pays 30% after Deductible Limited to licensed psychiatrists, psychologists, social workers and nurses Subject to retrospective review
Outpatient (all other) – includes Applied Behavior Analysis (ABA) treatment	100% after Deductible	70% plan payment; Eligible Member pays 30% after Deductible Limited to licensed psychiatrists, psychologists, social workers and nurses

Service	Network	Out-of-Network
Inpatient & Intermediate*	100% after Deductible	70% plan payment; Eligible Member pays 30% after Deductible Subject to retrospective review
SUBSTANCE USE		
Office Visits	100% after $20 Copayment For telehealth visits, the Copayment is waived	70% plan payment; Eligible Member pays 30% after Deductible
Outpatient (all other) – includes Applied Behavior Analysis (ABA) treatment	100% after Deductible	70% plan payment; Eligible Member pays 30% after Deductible
Inpatient	100% after Deductible	70% plan payment; Eligible Member pays 30% after Deductible
Ambulatory Detoxification	100% after Deductible	70% plan payment; Eligible Member pays 30% after Deductible
Medical Detoxification	Covered by medical plan	
EMERGENCY ROOM	$200 Copayment, waived if the visit leads to an inpatient admission	
* Intermediate care includes partial hospitalization, day treatment and intensive outpatient		

Benefit Highlights – Mental Health and Substance Use Program

For Eligible Members Enrolled in the HMO Option

Service	Network
DEDUCTIBLE (per calendar year)	None
OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the plan pays at 100% until the end of the benefit period. ***Includes costs for medical, Mental Health and Substance Use Program benefits and prescription drug costs (cost difference between brand and generic does not apply).***	$10,600 single $21,200 family Includes Deductibles, Coinsurance, Copayments, and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.
MENTAL HEALTH	
Office Visits	100% after $5 Copayment For telehealth visits, the Copayment is waived
Outpatient (all other)	100%
Inpatient & Intermediate*	100%
SUBSTANCE USE	
Office Visits	100% after $5 Copayment For telehealth visits, the Copayment is waived
Outpatient (all other) – includes Applied Behavior Analysis (ABA) treatment	100%
Inpatient	100%
Ambulatory Detoxification	100%
Medical Detoxification	Covered by medical plan
EMERGENCY ROOM	$150 Copayment, waived if the visit leads to an inpatient admission
*Intermediate care includes partial hospitalization, day treatment and intensive outpatient	

NOTE: Usual, Customary and Reasonable (UCR) charges for services are determined by the Claims Payor for the Mental Health and Substance Use Program. You are responsible for all costs in excess of UCR charges.

Services for Mental Health and Substance Use Disorders

Subject to applicable Deductibles, Copayments, and Coinsurance, as described in the medical plan sections, coverage is provided for the following services for the treatment of mental Illness and substance use disorders that is received as Inpatient treatment, residential treatment, partial hospitalization/day treatment, intensive Outpatient treatment, or other Outpatient treatment (including treatment in a Provider's office) and where the services are provided by or under the direction of a properly qualified behavioral health Provider:

- Diagnostic evaluations, assessment, and Treatment Planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention
- Ambulatory detoxification

Medical detoxification shall be provided through your medical plan option. Provider referrals, coordination of care and other administrative services relating to such treatment shall be provided by a person specifically designated by the applicable Mental Health Benefits Manager for the administration of services for mental health and substance use disorders.

To the extent applicable, Gene Therapy shall be covered under the Aetna medical plan, regardless of which medical plan you are enrolled in.

Behavioral Health Virtual Visits

You may talk and see a mental health Provider online, in the privacy and comfort of your own home. Virtual visits are a convenient option for Eligible Members who have busy schedules, have difficulty getting to appointments or where it may be a distance to visit a Provider. Log on to ***Liveandworkwell.com***, 24/7 with your smart phone or computer.

Preauthorization for Mental Health and Substance Use Treatment

Preauthorization is required for the following services provided for the treatment of Mental Illness or a substance use disorder.

- Inpatient admission, including admission to a residential treatment facility
- Partial hospitalization/day treatment
- Intensive Outpatient treatment
- Psychological testing
- Transcranial magnetic stimulation
- Intensive behavioral therapy

If your behavioral health Provider is In-Network, the Provider will be responsible for obtaining the preauthorization. If your behavioral health Provider is Out-of-Network (applicable only if enrolled in PPO Option, you are responsible for obtaining the preauthorization; Out-of-Network services are not covered if enrolled in the HMO Option). In the event of an emergency, notice to the In-Network Provider or the Mental Health Benefits Manager must be made as soon as reasonably possible.

If you use an Out-of-Network or Non-Participating Provider and preauthorization is not obtained, the amount that would be paid for the clinically necessary service is subject to a reduction of 20% as a penalty for failure to preauthorize.

Coverage for Autism Spectrum Disorders

Benefits for Autism Spectrum Disorders will be provided by the REHP medical plans, the Mental Health and Substance Use Program and the REHP Prescription Drug Plan. There is no annual maximum benefit limit.

Coverage is provided for Members who have a diagnosis of Autism Spectrum Disorders. The coverage is in accordance with the Pennsylvania's Autism Insurance Act (Act 62 of 2008 – HR 1150). Autism Spectrum Disorders include: Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Development Disorder (Not Otherwise Specified).

Subject to the Deductibles, Copayments, and Coinsurance applicable under your medical plan option, coverage is provided for behavioral therapy, including intensive behavioral therapy such as applied behavioral analysis (ABA), provided that the therapy is:

- Focused on the treatment of core deficits of the Eligible Member's autism spectrum disorder and maladaptive/stereotypic behaviors that are posing a danger to the Eligible Member themself, to others, or to property or that impair the Eligible Member's daily functioning.

- Provided by a Board Certified Applied Behavioral Analyst or other qualified Provider, acting in accordance with an appropriate Treatment Plan prescribed by the Eligible Member's physician.

Prior authorization is required for ABA and other forms of intensive behavioral therapy. Prior authorization is required for ABA and other forms of intensive behavioral therapy. To comply with Federal rules about mental health parity, ABA services are now considered "outpatient, other" services (rather than office visits). You will not pay a copayment as copayments do not apply to "outpatient, other" services but these services are subject to your annual Deductible under the PPO plan. ABA services are covered at 100% for HMO members and for PPO members, after your deductible is met.

Medical treatment of the autism spectrum disorder, apart from this behavioral treatment, shall be covered in accordance with the terms of your medical plan option.

Preventive Care

The full cost of an item or service under the Mental Health and Substance Use Program that is Preventive Care and that is provided In-Network shall be covered without any cost sharing by you. The Preventive Care effective date shall be the first day of the Plan year that follows the date on which the item or service becomes Preventive Care by at least one year or such earlier date required by law. If the Preventive Care item or service is not available In-Network, the full cost of the item or service shall be covered without any cost-sharing Out-of-Network. Except as expressly provided in this Section or as otherwise required by law, medical management otherwise applicable under the Mental Health and Substance Abuse Program shall apply to such Preventive Care items and services.

Therapies

Coverage for Speech Therapy (as well as Physical Therapy and Occupational Therapy) is provided, and subject to the Deductibles, Copayments, and Coinsurance, under the applicable Medical Plan Option in which the Member is enrolled, except to the extent such therapy is included in a program of ABA therapy.

Emergency Services

Emergency Services shall be covered without a requirement for prior authorization and without regard to whether services are rendered by a Network Provider. In accordance with applicable legal requirements, no administrative requirements, or limitations (and no cost-sharing requirements) shall apply to Emergency Services rendered by a Provider that does not participate in the Network that are more restrictive than the administrative requirements and limitations (and higher than the cost-sharing requirements) that apply to Emergency Services rendered by a Provider that does participate in the Network. Coverage for all follow-up services (that are not Emergency Services) will be provided only if such services are provided in a doctor's office or, if available and appropriate, through a telehealth visit, and such coverage will otherwise be subject to the terms under the Plan that apply to such (non-emergency) services. Your Copayment is waived if you are admitted as an Inpatient.

Filing an Out-of-Network Claim

All claims for benefits under the Mental Health and Substance Use Program option must be filed with the Mental Health and Substance Use Program and postmarked no later than one year from the date of service.

If your claim for benefits is denied, see page 113 for a description of the Appeals Process.

SERVICES EXCLUDED FROM ALL BENEFIT OPTIONS

Non-Medicare Eligible Members

The plans do not cover services, supplies, or charges for:

- Abortions, unless necessary to save the life of the mother or in the case of rape or incest (documentation will be requested)
- Activity therapy, mainstreaming and similar treatment
- Adult immunizations and immunizations for travel or employment, except the adult immunizations approved for coverage (see Benefits Under all Non-Medicare Health Plan options section)
- Any other medical or dental services or treatment except as provided in the Plan
- Automotive adaptations
- Autopsy
- Except as provided in the Prescription Drug section, balances for brand-name prescription drugs obtained when FDA approved generic is available
- Braces and supports needed for athletic participation or employment
- Care related to autism spectrum disorders except as provided in other sections of this REHP Benefits Handbook, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation that extends beyond traditional medical management, or for inpatient confinement for environmental change
- Charges associated with transportation of blood, blood components or blood products
- Charges for blood donors with blood donation
- Charges in excess of UCR charge or Plan Allowance as determined by the Claims Payor
- Cognitive rehabilitative therapy
- Copayment for prescription drugs
- Correction of myopia, hyperopia or presbyopia by corneal microsurgery, laser surgery or other similar procedure such as, but not limited to, keratomileusis, keratophakia or radial keratotomy and all related services
- Corrective appliances that do not require prescription specifications and/or used primarily for sports
- Cosmetic surgery intended solely to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies

or previous therapeutic processes (excluding surgery resulting from an accident while covered under this plan)

- Custodial care, intermediate care, Domiciliary Care or rest cures
- Ecological or environmental medicine, diagnosis and/or treatment
- Enuresis alarm(s) training program or devices
- Equipment costs related to services performed on high-cost technological equipment such as, but not limited to, computed tomography (CT) scanners, magnetic resonance imagers (MRI) and extracorporeal shock wave lithotripters, unless the acquisition of such equipment was approved through a Certificate of Need (CON) process, or was otherwise approved by the Claims Payor
- Equipment that does not meet the definition of Durable Medical Equipment in accordance with the Claims Payor's or REHP's medical policy, including personal hygiene or convenience items (air conditioner, air cleaner, humidifiers, adult diapers, fitness equipment, etc.)
- Estimates to repair a Durable Medical Equipment (DME) item
- Examinations or treatment ordered by the court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services
- Examinations for employment, school, camp, sports, licensing, insurance, adoption, marriage, registration of civil union or similar relationship, driver's license, foreign travel, passports, or those ordered by a third party
- Expenses directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impaction, alveolectomy and treatment of periodontal disease; emergency dental services resulting from an accidental injury are covered under all medical plans (see Emergency Medical Services in Benefits Under All Non-Medicare Health Plan Options). The medical plans may provide coverage for anesthesia services for dental care rendered to a patient who is seven years of age or younger or developmentally disabled for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia
- Expenses for injury sustained or sickness contracted while engaged in the commission or attempted commission of an assault or felony for which you have not been acquitted, provided that this exclusion from coverage will not apply to injuries to you that result from an act of domestic violence against you or your physical or mental health condition to the extent that the exclusion of such injuries would result in unlawful discrimination under 45 CFR 146.121(a)(1)(ii) and (b)(2).
- Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury)
- Genetic counseling and genetic studies that are not required for diagnosis or treatment of genetic abnormalities according to plan guidelines, except what is covered under Preventive Care under each medical plan option – see Section 2 for a list of Preventive Care

- Guest meals and accommodations
- Hearing exams or hearing aids
- Home services to help meet personal/family/domestic needs
- Hypnotherapy
- Illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit (e.g., Workers' Compensation)
- Illness or injury resulting from any act of war, whether declared or undeclared
- Injuries resulting from the maintenance or use of a motor vehicle if such treatment or services is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan or payable by the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Law
- Injury or illness resulting from an automobile accident where the Eligible Member failed to obtain automobile accident insurance as required by law
- Inpatient admissions primarily for physical therapy or diagnostic studies
- Local infiltration anesthetic
- Marriage counseling if not covered by the Mental Health and Substance Use Program
- Membership costs for health clubs, weight loss clinics or similar program, except as may be provided through your plan's wellness programs

- For services and supplies for the surgical treatment of obesity, including Morbid Obesity, for components of the treatment of obesity or Morbid Obesity (including without limitation nutritional counseling, nutritional supplements, commercial weight loss programs, exercise equipment or gym membership), or for the performance of a panniculectomy (a surgical procedure to remove an unwanted fatty abdominal apron or panniculus), or other surgical procedure to remove excess skin as the result of weight loss, regardless of the reason or reasons such a procedure is recommended. Notwithstanding the foregoing sentence, the following services shall not be subject to this exclusion: (i) eligible services and supplies with respect to a weight management program approved by the PEBTF; (ii) nutritional counseling that is covered as Preventive Care under the applicable Medical Plan option; and (iii) bariatric surgery, but only if the surgery meets each of the following criteria:

    (a) the surgery is authorized or certified in advance in accordance with the rules that apply to the pre-authorization or pre-certification of similar surgical procedures and rules that are specific to bariatric surgery under the medical Plan Option in which the Member on whom the procedure is to be performed ("Applicable Member") is enrolled

    (b) the surgery is otherwise covered under such Plan Option;

  Any Member who qualifies for coverage for bariatric surgery under the exception to this exclusion will qualify for coverage for only one such procedure; provided that the exception to this exclusion will apply to a repeat or revised surgical procedure that is performed specifically to correct complications from a prior bariatric surgery, where and to extent that

such repeat or revised procedure otherwise qualifies for coverage under the Plan Option in which the Member is enrolled at the time of the repeat or revised procedure (including without limitation the Medical Necessity criteria set forth in that Plan Option); where the requirements set forth in paragraphs (a) and (b) of this exclusion are satisfied with regard to the repeat or revised procedure, and where a failure by the Member to comply with one or more post-operative recommendations does not provide a reason for the repeat or revised procedure to be performed.

- Music therapy

- Non-prescription items such as vitamins, nutritional supplements, liquid diets and diet plans, food supplements, bandages, gauze, etc. (enteral formula may be covered with certain diagnoses); some over-the-counter medications are covered – see the Prescription Drug Plan section

- Outpatient prescription drugs

- Over-the-counter cold pads/cold therapy and heat pads/packs

- Palliative or cosmetic foot care, including flat foot conditions, supportive devices for the foot, the treatment of subluxation of the foot, care of corns, bunions (except capsular or bone surgery) calluses, toenails, fallen arches, weak feet, Chronic foot strain, symptomatic complaints of the feet (routine diabetic foot care, including gestational diabetes, is covered under all medical plans)

- Premarital blood tests

- Pre-operative care when the Eligible Member is not an inpatient and post-operative care other than that normally provided following operative or cutting procedures

- Prescription drugs under all medical plans, except those administered to an Eligible Member who is an inpatient and billed by the facility and those administered intravenously or by means of intramuscular or subcutaneous injection to an Eligible Member by a physician or other medical professional in a physician's office and billed by the physician (certain injectable medications may be covered exclusively under the Prescription Drug Plan and may be ineligible for coverage under the medical plan

- Primal therapy, Rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy

- Private Duty Nursing while confined to a facility

- Reversal of voluntary sterilization

- Screening examinations including x-ray examinations made without film

- Sensitivity training, educational training therapy or treatment for an education requirement (except for diabetic educational training, which is covered under all plans)

- Service, supply or charge which are not provided by a Center of Care, as defined in Section 2, where the REHP has determined that such service, supply or charge will be covered only if provided by a Center of Care

- Services and charges for supplies incurred by a surrogate mother, intended parents and child relating to pregnancy and childbirth, whether the Eligible Member is the surrogate

mother or the intended parent. A surrogate mother is an individual who has contracted with an intended parent to bear a child as a surrogate mother with the intention of relinquishing the child, following birth, to the intended parent, and so who, in fact, relinquishes the child (all expenses of the first 31 days become the other parent's insurance expenses). This exclusion does not apply to services provided to a child after his birth, who is born for the benefit of an Eligible Member by a surrogate mother, for services provided following a legal adjudication or custody or parentage by the Eligible Member with respect to that child. A child born by an Eligible Member who is acting as a surrogate mother will not be covered by the plan, except to the extent required by law

- Services and supplies determined to not be Medically Necessary by the Claims Payor, even if prescribed by a physician

- Services billed by unapproved Providers: home health aides, non-licensed individuals (except for those Providers approved under the Pennsylvania Autism Insurance Act (Act 62 of 2008), acupuncturists, naturopaths or homeopaths including those working under the direct supervision of an approved Provider

- Services denied by a primary carrier for non-compliance with the primary plan

- Services for which you have no legal obligation to pay

- Services incurred before your coverage is effective or after your coverage ends

- Services of a Provider that is not an eligible Provider under the plan

- Services paid for by any government benefits

- Services performed by a family member (including, but not limited to, spouse, parent, child, in-laws, grandparent, grandchild, sibling)

- Services performed by a professional Provider enrolled in an educational training program when such services are related to the education and training program and provided through a hospital or university (charges are usually part of the facility charges and cannot be billed separately)

- Services rendered by other than hospitals, physicians, facility other Providers or other professional Providers

- Services which are determined to be Experimental or Investigative by the Claims Payor

- Services which are not prescribed or performed by, or upon the direction of, a physician or other professional Provider

- Sports medicine Treatment Plans, surgery, corrective appliances, or artificial aids primarily intended to enhance athletic functions

- Telephone consulting, missed appointment fees or charges for completion of a claim form

- Therapy service which is not primarily provided for its therapeutic value in the treatment of an illness, disease, injury, or condition. By way of example, but not of limitation, therapy services provided primarily to maintain the patient's current condition rather than to improve it are excluded from coverage

- Tinnitus Maskers

- To the extent payment has been made under Medicare or would have been made if the Eligible Member had applied for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the Eligible Member elects this coverage as primary

- Travel – except as provided for transplants at Centers of Excellence, even if recommended by your physician

- Treatment for sexual dysfunction not related to organic disease

- Treatment for temporomandibular joint (TMJ) syndrome with intra-oral prosthetic devices (splints) or any other method to alter vertical dimension

- Treatment, procedure, or service related to infertility or assisted fertilization, and for fertilization techniques such as, but not limited to, artificial insemination, In-Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), and for all Diagnostic Services related to infertility or assisted fertilization

- Vision therapy

- Vocational therapy

- Xeloda, a prescription drug used as oral chemotherapy (NOTE: Xeloda may be covered under the Prescription Drug Plan)

- Any claim not properly and timely received within the time prescribed by the applicable plan option

This is a partial list of exclusions. If you have any questions about whether a particular expense is covered, you or your physician may contact the Claims Payor or the PEBTF.

