PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND

Summary Plan Description

Pennsylvania Employees Benefit Trust Fund (PEBTF)

September 2026

This Summary Plan Description (SPD) summarizes the main terms of the benefits provided to Members and their eligible Dependents under the Pennsylvania Employees Benefit Trust Fund Plan as of September 1, 2026. This SPD replaces all previous Summary Plan Descriptions for the Plan.

The SPD has been prepared to help you understand the main features of the health benefit coverage provided by the Pennsylvania Employees Benefit Trust Fund ("PEBTF"). Please use this document as a reference guide when you have questions about your PEBTF coverage. If there are any differences between this document and the Plan Document, the Plan Document will control. If any questions arise that are not addressed in this SPD, the Plan Document will determine how the questions will be resolved.

The SPD 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 PEBTF or its agents. This SPD does not constitute an implied or expressed contract or guarantee of employment. This SPD does not alter the right of the PEBTF to make unilateral changes to the Plan at any time without notice to or the consent of Members or their eligible Dependents.

The PEBTF was established on October 1, 1988, under the authority of the Agreement and Declaration of Trust dated September 8, 1988 between the Commonwealth of Pennsylvania and the American Federation of State, County and Municipal Employees ("AFSCME") Council 13, AFL-CIO.

The PEBTF Board of Trustees has full and complete discretion and authority over all Plan provisions, including their interpretation and application.



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To All Benefit Eligible Members:

The Pennsylvania Employees Benefit Trust Fund (PEBTF) was formed in 1988 to administer the health benefits of employees of the Commonwealth of Pennsylvania.

The PEBTF's goal is to maintain a comprehensive Plan of health benefits in a way that controls costs and responds to changing market conditions while meeting the needs of its Members. **The PEBTF is not an insurance company.** It is a tax-exempt, non-profit trust fund, which provides health and welfare benefits to Employee Members and their eligible Dependents. The level of benefits is determined by the Board of Trustees, an equal number designated by the Secretary of Administration of the Commonwealth of Pennsylvania and an equal number designated by participating unions in accordance with an Agreement and Declaration of Trust pursuant to which the PEBTF was established.

A Board of Trustees, equally comprised of employer and union representatives, manages the PEBTF. The Board of Trustees meets regularly to review the operations of the PEBTF. The Board of Trustees establishes PEBTF policies and determines the level of benefits and any changes to benefits. The Board of Trustees is solely responsible for applying and interpreting the Plan of health benefits, determining eligibility and deciding all final level appeals.

The day-to-day operations of the PEBTF are the responsibility of the Executive Director. Among other duties, the PEBTF's staff maintains eligibility records, responds to inquiries from PEBTF Members and pays claims. The PEBTF contracts with various independent Claims Payors to administer claims for coverage and benefits under the Plan Options described in this booklet. These Claims Payors are empowered with the discretion and authority to make decisions on benefit claims and to interpret and construe the terms of the Plan and apply them to the factual situation in accordance with their medical policies. Although the Plan provides for a final level of appeal to the Board of Trustees, if a claim for benefits is denied, the Member must appeal first to the Claims Payor in accordance with the procedures it has established for this purpose.

About the Summary Plan Description
This Summary Plan Description (SPD) is your guide to the health benefit coverage administered by the PEBTF. It is designed to help you and your eligible Dependents understand the benefits and the PEBTF's procedures.

The SPD contains a great deal of information about your benefits. Definitions of terms with which you may not be familiar are provided in the Glossary. Please read this SPD carefully so that you understand your benefits and rights under the Plan. The SPD is an excellent reference if you should have questions about your benefits.

The SPD does not include all of the details of your benefit coverage. The Plan Document describes the full terms and conditions of your benefit coverage, including exclusions and limitations. If any questions arise that are not covered by the SPD or in the case the SPD appears to conflict with the Plan Document, the text of the Plan Document will determine how the questions will be resolved. The Board of Trustees has the sole and exclusive authority and discretion to interpret and construe the Plan Document, amend the Plan Document, determine eligibility and resolve and determine all disputes which may arise concerning the PEBTF, its operation and implementation. The Board of Trustees may from time to time delegate some of its authority and duties to

others, including PEBTF staff and the Claims Payor for each of the Plan Options. Please note that PEBTF staff has no authority to amend the Plan Document or otherwise waive, alter or revise its provisions. Such authority rests solely, entirely and exclusively with the Board of Trustees.

Health benefit coverage is important to you and your family. As a Member covered under the Plan, the following medical plan options may be offered to you depending on your county of residence:

- Preferred Provider Organization (PPO) Option
- Health Maintenance Organization (HMO) Option
- Bronze Plan (for permanent part-time and nonpermanent employees who work an average of 30 hours a week)

All options cover a wide range of medical services and supplies – in and out of the hospital. Whatever your choice, your medical coverage will help protect you and your eligible Dependents against the financial impact of illness and injury. Each year, during Open Enrollment, you have the opportunity to select a new medical plan.

The PEBTF also provides mental health and substance use coverage, as well as prescription drug benefits and supplemental benefits (vision, dental and hearing aid) for eligible individuals.

We are pleased to provide this booklet to you describing your options and hope you will read it carefully. If you have any questions about your health benefits, contact the PEBTF at:

Pennsylvania Employees Benefit Trust Fund (PEBTF)
150 South 43rd Street, Suite 1
Harrisburg, PA 17111-5700
717-561-4750, 800-522-7279
www.pebtf.org

Employees at agencies under the Governor's jurisdiction and the Office of Attorney General and Office of the Auditor General can change their address, change health plans or enroll or disenroll Dependents through Employee Self Service (ESS) at www.myworkplace.pa.gov. In addition, employees can make plan changes during Open Enrollment through ESS. If you are unable to use ESS, please contact the HR Service Center at 1-866-377-2672 or your HR office if your agency is not supported by the HR Service Center.

Employees of PASSHE can make certain benefit changes through its own ESS at https://portal.passhe.edu/irj/portal or by contacting their university's HR office.
If your agency does not participate in ESS, follow your agency's procedures to make any changes to your personal and benefit information.

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Disclaimer of Liability

It is important to keep in mind that the PEBTF is a plan of coverage for medical benefits, and does not provide medical services nor is it responsible for the performance of medical services by the Providers of those services. Providers include physicians, dentists and other medical professionals, hospitals, psychiatric and rehabilitation facilities, birthing centers, mental or substance use Providers and certain other professionals, including pharmacists 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 PEBTF Plan Option you have chosen may provide payment for part or all of such services, or an exclusion from coverage may apply. The extent of such coverage, as well as limitations and exclusions, is explained in this booklet.

Medical coverage may be provided under the PPO, HMO or Bronze Plan, each including the Mental Health and Substance Use Program. Additional coverage may be provided under the prescription drug benefits and supplemental benefits (vision, dental and hearing aid). In each case, the PEBTF has contracted with independent Claims Payors to administer claims for coverage and benefits under the Plan Options. These Claims Payors, as well as the physicians and other medical professionals who actually render medical services, are not employees of the PEBTF. They are all either independent contractors or have no contractual affiliation with the PEBTF.

The PEBTF does 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 likewise does not assume any legal or financial responsibility for the maintenance of the networks of physicians, pharmacies or other medical Providers under 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 Plan with respect to the applicable Plan Options, and they are solely responsible for selecting and credentialing the members of those networks. Finally, the PEBTF does not assume any legal or financial responsibility for coverage and benefit decisions under the Plan made by the Claims Payor under each Plan Option, other than to pay for benefits approved for payment by such Claims Payor, subject to the final right of appeal to the Board of Trustees set forth in the claims procedures described in this booklet.

Benefits at a Glance

Medical Plan Choices

- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Bronze Plan (for permanent part-time and nonpermanent employees who work an average of 30 hours a week)

Mental Health and Substance Use Program

Get Healthy Program

Prescription Drug Benefits

Supplemental Benefits*

- Vision Benefit
- Dental Benefit
- Hearing Aid Benefit

*Bronze Plan Members do not have vision, dental or hearing aid benefits.

IMPORTANT NOTE: Under all medical plans, prescription drug benefits and supplemental benefits, coverage for benefits is 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 HMO, PPO and Bronze Plan options are always within Usual, Customary and Reasonable (UCR) limits or the Plan Allowance, but charges by Out-of-Network Providers may not be. You are responsible for all charges in excess of the Plan Allowance.

Section 1: Eligibility

Summary

- Unless otherwise noted, you are eligible for medical, prescription drug benefits and supplemental benefits (vision, dental, and hearing aid) and the reimbursement account if you are a permanent full-time employee or permanent part-time employee working at least 50% of full-time hours for the Commonwealth (see section below for employees hired or re-hired on or after August 1, 2003).

- If you enroll in prescription drug benefits and decline PEBTF medical benefits, you will have to attest that you and your Dependents are enrolled in a health plan that offers at least minimum value as outlined under the Patient Protection and Affordable Care Act. A group health plan that provides minimum value means the health plan pays at least 60% of the total cost of medical services for a standard population

- Non-permanent employees and permanent part-time employees working less than 50% of full-time hours are not eligible for PEBTF medical coverage.