2026 REHP Benefit Option Summary Comparison -- Non-Medicare Eligible Retiree Members

BENEFIT	PPO CHOICE OPTION		PPO BASIC OPTION		HMO OPTION
	No Referrals Needed		No Referrals Needed		No Referrals Needed
	In Network	Out-of-Network	In Network	Out-of-Network	
Deductible	$400 single/$800 family	$800 single/$1,600 family	$1,500 single/$3,000 family	$3,000 single/$6,000 family	$0
Out-of-Pocket Maximums (includes Deductibles, coinsurance, Copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Non-Network providers but it does include Out-of-Network cost sharing)	$10,600 single/$21,200 family	$10,600 single/$21,200 family	$10,600 single/$21,200 family	$10,600 single/$21,200 family	$10,600 single/$21,200 family
Physician Visits					
Primary Care Physician	$20 Copayment	70%* after Deductible; Member pays 30%	$20 Copayment	70%* after Deductible; Member pays 30%	$5 Copayment
Specialist	$45 Copayment	70%* after Deductible; Member pays 30%	$45 Copayment	70%* after Deductible; Member pays 30%	$10 Copayment
Preventative Care					
Adult (see list in REHP Handbook)	100%	70%* after Deductible; Member pays 30% **	100%	70%* after Deductible; Member pays 30% **	100%
Pediatric (see list in REHP Handbook)	100%	70%* after Deductible; Member pays 30% **	100%	70%* after Deductible; Member pays 30% **	100%
Urgent Care	$50 Copayment	70%* after Deductible; Member pays 30% **	$50 Copayment	70%* after Deductible; Member pays 30% **	$50 Copayment
Emergency Room Services	$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	$150 Copayment if considered a medical emergency as defined by the HMO (waived if admitted as an inpatient)
Hospital Expenses (Inpatient & Outpatient)	100% after Deductible (up to 365 days per year) Semi-private room (private room if Medically Necessary)	70%* after Deductible (up to 70 days per calendar year); Member pays 30%	100% after Deductible (up to 365 days per year) Semi-private room (private room if Medically Necessary)	70%* after Deductible (up to 70 days per calendar year); Member pays 30%	100%; semi-private room (private room if Medically Necessary)
Medical/Surgical Expenses Including Physician Services (except office visits)	100% after Deductible	70%* after Deductible; Member pays 30%	100% after Deductible	70%* after Deductible; Member pays 30%	100%
Skilled Nursing Facility Care (medically necessary)	100% after Deductible (240 days per calendar year)	70%* (240 days) after Deductible; Member pays 30%	100% after Deductible (240 days per calendar year)	70%* (240 days) after Deductible; Member pays 30%	(180 days per calendar year at participating facility)
Home Health Care (medically necessary)	100% after Deductible	70%* after Deductible; Member pays 30%	100% after Deductible	70%* after Deductible; Member pays 30%	100%; up to 60 visits in 90 days; may be renewed at the option of the HMO
Diagnostic Tests (Labs and Pathology)	100%	70%* after Deductible; Member pays 30%	100%	70%* after Deductible; Member pays 30%	100%
Imaging (X-ray, MRI, CT, etc.)	100% after Deductible	70%* after Deductible; Member pays 30%	100% after Deductible	70%* after Deductible; Member pays 30%	100%
Outpatient Therapies - Such as Outpatient Physical and Occupational Therapy, Speech Therapy, and Chiropractic Care (restorative, medically necessary; not for maintenance of a condition)	$20 Copayment	70%* after Deductible; Member pays 30%	$20 Copayment	70%* after Deductible; Member pays 30%	$5 Copayment
Mental Health & Substance Abuse Treatment	Provided by Optum	Provided by Optum	Provided by Optum	Provided by Optum	Provided by Optum
Durable Medical Equipment/Prosthetic	Covered 100%	70% plan payment; Member pays 30%	Covered 100%	70% plan payment; Member pays 30%	Covered 100%
Out of the Area Care	Urgent and Emergency Care Only, or as defined by the PPO	70%* after Deductible; Member pays 30%	Urgent and Emergency Care Only, or as defined by the PPO	70%* after Deductible; Member pays 30% (Possible BlueCard)	Emergency Care Only, or as defined by the HMO
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

* Non-participating/non-network providers may balance bill for difference between plan allowance and actual charge.

** If not available In-Network, full cost shall be covered without any cost sharing

This Benefit Option Summary Comparison is for illustrative purposes only. It is not all inclusive nor definitive. The actual benefits are as set forth in the REHP Benefits Handbook.

Rev 1-2026

MEDICARE OPEN ACCESS PPO
(Medicare Eligible Members)

Contact the PEBTF if you are not eligible for Medicare Part A or Part B.

As a Medicare eligible REHP Eligible Member, you are required to enroll in BOTH the REHP medical and prescription drug coverage OR decline both REHP medical and prescription drug coverage. You may enroll in only medical coverage if you are enrolled in PACE/PACENET, VA or TRICARE prescription drug coverage.

The Medicare Open Access PPO covers all the benefits of traditional Medicare and usually makes additional benefits available at a reduced or no cost. **You must be enrolled in Medicare Part A and Part B to be enrolled in one of these plans**. The Federal Government through the Centers for Medicare and Medicaid Services (CMS) oversees Medicare Advantage Plans, regulating the coverage that is provided. The Medicare Open Access PPO offered by the REHP is a Medicare Advantage plan. One of the aspects of CMS's regulations for REHP Eligible Members is that you must be allowed to return to traditional Medicare Parts A and B at any time (this rule may not be applicable in the future). If you return to traditional Medicare Parts A and B, you will not have medical or prescription drug coverage under the REHP. However, if you choose to opt out of REHP Medicare Open Access PPO coverage you may only have the option of re-enrolling one other time.

NOTE: Medicare regulations do not allow you to be enrolled in two Medicare Advantage Plans. If you have coverage through another employer or Retiree group, you may want to contact that group to determine if you should enroll in one of the plans offered by the REHP. You may contact the PEBTF to discuss your enrollment options.

Summary – Medicare Open Access PPO

- Annual Deductible, which is the Medicare Part B Deductible
- No specialist referral needed
- Preventive Care covered at 100%
- Hospital expenses (unlimited hospital stays when Medically Necessary) – covered 100%
- Primary Care Physician (PCP) – $20 Copayment per visit for In-Network care
- Specialist – $30 Copayment per visit for In-Network care
- Emergency medical care – $100 Copayment per visit (waived if the visit leads to an inpatient admission to the hospital)
- Ambulance services – Covered 100% for Medicare covered ambulance services

The Medicare Open Access PPO does not require the selection of a Primary Care Physician (PCP) to obtain medical services. Your Providers must be eligible to receive Medicare payment and accept your plan.

Advantages of the Medicare Open Access PPO

The Medicare Open Access PPO offers:

- **Comprehensive Services** – Benefits include those provided through traditional Medicare but usually at much lower out of pocket costs. Some additional items are covered.

- **Coordinated Care** – You do not have to select a Primary Care Physician (PCP). However, it is always prudent to have one family doctor who is knowledgeable about and documents all

of your medical treatments. Your Provider must be eligible to receive Medicare payment accept your plan.

- **Low out-of-pocket Expenses** – You pay an annual In-Network Deductible, which equals the annual Medicare Part B Deductible. Once you satisfy the annual Deductible, you pay a $20 Copayment for a PCP office visit and a $30 Copayment for a Specialist office visit. Other services will be paid at 100% as indicated in the Benefit Highlights Chart. In addition, you must continue to pay the Medicare Part B premium, which is usually deducted from your Social Security check. Services you need from a hospital or other facility, such as rehabilitation or skilled nursing, are covered in full if the services are approved by your plan, subject to any plan limitations and annual Maximums.

- **Little or No Paperwork** – In general, you will have no claim forms or other paperwork to complete or submit. You may have to submit a claim form if you have services out of the country.

- **Fitness Benefit** – The Medicare Open Access PPO plan offers a free fitness benefit, which is subject to change at the plan's discretion. Contact the plan for more information.

Claims Incurred Outside the Country

You are responsible for submitting claims incurred outside the country to the Medicare Open Access PPO. You should request an itemized bill and have it translated into English and into U.S. dollars. Include your name, address, Social Security number, and group number with the claim. All services will be subject to Medical Necessity review.

Eligibility and Enrollment Rules

Eligible Members must satisfy CMS and Commonwealth requirements to be eligible for the Medicare Open Access PPO enrollment, including:

- Enrollment in Medicare Parts A and B and continued payment of the Part B monthly premium
- Residence within the Medicare Open Access PPO plan's service area

Any non-Medicare eligible Dependents may remain enrolled in their current non-Medicare eligible health plan.

NOTE: Self-pay and $5 State-Paid REHP Retirees with two or more Dependents, some of whom are Medicare eligible and some who are not, should contact the PEBTF for rate information. Survivor spouses are eligible for single coverage only.

Enrollment Procedures

- Enrollment in the Medicare Open Access PPO is processed through the plan. You will be automatically enrolled in the Medicare Open Access PPO when you qualify for Medicare.

- If CMS approves your enrollment, the Medicare Open Access PPO will notify you of your coverage effective date and you will be provided with the Medicare Open Access PPO ID card. Use the ID card for all medical services. Remember, you should retain your original Medicare ID card to use for other services such as senior discounts. The Medicare Open Access PPO will advise you, in writing, of its appeal procedures, rules, and other important administrative information.

The following Benefit Highlights Chart provides a summary of Covered Services. Please refer to your specific plan materials for more detailed information and a list of exclusions.

Out-of-State Claims

You may see any Provider if they are eligible to receive Medicare payment and accept your plan anywhere in the United States and you will pay the appropriate Copayment. You are also covered for urgent and Emergency Services anywhere in the United States. Present your Medicare Open Access PPO ID card at the time of service. You will pay a $50 Copayment for urgent care or a $100 Copayment for Emergency Services, which is waived if the visit leads to an inpatient admission to the hospital.

Benefit Highlights - Medicare Open Access PPO

Benefit	In and Out-of-Network
DEDUCTIBLE (per calendar year) The Deductible must be met prior to benefits being payable.	Annual Medicare Part B Deductible
OUT-OF-POCKET MAXIMUM (per calendar year) When the Out-of-Pocket Maximum is reached, the PPO pays at 100% until the end of the benefit period	$2,500 per person
LIFETIME MAXIMUM	
PREVENTIVE CARE	
Annual well visit	Covered 100%
Adult routine physical exam and Preventive Care (every 12 months)	Covered 100%
Medicare-covered immunizations – flu vaccine, pneumonia vaccine, Hepatitis B, **NOTE**: Shingles vaccine (Shingrix and Zostavax) covered according to Medicare guidelines under the Prescription Drug Plan with a copay	Covered 100%
Routine GYN visit (cervical and vaginal cancer screenings) One routine GYN visit and pap smear every 24 months	Covered 100%
Annual routine mammogram - age 40 and older (one baseline mammogram for Eligible Members age 35 – 39)	Covered 100%
Bone mass measurement – for people at risk for osteoporosis (every 24 months)	Covered 100%

Benefit	In and Out-of-Network
Colorectal cancer screening ▪ Colonoscopy - No minimum or maximum age ▪ Flexible sigmoidoscopy – 45 years and older ▪ Screening fecal occult blood test – 45 years and older ▪ Screening Guaiac-based fecal occult blood test (gFOBT) – 45 years and older See Aetna Medicare Open Access PPO documents for detailed information	Covered 100%
Prostate cancer screening (age 50 or older, every 12 months)	Covered 100%
Additional Medicare-covered preventive services*	Covered 100%
PHYSICIAN SERVICES	
Primary Care Physician (PCP) office visits	$20 Copayment per visit (after Deductible)
Specialist office visits	$30 Copayment per visit (after Deductible)
Medicare covered podiatry services	$30 Copayment per visit (after Deductible)
Allergy Testing/Treatment Visits	$30 Copayment per visit (after Deductible)
DIAGNOSTIC PROCEDURES	
Medically necessary x-rays	Covered 100% (after Deductible)
Laboratory services	Covered 100%
HOSPITAL CARE	
Inpatient coverage (Semi-private room; private room if Medically Necessary)	Covered 100%; no limit to the number of days (after Deductible)
Outpatient hospital expenses (includes surgery)	Covered 100% (after Deductible)
MENTAL HEALTH CARE	
Inpatient mental health in a Medicare-participating psychiatric hospital	Covered 100% (unlimited lifetime days) (after Deductible)
Outpatient mental health care	Covered 100% for each Medicare covered individual or group therapy visit (after Deductible)
Inpatient substance use	Covered 100%; no limit to the number of days covered each benefit period (after Deductible)
Outpatient substance use	Covered 100% for Medicare covered individual or group visit (after Deductible)

Benefit	In and Out-of-Network
EMERGENCY SERVICES & URGENTLY NEEDED CARE	
Urgently needed care	$50 Copayment (waived if the visit leads to an inpatient admission to the hospital)
Emergency treatment for accident or medical emergency	$100 Copayment (waived if the visit leads to an inpatient admission to the hospital)
Ambulance service for Emergency Services	Covered 100% for Medicare covered ambulance service
OUTPATIENT REHABILITATION THERAPIES	
▪ Physical ▪ Occupational ▪ Cardiac ▪ Speech (medical/not developmental) ▪ Pulmonary ▪ Medicare covered chiropractic services	$20 Copayment per visit for each Medicare covered visit (after Deductible)
OTHER PROVIDER SERVICES	
Outpatient complex radiology, chemotherapy	Covered 100% (after Deductible)
Outpatient dialysis	Covered 100%
Home Health Care	Covered 100% (after Deductible)
Skilled Nursing Facility care	Covered 100% (100 days per benefit period) (after Deductible)
Hospice	Covered by Medicare at a Medicare-certified Hospice
DURABLE MEDICAL EQUIPMENT (DME)/PROSTHETIC DEVICES DME includes wheelchairs, oxygen, etc. Prosthetic devices includes braces, artificial limbs and eyes, etc.	Covered 100% (after Deductible)
DIABETIC SUPPLIES (Strips, lancets, insulin pumps and glucometer)	Covered 100%
Teladoc™	$0
Telehealth	Covered; Member cost share will apply based on services rendered – from $20 to $50 Copayment
HEARING SERVICES	
Routine hearing screening One exam every 12 months	$0
Medicare covered hearing exam	$30
Hearing aid benefit	Hearing aid reimbursement - $2,000 every 12 months through NationsHearing

Benefit	In and Out-of-Network
VISION SERVICES	
Routine eye exam One annual exam every 12 months	$0
Diabetic eye exams	$0
Medicare covered eye exam	$30
Vision Eyewear Reimbursement (in or out of network)	$175 once every 24 months
HEALTH & WELLNESS EDUCATIONAL PROGRAMS	Included
FITNESS BENEFIT	Included, which is subject to change at the plan's discretion; check with the plan for more information
MEAL DELIVERY	14 meals after inpatient hospital stay
TRANSPORTATION	40 one-way trips per year
OVER-THE-COUNTER (OTC) ITEMS	$30 quarterly
PERSONAL EMERGENCY RESPONSE SYSTEM	Medical alert through LifeStation, offered at no cost

Additional Medicare preventive services include: Abdominal aortic aneurysm screenings, cardiovascular disease testing, cardiovascular disease risk reduction visit (therapy for cardiovascular disease), diabetes screenings, diabetes self-management training, Medicare Diabetes Prevention Program – 12 months of core session for program eligible members with an indication of pre-diabetes, medical nutrition therapy, glaucoma screening, smoking and tobacco use cessation counseling, HBV infection screening, HIV screenings, lung cancer screenings and counseling, alcohol misuse screenings and counseling, depression screenings, sexually transmitted infections screenings and counseling, obesity screening and therapy to promote sustained weight loss, Welcome to Medicare preventive visit

MEDICARE OPEN ACCESS PPO ENROLLMENT AND REVIEW PROCESS

REHP Medicare-Eligible Members have the option of the Medicare Open Access PPO for their medical coverage. The REHP Medicare Supplemental and Major Medical (MS/MM) coverage is available to Eligible Members only under the following limited circumstances:

Automatic Enrollment Exceptions – To qualify for an automatic enrollment exception, the Eligible Member must verify that they meet the requirements of one of the three automatic enrollment exception categories identified below:

- Eligible Members who reside out-of-country in a region where the Medicare Open Access PPO is not offered; or
- United Mine Workers Retiree (UMW) plan members; or
- Eligible Members with Black Lung coverage

Eligible Members who meet one or more of these criteria, may **request an exception** to the normal plan enrollment of the Medicare Open Access PPO by calling the PEBTF at 1-800-522-7279 and requesting enrollment in the MS/MM plan. Eligible Members who are not satisfied with the PEBTF response to their request for exception may **file a written request for further review to the Commonwealth.** The postmark date of all correspondence in this process will be used to determine timelines. The steps in the written request process are:

1. Eligible Members must file a written request for review to the PEBTF which is postmarked or received (if sent by other than U.S. Mail First Class) within 30 days after their telephone request is denied. Requests are to be mailed to:
   REHP Reviews, PEBTF
   Mailstop: RPAED, 150 S 43rd Street, Harrisburg, PA 17111

   The request must include a letter and other supporting documentation explaining why you believe the PEBTF's decision should be reconsidered.