- Non-permanent or permanent part-time employees who work an average of 30 hours a week during an applicable measuring period are eligible for the Bronze Plan. You will be notified of your eligibility by the HR Service Center or your HR office if your agency is not supported by the HR Service Center.

- You will not be denied coverage in the PEBTF if you have a pre-existing medical condition.

- You must reside in the service area to enroll in an HMO. The HMO plan offered by the PEBTF is a Custom HMO and offers a limited network of Providers and facilities. Emergency Services only are covered outside of the service area. You should seek Emergency Services and contact the plan. If you have a Dependent 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.

- You may elect coverage for your eligible Dependents – see Eligibility Rules for New Hires or Re-hires – Hired on or After August 1, 2003.

- You can change your coverage option during the Open Enrollment period and under certain other limited circumstances.

- Coverage generally ends on your last day of employment or when you are no longer eligible.

Eligibility

- You are eligible for medical, prescription drug, supplemental benefits (vision, dental, hearing aid) and the reimbursement account if you are a permanent, full-time Commonwealth employee or a permanent part-time Commonwealth employee who works at least 50% of full-time hours, as determined by the Commonwealth. Other groups of employees may be

eligible based on their collective bargaining agreements. Your cost for these benefits is taken through payroll deduction. If enrolled in a medical plan, you may also participate in the reimbursement account, which is described in Section 14.

- Nonpermanent or permanent part-time employees who work an average of 30 hours a week during an applicable measuring period are eligible for the Bronze Plan. You will be notified of your eligibility by the HR Service Center or your HR office if your agency is not supported by the HR Service Center.

- The employee cost for coverage will be paid on a before-tax basis for federal and Pennsylvania income tax purposes (and for certain other states' income taxes). If you have questions, check with the HR Service Center or your HR office if your agency is not supported by the HR Service Center.

- For any special eligibility provisions regarding supplemental benefits (vision, dental, hearing aid) please see the supplemental benefits section.

Leave Without Pay With Benefits

If you are on a Leave Without Pay With Benefits (LWOPWB) and enrolled in benefits, you must continue to pay for coverage or it will be canceled and you will be responsible for any claims incurred when you were no longer eligible for coverage due to non-payment. You will receive invoices from the PEBTF while on LWOPWB, but will be responsible for payment regardless of whether an invoice is received. If you are enrolled and you do not want to continue your benefits while on LWOPWB you should contact the HR Service Center or your HR office if your agency is not supported by the HR Service Center within 60 days of being placed on LWOPWB. If you have any questions regarding your billing for LWOP you can contact the PEBTF.

Eligibility Rules for Employees – Hired Prior to August 1, 2003

You and your eligible Dependents are eligible for PEBTF coverage as follows:

- May enroll in a medical plan available in your county of residence as of hire/rehire date. If you elect medical benefits only, you will receive coverage, without cost sharing, for Preventive Care prescription drugs.
- Must pay the applicable biweekly employee contribution (refer to your collective bargaining agreement, if applicable).
- May enroll in prescription drug benefits.
- May enroll in supplemental benefits (vision, dental and hearing aid).
- May participate in the reimbursement account if enrolled in medical coverage, which is described in Section 14.
- If you are a part-time employee, you must pay 50% of the cost in addition to the above-mentioned employee contributions if enrolled in the PPO or HMO.
- If you are a permanent part-time or nonpermanent employee who works an average of 30 hours a week during an applicable measuring period, you are eligible for the Bronze Plan and pay the appropriate health care contribution.

Information for Retirees Returning to Commonwealth Service: You are considered an employee hired before August 1, 2003, if you were initially hired before August 1, 2003 **and** retired **and** were eligible to enroll in the Retired Employees Health Program (REHP) and are rehired by the Commonwealth. You are eligible for the prescription drug benefits and supplemental benefits (vision, dental and hearing aid) on the first date of eligibility under the PEBTF. Also, you are not subject to any medical plan buy-up costs.

Spouse Eligibility for Employees Hired Before August 1, 2003: To enroll for coverage in the PEBTF, if the spouse of an employee hired before August 1, 2003, is eligible for medical, prescription drug benefits or supplemental benefits (vision, dental and hearing aid) through their own employer **and** does not have to pay for coverage, your spouse must take their employer's coverage as primary coverage. In that event, your spouse's coverage in the PEBTF is limited to **secondary** coverage. If your spouse has to pay for coverage **or** is offered an incentive not to take their employer's coverage, your spouse does not have to enroll in their employer's coverage and the PEBTF will remain as primary.

Contact the HR Service Center or your HR office if your agency is not supported by the HR Service Center and your health plan any time there is a change to a spouse's medical, prescription drug or supplemental benefits (vision, dental and hearing aid).

Eligibility Rules for Employees Hired or Re-hired on or After August 1, 2003

If you were hired or re-hired on or after August 1, 2003, you and your eligible Dependents are eligible for PEBTF coverage as follows:

- May enroll in a medical plan available in your county of residence as of hire/rehire date. If you elect medical benefits only, you will receive coverage, without cost sharing, for Preventive Care prescription drugs. You may find a list of these medications in Sections 2 and 10 of this SPD.
- Must pay the applicable biweekly employee contribution (refer to your collective bargaining agreement, if applicable).
- May purchase a more expensive medical plan in your county of residence by paying the cost difference, as determined by the PEBTF, in addition to the employee contribution.
- May enroll in prescription drug benefits.
- May enroll in supplemental benefits (vision, dental and hearing aid).
- May participate in the reimbursement account if enrolled in medical coverage, which is described in Section 14.
- If you are a part-time employee, you must pay 50% of the cost in addition to the above-mentioned employee contributions if enrolled in the PPO or HMO.
- If you are a permanent part-time or nonpermanent employee who works an average of 30 hours a week during an applicable measuring period, you are eligible for the Bronze Plan and pay the appropriate health care contribution.

Information for Retirees Returning to Commonwealth Service: If you were considered an employee hired on or after August 1, 2003, and retired and were eligible to enroll in the Retired Employees Health Program (REHP), and are rehired by the Commonwealth, you are eligible for prescription drug benefits and supplemental benefits (vision, dental and hearing aid) on the first date of eligibility under the PEBTF. Also, you are subject to any medical plan buy-up.

Spouse Eligibility for Employees Hired or Re-hired on or After August 1, 2003: To enroll for coverage in the PEBTF, a spouse of an employee hired on or after August 1, 2003, who is eligible for medical, prescription drug benefits or supplemental benefits (vision, dental and hearing aid) coverage through their own employer **must** take their employer's coverage as their primary coverage; regardless of any employee contribution the spouse must pay and regardless of whether the spouse had been offered an incentive to decline such coverage. Coverage for such spouse in the PEBTF is limited to **secondary** coverage. This rule does not apply for those spouses who are self-employed. You will have to complete an annual attestation to continue coverage for your spouse. The PEBTF will notify you of the attestation deadlines.

Contact the HR Service Center or your HR office if your agency is not supported by the HR Service Center and your health plan any time there is a change to a spouse's medical, prescription drug benefits or supplemental benefits (vision, dental and hearing aid) coverage.

Definitions:

New Hire or Re-hire: Anyone hired on or after August 1, 2003, who is a new employee or an employee who has a break in service greater than 180 calendar days, **will** be considered a new hire for purposes of the above described eligibility rules. The effective date for a new hire/rehire not transferring from another Commonwealth or independent agency is the first date the employee reports to work.

Furloughed Employee: Any employee who is recalled or placed under the terms of their collective bargaining agreement will not be considered a new hire for purposes of the Plan eligibility rules.

How To Enroll

You are eligible to elect benefits at any time by completing and submitting the applicable forms. In no event can the effective date be retroactive more than 60 days from the date the form is received by the HR Service Center or your HR office if your agency is not supported by the HR Service Center. If you enroll during the Open Enrollment period, coverage begins on the day specified as the first date of new coverage, which typically is January 1.

Employees at agencies under the Governor's jurisdiction, the Office of Attorney General, and Office of the Auditor General: You can change your address and enroll in coverage through employee self service (ESS) at www.myworkplace.pa.gov. If you are unable to use ESS, please contact the HR Service Center at 1-866-377-2672 or your HR office if your agency is not supported by the HR Service Center.

Employees of PASSHE: You can make certain benefit changes through its own ESS at https://portal.passhe.edu/irj/portal or by contacting their university's HR office.

Eligibility Documentation

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

You are required to present documentation verifying the eligibility status for your Dependents. You are required to disclose medical, prescription drug and supplemental benefits (vision, dental and hearing aid) coverage available to your Dependents. Failure to provide this information is grounds for denying coverage to the Dependent(s). Providing false or misleading information with respect to eligibility documentation will be considered fraud and an intentional misrepresentation of a material

fact. If you present false or misleading information, the PEBTF will take appropriate action, up to and including the forfeiture of benefits (potentially retroactively).

Completion of an annual spouse attestation will be required for employees hired on or after August 1, 2003. Also, if you enroll in prescription drug benefits and decline medical benefits, you will have to attest that you and your Dependents are enrolled in a health plan that offers at least minimum value as outlined under the Patient Protection and Affordable Care Act. A group

health plan that provides minimum value means the health plan pays at least 60% of the total cost of medical services for a standard population.

Eligible Dependents

You may cover the following Dependents:

- Spouse (original marriage certificate required). An Affidavit Attesting to the Existence of Marriage Performed Outside of the United States (PEBTF-FM) should be completed if an employee was married outside of the country and cannot produce a valid marriage certificate.
- Child under age 26, including
  - Your natural child (original birth certificate required)
  - Legally-adopted child, including coverage during the adoption 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
  - Child for whom you are required to provide medical benefits by a Qualified Medical Child Support Order or National Medical Support Notice

You may enroll your eligible Dependent at any time. However, the effective date cannot be more than 60 days retroactive from the date the PEBTF-2 Enrollment/Change Form is received by the HR Service Center or your HR office if your agency is not supported by the HR Service Center. The necessary documentation must be presented when adding a new Dependent to PEBTF coverage. Information on the necessary documentation is available at www.employeeresourcecenter.pa.gov.

NOTE: You must reside in the service area to enroll in an HMO. The HMO plan offered by the PEBTF 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 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.

Coverage for Dependent Children to Age 26: 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.

Important: It is your responsibility to advise the HR Service Center or your HR office if your agency is not supported by the HR Service Center of any event that would cause your Dependent to no longer be eligible for coverage. If you fail to advise the appropriate party of any such event **within 60 days of the event**, your Dependent will not be able to elect COBRA continuation coverage. You will be responsible for any claims incurred when your Dependent was not eligible for benefits.

Disabled Dependent

Your unmarried disabled Dependent child age 26 and older may be covered if all of following the requirements are met:

- Is totally and permanently disabled, provided that the Dependent became disabled prior to age 26; and
- Was your or your spouse's Dependent before age 26; and
- Depends on you or your spouse for more than 50% support; and
- Is claimed as a Dependent on your or your spouse 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 by you every other year pursuant to a divorce decree or similar judgment; and
- Completes a Disabled Dependent Certification Form (must be completed by Employee Member)

NOTE: A disabled Dependent 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 taken into account 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 event that would cause your disabled Dependent 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 will not be able to elect COBRA continuation coverage. You will be responsible for any claims incurred when your Dependent was not eligible for benefits.

Recertification will occur every two years and will require a recertification form to be completed and returned within 45 days of the mailing. Based on the responses on the recertification form (PEBTF-6RC) the Dependent status will be continued or ended.
A Dependent 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 Board of Trustees (or their 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 Board of Trustees may require from time to time the provision of medical records and/or employment information, and/or may require an individual to submit to an examination by a physician of the Board of Trustees' 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 Board of Trustees to determine, without more information, that the individual is not, or is no longer, Totally and Permanently Disabled.

Adult Dependent Coverage

The PEBTF provides coverage for adult Dependents age 26 to age 30 on a self-paid basis under certain conditions. Your Dependent must meet 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 must enroll in the same PEBTF medical, prescription drug and supplemental benefits (vision, dental and hearing aid) coverage as you and must pay a monthly premium for coverage to continue. Coverage ends when your coverage ends.

While this option is available, you will have to pay a monthly premium directly to the PEBTF.

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

NOTE: You must reside in the service area to enroll in an HMO. The HMO plan offered by the PEBTF is a Custom HMO and offers a limited network of Providers and facilities. Emergency Services only are covered outside of the service area. You should seek Emergency Services and contact the plan. If you have a Dependent 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.

Common Law Marriages

If you and your spouse are married by common law, the PEBTF will permit you to enroll your common law spouse as a Dependent, 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. There are no exceptions to this rule.

Your common law marriage must be recognized as such by the state in which it was contracted. 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.

The PEBTF will only recognize a Pennsylvania common law marriage entered into prior to September 17, 2003.

If you entered into a common law marriage prior to September 17, 2003, and would like to cover your common law spouse, you will be required to provide proof of such a common law marriage by presenting documents dated prior to September 17, 2003, such as a deed to a house indicating joint ownership, joint bank accounts, and/or 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 by the PEBTF.

No Duplication of Coverage

If you and your spouse both work for the Commonwealth or a PEBTF-participating employer, you may **not** be enrolled as both an Employee Member and as a Dependent under your spouse's coverage.

Also, you cannot participate in both the PEBTF's Plan for Active Employees and the Retired Employees Health Program (REHP) of the Commonwealth of Pennsylvania. Finally, your Dependent child may be enrolled under your or your spouse's coverage, but not both.

To Save Money

If you and your spouse are both Commonwealth employees, the employee who makes the least amount of money should enroll in PEBTF benefits and the spouse should be on that coverage as a Dependent.

That way your family pays only one health care contribution, which is a percentage of salary.

The only exception to this rule is that RPSPP members and REHP members may be covered on a spouse's Active Member contract for supplemental benefits (vision, dental, hearing aid) only. The RPSPP member's and REHP member's coverage under their retiree plan will be primary for prescriptions and/or dental coverage, where applicable.

Eligibility – Prescription Drug and Supplemental Benefits (vision, dental, hearing aid)

The eligibility rules that apply to prescription drug and supplemental benefits are identical to those for medical benefits with the following exceptions:

- You and your eligible Dependents are eligible for prescription drug benefits immediately. If you are enrolled in a medical plan only, you receive Preventive Care prescription drug benefits at no additional cost (see Section 10 for a list of covered preventive medications).
- You may cover your spouse who is a Member of the REHP or the RPSPP for supplemental benefits (vision, dental and hearing aid).
- Pennsylvania State Police Cadets are not eligible for supplemental benefits (vision, dental and hearing aid). Cadets are eligible to enroll themselves and eligible dependents in medical coverage which includes Preventive Care prescription drug coverage. Cadets may purchase full prescription drug coverage (either single or family coverage) for 180 days (6 months).
- If you are a permanent part-time employee working at least 50% of full-time hours, you may make the same elections as permanent full-time employees.
- The Bronze Plan includes coverage for medical and prescription drug. Bronze Plan Members do not have coverage for supplemental benefits.
- If you are placed on workers' compensation as a result of a Commonwealth work-related injury, you may use your PEBTF prescription drug ID card to obtain prescription drugs relating to your injury. Employees of PASSHE and PHEAA should contact their local HR office for information regarding coverage for work-related injuries.

If you are hired or re-hired on or after August 1, 2003 with a break in service of more than 180 calendar days, you are eligible for medical, prescription drug and supplemental benefits (vision, dental and hearing aid) as of your date of hire or re-hire.

Adding and Removing Eligible Dependents

You may add Dependents at any time. However, the effective date cannot be more than 60 days retroactive from the date the form is received by the HR Service Center or your HR office if your agency is not supported by the HR Service Center.

Adding a New Child: 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. 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 and submitting to the HR Service Center or your HR office if you are in an agency not supported by the HR Service Center.

Don't Delay in Adding Your Child

Notify the HR Service Center or your local HR office as soon as you give birth or adopt a child to complete a PEBTF-2.
Then, you have six months to provide a birth certificate (or decree or other proof of adoption) and Social Security number.

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 other proof of adoption) and
- Social Security number

If you fail to provide the required documentation before the end of the six-month period, you will be contacted by the HR Service Center or your HR office if you are in an agency not supported by the HR Service Center. In addition, 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. If you have a child placed with you for adoption, you must provide a decree of 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 PEBTF 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.

Removing Dependents: You must drop coverage for a Dependent who is no longer eligible under the PEBTF due to a Qualifying Life Event. You may remove or disenroll a Dependent due to a Qualifying Life Event or during the annual Open Enrollment. Refer to the Glossary for a description of Qualifying Life Event.

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

If you wish to remove a Dependent because of a Qualifying Life Event, you must report the Qualifying Life Event within 60 days of the event by contacting the HR Service Center or your HR office if your agency is not supported by the HR Service Center. If you disenroll a Dependent, the Dependent will be terminated from PEBTF coverage effective as of the date of the Qualifying Life Event. For example, your ex-spouse will be removed from coverage effective as of the date of divorce.

Important: You must provide notice of a Qualifying Life Event within 60 days of the event to the HR Service Center or your HR office if your agency is not supported by the HR Service Center. If you wait more than 60 days to report your event, (for example, you wait to report your divorce from your spouse or your Dependent's loss of status as an eligible Dependent), your Dependent will lose the right to continue coverage under COBRA. You will be responsible for any claims incurred when your Dependent was not eligible for benefits.

NOTE: The PEBTF reserves the right to verify your or your Dependent's eligibility for benefits coverage and may require other documentation in addition to a completed enrollment form. All payments from the Plan to you or a Provider are contingent upon the accuracy of the personal and/or Dependent information you provide. If you present false or misleading information about yourself, your spouse, your child(ren) or your spouse's child(ren) or about expenses or entitlement to benefits or coverage, or fail to make any required contribution toward the cost of coverage, the PEBTF will take appropriate action, up to and including the forfeiture of benefits and/or loss of coverage. Coverage may be terminated retroactively for non-payment of premium, in the case of an act, practice or omission that constitutes fraud, or if you make an intentional misrepresentation of a material fact.