2. The PEBTF will forward the request for review to the Commonwealth.

3. The Commonwealth will review the request, including such other pertinent information as the Eligible Member may present, and will provide a written response to the PEBTF within 60 days of receipt.

4. The PEBTF will notify the Eligible Member of the Commonwealth's decision, and the reasons. Within 30 days of the postmark date of the PEBTF's notification, the Eligible Member may file a written request for review by the REHP Review Committee, which must be submitted in writing to the PEBTF at the address cited in #1 above.

5. The request will be submitted to the REHP Review Committee. The decision of the REHP Review Committee will be made within 60 days and will be final and binding.

The Commonwealth reserves the right to modify or rescind any and all portions of this process at its discretion and without advance notice.

PRESCRIPTION DRUG PLAN
(Non-Medicare Eligible & Medicare Eligible Retirees)

Non-Medicare Eligible Members: You are enrolled in a non-Medicare Part D prescription drug plan. If you have a Medicare-eligible spouse or Dependent(s), please refer to the information below.

Medicare Eligible Members: You must continue to be enrolled in Medicare Part A and B to be covered under the Medicare Part D prescription drug plan. You are enrolled in a Medicare Part D prescription drug plan offered by the REHP. Many standard Medicare Part D programs use the term "donut hole" to describe a coverage gap where Eligible Members pay the entire cost of the prescription. The REHP Medicare Part D prescription drug plan does not have a donut hole. Therefore, your benefits are like those offered to non-Medicare Eligible Members. Your non-Medicare spouse or Dependent(s) is enrolled in a non-Medicare Part D prescription drug plan.

IMPORTANT: **If you enroll in a private Part D standalone prescription drug plan or private Medicare Advantage Plan, you and your Dependents REHP coverage will be terminated.**

All Members: You should present the REHP Prescription Drug Plan ID card at the pharmacy when you need prescription drugs. The pharmacy will fill your prescription and charge you the appropriate Copayment plus any balance due if you elect to buy a brand name drug when a generic is available.

Summary

- Prescription drug coverage for you and your eligible Dependents
- Three Tier Copayment plan
- Retail and Maintenance Programs
- Medicare Eligible Members are enrolled in a Medicare Part D prescription drug plan

The Non-Medicare and Medicare Prescription Drug Plans have different copays for your 30-day and 90-day supplies.
See the charts on the following pages.

The Prescription Drug Plan gives you and your eligible Dependents the opportunity to obtain your required medications at participating pharmacies throughout the United States.

If you use a pharmacy that does not participate in the pharmacy network, or you do not present your Prescription Drug Plan ID card to a participating pharmacy, you pay the full cost of your prescription. You must then file a claim with the Prescription Benefit Manager in order to receive reimbursement. See "Filing a Direct Claim Form" for more information.

To find out if your pharmacy participates, call the number that appears on the back of your prescription drug ID card.

If any particular prescription drug expense that is covered under this section would also be covered under one or more other Plan Options: 1) an Eligible Member incurring such expense may obtain reimbursement for the expense under only one Plan Option; and 2) the PEBTF may, at its discretion, specify that certain types of prescription drug expenses, including without limitation infused medicines, will be covered under one or more Plan Options to the exclusion of one or more other Plan Options.

Three Tier Copayment Plan

Both the non-Medicare and Medicare prescription drug plans are generic reimbursement plans. You may obtain a brand-name drug, but if an FDA-approved generic is available, you will pay a higher Copayment and the cost difference between the brand and the generic drug. In no event will you pay more than the actual cost of the drug.

To save money, talk to your doctor about taking generic drugs.

The Prescription Drug Plan is a generic reimbursement plan. You may obtain a brand-name drug but if an FDA-approved generic is available, you will pay a higher Copayment and the cost difference between the brand and the generic drug. Both the non-Medicare and Medicare prescription drug plan uses a three-tier system, where the Prescription Benefit Manager maintains a list of generic and brand-name drugs called a formulary. The formulary summary is available at www.pebtf.org. Drugs included on that list are called "preferred". Drugs not on that list are called "non-preferred." The following details the Copayments under your Prescription Drug Plan.

Prescription Drug Plan – Non-Medicare Eligible Members

Prescriptions at a Network Pharmacy Up to a 30 Day Supply	**Your Copayment****
Tier 1: Generic drug	$15
Tier 2: Preferred brand-name drug	$40, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$80, plus the cost difference between the brand and the generic, if one exists
CVS Maintenance Choice Network (CVS, Costco or Kroger Pharmacy) & Mail Order Up to a 90 Day Supply*	**Your Copayment****
Tier 1: Generic drug	$22.50
Tier 2: Preferred brand-name drug	$60, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$120, plus the cost difference between the brand and the generic, if one exists

*CVS Maintenance Choice Network (90-day supplies obtained at a retail pharmacy) availability may vary by state. Visit www.caremark.com to locate network pharmacies

**Responsibility for the cost difference between brand and generic is subject to the exception set forth in this section

Prescription Drug Plan – Medicare Eligible Members

Prescriptions at a Network Pharmacy Up to a 30 Day Supply	**Your Copayment**
Tier 1: Generic drug	$12
Tier 2: Preferred brand-name drug	$30, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$60, plus the cost difference between the brand and the generic, if one exists
CVS – Retail Maintenance & Mail Order Up to a 90 Day Supply	**Your Copayment**
Tier 1: Generic drug	$18
Tier 2: Preferred brand-name drug	$45, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$90, plus the cost difference between the brand and the generic, if one exists
Retail Maintenance at a Preferred or Non-Preferred Network Retail Pharmacy (Medicare) Up to 90 Day Supply	**Your Copayment**
Tier 1: Generic drug	$24
Tier 2: Preferred brand-name drug	$60, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$120, plus the cost difference between the brand and the generic, if one exists

NOTE – Medicare-Eligible Members enrolled in the Medicare Part D prescription drug plan: You may obtain a 90-day supply at any pharmacy that agrees to be part of the Medicare Part D prescription drug plan's network at slightly higher copays than you pay at a CVS pharmacy or mail order.

Retail Prescriptions – up to a 30-day supply

- Present your prescription drug ID card at the participating pharmacy along with the prescription to be filled
- The pharmacist will ask the person picking up the prescription to sign a log
- The pharmacist will request the Copayment amount, and if necessary, the difference between the cost of the brand name drug and the cost of the generic

Except as otherwise noted, prescriptions purchased at a retail pharmacy cannot exceed a 30-day supply for short-term prescriptions.

Obtaining Prescriptions for up to a 90-day Supply

The Prescription Drug Plan includes these options for obtaining long-term maintenance prescriptions (up to a 90-day supply):

- Mail Order
- CVS Pharmacy
- CVS Maintenance Choice Network (CVS, Costco or Kroger Pharmacy) – for the Non-Medicare Prescription Drug Plan only

CVS Maintenance Choice Network (90-day supplies obtained at a retail pharmacy) availability may vary by state for the Non-Medicare Prescription Drug Plan.

The 90-day supply feature is appropriate if you have a Chronic condition and take medication on an on-going basis. For example, this feature works well for people who use maintenance drugs for conditions such as diabetes, arthritis, asthma, ulcers, high blood pressure or heart conditions.

NOTE – Medicare-Eligible Members enrolled in the Medicare Part D prescription drug plan: You may obtain a 90-day supply at any pharmacy that agrees to be part of the Medicare Part D prescription drug plan's network at slightly higher copays than you pay at a CVS pharmacy or mail order.

Generic Equivalents – Non-Medicare Members Only

Prescription Drug coverage under this Section is based on the purchase of generic equivalents, when available. The generic reimbursement provision is mandatory. All prescriptions with a federal Food and Drug Administration (FDA) approved "A" or "AB" rated generic equivalent (including without limitation single-source generics) will be dispensed generically unless you or your physician directs the pharmacist otherwise. If there is not an FDA-approved generic equivalent, the prescriptions will be dispensed as a brand name drug. Whenever the FDA has approved at least one generic substitute (as set forth in First Databank) and you wish to obtain the brand name drug, you are responsible, for the Copayment, and the difference in cost between the brand name and the generic, as determined by the Prescription Benefit Manager. In no event will you pay more than the actual cost of the drug.

You shall not be charged for the difference in cost between a brand name drug and a generic alternative (although you shall still be responsible for the applicable Copayment) if the prescription for the brand name drug is Dispensed as Written (DAW) and the prescribing Provider confirms that one or more of the following apply: (i) you have experienced, through trial and failure, an inadequate treatment response from or intolerance for the generic alternative; (ii) the prescribing Provider has determined that the generic alternative is inappropriate because of an allergic condition, a contraindication or other clinical concern; or (iii) you have a specific sensitive clinical condition (on the order of fragile epilepsy, transplant immunosuppression etc.) that has been stabilized through the use of a brand name medication.

Specialty Medications

Specialty medications are used to treat complex conditions and usually require injection and special handling. To obtain these specialty medications, you should use the Prescription Benefit Manager's specialty care pharmacy or CVS pharmacy.
You also have the ability to obtain certain specialty medications at $0 cost by using the PrudentRx program. PrudentRx works with drug manufacturers to obtain copay assistance to keep your cost at $0. If you do not enroll in the PrudentRx program, you will be responsible for 30% coinsurance and your out-of-pocket costs will be high.

The specialty care pharmacy is a mail order service, and it offers access to personalized counseling from a dedicated team of registered nurses and pharmacists to help you throughout your treatment. This personalized counseling provides you with 24-hour access to additional support and resources that are not available through traditional pharmacies.

If you use a pharmacy other than the specialty care pharmacy or CVS pharmacy to purchase specialty medications, you will be responsible for the full cost of each prescription. You may then file a Direct Claim Form. The amount reimbursed to you, however, will be limited to the amount that would have been paid to the specialty care pharmacy or to CVS pharmacy and may result in significant out-of-pocket expenses.

Contact the Pharmacy Benefit Manager for information on the specialty care pharmacy. The phone number appears at the back this book and on your Prescription Drug ID card.

Covered Drugs

- Federal legend drugs
- State restricted drugs
- Compound prescriptions (will not be covered if the compound includes a drug excluded by the Prescription Drug Plan)
- Insulin or other prescription injectables
- Federal legend oral contraceptives (no Copayment for non-Medicare Eligible Members)
- All Medicare-eligible Retirees receive insulin, syringes, and needles through the Prescription Drug Plan
- Genetically engineered drugs (with prior authorization)
- Shingles vaccine (Shingrix and Zostavax) – ***Non-Medicare Eligible Members:*** Immunizations are covered under your medical plan. Shingrix is covered age 50 and older; Zostavax is covered age 60 and older. ***Medicare-Eligible Members***: Shingles vaccines are covered according to Medicare guidelines – covered under the Prescription Drug Plan
- Infused medicine (with prior authorization)

Preventive Care Covered Medications – No Copayment for Non-Medicare Eligible Members

The following medications are covered at no cost under your prescription drug plan with a prescription from your doctor.

- Aspirin to help prevent illness and death from preeclampsia in individuals age 12 and older after 12 weeks of pregnancy who are at high risk for the condition
- Bowel preparation medications for screening colorectal cancer for adults age 45 through 74
- Contraceptives including emergency contraceptives and over-the-counter contraceptive products (condoms, sponges, spermicides, oral contraceptives), with or without a prescription
- Diabetes prevention medicine – Metformin 850 mg – for preventing or delaying diabetes for adults age 35 to 70 who have overweight or obesity
- Folic acid daily supplement for individuals age 55 or younger who are planning to become pregnant or are able to become pregnant
- Medications for risk reduction of primary breast cancer in individuals age 35 and older who are at risk
- Oral fluoride for preschool children older than six months to five years of age without fluoride in their water
- Tobacco cessation and nicotine replacement products – prescription drug coverage is for the generic form of Zyban or Chantix and nicotine replacement products (limited to a Maximum of 168-day supply)

- Statins to help prevent serious heart and blood vessel problems (cardiovascular disease) in adults age 40 – 75 who are at risk. This covers generic low to moderate intensity statins only
- Antiretroviral therapy for pre-exposure prevention of Human Immunodeficiency Virus (HIV) infection in people who are at an increased risk
- Vaccines and immunizations to prevent certain illness in infants, children and adults

Remember that a prescription is required for you to obtain reimbursement for any of these preventive prescription drugs, even those that are available over the counter.

NOTE: The list of covered preventive prescription drugs is subject to change.

As of the Preventive Care Effective Date, the full cost of a medication that is Preventive Care and that is provided In-Network shall be covered without any cost-sharing by you. The Preventive Care Effective Date shall be the first day of the Plan Year that follows the date on which the item or service becomes Preventive Care by at least one year or such earlier date required by law. If a Preventive Care medication is not available In-Network, the full cost of the medication shall be covered without any cost-sharing Out-of-Network. With regard to contraception, if your attending physician prescribes a particular Preventive Care contraceptive based on Medical Necessity for you, the full cost of that contraceptive will be covered provided that it has been approved by the Food and Drug Administration for the applicable situation. Except as expressly provided in this section or as otherwise required by law, medical management that is otherwise applicable to a Preventive Care medication under the Plan shall apply to such medications.

Flu Vaccine

Non-Medicare Eligible Members

You have two options for getting your flu shot – your doctor's office or a network pharmacy.

You have two options for getting your flu shot:

1. **At your doctor's office:** Present your medical plan ID card and pay the appropriate copay.

2. **At a CVS Caremark Flu Shot network pharmacy**: For Eligible Members age 9 and older – present your prescription drug ID card.

You can go to any pharmacy that participates in the CVS Caremark Flu Shot network to receive your shot. The Flu Shot network includes most chain pharmacies such as Acme, Giant, Giant Eagle, Target and Weis Markets, in addition to CVS pharmacies and many independent pharmacies. Call or stop by your local pharmacy to make sure they have the flu shots in stock, and that they participate with CVS Caremark Flu Shot Program for insurance.

Simply present your CVS Caremark prescription drug ID card at the pharmacy and you and your Dependents will get the flu shot at no cost. If you have filled a prescription at that pharmacy since July 2012, the pharmacy should have a record of your ID number in its system.

Other Preventive Immunizations: You may also obtain other covered vaccines at your doctor's office or at a CVS Caremark Vaccine Network pharmacy.

Medicare-Eligible Members

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.

Plan Exclusions

- Blood or blood products
- Charges for the administration of a drug
- Devices and appliances
- Diagnostic agents
- Drugs dispensed in excess of Quantity Limits or lifetime supply limits unless exception has been granted
- Drugs subject to prior authorization for which such authorization has not been obtained
- Drugs subject to Step Therapy rules if these rules have not been followed
- Drugs used for athletic performance enhancement or cosmetic purposes, including but not limited to, anabolic steroids, tretinoin for aging skin and minoxidil lotion
- FDA approved drugs for use of a medical condition for which the FDA has not approved the drug (unless prior authorization is obtained)
- Fertility medications
- Immunologic agents (including RhoGAM)
- Experimental or Investigative drugs (non-FDA approved indications)
- Sexual dysfunction (MSD) drugs
- Medications lawfully obtainable without a prescription (over the counter items), except (i) those over-the-counter contraceptive medications included as Preventive Care, which may be obtained with or without a doctor's prescription; and (ii) standard over-the-counter test kits for COVID-19, limited to four test kits per month
- Prescription drugs or medications prescribed primarily for weight loss, weight management, anti-obesity, or appetite suppression, regardless of whether they are FDA- approved or prescribed for other indications
- Non-sedating antihistamines
- Prescription drugs administered while you are an inpatient at a facility and billed by the facility (charges for such drugs may be considered for coverage under the applicable medical plan option)
- Prescription drugs for which coverage is provided under a plan option for medical benefits
- Refill prescriptions resulting from loss, theft, or damage
- Syringes, needles, lancets, and test strips – excluded for non-Medicare Eligible Members who should obtain these through the DME benefit; lancets and test strips excluded for Medicare-Eligible Members who should obtain these through the Medicare Open Access PPO
- Unauthorized refills
- Any other exclusion as determined by the Commonwealth

Non-Medicare Eligible Members: There is a list of formulary exclusions of medications that are not covered by the prescription drug plan without a prior authorization for Medical Necessity. If prior authorization is denied, you will pay the full cost of the drug. This list of formulary exclusions is modified on an annual basis by the Prescription Benefit Manager and may be found on the PEBTF website.

Limits on Certain Drug Classes

Quantity Limitations

There are certain prescription drugs that are subject to quantity limits. The quantity limit list is posted on the PEBTF web site, https://www.pebtf.org/General/Publications.aspx.

You may find that the quantity of a medication you receive and/or the number of refills is less than you expected. This is because the pharmacists must adhere to certain federal/state regulations and/or recommendations by the manufacturer or Prescription Benefit Manager that restrict the quantity per dispensing and/or the number of refills for a certain medication.

Step Therapy

When many different drugs are available for treating a medical condition, it is sometimes useful to follow a stepwise process for finding the best treatment for individuals. The first step is usually a simple, inexpensive treatment that is known to be safe and effective for most people. Step therapy is a type of prior authorization that requires that you try a first-line therapy before moving to a more expensive drug. The first-line therapy is the preferred therapy for most people. But, if it doesn't work or causes problems, the next step is to try second-line therapy.