If adding or removing a Dependent changes the amount you pay for coverage with pre-tax dollars, the change in contribution must conform to any additional requirements under the Internal Revenue Code. If your Qualifying Life Event results in the provision of retroactive coverage, the cost for any retroactive coverage will be paid with after-tax dollars.

When Coverage Ends

Your coverage will generally end on the date when:

- Your employment ends (effective date is the close of business on the last workday paid)
- You are no longer eligible to participate in the Plan
- Your employer no longer makes contributions on your behalf
- You fail to pay any money due to the PEBTF with respect to coverage or benefits
- Your employment status changes to Leave Without Pay Without Benefits (LWOPWOB)
- Your percent of time worked decreases to less than 50% of full-time employment
- You are furloughed
- You are suspended from PEBTF coverage for fraud and/or abuse, and/or intentional misrepresentation of a material fact, and/or failure to provide requested information and/or failure to cooperate with the PEBTF in the exercise of its subrogation rights and/or failure to repay debt to the PEBTF with respect to coverage of benefits

Refer to the Glossary for a description of a Qualifying Life Event.

Employees of PASSHE who have been promoted into positions that would normally make them ineligible for PEBTF benefits shall continue to remain eligible for coverage until the date that the PEBTF is notified of their promotion by PASSHE provided that the required Employer and Employee contributions have been remitted to the PEBTF through the date of notification.

Dependent coverage will generally end on the date when:

- Your coverage ends
- Your Dependent no longer qualifies as an eligible Dependent under the rules of the Plan (for example, divorce, etc.)*
- You lose a Dependent through divorce, death, etc.)
- You voluntarily drop coverage for your Dependent as permitted under PEBTF rules
- You fail to make a required contribution for coverage for your Dependent
- You or your Dependent is suspended from PEBTF coverage for fraud and/or abuse, and/or intentional misrepresentation of a material fact, and/or failure to provide requested information and/or failure to cooperate with the PEBTF in the exercise of its subrogation rights and/or failure to repay debt to the PEBTF
- The PEBTF determines an individual had been incorrectly enrolled as a Dependent (in certain instances, coverage may be canceled back to the date the individual was incorrectly enrolled)

Notify the HR Service Center or your local HR office as soon as your divorce is final.

***Divorce**: In the case of divorce, you must notify the HR Service Center or your HR office if your agency is not supported by the HR Service Center as soon as the divorce is final. 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 HR. The effective date of the ex-spouse's termination of benefits will be the actual date of divorce. If the divorce is reported to the HR Service Center or the HR office if your agency is not supported by the HR Service Center within 30 days of the effective date of the divorce, you will not be held liable for any benefit utilization during the 30 day grace period.

You may wish to contact the HR Service Center or your HR office if your agency is not supported by the HR Service Center sooner 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 PEBTF 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 PEBTF coverage will be terminated on the actual date of divorce.

Dependents: You must notify the HR Service Center or your HR office if your agency is not supported by the HR Service Center if your Dependent no longer qualifies for PEBTF coverage within 60 days of the Qualifying Life Event.

If the Plan pays benefits for an individual who was covered under the Plan as your Spouse or Dependent when benefits are incurred after that individual ceases to be eligible for coverage, you will be required to repay the PEBTF 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.

If your coverage ends, in certain circumstances Members may qualify for continued coverage of health benefits. Please refer to the "COBRA Continuation Coverage" section for more details.

Upon an employee's death, certain eligible Dependents may qualify for continued coverage. See page 110 of this SPD. For further information, your Dependents may contact the HR Service Center, your HR office if your agency is not supported by the HR Service Center or the PEBTF. If your death is a result of a work-related accident, eligible Dependents may qualify for paid coverage.

Refer to the Glossary for a description of a Qualifying Life Event.

Last Date of Coverage for a Child

A child becomes ineligible as of the day they:

- Turn 26 (if not disabled) – Dependent is terminated from coverage on the last day of the month in which the Dependent turns 26
- Are determined by the Board of Trustees to no longer be Totally and Permanently Disabled if age 26 or older
- No longer meets the Dependent eligibility requirements of the PEBTF

Your child may remain on benefits until age 26. Coverage ends on the last day of the child's birth month.

NOTE: You must reside in the service area to enroll in an HMO. The HMO plan offered by the PEBTF is a Custom HMO and offers a limited network of Providers and facilities. Emergency Services only are covered outside of the service area. You should seek Emergency Services and contact the plan. If you have a Dependent 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.

Important: You must advise the HR Service Center or your HR office if your agency is not supported by the HR Service Center **within 60 days of an event** that causes a child to no longer be an eligible Dependent. If you or your Dependent fails to do so, your Dependent will not be able to elect COBRA continuation coverage. You will be responsible for any claims incurred when your Dependent was not eligible for benefits.

Changing Coverage

You may enroll for coverage and/or change Plan Options during the Open Enrollment period. You may enroll in any PEBTF-approved medical plan for which you are eligible that offers service in your county of residence. Any change in coverage during Open Enrollment is effective usually as of the next January 1. If you were first hired or re-hired on or after August 1, 2003 and switch to a more expensive medical plan, you will have to pay the cost difference or biweekly buy-up cost (in addition to the employee health care contribution). The buy-up amount is deducted from your biweekly pay and begins on the effective date of the plan change.

Most Qualifying Life Events relate to enrollment for or disenrollment from coverage for you or a Dependent. If you move outside of the relevant service area for your coverage, you must elect to change your coverage option. If you do not make an election, you automatically will be enrolled in the Basic PPO or Choice PPO option, depending on your date of hire. You will also be responsible for the full annual Deductible, if you change plans mid year.

You may change medical plans during non-Open Enrollment periods only under certain limited circumstances as a result of a Qualifying Life Event. The change in coverage must be on account of and correspond with the Qualifying Life Event and must be within 60 days of the event. The documentation must be submitted through ESS or postmarked or actually received (if sent by other than U.S. Mail First Class) within 60 days of the event. You may contact the PEBTF or the HR Service Center or your HR office if your agency is not supported by the HR Service Center with questions.

A plan change does not mean coverage ends. Refer to the section, When Coverage Ends earlier in this section for information on canceling coverage.

Refer to the Glossary for a description of a Qualifying Life Event.

Employees at agencies under the Governor's jurisdiction and the Office of Attorney General and Office of the Auditor General can change their address, change health plans or enroll or disenroll Dependents through Employee Self Service (ESS) at www.myworkplace.pa.gov. In addition, employees can make plan changes during Open Enrollment through ESS. If you are unable to use ESS, please contact the HR Service Center at 1-866-377-2672 or your HR office if your agency is not supported by the HR Service Center.

Employees of the PASSHE can make certain benefit changes through its own ESS at https://portal.passhe.edu/irj/portal or by contacting their university's HR office.

If your agency does not participate in ESS, follow your agency's procedures to make any changes to your personal and benefit information.

If Eligibility is Denied

The Board of Trustees has established the PEBTF's eligibility rules**.** If eligibility for you or one of your Dependents is denied, you have the right to appeal to the Board of Trustees. Please see page 115 for a description of the Claims and Appeals Process.

Section 2: Benefits Under All Medical Plan Options

See PPO, HMO or Bronze Plan option sections for more detail.

Important – Please Read

The PEBTF offers several Plan Options for medical benefits. You choose the option – PPO, HMO or Bronze Plan option – that best fits your needs. Not all options are available in all areas. The Bronze Plan is available for eligible nonpermanent and permanent part-time employees who work an average of 30 hours a week. The PEBTF covers mental health and substance use benefits under each medical plan. The PEBTF also offers prescription drug and supplemental benefits (vision, dental and hearing aid). Prescription drug and supplemental benefits are separate from your medical benefits. The Bronze Plan does not include coverage for vision, dental or hearing aid benefits. If enrolled in a medical plan you may also participate in the reimbursement account, which is described in Section 14.

There are two PPO plans – the Choice PPO and the Basic PPO. Both PPO plans have annual 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 and diagnostic tests. 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.

In each case, the PEBTF has contracted with one or more outside professional Claims Payors to administer benefits under the Medical Plan Options and supplemental benefits.

To understand the benefits available to you, you should read this section, which describes information that applies under all Medical Plan Options, as well as the description in this booklet of the particular Medical Plan Option that covers you. You may also refer to the supplemental benefits section for more information about those benefits. In addition, you should read the section “Services Excluded from All Medical Plan Options” for a description of limitations applicable to all Plan Options.

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

- This booklet is a summary only. In the event of a conflict between this Summary Plan Description and the Plan Document, the Plan Document will control.
- The Claims Payor with respect to your Medical Plan Options or supplemental benefits has the authority to interpret and construe the Plan, and apply its terms and conditions with respect to your factual 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 benefits policies.

With respect to certain Plan Options, if you use an Out-of-Network Provider, the Plan 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 limitations on benefits under the terms of the Plan. 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. 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, 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 and Bronze Plan options: Failure to precertify Out-of-Network, non-emergency ambulance services may result in a 20% reduction in benefits payable. 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. Transportation by an Out-of-Network ambulance is subject to Deductible and Coinsurance provisions (PPO option) or Member Deductible benefit level percentage and Out-of-Pocket Maximum (Bronze Plan) and the eligible charge will not exceed the Usual, Customary and Reasonable (UCR) allowance or (as applicable) Plan Allowance as determined by the Claims Payor.

Care Outside of the Country

The Plan will cover urgent and emergency medical care obtained outside of the country. In limited instances, a medical facility in a foreign country will accept coverage from the Plan. If the out-of-country medical facility does not accept coverage from the Plan, you will be required to pay for medical services. You may then submit your claim for reimbursement from the Plan when you return home. You should ask for an itemized billing statement that includes your diagnosis and is translated into U.S. dollars.

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. 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 a setting other than the hospital. The services are provided to you at no additional cost through the medical plans.

Centers of Care

Notwithstanding anything in this Plan to the contrary, the Board of Trustees 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 Board of Trustees as a "Center of Care" for such expense. If the Board of Trustees make 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 Board of Trustees may prescribe.

Chiropractic Care/Spinal Manipulations

Benefits:

PPO Option	HMO Option
• 12 Medically Necessary visits per year, then a Treatment Plan must be submitted for additional visits • $20 Copayment for Network chiropractic care • Out-of-Network care is subject to an annual Deductible and 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 you 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 HMO-Network chiropractor

See the Bronze Plan section for information on chiropractor care under that plan.

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 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 preauthorization or case management procedures). See, for example, Services Excluded From All Medical Benefit Options

The Plan Document authorizes the Claims Payor with respect to each Plan Option to make decisions regarding 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 preauthorization. Such decisions may be made pursuant to the Claims Payor's medical policies and procedures, consistent with the terms of the Plan. The Board of Trustees will generally not overturn on appeal a decision made by the Claims Payor which is made within its authority under the terms of the Plan Document.

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

For Bronze Plan Members: You have both a Network and an Out-of-Network benefit, which are both subject to your annual deductible.

Covered, Medically Necessary equipment and supplies obtained from a Network Provider, as determined by your medical plan, are paid at 100% of the eligible covered expense after Deductible and OOP Max.

Covered Medically Necessary equipment and supplies obtained from an Out-of-Network Provider, 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.
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 a sudden and unexpected change in your physical or mental condition, which is severe enough to require immediate medical care, as follows:

You pay an Emergency Room Copayment under the PPO or HMO plans.

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
- Severe chest pain
- Seizure or convulsion
- Severe or unusual bleeding
- Severe burn
- 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 Emergency Room visit, you will be required to

pay your $150 Emergency Room Copayment (HMO) or $200 Emergency Room 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 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.

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) or $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 $5 Copayment (HMO) or $20 Copayment (PPO) 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 accidental injury.

Facility and Professional Provider Services

Covered inpatient services at a participating Network facility 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 each medical plan section.

- 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, dressings, splints and casts
- Chemotherapy, radiation and dialysis services, physical, respiratory, occupational, speech, cardiac and pulmonary rehabilitation therapies, including spinal manipulation (see charts under each option for the annual Maximums); subject to Copayments; Gene Therapy (not subject to the Deductible or Copayment under the PPO and Custom HMO plans). Gene Therapy is subject to the Deductible under the Bronze plan.

Medically Necessary services are also covered Out-of-Network (PPO and Bronze Plan options) but they are subject to an annual Deductible and Coinsurance. Also, any charges in excess of

the Plan Allowance as determined by the Claims Payor are non-eligible expenses and are entirely your responsibility.

Home Health Care

Benefits:

PPO Option	HMO Option
• Covered 100% In Network after annual Deductible • No day limit for Network care. You must precertify for both Network and Out-of-Network Home Health Care Services • **Out-of-Network**: 70% plan payment after Deductible. Non-Participating 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

See the Bronze Plan section for information on Home Health Care under that plan.

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 parent/well baby care following release from an inpatient maternity stay (the mother does not have to be essentially homebound for this service)

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 provided only 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 remains 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 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 Medically Necessary services (Bronze Plan – after applicable Deductible and Out-of-Pocket Maximum). You must use a participating Hospice. You may contact your Plan Option Claims Payor for a list of participating Hospices. This benefit is not renewable.

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 treatments)
- Medical and surgical supplies and Durable Medical Equipment
- Prescription drugs and medications
- Oxygen and its administration
- Medical social services consultations
- 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 Claims Payor.

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 or continue to receive 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 below are covered, subject to the following:

- When both the recipient and the donor are Members, each is entitled to the benefits of the Plan.
- When only the recipient is a 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 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 donor will be charged against the recipient's coverage under this Plan.
- When only the donor is a Member, only 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 benefit will be provided to the transplant recipient.
- If any organ or tissue is sold rather than donated to the 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 an annual Deductible. **HMO option**: Services are covered 100%.

Mastectomy & 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 Plan 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 Plan also covers physical complications at all stages of the mastectomy, including lymphedemas.

Maternity Services

Childbirth services, including pre- and post-natal care, are covered for all Members (including covered Dependents of Employee Members). **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 the health of the Member, as certified by the Member's treating physician.
- 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 Services

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

Mental health and substance use treatment and services are not covered under the medical plan, except as described below. Please see the section describing the Mental Health and Substance Use Program. Medical providers may treat mental health conditions within their scope of practice. 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).

Medical Detoxification Treatment for Substance Use: The medical plan covers inpatient medical detoxification, whichever is determined to be Medically Necessary by the Claims Payor. The medical plan will coordinate these services with the Mental Health and Substance Use Program. The Mental Health and Substance Use Program covers ambulatory detoxification.

Special Medical/Behavioral Health Care Benefits: Both the 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 PEBTF medical plans, the Mental Health and Substance Use Program and the Prescription Drug Plan. There is no annual maximum benefit limit.

Coverage is provided for Members who have a diagnosis of autism spectrum disorder. The coverage is in accordance with the Pennsylvania Autism Insurance Act (Act 62 of 2008). 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:

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

(b) Provided by a Board Certified Applied Behavioral Analyst or other qualified Provider, acting in accordance with an appropriate Treatment Plan prescribed by the 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 and Bronze plans. ABA services are covered at 100% for HMO members and for PPO and Bronze Plan 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 medical plan also covers the following Medically Necessary services when ordered by your physician and authorized by your Claims Payor. Services where you do not pay a Copayment are subject to an annual Deductible under the PPO option.

- Sterilization – PPO and HMO Members no Copayment for the surgery

- Bariatric surgery (subject to particular 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 Members have a $45 Specialist Copayment. HMO Members have a $10 Specialist Copayment and must use a medical plan Network dentist or oral surgeon
- Podiatric care for treatment of disease or injury – PPO Members have a $45 Specialist Copayment and HMO 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. Syringes, needles, lancets and test strips are covered under the DME benefit – 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 PEBTF provides coverage for the following Preventive Care services under all of its medical plans at 100% for 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.

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 ACIP (CDC). For more information, visit: https://www.cdc.gov/vaccines/hcp/imz-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 PEBTF 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

Preventive Care Services	Frequency/Comments
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
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

Preventive Care Services	Frequency/Comments
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
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 40

Preventive Care Services	Frequency/Comments
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	
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

Preventive Care Services	Frequency/Comments
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
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

Preventive Care Services	Frequency/Comments
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 opthalmia neonatorum	Prophylactic ocular topical medication for all newborns to prevent gonococcal opthalmia 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

Preventive care covered medications are covered under your prescription drug coverage, which is at no cost to you when medical is elected (for full-time employees).

For Members Enrolled in Medical Only: If you are enrolled for coverage in a medical plan but not in the prescription drug benefits, your medical benefits shall be supplemented, without cost-sharing, for the Preventive Care prescription drugs listed below. You will receive a CVS Caremark Preventive Drug Plan ID card which you should use at a CVS Pharmacy to obtain Preventive Care prescription drugs without any Deductible, Copayments or Coinsurance. Please refer to the list of covered medications below. The following preventive prescription drugs are covered at no cost 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 prescription 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, ovarian, tubal or peritoneal cancer or an ancestry associated with BRCA1/2 gene mutation.

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 and the Bronze Plan options 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 Deductible for both the PPO and the Bronze Plan options. 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 2)
- Allergy diagnosis and treatment (including allergy serum)
- Gynecological care and services
- Maternity/obstetrical care (HMO and PPO – no charge for all visits); Bronze Plan – no charge for first visit to determine pregnancy
- Family planning consultation
- Diagnosis and treatment for mental health or substance use disorders
- 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 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)

Benefits:

PPO	HMO
• 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 • **Out-of-Network**: 70% plan payment after Deductible, up to 240 days. Non-Participating Providers may balance bill for the difference between Plan Allowance and actual charge	• 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

See the Bronze Plan section for information on Skilled Nursing Facility (SNF) care under that plan.