You will be required to use a first-line drug before you can obtain a prescription for a second-line drug on the following classes of drugs:

- ACE's and ARB's which are used for hypertension
- COX-2 or NSAID drugs which are used for pain and arthritis.

Prior Authorization

Your Prescription Drug Plan requires prior authorization for certain medications. This requirement helps to ensure that Eligible Members are receiving the appropriate drugs for the treatment of specific conditions and in quantities as approved by the U.S. Food and Drug Administration (FDA).

For most of the drugs that appear on the prior authorization list, the process takes place at the pharmacy. If you try to obtain a drug that appears on the prior authorization list, your pharmacist will be instructed to contact the Prescription Benefit Manager. Participating Pharmacies then will contact your physician within 24 hours to verify diagnosis and to obtain other relevant information to make a determination of coverage.

If the request is approved, you will be notified to go to the pharmacy to obtain the medication. The approval for that specific drug will be for a period from several days up to a Maximum of one year. If the request is denied, you have the right to appeal this decision to the Prescription Benefit Manager. Please see page 114 for the Appeals Process.

The prior authorization List is on the PEBTF web site – www.pebtf.org.

Filing a Prescription Drug Direct Claim

File a prescription drug claim with the Prescription Benefit Manager if you or a covered Dependent(s):

- Use a pharmacy that is not part of the pharmacy network
- Do not use the prescription drug ID card when filling a prescription
- Purchase a prescription drug from a physician

Prescription Drug Direct Claim/Coordination of Benefits Forms are available from the Prescription Benefit Manager, the PEBTF or may be downloaded from the PEBTF website, www.pebtf.org. The Prescription Benefit Manager will accept Direct Claim/Coordination of Benefits Forms completed in their entirety along with the receipt that must include:

- Pharmacy or physician's name and address
- Date filled
- Drug name, strength, National Drug Code (NDC)
- RX number, if applicable
- Quantity
- Days supply
- Price
- Patient's name

All Prescription Drug Direct Claim/Coordination of Benefits Forms must be postmarked within one year from the date the prescription was filled.

You will be reimbursed based on the amount a Participating Network Pharmacy would have been paid by the Prescription Drug Plan for filling the prescription minus your Copayment. The balance, if any, is your responsibility and is not eligible for consideration under any medical plan.

Filing a Claim for Residents of Nursing Homes

To obtain reimbursement for prescription drug claims incurred while you or a Dependent(s) are a resident of a nursing home whose pharmacy does not participate with the REHP Prescription Drug Plan, claims should be submitted to the Prescription Benefit Manager using a Direct Claim/Coordination of Benefits Form.

You or your representative should notify the Prescription Benefit Manager that the direct reimbursement is being requested because the Eligible Member is a resident of a nursing home and could not use a network pharmacy. The timely filing limitation will be enforced.

The mandatory generic provision will not apply to residents of nursing homes whose pharmacies do not participate with the REHP Prescription Drug Plan. You will save money by choosing generic drugs.

Workers' Compensation Claims

If you have workers' compensation claims, which resulted from Commonwealth employment and are administered by the Commonwealth's workers' compensation claims administrator, you are required to use the prescription drug ID card provided at the time of injury or provided by the worker's compensation claims administrator to obtain medications used to treat those work-related injuries unless the Workers Compensation carrier has made other arrangements. If you do not have a worker's compensation prescription drug card, contact your claims adjuster. You may continue to use your prescription ID card and present it to a participating pharmacy and pay the usual Copayment. The Commonwealth will automatically reimburse you, within 45 days, for any prescription drug Copayments incurred for treatment of work-related injuries.

NOTE: Any workers' compensation claims for which you have signed a Compromise and Release Agreement that includes medical claims may not be submitted for prescription or medical payment under the REHP.

PACE/PACENET Prescription Drug Program

Low-income Medicare eligible Retirees and Dependents age 65 years old and older who qualify for Pennsylvania's PACE/PACENET Prescription Drug Program may be able to reduce their out-of-pocket expenses if they enroll in PACE/PACENET. Please call 1-800-225-7223 for more information.

COBRA COVERAGE AND SURVIVOR SPOUSE COVERAGE
(ALL RETIREES)

Summary

- If you or your Dependent(s)'s health benefit coverage ends due to certain reasons, the REHP may continue your coverage for a limited period of time
- Federal law also allows you to continue coverage at your own expense under certain circumstances under the Federal law commonly known as COBRA

If you or your Dependent(s)'s REHP coverage ends, you may elect COBRA coverage and continue to pay the monthly cost.

Continued Coverage as Provided by the REHP

In certain situations, medical coverage for you and your eligible Dependents may be extended. If coverage would end while an Eligible Member is in the hospital, coverage continues until the Eligible Member is discharged from the facility or benefits are exhausted, whichever occurs first.

In considering whether to elect continuation coverage, you should consider that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed below. You can also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the Maximum time available to you.

There may be other coverage options for you and your family. You also may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums, and you can see what your premium, Deductibles, and out-of-pocket costs will be before you decide to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. For more information about health insurance options available through a Health Insurance Marketplace, visit www.pennie.com (for residents of Pennsylvania) or www.healthcare.gov.

Dependent(s) Coverage After Retiree's Death

When your family notifies SERS (or the PEBTF for PSERS or ARS Members) of your death, the PEBTF will automatically notify your Dependent(s) of survivor spouse coverage and COBRA. COBRA is also available in other situations involving a loss of coverage. Coverage ends if you or your eligible Dependents fail to make any required contribution.

Survivor Spouse Coverage

Act 183 allows the survivor spouse (only) of a SERS Retiree to continue coverage under the REHP on a direct pay basis. Survivor Spouse Coverage may be elected under the following circumstances:

(1) The spouse was enrolled as an eligible Dependent under the PEBTF coverage, and the Employee was eligible for Contribution Rate Coverage REHP coverage at the time of their death.; or

(2) The spouse was enrolled as an eligible Dependent under the REHP at the time of the Retiree's death.

If a survivor spouse is not Medicare eligible, they may elect the options available based on the Retiree's date of retirement. Survivor spouse coverage is available for spouses of PSERS, or ARS Retirees participating in the REHP.

If a survivor spouse is eligible for Medicare, the survivor spouse must elect Medicare Parts A and B. They also may enroll in the Medicare Open Access PPO and the Prescription Drug Plan.

A survivor spouse must elect the coverage type and plan in place at the time of the Retiree's death. A survivor spouse may change plans during Open Enrollment.

If the deceased annuitant elected a survivor retirement annuity, the cost of the health coverage will be deducted each month from the survivor's annuity. If the monthly cost of the health coverage is greater than the monthly survivor annuity, the PEBTF will bill the survivor the full amount of the premium. Coverage ends if the survivor spouse fails to make any required contribution.

Non-Medicare Eligible Members

If the survivor spouse returns the form to SERS electing coverage within 30 days of receipt, coverage will be retroactive to the date their coverage ended. The cost of this retroactive coverage will be the survivor spouse's responsibility. However, if the survivor spouse pays the premiums for retroactive coverage, then any claims they incurred after their coverage ended can be considered for payment. If the enrollment application is not received by SERS within 30 days, then coverage will be effective the first of the month following the postmark date. In this instance, coverage will not be retroactive and any claims that were incurred will not be considered for payment by the REHP.

Medicare Eligible Members

Under CMS Medicare COBRA regulations, Medicare eligible survivor spouses must be given a 21-day notice from the date that the PEBTF receives notification of the qualifying event (death) prior to termination of REHP coverage. If the notification date does not allow the 21-day notice before the end of the month, the REHP coverage will be extended an additional month. For example, if the PEBTF is notified on November 15th of the death and the spouse is in the Medicare Open Access PPO; the spouse would be covered until December 31st.

The Medicare eligible spouse then would be returned to Traditional Medicare Parts A and B effective the 1st day of the next month and will not receive REHP medical or prescription drug coverage. If survivor spouse coverage is elected, the effective date in the Medicare Open Access PPO would be the 1st of the month following the receipt of the election notice. Any claims incurred between the end the month and the 1st of the month following election of survivor spouse coverage will be processed under the Medicare Supplemental plan.

On rare occasions, a spouse dies so soon after the death of a Retiree that there is insufficient time for the spouse to elect continued coverage under the REHP. The REHP allows for retroactive election of survivor spouse coverage by the executor of a deceased spouse's estate if a survivor spouse dies within 60 days of the death of a Retiree. The executor shall be limited to electing coverage under the health plan in which the survivor spouse was enrolled prior to the date of their death. If a survivor spouse dies later than 60 days after the death of the Retiree, the PEBTF shall assume that either the spouse or their authorized representative had sufficient time to elect either COBRA or survivor spouse coverage. In the latter instance, the executor of the spouse's estate shall not be allowed to retroactively elect survivor spouse or COBRA coverage.

NOTE: If the survivor spouse is also a Commonwealth Retiree and REHP eligible, they may elect to return to their own REHP coverage instead of electing the survivor spouse benefits. If this is the case, the survivor spouse should contact SERS for enrollment in their own Retiree coverage. If the survivor spouse is covered under PSERS, or ARS, the survivor spouse should contact the PEBTF.
Coverage under the survivor spouse benefit also is available to those spouses of active or former Commonwealth Employees that could have retired with REHP coverage the day prior to their death. The SERS office will send a notice to the survivor spouse, if appropriate.

NOTE: Please see page 15 for information on your REHP medical and prescription drug options. **If you enroll in a private Part D prescription drug standalone plan or private Medicare Advantage Plan, you and your Dependents' REHP coverage will be terminated.**

COBRA Continuation Coverage

As provided by the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), your eligible Dependents have the right to continue benefits under the REHP if coverage ends for certain specified reasons which are referred to as "qualifying events:"

- Your death - in the event of your death, your Dependents should report the death to SERS. SERS will report it automatically to the PEBTF
- Your divorce or legal separation (in states that recognize legal separation) – SERS must be notified within 60 days of the date of divorce to issue a COBRA Election Notice
- Your Dependent(s) child no longer meets the eligibility requirements for coverage

NOTE: If you voluntarily drop (disenroll) a Dependent(s) from coverage as permitted by the REHP rules, who would otherwise be an eligible Dependent(s) if not disenrolled, this is not a COBRA qualifying event. Likewise, if your or your Dependent(s)'s coverage is suspended by the REHP for failure to repay amounts owed, or for failure to cooperate with respect to subrogation or coordination of benefits, such suspension is not a COBRA qualifying event.

NOTE 2: Federal law (COBRA) includes legal separation as a qualifying event. However, Pennsylvania law does not recognize or provide for a legal separation.

Notices – Important

You or another qualified beneficiary in your family has the responsibility to inform SERS of a divorce, legal separation, or child's loss of Dependent(s) status under the plan. This information must be provided within 60 days of the date of the qualifying event. Otherwise, you (or your family member) will not be permitted to continue coverage under COBRA. If coverage is lost due to a Retiree's death, your Dependents should report the death to SERS. SERS will report it automatically to the PEBTF.

When the PEBTF becomes aware of a qualifying event, the PEBTF will notify the affected Dependent(s) that they have the right to choose continuation coverage. That notice will include more information about rights under COBRA. As discussed above, the former Eligible Member will have 60 days to elect COBRA coverage. If they fail to elect COBRA, the PEBTF coverage will terminate under the ordinary terms of the plan. You should notify the PEBTF or SERS of any changes in your address or other changes that may affect how COBRA information is provided to you.

Support Orders

Either you or the Dependent(s) spouse member may elect COBRA coverage for the Dependent(s) spouse member. It should be noted that a court spousal support order which directs that you provide medical coverage for your spouse does not, and cannot, require that the REHP do anything other than comply with the terms of the benefit plan, including the plan's provisions and procedures for continuation coverage under COBRA. Therefore, you or the spouse member must duly elect, and timely pay for, COBRA coverage in accord with the plan's COBRA requirements in order to fulfill the Retiree Eligible Member's obligation under the court order. Such a court order for spousal support relates only to the Retiree Eligible Member's obligation, as the PEBTF, the REHP, and the Commonwealth are not parties under the court's jurisdiction in such a legal action.

Cost of Continued Coverage

Continued coverage is available to your Dependent(s) at your or your eligible Dependent(s)'s expense. The cost to you or your Dependents for this continued coverage will not exceed 102% of the REHP's cost, as determined by the Commonwealth. However, in the case of a disabled individual whose 18-month continued coverage is extended to 29 months, the cost can be up to 150% of the REHP's cost during this 11-month period.

You also will receive a notice from your health plan indicating that your coverage has been terminated.

Applying for Continued Coverage

You, your spouse, or former Dependent(s) child is obligated to notify SERS, in writing, within 60 days of a divorce or a Dependent(s) child losing Dependent(s) status for the COBRA notice to be sent timely. If you, your spouse, or former Dependent(s) child does not notify SERS within 60 days of a divorce or loss of Dependent(s) status, then the spouse or former Dependent(s) child will not be eligible to elect COBRA continuation coverage. Failure to notify the PEBTF of these events within the 60-day time limit will cause COBRA coverage to be unavailable.

If the PEBTF is notified within the 60-day time limit of the qualifying event, the PEBTF shall, within 14 days, send a COBRA election notice to the affected Dependents, by First Class Mail. The former Eligible Member will have 60 days to elect COBRA continuation coverage. They must elect and send the Election Form to the PEBTF on or before the 60th day from such notification date. **If the Election Form is not mailed (postmarked) before or by the 60th day, the former Eligible Member will not receive another opportunity to elect COBRA coverage.**

If they elect continued coverage within 60 days of losing coverage or the date they are notified, whichever is later, their coverage will be effective as of the date they became ineligible. The coverage is reinstated retroactive to the qualifying event. However, expenses incurred by the Eligible Member who lost coverage must be resubmitted for payment.

If you or your Dependent(s) has informed the PEBTF of a qualifying event within the 60-day time limit, but are determined to be ineligible for COBRA coverage, the PEBTF will send you a notice of COBRA unavailability explaining the reason.

PLEASE NOTE: You will be responsible for any claims incurred by your former spouse or Dependent(s) child after eligibility for REHP coverage is lost unless SERS is notified within 30 days of the effective date of the divorce. SERS has the responsibility to notify the PEBTF of the Retiree's death within 30 days from the date SERS is notified. It is your responsibility to notify the PEBTF, in writing, of any address changes.

Paying for COBRA Coverage

Within 45 days of the election of COBRA, you must pay an initial premium which will be billed by the PEBTF. This premium includes the period of coverage from the date of your qualifying event to the date of the election notice, and any regular monthly premium that becomes due between the election and the end of the 45-day period. Thereafter, premiums must be paid monthly and must be postmarked to the PEBTF on or before the due date or COBRA coverage will be terminated. This time limit will be strictly enforced. If your premium is not postmarked timely, you will receive a "reminder notice" which identifies the grace period – the end of the month for which the premium is due. However, if payment is not postmarked by the last day of the month, coverage will be terminated, and you will receive a "termination notice" within two weeks. Initial COBRA notices are sent to your last known address according to PEBTF records. Notices to COBRA Eligible Members are sent to the address specified on the COBRA Election Form. It is the responsibility of the COBRA member to notify the PEBTF, in writing, of any address change.

Effect of Waiving COBRA Coverage

If coverage is waived or the former Eligible Member fails to timely respond to the COBRA Election Notice, COBRA may not be elected after the 60-day election period. In addition, if the Dependent(s) experiences a gap in coverage as a result of a waiver of COBRA, the waiver of COBRA may affect a Dependent(s)'s Certificate of Coverage (which protects a member's right not to be affected by pre-existing medical condition requirements when obtaining new medical insurance, e.g., under a new employer's plan of benefits).

Length of Continued Coverage

COBRA continuation coverage will end on the earliest of the following dates:

- At the end of 18 months from the date COBRA coverage began if the qualifying event is because your disability retirement is denied after re-examination
- At the end of 36 months from the date COBRA coverage began for your Dependent(s) if the qualifying event is your death, divorce or separation, your child's loss of Dependent(s) status, or the Dependent(s)'s entitlement to Medicare
- Failure to pay the required monthly premium, other than the first premium, within 30 days of the due date. Coverage will be canceled retroactive to the paid thru date. The PEBTF will not issue a pro-rata refund for COBRA premiums.
- Your eligible Dependent(s) becomes, after the date of the COBRA election, entitled to Medicare
- Your eligible Dependent(s) becomes, after the date of the COBRA election, covered under another group health plan (as an Employee or otherwise)
- The REHP terminates all of its health care plans
- The end of the period for which the premium was paid for the COBRA benefit

If COBRA coverage is terminated prior to the end of scheduled period of coverage, the PEBTF will send the COBRA member a notice of early termination of COBRA explaining (1) the reason for termination, (2) the effective date and (3) an explanation of any rights the COBRA member may have to elect alternative coverage.

Special Disability Rules

An 18-month continuation of COBRA coverage may be extended to 29 months if:

- Your Dependents are determined by the Social Security Administration to be totally disabled and the disability occurred within the first 60 days of COBRA coverage provided that:

1. Your Dependent(s) notifies the PEBTF of the disability determination before the end of the 18-month period, and
2. The disability continues throughout the continuation period

- The special rules apply to the disabled individual and to other Dependents

In order to qualify for the additional 11 months of extended coverage, your disabled Dependents must notify the PEBTF within 60 days of being classified as totally disabled under Social Security. Likewise, if Social Security determines that a Dependent(s) is no longer totally disabled, you must notify the PEBTF within 30 days.

Extension of COBRA Due to a Second Qualifying Event

If a second qualifying event occurs before the end of the 18 months of COBRA coverage due to termination of employment or reduction in work hours, you may be entitled to an additional 18 months of COBRA coverage for a total of up to 36 months.

A second qualifying event includes:

- Death of a COBRA Employee member
- Divorce
- Change in Dependent(s) status
- Medicare entitlement of Employee member

You must notify the PEBTF of a second qualifying event within 60 days.

COBRA Open Enrollment

During the Open Enrollment period, the COBRA member may change plan options. As a COBRA participant, you may enroll in any REHP approved plan for which you are eligible (based on Retiree's date of retirement) which offers service in your county of residence.

Further Information

The rules that apply under COBRA may change from time to time. If you have any questions about COBRA, please write or call the PEBTF or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Office are available through EBSA's website at www.dol.gov/ebsa.

Additional Information
(All Retirees)

Changing Coverage

All Retirees

Non-Medicare Retirees, eligible survivor spouses and COBRA enrollees may change plan options during the annual Open Enrollment period. The PEBTF will notify you in advance of the dates of the annual Open Enrollment; you will be provided with enrollment materials. Cost information of each of the plans will be provided to Eligible Members who pay for their medical coverage. You and your eligible Dependents may enroll in any REHP approved plan which offers service in your county of residence. Any change in coverage is effective on the date specified as the beginning of the next plan year.

You may change plan options during the non-Open Enrollment periods under certain circumstances:

- At the time of retirement and/or initial enrollment or re-enrollment in the REHP
- If the Primary Care Physician (PCP) in an HMO plan terminates affiliation with the HMO
- You move outside of your plan's service area or into the service area of a plan not offered in your prior county of residence
- You have complied with the grievance procedure of your plan, but were unable to resolve the problem
- A Qualifying Life Event that causes a minor Dependent(s) to lose coverage

See the Glossary for a list of Qualifying Life Events.

If you change plan options during non-Open Enrollment periods, the effective date of coverage cannot be more than 60 days prior to the date you sign your Enrollment/Change Form and submit any necessary accompanying documentation, or, not more than 60 days if the change is due to a Qualifying Life Event. You must contact SERS (or the PEBTF for PSERS or ARS Members) to initiate a change in coverage. If you elect to enroll in a PPO mid-year, you will be responsible for the full annual Deductible. The annual Deductible is not prorated for mid-year enrollments.

Medicare Eligible Retirees

Medicare eligible Retirees are enrolled in the Medicare Open Access PPO and the Medicare Part D Prescription Drug Plan.

Do not destroy your traditional Medicare ID card (red, white, and blue card). You may use this ID card for other services or discounts in your community. Do not present your Medicare ID card at the doctor's office if you are enrolled in the Medicare Open Access PPO. Present your Medicare Open Access PPO ID card only. You will receive a new prescription drug ID card for the Medicare Part D prescription drug plan. Any non-Medicare Dependents will remain with the non- Medicare Part D prescription drug plan.

Appeals – Expedited Appeal Process For Non-Medicare Retirees Only

You have the right to appeal. Refer to the information on the following pages and adhere to the timeframes for filing your appeal.

The REHP offers an expedited appeal process. An expedited procedure for conducting such review is available, as follows:

The Commonwealth recognizes that there may be appeal cases where expedited review is Medically Necessary in order to secure prompt and appropriate medical treatment. Where the Commonwealth is authorized to review appeals, the Executive Director of the PEBTF, in consultation with such PEBTF staff as the Executive Director deems appropriate may, in their sole discretion, submit an appeal for expedited review to the Commonwealth, due to Medical Necessity. The Commonwealth will review the appeal in accordance with established procedures.

Appeals – Right to Appeal Prior Authorization Determinations For Non-Medicare Retirees Only

The Claims Payor acting under the authority of the PEBTF, and not the PEBTF itself, shall be responsible for reviewing and making all determinations, on initial request and every level of appeal, for any authorization or approval that you are required to obtain under the terms of this plan prior to the provision of any service or product. Such reviews and determinations shall be made in accordance with the procedures of the Claims Payor. The Commonwealth shall not review any of these prior authorizations or approval decisions, except, to the extent that:

1. The Claims Payor has issued the final determination that it will render under its procedures with respect to a request by you for prior authorization; and

2. You are not satisfied with such determination; and

3. The denial is not based on any decision as to the Medical Necessity or Experimental or Investigative nature of a service or product or on any other clinical or medical judgment; you may appeal such decision to the Commonwealth and the Commonwealth shall review such appeal in accordance with the procedures set forth in the appeals section of this Handbook. To the extent a Claim's Payor's prior authorization or appeal determination is not or cannot be appealed, the determination shall be final and binding.

The provisions of this section shall be subject to any rights that you have under applicable law to review a plan determination by a governmental or other entity, other than the PEBTF or a Claims Payor.

Appeal Process – Eligibility Denied

Your written appeal must be made in writing, by completing the Appeal Request Form, to the PEBTF with the appeal made within 180 days of the date you receive notice that your eligibility has been terminated. A failure to appeal within this 180-day period will result in an automatic denial of your appeal. The Appeal Request Form, which may be found on www.pebtf.org, should include information as to why you believe that the eligibility rules were not correctly applied. Instructions for submitting the Appeal Request Form are found on the form.

The Commonwealth will review your appeal, including such other pertinent information as you may present and the PEBTF will notify you of the Commonwealth's decision, and the reasons therefore.

All appeal decisions rendered by the Commonwealth are final.

Appeal Process – Non-Medicare PPO & HMO Options

If your claim for benefits under the health plan is denied, the Claims Payor will advise you in writing of the denial, the reason(s) for it, and the steps you can take to appeal the denial. You must follow the Claims Payor's procedures for appealing a denied claim.

Your appeal must be made in writing within 180 days after you receive notice that the claim has been denied (which may take the form of an Explanation of Benefits). You (or your authorized representative) can submit issues and comments in writing. The Claims Payor will advise you of its decision on appeal, including if you have the right (if your appeal is denied) to a second-level appeal to the Claims Payor. The Claims Payor will advise you of the specific reason(s) for its decision, including references to the provisions of the plan (or the Claims Payor's policies and procedures) on which it is based. You have the final right of appeal to the Commonwealth of Pennsylvania's Office of Administration, as set forth below in the paragraph entitled "Final Appeal Process."

Appeal Process – Mental Health and Substance Use Program

You must comply with the written grievance and appeal procedures of the Mental Health and Substance Use Program. If you have had an In-Network or Out-of-Network claim denied, you must make a written request for review to the Mental Health and Substance Use Program within 180 days after you receive notice that the claim has been denied. You (or your authorized representative) can submit issues and comments in writing. The Claims Payor will advise you of its decision on appeal, including if you have the right (if your appeal is denied) to a second-level appeal to the Claims Payor. The Claims Payor will advise you of the specific reason(s) for its decision, including references to the provisions of the plan (or the Claims Payor's policies and procedures) on which it is based. You have the final right of appeal to the Commonwealth of Pennsylvania's Office of Administration, as set forth below in the paragraph entitled "Final Appeal Process."

Appeal Process – Prescription Drug Plan

Prior Authorization

Your Prescription Drug Plan requires prior authorization for certain medications. This requirement helps to ensure that Eligible Members are receiving the appropriate drugs for the treatment of specific conditions and in quantities as approved by the U.S. Food and Drug Administration (FDA). For most of the drugs that appear on the prior authorization list, the process takes place at the pharmacy. If you try to obtain a drug that appears on the prior authorization list, your pharmacist will be instructed to contact the Prescription Benefit Manager. Participating pharmacies will then contact your physician within 24 hours to verify the diagnosis and to obtain other relevant information to make a determination of coverage.

If the request is approved, you will be notified to go to the pharmacy to obtain the medication. The approval for that specific drug will be for a period from several days up to a Maximum of one year. If the request is denied, you have the right to appeal this decision to the Prescription Benefit Manager.

Brand Versus Generic Cost Difference

If you or your doctor believe that a brand-name drug is necessary, you may appeal the generic reimbursement policy to the Prescription Benefit Manager.

All appeals must include information on why you are unable to take the generic drug. Your written request for appeal must be postmarked or received (if sent by other than U.S. Mail First Class) to the Prescription Benefit Manager within 180 days after you last filled your prescription.

Final Appeal Process

If you are not satisfied with the Claims Payor's decision on appeal, you have the right to appeal to the Commonwealth of Pennsylvania's Office of Administration. All final appeals must include copies of the Claims Payor's final denial(s), along with the completed Appeal Request Form and other supporting documentation explaining why you believe the Claims Payor's decision should be reconsidered. Instructions for submitting the Appeal Request Form, which may be found on www.pebtf.org, are found on the form. Your appeal must be postmarked or received (if sent by other than U.S. Mail First Class) within 30 days of receipt of the Claims Payor's final decision. The PEBTF will then forward the appeal to the Commonwealth's Office of Administration for review. The Commonwealth's Office of Administration will review your appeal, including such other pertinent information as you may present and the PEBTF will notify you of the Commonwealth's Office of Administration's decision, and the reasons, therefore.

All decisions rendered by the Commonwealth of Pennsylvania's Office of Administration are final and binding.

If you fail to file an appeal, as set forth above, then you shall be deemed to have forfeited your right to commence legal action. You may not commence legal action until after you have exhausted all claim and appeal rights and received a final decision from the Commonwealth's Office of Administration.

In the event you are awarded an amount in benefits that were denied under the Plan when you failed to exhaust your claim and appeals rights, you will forfeit the right to that amount of benefits with respect to future claims.

The Commonwealth will not consider appeals of claim denials based on Medical Necessity or Experimental or Investigative nature of a service or product or on any other clinical or medical judgment. The Claims Payor's decision on such claims is final and binding.

Appeals – Expedited Appeals Process

The PEBTF offers an expedited appeal process. An expedited procedure for conducting such review is available, as follows:

The PEBTF recognizes that there may be appeal cases where expedited review is Medically Necessary to secure prompt and appropriate medical treatment. For this reason, the PEBTF offers an expedited appeal process. An expedited procedure for conducting such review is available as follows: Where the PEBTF is authorized to review appeals, the Executive Director of the PEBTF, in consultation with such PEBTF staff as the Executive Director deems appropriate may, in their sole discretion, submit an appeal for expedited review to the Commonwealth's Office of Administration. The Commonwealth's Office of Administration will review the appeal in accordance with established procedures and provide a decision within 72 hours of the PEBTF's receipt of appeal.

Independent Review

You shall have the right to request an independent review of a denial of an appeal for a claim that involves medical judgment or a rescission of your coverage under the Plan in accordance with the rules set forth in applicable law and regulations. The request for independent review must be received by the designated Claims Payor within four months of the date that you receive notice of a final adverse benefit determination. Within five business days of the request for independent review, the Claims Payor will conduct a preliminary review to determine if the request is proper and complete to proceed with an independent review. Within one business day of its determination, the Claims Payor will notify the claimant of its determination and, as applicable, any additional information that the claimant needs to submit to proceed with an independent review. If more information is required, the claimant must provide that information before the end of the four-month period to request independent review or, if later, within 48 hours of receiving notice that more information is required.

If approved for independent review, the Claims Payor will assign the request to an Independent Review Organization (IRO). Within five business days of the assignment, the Claims Payor will furnish the IRO the information that was considered in making the determination subject to independent review. Within ten business days of receiving notice that the request has been approved for independent review, the claimant may submit additional information to the independent review organization. Within one business day of receipt, the IRO shall furnish such information to the Claims Payor, which may reconsider its determination on the basis of such information. Unless the Claims Payor reverses its determination, the IRO shall provide written notice of its decision on independent review to the claimant and the Claims Payor within 45 days of the IRO's receipt of the request for review.

In the event of an urgent claim, the claimant may request an expedited review. For such a claim, these procedures will be expedited to allow for an immediate preliminary review and a determination by the IRO as expeditiously as required by the claimant's medical condition and other circumstances, but in any event within 72 hours of the IRO's receipt of the request for expedited review.

Certain Out-of-Network Services

Notwithstanding any provisions of this Plan to the contrary (but, for purposes of clarity, subject to Plan provisions regarding exclusions of coverage, coordination of benefits, waiting periods, and other applicable Plan terms), for items and services described in the next sentence, the amount of benefits payable under the Plan and the amount of cost-sharing paid by a Plan participant and the process for determining such amount, including all processes for resolving claims and appeals, shall be subject to and in accordance with rules set forth in the Public Health Services Act and the rules, forms, and standards promulgated thereunder relevant to such items and services (the "Out-of-Network Rules"). The rules set forth in this Section apply to the following items and services:

- Out-of-Network Emergency Services;
- Items and services provided by an Out-of-Network Provider in connection with your inpatient stay at an In-Network Hospital or Facility Other Provider, except where appropriate notice and consent for charges have been, respectively, provided and received by the Provider, which would allow the Provider's charges to be processed in accordance with the rules prescribed elsewhere in this section in accordance with applicable law; and
- Items and services furnished by an Out-of-Network air ambulance service.
- The independent review process described in the previous section shall be available in the event a determination under this process calls into consideration issues of compliance with the applicable provisions of the Out-of-Network Rules. A request for such review must meet the standards prescribed under the Public Health Services Act and include information

sufficient to identify the items or services furnished, including the relevant dates, service codes, and initial payment amount, if any.

Appeal Process – Medicare Open Access PPO

If you have a problem with your Medicare Open Access PPO or you believe a claim has been unfairly denied, you must follow the guidelines established by the Medicare Open Access PPO and Centers for Medicare and Medicaid Services (CMS) and published in your Evidence of Coverage (EOC). There also is a State Health Insurance Advisory Program (SHIAP) which you can call for assistance with Medicare bills including payment denials or appeals. In Pennsylvania, SHIAP can be reached at 1-800-783-7067. Claims denied by the Medicare Open Access PPO may not be appealed to the Commonwealth of Pennsylvania's Office of Administration. The Commonwealth does not have the authority to change the Medicare Open Access PPO's claim decision.

Section 1557 of the Patient Protection and Affordable Care Act – Grievance Procedures

Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services prohibit discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. The PEBTF has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557. The PEBTF has also designated a Civil Rights Coordinator to coordinate efforts to comply with Section 1557. The text of Section 1557 and its implementing regulations may be examined in the office of the Civil Rights Coordinator.

At the time these grievance procedures are established, you may contact the Civil Rights Coordinator at PEBTF, Mailstop: CRAC, 150 S. 43rd Street, Harrisburg, PA 17111, [717-565-7200], [717-307-3372], [civilrightscoordinator@pebtf.org].

Any person who believes someone has been subjected to discrimination based on race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for the PEBTF to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Civil Rights Coordinator within 90 days of the date of the alleged discriminatory action or, if it is not reasonable to expect the individual filing the grievance to be aware of such action when it occurs, the date of the first notice or other communication of the action to the individual.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Civil Rights Coordinator (or their designee) shall investigate the complaint. This investigation may be informal, but it will be thorough and consider all the evidence relevant to the complaint submitted by the individual filing the grievance. The Civil Rights Coordinator will maintain the files and records of the PEBTF relating to such grievances. To the extent possible, and in accordance with applicable law, the Civil Rights Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Civil Rights Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 90 days after the Civil Rights Coordinator

receives the grievance, including a notice to the complainant of the right to pursue further administrative or legal remedies.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination based on race, color, national origin, sex, age, or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201.

Additional information about filing a civil rights complaint, including complaint forms, may be accessed through: https://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

The PEBTF will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Civil Rights Coordinator will be responsible for such arrangements.

Benefits From Other Plans (Subrogation and Third Party/ Reimbursement)

If you or any of your enrolled Dependents receive benefits under the REHP for injuries caused by the negligence of someone else, the PEBTF has the right to seek from the responsible party repayment in full for such benefits or to seek reimbursement from you for the full amount of benefits paid to you or your Dependent(s), or on your or your Dependent(s)'s behalf. The PEBTF has the right to recover the full 100% of all benefits paid to you or on your behalf from any third party who may have been responsible, in whole or in part, for the accident or condition which caused such benefits to be paid by the REHP. The "make whole" doctrine shall be inapplicable and shall not preclude such full recovery.

This right of subrogation/reimbursement may be exercised by the PEBTF without regard to whether you have recovered or received damages or reimbursement of any kind, in whole or in part, from any such third party. This right of first recovery applies regardless of how the damages or reimbursement is characterized (economic damages, pain and suffering, etc.) or whether the recovery is due to a court award or a formal or informal settlement. In this respect the REHP is entitled to a right of first recovery for 100% of the benefits which it paid to you or your Dependents or on your or their behalf. This obligation includes benefits paid to, or on behalf of, minor children. The PEBTF pays such benefits on the condition that it will be reimbursed by you, or the guardian of a minor child, to the full extent of the benefits which it has paid.

As a condition of continued eligibility for benefits under the REHP, if you or your eligible Dependents are involved in a matter in which the REHP is exercising its subrogation/reimbursement rights, you and they and anyone acting on your behalf, including an attorney, must cooperate fully and entirely to enable the PEBTF to pursue and exercise its full 100% subrogation/reimbursement rights. In addition, by accepting benefits under the REHP, you accept that the REHP has an equitable lien against any amounts from a third party to the extent that benefits have been paid or are payable under the REHP.

This cooperation requires you (or your Dependents, if applicable) to:

a. Notify the PEBTF, in writing, postmarked or actually received (if sent by other than U.S. Mail First Class) within 30 days of the date you file a claim or complaint or otherwise commence litigation, arbitration or any other legal or administrative proceedings involving or referring to an expense or loss that has been or will be submitted to the PEBTF for payment. This responsibility arises whether the expense or loss is from an accident, malpractice claim or any other source. The notice to the PEBTF must include a copy of the claim or complaint;

b. Notify the PEBTF, in writing, postmarked or actually received (if sent by other than U.S. Mail First Class) within 30 days of the entry of any judgment, award or decision that involves or refers to any expense or loss that has been paid by or has been or will be submitted to the PEBTF for payment. This applies whether or not the PEBTF or the Commonwealth are referenced in such judgment, award or decision; and

c. Notify the PEBTF, in writing postmarked or actually received (if sent by other than U.S. Mail First Class) within 30 days of the date a settlement offer is made or settlement discussions commence with respect to any claim (filed or not filed) relating to an expense or loss that has been paid by the PEBTF. No such settlement may be entered into with a third party without the PEBTF's prior written consent.