Benefit Limitations:
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 the patient's care plan
- Observation and assessment of the patient's changing condition
- Enteral feedings that comprise at least 26% of daily caloric requirements and provides 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 patient's potential
- Therapeutic exercises
- Gait evaluation and training
- Patient education services to teach a patient self-maintenance
- Initial phases of a regimen involving administration of medical gases, such as oxygen
- Intravenous or intramuscular injections 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 and 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 Benefits

The PEBTF website includes a list of wellness benefits including discounts offered by the medical plans. A Diabetes Prevention Program (DPP) is offered at no cost through the medical plans.

For additional medical plan information, please refer to the various Medical Plan sections.

Section 3: Preferred Provider Organization (PPO) Option

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 in the PEBTF Plan Document. The difference is in the annual Deductible.

- Deductibles differ between the Choice PPO and the Basic PPO
- PPO option covers medical services as set forth in the PEBTF Plan Document
- PPO option offers both a Network and Out-of-Network benefit
- In order to receive the highest level of benefits, you must choose one of the Network facilities or Providers
- 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

Benefit Highlights – Choice PPO Option

	Network Providers	Out-of-Network Providers *
DEDUCTIBLE (per calendar year) Annual 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
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%

	Network Providers	Out-of-Network Providers *
COMBINED OUT-OF-POCKET MAXIMUM (per calendar year) When the Out-of-Pocket Maximum is reached, the PPO pays at 100% of the allowable amount until the end of the benefit period.	$10,600 single $21,200 family ***Includes costs for medical, mental health and substance use 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 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 Section 2 for a list of preventive care services	Covered 100% – not subject to annual Deductible	70% plan payment; 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; Member pays 30%
• Hospital and newborn care	Covered 100% after Deductible	70% plan payment; Member pays 30%
PHYSICIAN VISITS		
• Office visits (PCP's include family practice, general practice, internal medicine and pediatrics)	$20 Copayment per office visit	70% plan payment; Member pays 30%
• Specialist office visits	$45 Copayment per office visit	70% plan payment; Member pays 30%
• Diagnostic tests (imaging, X-ray, MRI, etc.), inpatient visits, surgery and anesthesia	Covered 100% after Deductible	70% plan payment; Member pays 30%
• Diagnostic tests (lab and pathology)	Covered 100%	70% plan payment; Member pays 30%

	Network Providers	Out-of-Network Providers *
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; 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) • 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; Member pays 30%
• Hospice (outpatient – see page 28 for more information)	Covered 100%	70% plan payment; 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; 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; Member pays 30% Out-of-Network: 70 days per calendar year
EMERGENCY SERVICES		
• Urgent care	$50 Copayment	70% plan payment; 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; 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 Section 6 on the 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 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.	$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 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 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 Section 2 for a list of preventive care services	Covered 100% – not subject to annual Deductible	70% plan payment; 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; Member pays 30%
• Hospital and newborn care	Covered 100% after Deductible	70% plan payment; Member pays 30%

	Network Providers	Out-of-Network Providers *
PHYSICIAN VISITS		
• Office visits (PCPs include family practice, general practice, internal medicine and pediatrics)	$20 Copayment per office visit	70% plan payment; Member pays 30%
• Specialist office visits	$45 Copayment per office visit	70% plan payment; Member pays 30%
• Diagnostic tests (imaging, X-ray, MRI, etc.), inpatient visits, surgery and anesthesia	Covered 100% after Deductible	70% plan payment; Member pays 30%
• Diagnostic tests (lab and pathology)	Covered 100%	70% plan payment; 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; 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) • 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; Member pays 30%
• Hospice (outpatient – see page 28 for more information)	Covered 100%	70% plan payment; 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; Member pays 30%
• Outpatient Diabetic Education	Covered 100%	Not covered

	Network Providers	Out-of-Network Providers *
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; Member pays 30% Out-of-Network: 70 days per calendar year
EMERGENCY SERVICES		
• Urgent care	$50 Copayment	70% plan payment; 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
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; 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 Section 6 on the Mental Health and Substance Use Program provided under the Basic PPO Plan.

If you or your Dependents receive or plan to receive services from a Non-PPO Network Provider who recommends services, it is your responsibility to obtain preauthorization from the Claims Payor. See the section 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 Benefits Highlights Chart, 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. All expenses must be Medically Necessary.

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 in excess of the Plan Allowance. If you use an Out-of-Network Provider, you are responsible for the Deductible, applicable Coinsurance and all amounts more than the Plan Allowance.

Non-Network or Out-of-Network Services

Choice PPO: Each year, you pay the first $800 (the Deductible) 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 covered 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 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 more than 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 phone number on your ID card for more information.

Care or Treatment Requiring Preauthorization

Preauthorization is an advance review by the Claims Payor 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 in a hospital emergency room by an emergency room Provider. If an inpatient admission results from an emergency room visit, notification to the Claims Payor must occur within 48 hours or two business days of the admission. If the hospital is a Participating Provider, the hospital is responsible for performing the notification. If the hospital is a Non-Participating 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 Participating 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 a Non-Participating Provider and preauthorization is not obtained, the amount that would be paid for the Medically Necessary service is subject to a reduction of 20% as a penalty for failure to preauthorize. The penalty is in addition to your Out-of-Network Deductible and Coinsurance.

Care Outside of the PPO 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 urgent/emergency 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. You should ask for an itemized billing statement that includes your diagnosis and is translated into U.S. dollars.

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 a PPO Option 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 phone number on your ID card for more information.

If your claim for benefits is denied, see page 116 for a description of the Appeals Process.

For additional information, please refer to the sections: Benefits Under all Health Plan Options and Services Excluded From all Medical Plan Options.

Section 4: Health Maintenance Organization (HMO) Option

Summary

- The HMO is a Custom HMO which offers a limited network of Providers and facilities
- HMO option covers medical services as set forth in the PEBTF Plan Document
- 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 (for general practitioners, family practitioners, internists and pediatricians)
- $10 Copayment for telehealth visit (through Teladoc™)
- $10 Copayment for specialist office visit
- $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 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.

Benefit Highlights – HMO Option

	Network Providers
DEDUCTIBLE (per calendar year)	None
COMBINED OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the HMO pays at 100% until the end of the benefit period. ***Includes costs for medical, mental health and substance use 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 billing amounts for Out-of-Network Providers.
PREVENTIVE CARE	
• See Section 2 for a list of preventive care services	Covered 100% If not available in Network, full cost shall be covered without any cost sharing
MATERNITY SERVICES	
• Office visits	Covered 100% including first prenatal visit
• Hospital and newborn care	Covered 100%
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

	Network Providers
• Diagnostic tests (lab and pathology tests, imaging, X-ray, MRI, etc.) inpatient visits, surgery and anesthesia	Covered 100%
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)
OTHER PROVIDER SERVICES	
• Radiation therapy, chemotherapy, kidney dialysis • Gene Therapy (no Copayment) • Home Health Care (60 visits in 90 days) • Hospice (outpatient and inpatient; inpatient covered 365 days per admission) – see page 29 for more information) • Skilled Nursing Facility (180 days per calendar year)	Covered 100%
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 100%
INPATIENT HOSPITAL SERVICES	
• Professional fees & facility services including: room & board & other Covered Services	Covered 100% (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 100%
DURABLE MEDICAL EQUIPMENT	
• Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics in accordance with the medical plan’s DME policy	Covered 100%
LIFETIME MAXIMUM BENEFIT	Unlimited

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

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.

An HMO pays for services only if the services are rendered by a Provider or facility which is in that HMO's network. There is no payment 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 the HMO's Member Services Department.

Failure to receive authorization for services from the HMO will result in nonpayment of those services.

Care or Treatment Requiring Preauthorization

Preauthorization is an advance review by the Claims Payor 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 in a hospital emergency room by an emergency room Provider. If an inpatient admission results from an emergency room visit, notification to the Claims Payor must occur within 48 hours or two business days of the admission. If the hospital is a Participating Provider, the hospital is responsible for performing the notification. If the hospital is a Non-Participating Provider, you or your responsible party acting on your behalf are responsible for the notification.

The telephone number for preauthorization appears on your HMO ID card. Present your ID card to your health care Provider. A Participating Provider will obtain preauthorization. If you use a Non-Participating Provider, it is your responsibility to obtain preauthorization.

Care Outside of the HMO Plan's Network

You must reside in the service area to enroll in an HMO. The HMO plan offered by the PEBTF 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 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 Out-of-Pocket. You may then submit your claim to the HMO when you return home. You should ask for an itemized billing statement that includes your diagnosis and is translated into U.S. dollars. Under the HMO option, benefits for services obtained Out-of-Network are generally limited to emergency situations.

Filing an HMO Option Claim

All claims for benefits under the HMO option must be filed on forms provided by the HMO. The claims must be filed with the HMO and postmarked no later than one year from the date of service. Please contact the phone number on your ID card for more information

If your claim for benefits is denied, see page 116 for a description of the Appeals Process.

For additional information, please refer to the sections: Benefits Under all Health Plan Options and Services Excluded From all Medical Plan Options.