Failure to cooperate fully will result in disqualification from all REHP benefits for a period of time as determined by the Commonwealth.

The PEBTF and/or the Commonwealth may commence or intervene in any litigation, arbitration, or other proceeding to assert its subrogation/reimbursement rights. You and your Dependents, if applicable, may not oppose such participation and will assist the PEBTF in all matters relating to its subrogation/reimbursement rights, including authorizing the PEBTF, at its request, to assert a claim against, compromise or settle a claim in your name, on your behalf.

If the PEBTF takes legal action against you for failure to reimburse the PEBTF, you may be liable for all costs of collection, including reasonable attorney's fees, in such amounts as the court may allow.

To the extent required by law, this right of subrogation/reimbursement **does not apply** to any payments the PEBTF makes because of injuries to you, or your Dependents sustained in a motor vehicle accident that occurred in Pennsylvania (exception is for Eligible Members enrolled in an HMO). The applicability of the PEBTF's subrogation/reimbursement rights when you or your Dependents sustain an injury in an automobile accident in another state or foreign country will depend on laws of the other state or country in which the automobile accident occurred.

If the PEBTF makes a demand for reimbursement of benefits paid and you do not reimburse or repay the money, or otherwise cooperate with the PEBTF in its recoupment of monies owed, you and your Dependents will be ineligible for all future benefits until the money is repaid in full, or until you make the first payment under a repayment plan agreed to between you and the PEBTF.

If you agree to a repayment plan, so that coverage is reinstated, and then fail to make any subsequent repayments when due, you and your Dependents will again be ineligible for all future benefits until the money is repaid in full.

You have the right to appeal the PEBTF's demand that you reimburse amounts paid by the PEBTF in a subrogation/reimbursement situation. To do so, complete an Appeal Request Form, which may be found on www.pebtf.org, and return it to the PEBTF along with any supporting documentation. Instructions for submitting the Appeal Request Form are found on the form.

Your appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class within 180 days of the date of the notice or demand to you. If you file an appeal, the suspension of your and your Dependents coverage will be stayed pending resolution of the appeal. The appeal will be considered by the Commonwealth, and you will be advised in writing of their decision.

All decisions rendered by the Commonwealth of Pennsylvania's Office of Administration are final and binding.

If you fail to file an appeal, as set forth above, then you shall be deemed to have forfeited your right to commence legal action. You may not commence legal action until after you have exhausted all claim and appeal rights and received a final decision from the Commonwealth's Office of Administration.

NOTE: A suspension of benefits as described above is not a qualifying event for self-pay continuation coverage under COBRA.

Coordination of Benefits

The PEBTF coordinates benefits with other group insurance plans under which you may be covered. For instance, your spouse may be covered under their own medical plan. This provision is for the purpose of preventing duplicate payments for any given service under two or more plans.

- Benefits coordinated with other plans include medical, prescription drug and Mental Health and Substance Use services
- You cannot receive duplicate payment for the same service
- Other coverage must be reported any time there is a change in such coverage.

Example: You are not allowed to receive more than one payment for the same services. If your spouse is employed by a non-Commonwealth employer, they may be covered under their own employer's plan as an Employee and under the REHP as a Dependent(s). To prevent duplicate payments for any given service under two or more plans, the PEBTF coordinates benefits with other group insurance plans under which you or your Dependents may be covered.

When filing claims for medical or prescription drug services, you are required to indicate and identify any other insurance or group health plan(s) in which you or a Dependent(s) participates. You may be entitled to be paid up to 100% of the reasonable expenses under the combined plans. In coordinating benefits, one plan, called the primary plan, pays first. The secondary plan adjusts its benefits so that the total amount available will not exceed allowable expenses. Failure to disclose other coverage or to follow the compliance provisions of either the primary or secondary plan shall disqualify a member for coverage under this section.

The following rules are used to determine the order that benefits are paid:

The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expenses for the claim. In no event shall this plan pay more than it would have paid had it been primary.

A plan for purposes of this Section is any of the following that provides benefits or services for health care or treatment: Group and nongroup insurance contracts, Health Maintenance

Organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law. A plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

A plan without a coordination of benefits provision is the primary plan. If all plans have coordination of benefits provisions, the following rules shall apply in order until a determination as to which plan is primary is made:

1. **Non-Dependent(s) or Dependent(s)**. The plan that covers the person other than as a Dependent(s) is the primary plan and the plan that covers the person as a Dependent(s) is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent(s) and primary to the plan covering the person as other than a Dependent(s) (e.g., a retired Employee) then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee (Eligible Member, policyholder, subscriber or Retiree) is the secondary plan and the other plan is the primary plan.

2. **Dependent(s) Child Covered Under More Than One Plan**. Unless there is a court decree stating otherwise, when a Dependent(s) child is covered by more than one plan, the order of benefits is determined as follows:
   a. For a Dependent(s) child whose parents are married or are living together, whether or not they have ever been married.
      - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
   b. For a Dependent(s) child whose parents are divorced or separated or not living together, whether or not they have ever been married.
      - If a court decree states that one of the parents is responsible for the Dependent(s) child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
      - If a court decree states that both parents are responsible for the Dependent(s) child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
      - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent(s) child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
      - If there is no court decree allocating responsibility for the Dependent(s) child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The plan covering the custodial parent;
        - The plan covering the spouse of the custodial parent;
        - The plan covering the non-custodial parent; and then
        - The plan covering the spouse of the non-custodial parent.

c. For a Dependent(s) child covered under more than one plan of individuals who are not the parents of the child, the provisions of Subparagraphs (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

3. **Active Employee or Retired or Laid-off Employee**. The plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off Employee is the secondary plan. The same would hold true if a person is a Dependent(s) of an active Employee and that same person is a Dependent(s) of a retired or laid-off Employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule set forth in Subsection (a)(1) above can determine the order of benefits. The rule also does not apply if the Retiree is covered under the Retired Employees Health Program ("REHP") or the Retired Pennsylvania State Police Program ("RPSPP") in which event the REHP or RPSPP shall be primary and the PEBTF shall be secondary.

4. **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan that covers the person as an Employee, member, subscriber or Retiree or that covers the person as a Dependent(s) of an Employee, member, subscriber or Retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule set forth in Subsection (a)(1) above can determine the order of benefits.

5. **Longer or Shorter Length of Coverage**. The plan that covered the person as an Employee, member, policyholder, subscriber, or Retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on Benefits: When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

Right to Receive and Release Information: Certain facts about health care coverage and services are needed to apply the rules set forth in this Section and to determine benefits payable under this plan and other plans. The PEBTF may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the Eligible Member claiming benefits. The PEBTF need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the PEBTF any facts it needs to apply those rules and determine benefits payable.

Facility of Payment: A payment made under another plan may include an amount that should have been paid under this plan. If it does, the PEBTF may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. The PEBTF will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery: If the amount of the payments made by the PEBTF is more than it should have paid under this Section, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When the REHP is primary for coordination of benefits, and you and your Dependents have other prescription drug coverage, fill your prescription through the REHP Prescription Drug Plan. When another prescription drug plan is primary for you and your Dependents, submit balances to the REHP Prescription Drug Plan with a Direct Claim/Coordination of Benefits Form along with a copy of your pharmacy receipt and the primary plan's Explanation of Benefits.

Felony Claims

If you or your Dependents sustain injuries during the commission by you or them of a felony, the claims resulting from those injuries are excluded from coverage. If you or your Dependents are acquitted of the felony charge, payment for medical expenses will be provided on a retroactive basis, to the extent covered under the Plan. This exclusion from coverage will not apply to injuries to you or your Dependents that result from an act of domestic violence against you or your physical or mental health condition to the extent that the exclusion of such injuries would result in unlawful discrimination under 45 C.F.R. § 146.121(a)(1)(ii) and (b)(2).

Information about Help in Paying for Your Health Insurance Coverage

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Please note that most children of Commonwealth of Pennsylvania Employees are not eligible for CHIP. Children of Commonwealth Retirees who are eligible for health insurance through the Retired Employees Health Program (REHP) are not eligible for the Children's

Health Insurance Program (CHIP) administered by the Pennsylvania Insurance Department's Office of CHIP.

Commonwealth Retirees who have children who are **eligible** for REHP coverage and are currently enrolled in CHIP should immediately contact the (SERS at 1-800-633-5461 to enroll their children in the REHP, then immediately contact their CHIP insurer to end CHIP coverage.

If you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Pennsylvania offers an assistance program only for Medical Assistance (Medicaid). For a list of the other states' assistance information, please review the information below.

PENNSYLVANIA – Medical Assistance (Medicaid) Premium Assistance
www.dhs.pa.gov1-800-644-7730

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance

Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 5/31/2029)

Motor Vehicle Insurance

If you or one of your Dependents are injured as a result of a motor vehicle accident, you should contact your Motor Vehicle Insurance carrier for information regarding submission of a claim for medical benefits.

Medical benefits payable under your Motor Vehicle Insurance policy, including self-insurance, will not be paid by the REHP. A letter from the insurance company noting that benefits have been exhausted must accompany claims for any additional charges.

Within the Commonwealth of Pennsylvania, bills for medical services required as a result of a motor vehicle accident may not be billed at a rate greater than 100% of the Medicare Allowance. If you are billed an amount in excess of the Medicare Allowance, you should contact your Motor Vehicle Insurance company.

If you or one of your Dependents fail to obtain primary automobile insurance as required by Pennsylvania law, the first $5,000 of claims resulting from an automobile accident is excluded from coverage. The reduction in plan benefits shall also apply to your Dependents, whether or not such Dependents are legally permitted to drive. However, if your Dependent(s) has automobile insurance coverage that meets the requirements of applicable law, independent of any automobile insurance coverage that you have or have not obtained, the benefits available under the plan shall be coordinated with the Dependent(s)'s automobile insurance coverage in accordance with other applicable plan provisions.

National Medical Support Notice (NMSN)

A National Medical Support Notice (NMSN) is a medical child support order transmitted by the state child support enforcement agency which is legally empowered to secure medical coverage for children under their non-custodial parent's group health plans. It is a standardized medical child support order used by the state child enforcement agencies to enforce medical child support obligations of non-custodial parents who are required to provide health care coverage through any employment related group health plan pursuant to a child support order.

A NMSN may be based on a court order (of this or another state) or an order of the state agency itself. A NMSN requires that the PEBTF immediately enroll the children, if eligible and if the NMSN meets the requirements of a qualified medical support order (and also to enroll the Retiree Eligible Member/non-custodial parent, if not already enrolled). The NMSN, like other qualified medical support orders, may not order the REHP to provide any benefits which are not a part of the plan of benefits.

Nondiscrimination Notice: Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, (or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). The Plan does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary

aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PEBTF, Mailstop: CRAC,150 S. 43rd Street, Harrisburg, PA 17111, 1-800-522-7279, TTY number—711, Fax: 717-307-3372, Email: CivilRightsCoordinator@pebtf.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-522-7279 (TTY: 711) or speak to your provider.

Spanish: Español ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-522-7279 (TTY: 711) o hable con su proveedor.

Chinese: 中文 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-522-7279 (文本电话：711）或咨询您的服务提供商。”

Vietnamese: Việt LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-522-7279 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.”

Russian: РУССКИЙ ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-522-7279 (TTY: 711) или обратитесь к своему поставщику услуг.

Pennsylvania Dutch: Pennsylvanisch Deitsch ACHTUNG: Wann du Pennsylvanisch Deitsch schwetzscht, sin Hilfsdienst fer die Sprooch fer dich gratis verfügbar. Passende Hilfsmittel un Dienscht, fer Informatione in zugängliche Formate ze gebbe, sin aa gratis verfügbar. Ruf 1-800-522-7279 (TTY: 711) oder schwetz mit dein Anbieter."

Korean: 한국어 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-522-7279 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오."

Italian: Italiano ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-522-7279 (tty: 711) o parla con il tuo fornitore."

Arabic: العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-522-7279(1-800- tty: 711) أو تحدث إلى مقدم الخدمة".

French: Français ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-522-7279 (TTY : 711) ou parlez à votre fournisseur. »

German: Deutsch ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-522-7279 (TTY: 711) an oder sprechen Sie mit Ihrem Provider."

Gukarati: ગુજરાતી ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-522-7279 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો."

Polish: POLSKI UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-522-7279 (TTY: 711) lub porozmawiaj ze swoim dostawcą".

French Creole: Kreyòl Ayisyen ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-522-7279 (TTY: 711) oswa pale avèk founisè w la."

Mon-Khmer, Cambodian: ភាសាខ្មែរ
សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយជ័សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបាន ដោយឥតគិតថ្លៃដងដែរ។ ហៅទូរសព្ទទៅ 1-800-522-7279 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។"

Portuguese: Português do Brasil ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados

para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-522-7279 (TTY: 711) ou fale com seu provedor."

Qualified Medical Child Support Orders (QMCSOs)

Divorce situations often require the non-custodial parent to continue to provide health insurance coverage for their Dependent(s) children. The PEBTF also must house the address of the custodial parent on its system so that the custodial parent receives important health care information relating to the child. To protect the privacy of the custodial parent, the address of the custodial parent is **never** disclosed to the non-custodial parent who is the REHP Eligible Member.

A Qualified Medical Child Support Order (QMCSO) is a medical child support which creates or recognizes an alternate recipient's right to receive benefits for which an Eligible Member is eligible.

To define the above terms:

A **Medical Child Support Order** is a court judgment, decree, or order, including that of an administrative agency authorized to issue a child support order under state law including approval of settlement agreement, which provides for child support under a group health plan or provides for health coverage to such a child under state domestic relations law, including a community property law and related to benefits under this plan.

An **alternate recipient** is any child of a participant who is recognized under a Medical Child Support Order as having a right to enroll under a group health plan.

To be qualified, a Medical Child Support Order must clearly:

- Specify the name and last known mailing address of the Eligible Member and the name and mailing address of each alternate recipient covered by the order
- Include a reasonable description of the type of coverage to be provided or the manner in which the coverage is to be determined
- Specify each period of time to which the order applies
- Specify each plan to which the order applies

A Medical Child Support Order cannot require the coverage of an individual who is not otherwise eligible as a Dependent(s) under the terms of the plan.
The PEBTF will determine, within a reasonable period of time, whether a Medical Child Support Order is qualified, and if qualified, it will proceed to administer benefits in accordance with the applicable terms of each order and the plan of benefits.

No Assignment of Benefits

No benefits payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge (collectively "Assignment") by any person, and any attempt to affect such an Assignment by an Eligible Member or any other person shall be void. The REHP has no obligation to accept any direction from any Eligible Member to make payment to any person, and any payment of benefits under the Plan that is made directly to a Provider or its agent or representative shall be made as a convenience to the Retiree Eligible Member or Dependent(s) and will not constitute an Assignment. All benefits under the Plan shall be exempt, to the extent permitted by law, from the claims of creditors and from all orders, garnishments, executions, or other legal process or proceedings.

Notice of Creditable Coverage

Coverage under the REHP Prescription Drug Plan is considered to be "creditable coverage" for purposes of meeting the requirements specified under Medicare Part D. The Notice is available by contacting the PEBTF. Medicare-Eligible Members enrolled in the Medicare Part D plan offered by the REHP will not receive the Notice of Creditable Coverage

PEBTF Compliance Plan

The PEBTF has a Compliance Plan. The purpose of the Compliance Plan is to educate the PEBTF's Employees, agents, and staff with respect to the laws, rules and policies that govern the operation of, and their responsibilities to the PEBTF. Eligible Members may request a copy of the Compliance Plan.

Privacy of Protected Health Information

The REHP and the PEBTF adhere to the medical privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and applicable state law and have entered into agreements with the Claims Payors and other professional advisors committing them to matching the confidentiality of personal health information as required by HIPAA. The REHP and the PEBTF have distributed to Eligible Members a Notice of Privacy Practices describing the protections of HIPAA and how these rules are applied. The Notice of Privacy Practices is on page 133 of this Handbook.

The plan or any health insurance issuer or business associate servicing the plan may only disclose Eligible Member's Protected Health Information to the Plan Sponsor (Commonwealth of Pennsylvania) for purposes of plan administration consistent with the plan's governing documents and the Commonwealth's agreement to abide by its obligations under this section/article.

Termination or Suspension of Benefits

The REHP may terminate or suspend your benefits for any of the following reasons: (1): Failure to Repay Payments Made in Error; (2) Unauthorized Utilization; or (3) Misrepresentation or Fraud.

Failure to Repay Payments Made in Error

In the event that the PEBTF or a Claims Payor makes any payment to you or your dependents, or on your or your Dependents' behalf, which are made in error, the PEBTF or the Claims Payor shall have the right to recoup the payment from you or, at its option, to deduct the payment from future payments to which you may be entitled or which might otherwise be payable on your or your Dependents' behalf. Should you fail to repay the money, you and your Dependents will be ineligible for all future benefits until the money is repaid in full, or until the PEBTF receives the initial repayment in accordance with the terms of a voluntary repayment plan agreed to between you and the PEBTF. Such repayment plan shall contain such terms and conditions as the PEBTF may require. However, in the event you should fail to make a timely payment under the repayment plan, the PEBTF may suspend coverage, effective as of the paid-through date, for you and your dependents, and you (and your Dependents) shall thereafter be ineligible for all future benefits until the entire amount owed to the PEBTF is repaid in full.