Section 5: Bronze Plan Option

Summary

If you work an average of 30 hours a week, you will be notified if you qualify for the Bronze Plan – a high-Deductible plan that includes medical and prescription drug coverage.

- Bronze Plan option is available to permanent part-time and nonpermanent employees who work an average of 30 hours a week and are notified by the HR Service Center or their HR office if their agency is not supported by the HR Service Center that they qualify for the plan
- Bronze Plan option covers medical services as set forth in the PEBTF Plan Document
- Bronze Plan option offers both an In-Network and Out-of-Network benefit
- In order to receive the highest level of benefits, you must choose one of the Network facilities or Providers
- You may self refer for Medically Necessary care, as defined by the Plan
- The Bronze Plan is a High Deductible Plan and the plan pays 100% in Network after you fulfill annual Deductible and Out-of-Pocket Maximum
- 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
- Annual In-Network Deductible is $10,600 single/$21,200 family
- $40 Copayment for telehealth visit (through Teladoc™)
- The Bronze Plan includes coverage for medical and prescription benefits only.

Benefit Highlights – Bronze Plan Option

	Network Providers	Out-of-Network Providers *
DEDUCTIBLE (Per Calendar Year) ***Includes costs for medical, mental health and substance use benefits and prescription drug costs.***	$10,600 single $21,200 family	$10,716 single $21,432 family

	Network Providers	Out-of-Network Providers *
COMBINED OUT-OF-POCKET MAXIMUM (OOP MAX) When the Out-of-Pocket Maximum is reached, the Bronze Plan pays at 100% of the allowable amount until the end of the benefit period.)	$10,600 single $21,200 family ***Includes costs for medical, mental health and substance use benefits and prescription drug costs.*** Includes Deductibles, Coinsurance, Copayments and any other expenditure required of an individual, which is a qualified medical expense for the essential health benefits.	$14,134 single $28,268 family ***Includes costs for medical, mental health and substance use benefits and prescription drug costs.*** 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 Section 2 for a list of preventive care services	Covered 100% – not subject to annual Deductible	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX If not available in Network, full cost shall be covered without any cost sharing
MATERNITY SERVICES		
• Office visits	100% for the first prenatal visit; 100% Plan Allowance after Deductible and OOP MAX for subsequent maternity charges including hospitalization and delivery charges	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX
• Hospital and newborn care	Covered 100% after Deductible and OOP MAX	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX
PHYSICIAN VISITS		
• Office visits (PCP's include family practice, general practice, internal medicine and pediatrics) • Specialist office visits • Diagnostic tests (imaging, lab tests, X-ray, MRI, etc.) inpatient visits, surgery and anesthesia	Covered 100% after Deductible and OOP MAX	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX

	Network Providers	Out-of-Network Providers *
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)	Covered 100% after Deductible and OOP MAX	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX
OTHER PROVIDER SERVICES		
• Radiation therapy, chemotherapy, kidney dialysis (not covered at an Out-of-Network freestanding dialysis center) • Gene Therapy • Home Health Care • Outpatient Private Duty Nursing (240 hours per year/8 hours per day) • Skilled Nursing Facility (240 days per calendar year)	Covered 100% after Deductible and OOP MAX	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX
• Hospice (outpatient and inpatient – see 28 for more information)	Covered 100% after Deductible and OOP MAX	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX
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 and OOP MAX	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX
• Outpatient Diabetic Education	Covered 100% after Deductible and OOP MAX	Not covered
INPATIENT HOSPITAL SERVICES		
• Professional fees & facility services including: room & board & other Covered Services (precertification is required for most services)	Covered 100% after Deductible and OOP MAX (365 days per benefit period)	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX Out-of-Network: 70 days per calendar year

	Network Providers	Out-of-Network Providers *
EMERGENCY SERVICES		
• Urgent Care	Covered 100% after Deductible and OOP MAX	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX
• Emergency treatment for accident or medical emergency	Covered 100% after Deductible and OOP MAX	Covered 100% after Deductible and OOP MAX
• Ambulance services for emergency services	Covered 100% after Deductible and OOP MAX	Covered 100% after Deductible and OOP MAX
DURABLE MEDICAL EQUIPMENT		
Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics in accordance with the medical plan's DME policy	Covered 100% after Deductible and OOP MAX	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited

PRESCRIPTION DRUG BENEFIT • Provided by CVS Caremark	You pay 100% of your prescription drug costs up to the Out-of-Pocket Maximum; the plan then pays at 100% for prescription drugs covered under your plan. You do not need to submit claims – the Prescription Drug Plan works with your medical plan to total all expenses

* Network Providers agree to accept the Bronze Plan 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 Bronze Plan to be Medically Necessary.

See Section 6 on the Mental Health and Substance Use Program provided under the Bronze Plan.

If you or your Dependents receive or plan to receive services from a Non-Bronze Plan Network Provider who recommends services, it is your responsibility to obtain preauthorization from the Claims Payor. See the section 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 Bronze Plan 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 Benefits Highlights Chart, 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 Bronze Plan (the "Claims Payor"). You are responsible for all costs in excess of the Plan Allowance. All expenses must be Medically Necessary.

You can save money by using a Bronze Plan Network Provider. Network Providers, sometimes called Participating Providers, have agreed to accept the Bronze Plan'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 in excess of 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.

In Network and Non-Network or Out-of-Network Services

Each year, you pay the Deductible and Out-of-Pocket Maximum for covered expenses for each covered person.

After the Deductible and Out-of-Pocket Maximum, the Bronze Plan will pay 100% in Network and 70% of the Out-of-Network covered expenses. In addition, you are responsible for any charges in excess of the Plan Allowance (as applicable).

NOTE: Covered expenses do not include charges in excess of the Plan Allowance for a service or supply as determined by the Bronze Plan. 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 Bronze Plan. All claims must be filed with the Bronze Plan and postmarked no later than one year from the date of service. Please contact the phone number on your ID card for more information.

Care or Treatment Requiring Preauthorization

Preauthorization is an advance review by the Claims Payor 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 in a hospital emergency room by an emergency room Provider. If an inpatient admission results from an emergency room visit, notification to the Claims Payor must occur within 48 hours or two business days of the admission. If the hospital is a Participating Provider, the hospital is responsible for performing the notification. If the hospital is a Non-Participating Provider, you or your responsible party acting on your behalf are responsible for the notification.

The telephone number for preauthorization appears on your Bronze Plan ID card. Present your ID card to your health care Provider. A Participating Provider will obtain preauthorization. If you use a Non-Participating Provide, it is your responsibility to obtain preauthorization.

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

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

The Bronze Plan provides an out-of-area benefit for Members. Contact the plan or visit the Bronze Plan's website to search for Providers.

Care Outside of the Country –Emergency Services

If you are traveling outside the United States, you should remember to always carry your Bronze Plan identification card. There may be instances where a medical facility in a foreign country will recognize the Bronze Plan as providing payment for services. If the out-of-country medical facility does not recognize the Bronze Plan, you will probably be required to pay for medical services Out-of-Pocket. You may then submit your claim to the Bronze Plan when you return home. You should ask for an itemized billing statement that includes your diagnosis and is translated into U.S. dollars. If non-emergency services are needed, contact your plan. If you need emergency services, you should go to the nearest hospital. If admitted, contact your plan.

Filing a Bronze Plan Option Claim

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

If your claim for benefits is denied, see page 116 for a description of the Appeals Process.

For additional information, please refer to the sections: Benefits Under all Health Plan Options and Services Excluded From all Medical Plan Options.

Prescription Drug Benefit Portion of the Bronze Plan

See Section 10: Prescription Drug Plan for a full description.

Through the Prescription Drug Plan, you may obtain required medications at Participating pharmacies throughout Pennsylvania and the United States at a reduced, prenegotiated cost. See Section 10: Prescription Drug Plan for a full description, including covered and excluded prescriptions.

If any particular prescription drug expense that is covered under this section would also be covered under one or more other Plan Options: 1) if incurring such expense, you 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.

Deductible (per calendar year)

Your prescription drug coverage is based on a combined Deductible of medical, mental health and substance use benefit coverage and prescription drug claims. You must pay an annual In-Network Deductible of $10,600 for individual or $21,200 for a family before the plan coverage takes effect. Until the Deductible is met, you will pay 100% for your prescription drugs.

Prescriptions at a Network Pharmacy – Up to a 30 Day Supply	**Your Copayment****
Tier 1: Generic drug	$0 (after Deductible)
Tier 2: Preferred brand-name drug	$0 (after Deductible), plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$0 (after Deductible), plus the cost difference between the brand and the generic, if one exists
Mail Order – Up to a 90 Day Supply	**Your Copayment****
Tier 1: Generic drug	$0 (after Deductible)
Tier 2: Preferred brand-name drug	$0 (after Deductible), plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$0 (after Deductible), plus the cost difference between the brand and the generic, if one exists
CVS Maintenance Choice Network (CVS, Costco, or Kroger Pharmacy) Up to 90 Day Supply *	**Your Copayment****
Tier 1: Generic drug	$0 (after Deductible)
Tier 2: Preferred brand-name drug	$0 (after Deductible), plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$0 (after Deductible), plus the cost difference between the brand and the generic, if one exists

Annual In-Network Deductible: $10,600 single/$21,200 family (combined with medical and mental health and substance use coverage)

Out-of-Pocket Maximum: $10,600 single/$21,200 family (combined with medical and mental health and substance use coverage)

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

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

Section 6: Mental Health and Substance Use Program

Summary

The Mental Health and Substance Use Program will provide mental health and substance use rehabilitation treatment services, whether Inpatient or Outpatient. **(Inpatient detoxification services will be coordinated by the Mental Health and Substance Use Program but services are covered under the PPO, HMO or Bronze Plan option when Medically 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 thoroughly 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 mental health and well-being.