You have the right to appeal the PEBTF's demand that you reimburse amounts paid by the PEBTF in the above situation. To do so, complete an Appeal Request Form, which may be found on www.pebtf.org, and return it to the PEBTF along with supporting documentation. Instructions for submitting the Appeal Request Form are found on the form. Your appeal must

be postmarked or actually received (if sent by other than U.S. Mail First Class) within 180 days of the date that you receive the demand for payment or notice of suspension. If you appeal a demand for repayment prior to the suspension of benefits, the suspension of your and your Dependent(s)'s coverage will be stayed pending resolution of the appeal. The appeal will be considered by the Commonwealth, and you will be advised in writing of its decision. **The decision of the Commonwealth is final.**

NOTE: Suspension of benefits in the event of a failure to repay is not a qualifying event for self-paid continuation coverage under COBRA.

Right to Withhold Future Benefits

In the event the PEBTF determines that you are obligated to reimburse amounts owed to the PEBTF, the PEBTF may require immediate reimbursement in full or, as an alternative, may permit you to reimburse the Plan in accordance with a voluntary repayment plan agreed to between you and the PEBTF. Should you fail to reimburse the Plan, you and your Dependents will be ineligible for all future benefits until the date the reimbursable amount is paid to the Plan in full, or until the PEBTF receives the initial repayment in accordance with the terms of a voluntary repayment plan containing such terms and conditions as the PEBTF may require. However, in the event you should fail to make timely payment under the repayment plan, you and your Dependents, shall thereafter be ineligible for all future benefits, even if all amounts are repaid to the PEBTF. The PEBTF shall have discretion to determine if you may regain eligibility for benefits in the future, based on the facts and circumstances.

Unauthorized Utilization

If you or your Dependent(s) utilizes benefits when not eligible for such benefits (i.e., loss of benefits due to divorce, etc.), you will be required to repay the PEBTF for the full amount paid. If you do not repay the money or otherwise fail to cooperate with the PEBTF in its recoupment of monies owed, see the section above, Right to Withhold Future Benefits. You have the right to appeal the PEBTF's demand that you reimburse amounts paid by the PEBTF in the above situation. To do so, complete an Appeal Request Form, which may be found on www.pebtf.org, and return it to the PEBTF along with any supporting documentation. Instructions for submitting the Appeal Request Form are found on the form. Your appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class) within 180 days of the date of the notice or demand to you. If you file an appeal, the suspension of your and your Dependent(s)'s coverage will be stayed pending resolution of the appeal. The appeal will be considered by the Commonwealth, and you will be advised in writing of its decision. **The decision of the Commonwealth is final.**

NOTE: Suspension of benefits in the event of a failure to repay is not a qualifying event for self-paid continuation coverage under COBRA.

Misrepresentation or Fraud

If you receive benefits under the Plan as a result of the provision of false information, you shall be suspended from such benefits. The term "suspended" shall mean that your eligibility for coverage (including eligibility for your dependents) under the Plan is terminated retroactively to the Suspension Application Date (as defined below). In no event will your eligibility be reinstated unless the amount owed to the REHP is repaid in full. You shall repay all amounts paid by the REHP on or after the Suspension Application Date for as long as the suspension remains in effect, and shall be liable for all costs of collection, including attorneys' fees in accordance with the following rules:

1. The "Suspension Application Date" shall be the date of the notice to the Eligible Member (or the Retiree Eligible Member) that benefits are being suspended, provided that, if the suspension arises from a Eligible Member's fraud or intentional misrepresentation of a material fact, the Suspension Application Date shall be the date of such fraud or intentional misrepresentation (or the date that such fraud or intentional misrepresentation begins or is first committed in the event of an ongoing or repeated occurrence).
2. Where the Eligible Member who is responsible for the false information is a Retiree Eligible Member, the suspension shall apply to the Retiree Eligible Member and all of their Dependents. The Retiree Eligible Member shall be fully responsible for the repayment of benefits and collection costs resulting from the false statement for all such individuals.
3. Where the Eligible Member who is responsible for the false information is the Dependent(s) of a Retiree Eligible Member, the suspension shall apply to such Dependent(s).
4. If a Member's benefits have been suspended under this Section, such benefits shall remain suspended indefinitely unless, in its sole discretion, the PEBTF determines that the Member is eligible to re-enroll benefit coverages, based on the facts and circumstances.
5. For purposes of this Section, an individual shall be regarded as the Dependent(s) of a Retiree Eligible Member if the individual is or was covered under the Plan as the Retiree Eligible Member's Dependent(s), whether or not the individual is or ever was such a Dependent(s).
6. A suspension of coverage resulting from the provision of false information will not be a qualifying event for self-pay continuation under COBRA.
7. For purposes of appropriate Plan administration, the Plan Administrator shall report the suspension of an Eligible Member's eligibility for coverage to the Commonwealth.

An Eligible Member may appeal their suspension of benefits under this Section to the PEBTF. To do so, complete an Appeal Request Form, which may be found on www.pebtf.org, and return it to the PEBTF along with any supporting documentation. Instructions for submitting the Appeal Request Form are found on the form. Your appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class) within 180 days after the date that notice of suspension is received by the Eligible Member.

If the appeal is approved, benefits will be paid retroactively to cover any period for which benefits were improperly suspended. **The decision of the Commonwealth is final.**

Recovery of Benefits for Ineligible Individuals

1. **Prescription Drug Benefits (non-Medicare eligible retirees):** In the event that the Plan pays benefits under a Prescription Drug Benefits for the expenses of an individual who does not meet the Plan's definition of Eligible Member and is therefore not otherwise eligible to be covered under the Plan, the Retiree member shall be required to repay the PEBTF the full amount of such overpaid benefits within 60 days of the date that the Retiree member is notified of the amount due, unless alternative repayment arrangements are made with the PEBTF in accordance with the provisions of this Section.

2. **Medical Benefits (non-Medicare eligible retirees):** In the event the Plan pays any medical benefits for the expenses of an individual who does not meet the Plan's definition of Eligible Member and is therefore not otherwise eligible to be covered under the Plan, such benefits may be reprocessed by the Claims Payor and recouped from the Provider. The Member (or the Member's Dependent) may be billed directly by the Provider, at the discretion of the Provider. To the extent the Claims Payor is not able to recoup such overpaid benefits, the Retiree member shall be required to repay the PEBTF the full amount

of such overpaid medical benefits within 60 days of the date that the Retiree member is notified of the amount due, unless alternative repayment arrangements are made with the PEBTF in accordance with the provisions of this Section.

3. **Repayment and Nonpayment of Amounts Owed to the Plan (non-Medicare eligible retirees).** To address amounts owed a voluntary repayment plan agreed to between Member and the PEBTF can be arranged. Should the Retiree member fail to repay any amounts owed to the Plan for benefits paid to ineligible individuals, the Member and all of the Member's dependents will be ineligible for future Plan benefits (provided the individual is otherwise eligible for coverage) until the date the money is repaid in full, or until the PEBTF receives the initial repayment in accordance with a voluntary repayment plan agreed to between the Member and the PEBTF. The repayment plan shall contain such terms and conditions as the PEBTF may require. However, in the event the Member should fail to make a timely payment under the repayment plan, the PEBTF may suspend coverage, effective as of the paid-through date, for the Member and the Member's dependents, and the Member (and the Member's dependents) shall thereafter be ineligible for all future benefits until the entire amount owed to the PEBTF is repaid in full.

   The Member may appeal any demand for repayment or suspension of coverage described in this Section by filing an appeal to the PEBTF. To do so, complete an Appeal Request Form, which may be found on www.pebtf.org, and return it to the PEBTF along with any supporting documentation. Instructions for submitting the Appeal Request Form are found on the form. Your appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class) within 180 days of the demand for repayment or notification of suspension. The PEBTF reserves the right to seek recovery of amounts owed to the Plan through any method permitted by law including, but not limited to, litigation.

Time Limits

Throughout this Handbook there are provisions regarding time limits for filing claims, paying COBRA premiums, and notifying the PEBTF about various matters. The time limits apply to receipt of appeals or other matters within the specified time periods as set forth in this Handbook. This means that the Claims Payor to whom the appeal or other notification is addressed must actually receive the claim notification or appeal within the specified time. The postmark of the claim notification or appeal within the specified time is the controlling factor. These time limits must be strictly adhered to as they are strictly enforced. Do not jeopardize your rights to receive benefits by failing to observe the applicable time limits.

Veterans Administration Claims

If you receive services at a Veterans Administration (VA) hospital or outpatient facility for a non-service-related injury or illness, the VA can submit a claim to the proper Claims Payor for the amount that would have been paid if you were not treated in a VA facility. Federal Law requires that payment go directly to the VA facility.

Some of the health plans may require that you pay for the services at the time of your visit. You will then submit a claim form to the plan. Contact your health plan for information on how the plan handles VA facility claims.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Legal Duty of the PEBTF

The PEBTF is required by applicable federal and state laws to maintain the privacy of your personal health plan information, otherwise known as "protected health information" ("PHI"), and to notify you in the event of a breach of unsecured PHI. We are also required to give you this notice about our privacy practices, our legal duties with regard to PHI, and your rights and the rights of your dependents concerning PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on September 23, 2013. It revises and replaces the notice of our privacy practices that was in effect prior to that date.

The PEBTF reserves the right to change our privacy practices, and the terms of this notice, at any time, according to applicable law. Before we make a material change in our privacy practices, we will change this notice and provide the new notice (or notice of the changes) to you if you remain enrolled in our health plans at the time of the change. You may request a copy of this notice at any time. For more information about our privacy practices, or to request an additional copy of this notice, please contact the PEBTF by using the information listed at the end of this notice. The notice is also available on our website, www.pebtf.org.

PHI

Protected health information, also known as "PHI", is a special term defined by government regulation to include any information, including genetic information, that: (i) is created or maintained by a health plan or certain other entities; (ii) relates to the past, present or future physical or mental health or condition of an individual or the provision of and/or payment for the provision of health care to an individual; and (iii) identifies the individual or provides a reasonable basis to believe that the individual could be identified. PHI may be received or maintained in any form, including oral statements. Examples of PHI are a diagnosis or a diagnosis or procedure code combined with your name, address, Social Security number, birth date, date of service, telephone number, or fax number.

The PEBTF may receive PHI about you and your family members from enrollment forms, which include name, address, Social Security number, birth date, telephone number, health care provider, and other health insurance coverage. We may also receive PHI about you from various other sources, such as employers, health care providers, federal and state agencies, or third-party vendors.

Except as described below, the PEBTF will provide access to your PHI only to you, your authorized representative, and those persons who need the information to aid the PEBTF in the conduct of its business (our "Business Associates") or as you specifically authorize us to do so in accordance with defined procedures. You have the right to revoke this authorization, also in accordance with defined procedures. These formal "Authorization" rules are described later in this notice.

When using or disclosing PHI, the PEBTF will make reasonable efforts to limit the use and disclosure of that information to the minimum amount necessary to accomplish the intended purpose. The PEBTF maintains physical, technical and procedural safeguards to protect PHI and our vendors who obtain or create PHI in providing health plan services (our "Business Associates") are limited by contract and by law to using or disclosing that PHI only for the purposes that it was obtained or created.

Our Uses and Disclosures of PHI

The PEBTF is permitted to use and to disclose PHI in order to aid in your treatment, make payment for health care services provided to you and conduct our own "health care operations." Under limited circumstances, we may be able to provide PHI for the health care operations of other providers and health plans. We may use your PHI for purposes of treatment, payment and health care operations without your authorization. Our Business Associates will assist us in these functions, for example, by processing your claims for benefits. At times our Business Associates, including our prescription drug, behavioral health, and disease management vendors may handle PHI to assist us with our health care operations. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is representative only and does not include every use and disclosure in a category.

Treatment: Although the PEBTF does not engage in treatment activities, we may disclose your PHI to a doctor or a hospital which asks us for this information to assist in your treatment.

Payment: The PEBTF may use and disclose your PHI for a variety of permitted payment activities that include, but are not limited to paying claims from doctors, hospitals and other providers for services delivered to you that are covered by your health plan.

- Eligibility, Enrollment and Contributions: At the time of your enrollment, the PEBTF receives PHI including your name, address, Social Security number and birth date. This "enrollment information" is used by the PEBTF to provide coverage for health care benefits and for eligibility determinations. We will use this information to determine if you qualify for benefits and provide you with appropriate notices. We may share enrollment information with the "plan sponsor" of the PEBTF. Our plan sponsor is composed of the Commonwealth of Pennsylvania, AFSCME Council 13, and all other unions, with the exception of the Pennsylvania State Police, who have a collective bargaining unit agreement with the Commonwealth of Pennsylvania. The plan sponsor also includes the PEBTF itself and Wood Dining. The plan sponsor may use this information to, for example, determine how much each subscribing Member must contribute toward the cost of coverage.

- Benefits and Claims: The PEBTF will use and disclose PHI to process claims and appeals and pay benefits. In doing so, we may request PHI from or disclose PHI to your health care provider or share PHI with an independent medical reviewer to obtain its clinical view as to the medical necessity or experimental nature of a medical treatment. We will send Explanations of Benefits containing PHI to notify Members who subscribe for coverage about claim determinations. We may also use and disclose PHI for precertification and medical necessity reviews, claims management; and billing and collection activities. For example, we may provide information to the billing agent of a health care provider.

- Coordination of Benefits, Adjudication, Subrogation: The PEBTF and other health plans use and disclose PHI to coordinate the payment of benefits with other health plans (e.g., Medicare or a spouse's health insurance plan). It may be necessary for the PEBTF to disclose PHI to the other plan to determine which plan should pay first and how much the secondary plan should pay. The PEBTF may also share information

  with an automobile carrier, Workers' Compensation carrier, or other relevant person in determining if a third-party should be liable for your medical expenses. Depending on the situation, this may be called third-party reimbursement of subrogation.

Health Care Operations: The PEBTF may use and disclose your PHI for health care operations. Our health care operations encompass a broad range of activities. For example, we may use and disclose PHI to rate our risk and determine our premiums for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and to properly conduct our business.

- Complaints: The PEBTF may use and disclose PHI to investigate a complaint or respond to an inquiry by a Member. In order to do so, it may be necessary for us to gather information or documents, including medical records, that are in our possession or held by others.

- Customer Service: We may provide PHI to a provider, a health care facility, or another health plan that contacts us with questions regarding your health care coverage, including questions concerning eligibility, claim status, effective dates of coverage, or other issues.

- Audits: We may obtain, use, and disclose PHI to audit our Business Associates, such as our managed care plans and prescription vendors, to confirm that they are paying claims accurately and otherwise performing services correctly under their contracts.

- Fraud and Abuse Detection and Compliance Programs: The PEBTF may use and disclose PHI for fraud and abuse detection and in activities required by our compliance program. We may also share this information with outside Health Oversight Agencies or other appropriate entities.

- Health Promotion and Disease Prevention: The PEBTF may use and disclose PHI for certain activities relating to improving health or reducing health care costs. In some instances, these uses may involve direct contact with you regarding matters such as disease management, health-related benefits and services, or treatment alternatives that may be of interest to you. For example, we may contact you regarding participation in a disease management program or to recommend case management or certain preferred durable medical equipment vendors.

- Legal Matters: In the event that the PEBTF is evaluating compliance with certain laws, including privacy laws, or is involved in a lawsuit or other judicial or administrative proceeding, the PEBTF may use and disclose PHI. Information in these situations may need to be disclosed to our attorneys and to other parties involved in the proceeding. For example, we may be required to disclose PHI in response to a subpoena, warrant, or other lawful process.

- Quality Improvement: The PEBTF may use or disclose PHI to help us evaluate the performance of our health plan. For example, we may disclose names and

addresses of our Members to a mailing house for use in mailing customer satisfaction surveys.

- Research and Reporting: The PEBTF may use your PHI in order to conduct an analysis of our data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

- Underwriting: The PEBTF may use and disclose PHI for premium rating, the creation, renewal or replacement of contracts for health insurance, or any underwriting activities; except that we may not use genetic information for underwriting purposes.

Other Uses and Disclosures of PHI

There are a number of other situations where your PHI may be used or disclosed. In some instances, different state and federal laws will apply. In certain situations, the use or disclosure may be subject to certain restrictions or procedures. It is not possible to include all of the examples or all of the rules applicable to the categories of permissible uses and disclosures described, below.

To You and with Your Authorization: The PEBTF must disclose PHI to you, as described below in the Member's Rights section of this notice.

By law, the PEBTF is prohibited from undertaking certain activities involving your PHI without your Authorization. You may, subject to the PEBTF's policy for Authorizations, give us written Authorization to use PHI or to disclose your PHI to anyone for any purpose. In this case, the PEBTF will be permitted (but not required) to use or disclose PHI, as stated in the Authorization. The PEBTF may prescribe an Authorization form for you to use for this purpose. You may revoke an Authorization in writing at any time; however, such revocation will not affect any uses or disclosures that were made under the Authorization while it was in effect. For additional information regarding revocation, use the contact information found at the end of this notice.

- It is unlikely that the PEBTF will obtain psychotherapy notes, but it is required to obtain your Authorization for almost every type of use or disclosure that we might undertake with such information.

- The PEBTF would also need to obtain your Authorization before using or disclosing your PHI for marketing purposes other than in face-to-face meetings with you or providing you with a nominal promotional gift.

- Similarly, the PEBTF would need to obtain your Authorization before a disclosure that is regarded as a sale of PHI.

- Authorization is required for any use or disclosure that is not for treatment, payment, health care operations or other purpose described in this notice.

Except with regard to long term care plans, the regulations strictly prohibit the use and disclosure of PHI that is genetic information for underwriting purposes, even if Authorization is provided.

Personal Representatives: The PEBTF will treat your personal representative as if he/she were you for purposes of disclosing PHI. A "personal representative" is a parent of an unemancipated child, or a person who, as evidenced by a valid legal document under state law, is designated to make medical decisions on behalf of an individual. Personal representatives include court appointed guardians; persons appointed in "living wills" or medical directives; persons with powers of attorney that extend to medical decisions; and/or executors/administrators of estates.

Parents and Minors: As a general rule, parents or other legal guardians (persons acting *in loco parentis*) have the right to access the PHI of an otherwise unemancipated minor child (defined by Pennsylvania law as a person under the age of twenty-one). However, Pennsylvania law allows a minor to obtain contraception, pregnancy testing and treatment, prenatal care, and testing and treatment for reportable diseases, sexually transmitted diseases, and HIV/AIDS, mental health treatment and drug and alcohol treatment without parental consent. Pennsylvania law also gives a minor the authority to control parental or other access to the PHI pertaining to such health care services. Therefore, a parent will need to obtain authorization from the minor before the PEBTF will release this type of information.

Health Oversight Activities: The PEBTF may share PHI as provided by law with Health Oversight Agencies, regulatory authorities or their appointed designees and reporting agencies. Examples of such "Health Oversight Agencies" include, but are not limited to, Centers for Medicare and Medicaid Services, and the Pennsylvania Department of Health, Insurance Department, Attorney General, and Auditor General.

Substance use disorder treatment records. Though it is unlikely PEBTF will have access to or content of these records, they shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the individual or the holder of the record, as provided in 42 CFR part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Reproductive Care: The Privacy Rule permits uses or disclosures of PHI without an individual's authorization only where such uses or disclosures are expressly permitted or required by the Privacy Rule. The Privacy Rule permits, but does not require, certain disclosures to law enforcement and others, subject to specific conditions. Thus, PEBTF is only permitted to disclose PHI for law enforcement purposes where they suspect an individual of obtaining reproductive health care (lawful or otherwise) if PEBTF is required by law to do so and all applicable conditions are met. Accordingly, such disclosure is only permitted where all three of the following conditions are met:

- The disclosure is not subject to the prohibition.
- The disclosure is required by law.
- The disclosure meets all applicable conditions of the Privacy Rule permission to use or disclose PHI as required by law.

To implement the prohibition, the Final Rule requires PEBTF, when it receives a request for PHI potentially related to reproductive health care, to obtain a signed attestation that the use or

disclosure is not for a prohibited purpose. This attestation requirement applies when the request is for PHI for any of the following:

- Health oversight activities.
- Judicial and administrative proceedings.
- Law enforcement purposes.
- Disclosures to coroners and medical examiners.

Business Associates: The PEBTF works with many entities that perform a wide variety of services on our behalf. For example, we work with auditors, attorneys, actuaries, consultants, and other health care plans who act as third-party administrators for the PEBTF. We will ensure that appropriate agreements are in place to govern the permitted and required uses and disclosures of Member information by our Business Associates, to require our Business Associates' compliance with applicable privacy laws, and to require our Business Associates to apply reasonable safeguards to the PHI they obtain or create in the services that they provide with regard to the PEBTF.

To Individuals Involved in Your Care or Payment for Your Care: We generally will not disclose PHI to your family members, close friends or others without your written Authorization. However, under certain circumstances, the PEBTF may disclose PHI to such persons. For example, if you appear at the PEBTF office with your spouse and ask for PHI, we may ask you if we can provide you with your PHI in front of your spouse or even, as appropriate, infer that it is permissible because you have brought your spouse with you. However, this non-written authorization applies only to the particular disclosure; future disclosures of PHI to family members will require a new authorization (written or otherwise).

We may also disclose PHI to your family members, close friends or others in cases of a medical emergency where you are unable to provide authorization. In such cases, the PEBTF will disclose PHI to another person if we determine, using our professional judgment, that the disclosure would be in your best interest. In such cases, we will disclose only the PHI that is relevant to that person's involvement with your health care.

Disaster Relief: The PEBTF may use or disclose your name, location and general condition or death to a public or private organization authorized by law or by its charter to assist in disaster relief efforts, such as the American Red Cross.

Plan Sponsor: The PEBTF may disclose eligibility, enrollment, and limited disenrollment information to our plan sponsors to permit them to perform their plan administration functions on behalf of the PEBTF. We may provide our plan sponsor with information as to your enrollment or disenrollment for coverage.

We may also disclose summary health information about you and the participants in your group health plan to our plan sponsor for them to use to obtain premium bids for the health insurance coverage offered through your group health plan and/or to decide whether to modify, amend or terminate your group health plan. This summary health information may contain claims history, claims expenses, or types of claims experienced by the participants in the PEBTF. However, it will be stripped of demographic information (e.g., name and address) other than your zip code information. In order to obtain any of the above information, the plan sponsor will be required to certify to us that the plan has been amended to provide that the confidentiality of the information will be protected and that the information will not be used in any employment-related decisions. No other information will be shared with the plan sponsor without your Authorization, executed according to the PEBTF's Authorization policy.

Public Health and Communicable Disease Reporting: The PEBTF may disclose your PHI to a public health authority who is permitted by law to collect or receive the information. Our reporting may be made in order to prevent or control disease, injury or disability, or report child abuse or neglect. We may notify a person who may have been exposed to a disease or may be at risk for contracting a disease or condition. We may notify appropriate law enforcement officials or other appropriate government authority if we believe a Member has been the victim of abuse, neglect or domestic violence. The PEBTF may use or disclose PHI to assist in certain other public health activities. Unless the sole basis of the report of abuse, neglect, or domestic violence is the provision or facilitation of reproductive health care.

Research, Death, Organ Donation: The PEBTF may use or disclose PHI for research purposes, in limited circumstances and with certain safeguards. We may also disclose the PHI of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Required by Law: The PEBTF may use or disclose your PHI when we are required to do so by law. For example, we are required by federal law to disclose PHI to the U.S. Department of Health and Human Services if it asks to see it for purposes of determining whether we are in compliance with federal privacy laws. We may also disclose your PHI when authorized by Workers' Compensation or similar laws. We are permitted to make other disclosures when required by law.

Litigation or Administrative Proceedings. Even when the PEBTF is not party to a lawsuit or other judicial or administrative proceeding, it may disclose PHI lawfully requested, for example, through a subpoena, as part of that proceeding. For example, a Member may be engaged in a lawsuit that that does not generally pertain to the PEBTF, but for which PEBTF records are relevant.

To Law Enforcement and for Public Safety: Under certain circumstances, we may disclose your PHI for law enforcement purposes. Examples of such situations include responding to court orders, warrants, or grand jury subpoenas; providing limited PHI in response to requests by law enforcement officials for the identification and/or location of a suspect, witness, or certain other individuals; responding to inquiries by law enforcement relating to victims of crime; and providing information to law enforcement with respect to crimes occurring on the PEBTF's premises. In addition, under some circumstances, we may disclose your PHI in order to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. This may include providing information to law enforcement authorities to apprehend a suspect or fugitive or advising individuals about threats made against them. Finally, we may disclose your PHI if you are an inmate or other person in lawful custody and we are requested to do so by an appropriate law enforcement official or correctional institution.

Military and National Security: Under certain circumstances, the PEBTF may disclose the PHI of armed forces personnel to military authorities. We may also disclose PHI to authorized federal officials for lawful intelligence, counterintelligence, and other national security activities.

Member Rights

As a Member of the PEBTF, you have the following rights regarding your PHI:

- **Right to Inspect and Copy**: With limited exceptions, you have the right to inspect and/or obtain a copy of your PHI that the PEBTF maintains in a designated record

set. A "designated record set" consists of all records used by the PEBTF to make health plan decisions about you, including documentation relating to your enrollment, payment, claims adjudication, and case or medical management (e.g., disease management). You may request that we provide copies of your PHI to you in a format other than photocopies, such as CD or diskette. If we can readily produce the PHI in that format, we will do so. You may also clearly designate another person to receive this PHI and request that we send the PHI to that person directly. These requests need to be submitted on a written form prescribed by the PEBTF. You may obtain a form to make these requests by using the contact information found at the end of this notice.

If the designated record set is located on-site, the PEBTF will act upon your written request within 30 days after receipt. If the PHI is not maintained by, or accessible to, the PEBTF on-site, then we will respond to you no later than 60 days after receipt of the request. If these time-frames cannot be met, we are entitled to as much as a 30-day extension. We will provide you with a notice of the reasons for the delay and the length of the extension. The PEBTF may charge you a reasonable cost-based fee to process and fulfill your request. If you prefer, you may request that we prepare a summary or an explanation of your PHI for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure. If your request for access is denied, we will provide a written explanation for the denial and your rights regarding the denial.

To obtain information about your treatment, you may wish to contact your treating physician, facility, or other provider that created and/or maintains the records.

- **Right to Amend**: You have the right to request that the PEBTF amend the PHI that we have created and that is maintained in your designated record set. Your request must be in writing, and it must explain why the information should be amended. You may obtain a form to request an amendment by using the contact information found at the end of this notice.

  We cannot amend demographic information, treatment records or any other information created by others. If you would like to amend any demographic information, please contact your Human Resources Office. If you would like to amend your treatment records, you must contact the treating physician, facility or other provider that created those records.

The PEBTF will act on a request for an amendment within 60 days of receipt, or provide a written statement of the reason why we cannot do so and the date by which we will complete action on the request. If we accept the amendment, we will advise you and make reasonable efforts to inform others who have the relevant record, including people you name, of the amendment and to include the changes in any future disclosures of that information.

The PEBTF may deny your request if: 1) we did not create the information you want amended; 2) the information is not part of the designated record set maintained by the PEBTF; 3) you do not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny your request, we will provide a written explanation for the denial and your rights regarding the denial.

- **Right to an Accounting of Disclosures**: You have the right to receive an accounting of certain specific instances in which the PEBTF or our Business Associates have disclosed your PHI. The accounting will review disclosures made over the past

six years. We will provide you with the date on which we made a disclosure, the name of
the person or entity to whom we disclosed your PHI (unless this information is PHI about another member), a brief description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures, including the most routine disclosures (e.g., those made for treatment, payment or health care operations or made in accordance with an Authorization) are not subject to this requirement and will not appear in the accounting.

Your request for an accounting must be made in writing. You may obtain a form to request an accounting by using the contact information found at the end of this notice. The PEBTF will act on your request within 30 days of receipt, or we will provide you with a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request an accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. You will have the opportunity, in writing, to withdraw or modify your request for any subsequent accounting in order to avoid or reduce the fee. You may contact us using the information listed at the end of this notice for a full explanation of our fee structure.

- **Right to Request Restrictions:** You have the right to request that the PEBTF place additional restrictions on the use or disclosure of your PHI for treatment, payment, health care operations purposes, and for disclosures made to persons involved in your care. We are not required to agree, and for administrative and other reasons, we generally will not agree to these additional restrictions. However, if we do agree, we will abide by our agreement (except in an emergency). If we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. If we agree to a restriction, we reserve the right to terminate that agreement by providing you with written notice of that termination.

Your request for restrictions must be in writing. You may obtain a form to request such restrictions, or additional information about your rights to request restrictions, by using the contact information found at the end of this notice.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you in confidence about your PHI by using "alternative means" or an "alternative location" if the disclosure of all or part of that information to another person could endanger you. We will accommodate such a request in situations where you clearly advise us in your request that the usual means of communication could endanger you and if your request for an alternative is reasonable. Your request must, among other thing, continue to permit the PEBTF to collect premiums and pay claims under the health plan.

To request confidential communication changes, you must make your request in writing, you must specify the alternative means or location for communication, and you must clearly state that the information could endanger you if it is not communicated in confidence as you request. To obtain a form to request confidential communications, use the contact information found at the end of this notice.

Right to Receive a Paper Copy of the Notice

Who Do I Contact?				
	PEBTF 800-522-7279	**SERS 800-633-5461**	**PSERS/ ARS**	**Health Plan (refer to your plan ID card)**
If I have questions about my health benefits	✓			
If I have a question about my retirement annuity		✓	✓	
If I have to report an address change or phone number change	✓	✓	✓	
To add or remove a Dependent(s) from coverage		✓	Contact PEBTF	
To report a divorce (spouse must be removed from REHP benefits)		✓	Contact PEBTF	
To report a Retiree's death		✓	Contact PEBTF	
To apply for disabled Dependent(s) coverage	✓		Contact PEBTF	
To voluntarily "opt out" of medical and/or prescription drug benefits		✓	Contact PEBTF	
To report eligibility for Medicare – Medicare Part A and Medicare Part B	✓			
To order a new medical ID card				✓
If I have a question about claims or to appeal a denied claim or service	✓ Secondary Contact			✓* Primary Contact
To request an exception to the Medicare plan enrollment requirements	✓			

*Medicare eligible Retirees who are enrolled in Medicare Supplemental should direct their questions to their Medicare Carrier for Medicare Claims and Aetna for their Medicare Supplemental Claims.

IMPORTANT TELEPHONE NUMBERS

PEBTF	717-561-4750 (Local)
www.pebtf.org	800-522-7279 (Toll Free)

Non-Medicare Retirees and Dependents

PPO Option

Choice PPO - Aetna	800-991-9222
Basic PPO - Aetna	800-991-9222

HMO Option (Custom HMO)

Custom HMO - Aetna	800-991-9222

Mental Health and Substance Use Program

Optum	800-924-0105
State Employee Assistance Program	800-692-7459

Medicare Eligible Retirees and Dependents

Medicare Open Access

Aetna Medicare Open Access PPO	888-272-5651

Non-Medicare & Medicare Eligible Members

Prescription Drug Benefits

CVS Caremark (non-Medicare)	888-321-3261
SilverScript (Medicare)	866-329-2088

For health plan website addresses, log on to the PEBTF website, www.pebtf.org.
You will find the plan's website addresses listed under the Links section.

Appendix A – List of Agencies Eligible to Participate in the Group Life Insurance Program & REHP

Personnel Area		Eligible* to Participate in GLIP	Participating in REHP
3	Treasury Department	YES	YES
10	Aging	YES	YES
11	Corrections	YES	YES
12	Labor and Industry	YES	YES
13	Military Affairs	YES	YES
14	Office of Attorney General	YES	YES
15	General Services	YES	YES
16	Education	YES	YES
17	Public Utility Commission	YES	YES
18	Revenue	YES	YES
19	State	YES	YES
20	Pennsylvania State Police	YES	YES (except for L1 or L3)
21	Human Services	YES	YES
22	Fish and Boat Commission	YES	YES
23	Game Commission	YES	YES
24	Community & Economic Development	YES	YES
25	Board of Probation and Parole	YES	YES
26	Liquor Control Board	YES	YES
27	Milk Marketing Board	YES	YES
28	Lt. Governor's Office	YES	YES
30	Historical and Museum Commission	YES	YES
31	PEMA-Emergency Management Agency	YES	YES
32	Civil Service Commission	YES	YES
33	PENNVEST	YES	YES
35	Environmental Protection	YES	YES
37	Environmental Hearing Board	YES	YES
38	Conservation and Natural Resources	YES	YES
39	PHEAA	YES	YES
40	State Ethics Commission	YES	YES
41	Senate	YES	NO
42	House	YES	NO
43	PA Health Care Cost Containment Council	YES	YES
44	Legislative Reference Bureau	YES	NO
45	Local Government Commission	YES	NO
46	Joint State Government Commission	YES	NO
47	Legislative Budget & Finance Comm	YES	NO
48	Legislative Data Processing Center	YES	NO

49	Joint Legislative Air & Water Pollution Control & Conservation Committee	YES	NO
57	Judiciary	YES	NO
65	PA Gaming Control Board	YES	YES
67	Health	YES	YES
68	Agriculture	YES	YES
70	SERS	YES	YES
71	PA Municipal Retirement System	YES	YES
72	Public School Employees' Retirement System	YES	YES
74	Drug and Alcohol Programs	YES	YES
75	Banking and Securities	YES	YES
78	Transportation	YES	YES
79	Insurance Department	YES	YES
81	Executive Offices	YES	YES
82	Supreme Court - Eastern PA	YES	NO
83	Patient Safety Authority	YES	YES
84	PA E-Health Partnership Authority	YES	YES
89	Thaddeus Stevens	YES	YES
90	State System of Higher Education	YES	YES
92	Auditor General	YES	YES
98	State Public School Building Authority	YES	YES
99	Governor's Office	YES	YES
720	ICA	YES	YES
743	Capitol Preservation Committee	YES	NO
748	Senate Leadership OPNS - R	YES	NO
749	Senate Appropriations Committee - R	YES	NO
751	House Special Leadership	YES	NO
752	House Special Leadership - R	YES	NO
753	House Appropriations Committee - D	YES	NO
754	Independent Regulatory Review Commission	YES	NO
757	Administrative Office - PA Courts	YES	NO
791	Turnpike Commission	YES	NO
951	House Appropriations Committee - R	YES	NO
966	Independent Fiscal Office	YES	NO
978	PA Housing Finance Agency	YES	NO
979	University of Pittsburgh	YES	NO
8101	Human Relations Commission	YES	YES
8102	Juvenile Court Judges Commission	YES	YES
8801	Philadelphia Regional Port Authority	YES	YES
8802	Port of Pittsburgh Commission	YES	YES
9011	Indiana University	YES	NO
9021	Bloomsburg University	YES	NO
9022	California University	YES	NO
9023	Cheyney University	YES	NO
9031	Clarion University	YES	NO

9041	East Stroudsburg University	YES	NO
9051	Edinboro University	YES	NO
9061	Kutztown University	YES	NO
9062	Lock Haven University	YES	NO
9063	Mansfield University	YES	NO
9064	Millersville University	YES	NO
9065	Shippensburg University	YES	NO
9066	Slippery Rock University	YES	NO
9067	West Chester University	YES	NO

*some agencies are eligible for the GLIP, but choose not to participate