You should experience lower Out-of-Pocket expenses and no claim forms as long as you use Mental Health and Substance Use Program Network Providers. However, PPO and Bronze option Members have the freedom to receive eligible mental health and substance use 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 to track any Deductibles that may apply to both medical and mental health and substance use rehabilitation treatment services. You will not have two Deductibles to satisfy under the PPO and Bronze Plan options. Medical and mental health and substance use 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. The following pages detail the Mental Health and Substance Use Program benefits for Members under all Medical Plan Options. Please refer to the applicable chart that highlights the mental health and substance use benefits for the Medical Plan Option in which you are enrolled.

Benefit Highlights – Mental Health and Substance Use Program
For Members Enrolled in the Choice PPO Option

Service	Network Providers	Out-of-Network Providers **
DEDUCTIBLE (per calendar year)	$400 single $800 family	$800 single $1,600 family
COMBINED OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the plan pays at 100% of the allowable amount until the end of the benefit period	$10,600 single $21,200 family ***Includes costs for medical, mental health and substance use 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 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; 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; Member pays 30% after Deductible Limited to licensed psychiatrists, psychologists, social workers and nurses Subject to retrospective review

Service	Network Providers	Out-of-Network Providers **
Inpatient & Intermediate*	Covered 100% after Deductible	70% plan payment; 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; Member pays 30% after Deductible
Outpatient (all other)	100% after Deductible	70% plan payment; Member pays 30% after Deductible
Inpatient	Covered 100% after Deductible	70% plan payment; Member pays 30% after Deductible
Ambulatory Detoxification	Covered 100% after Deductible	70% plan payment; Member pays 30% after Deductible
Medical Detoxification	Covered by medical plan	
EMERGENCY ROOM	$200 Emergency Room Copayment (waived if the visit leads to an inpatient admission to the hospital)	
* Intermediate care includes partial hospitalization, day treatment and intensive outpatient		

Benefit Highlights – Mental Health and Substance Use Program
For 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
COMBINED OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the plan pays at 100% of the allowable amount until the end of the benefit period	$10,600 single $21,200 family ***Includes costs for medical, mental health and substance use 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 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; 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; 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*	Covered 100% after Deductible	70% plan payment; 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; Member pays 30% after Deductible
Outpatient (all other)	100% after Deductible	70% plan payment; Member pays 30% after Deductible
Inpatient	Covered 100% after Deductible	70% plan payment; Member pays 30% after Deductible
Ambulatory Detoxification	Covered 100% after Deductible	70% plan payment; Member pays 30% after Deductible
Medical Detoxification	Covered by medical plan	
EMERGENCY ROOM	$200 Emergency Room Copayment (waived if the visit leads to an inpatient admission to the hospital)	
* Intermediate care includes partial hospitalization, day treatment and intensive outpatient		

** 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.

Benefit Highlights – Mental Health and Substance Use Program
For Members Enrolled in the HMO Option

Service	Network
DEDUCTIBLE (per calendar year)	None
COMBINED OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the plan pays at 100% of the allowable amount until the end of the benefit period	$10,600 single $21,200 family ***Includes costs for medical, mental health and substance use 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.
MENTAL HEALTH	
Office Visits	100% after $5 Copayment For telehealth visits, the Copayment is waived
Outpatient (all other) – includes Applied Behavior Analysis (ABA) treatment	100%
Inpatient & Intermediate*	Covered 100%
SUBSTANCE USE	
Outpatient	$5 Copayment per visit For telehealth visits, the Copayment is waived
Outpatient (all other)	100%
Inpatient	Covered 100%
Ambulatory Detoxification	Covered 100%
Medical Detoxification	Covered by medical plan
EMERGENCY ROOM	$150 Emergency Room Copayment (waived if the visit leads to an inpatient admission at the hospital)

Benefit Highlights – Mental Health and Substance Use Program
For Members Enrolled in the Bronze Plan Option

Service	Network	Out-of-Network
DEDUCTIBLE (per calendar year) Includes all medical, mental health and substance use services and prescription drug costs.	$10,600 single $21,200 family	$10,716 single $21,432 family
COMBINED OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the plan pays at 100% of the allowable amount until the end of the benefit period	$10,600 single $21,200 family **Includes costs for medical, mental health and substance use benefits and prescription drug costs** 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.	$14,134 single $28,268 family ***Includes costs for medical, mental health and substance use benefits and prescription drug costs*** 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.
MENTAL HEALTH		
Office Visits & Outpatient (all other) – includes Applied Behavior Analysis (ABA) treatment	Covered 100% after Deductible and OOP MAX Telehealth visits are covered at no cost	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX Limited to licensed psychiatrists, psychologists, social workers and nurses Subject to retrospective review
Inpatient & Intermediate*	Covered 100% after Deductible and OOP MAX	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX Subject to retrospective review

Service	Network	Out-of-Network
SUBSTANCE USE		
Office Visits & Outpatient (all other)	Covered 100% after Deductible and OOP MAX Telehealth visits are covered at no cost	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX
Inpatient	Covered 100% after Deductible and OOP MAX	70% plan payment; Member pays 30%; 100% Plan Allowance after OOP MAX
Ambulatory Detoxification	Covered 100% after Deductible and OOP MAX	70% plan payment; Member pays 30%; Plan Allowance after OOP MAX
Medical Detoxification	Covered by medical plan	
EMERGENCY ROOM	Covered 100% after Deductible and OOP MAX	Covered 100% after Deductible and OOP MAX
* 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:

(a) Diagnostic evaluations, assessment and treatment planning

(b) Treatment and/or procedures

(c) Medication management and other associated treatments

(d) Individual, family, and group therapy

(e) Provider-based case management services

(f) Crisis intervention

(g) 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 Claims Payor 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 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.

(a) Inpatient admission, including admission to a residential treatment facility

(b) Partial hospitalization/day treatment

(c) Intensive Outpatient treatment

(d) Psychological testing

(e) Transcranial magnetic stimulation

(g) 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 or Bronze Plan Options, 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 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 PEBTF medical plans, the Mental Health and Substance Use Program and the Prescription Drug Plan. There is no annual maximum benefit limit.

Coverage is provided for Members who have a diagnosis of autism spectrum disorder. The coverage is in accordance with the Pennsylvania Autism Insurance Act (Act 62 of 2008). 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:

(a) Focused on the treatment of core deficits of the Member's autism spectrum disorder and maladaptive/stereotypic behaviors that are posing a danger to the Member themself, to others, or to property or that impair the Member's daily functioning.
(b) Provided by a Board Certified Applied Behavioral Analyst or other qualified Provider, acting i11 accordance with an appropriate Treatment Plan prescribed by the 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 and Bronze plans. ABA services are covered at 100% for HMO members and for PPO and Bronze 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

As of the Preventive Care effective date, 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 Use 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 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.

Filing a Mental Health and Substance Use Program 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 116 for a description of the Appeals Process.

Section 7: Services Excluded From All Medical Plan Options

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 medical plan options section)
- Any other medical or dental service or treatment except as provided in the Plan
- Automotive adaptions
- 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 SPD, 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
- Copayments for prescription drugs
- Correction of myopia or 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 (DME) in accordance with the Claims Payor'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, 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 Section 2). 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 as Preventive Care under each medical plan option – see Section 2 for a list of preventive benefits

- 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 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 (or couples 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 the Get Healthy Program or 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 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 a Member who is an inpatient and billed by the facility and those administered intravenously or by means of intramuscular or subcutaneous injection to a 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 Board of Trustees have 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 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 birth, who is born for the benefit of a Member by a surrogate mother, for services provided following a legal adjudication or custody or parentage by the Member with respect to that child. A child born by a 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 Member had applied for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the 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 option)

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.

Section 8: Get Healthy Program

Summary

- The Get Healthy Program is a program that promotes health and wellness to employees and covered spouses and other Dependents. The Get Healthy Program is intended to help you live the healthiest life possible while generating cost savings from lower health care claims.
- The eligibility criteria for a spouse or other Dependent to participate in the Get Healthy Program shall be determined by the Board of Trustees.

You will receive mailings and emails on the Get Healthy Program. Participate to save money!!

Get Healthy Incentive

You are required to contribute a certain percentage of your gross biweekly pay for PEBTF medical and prescription drug benefits (refer to the applicable collective bargaining agreement). The Get Healthy Program offers an incentive to participate in these benefits – a partial waiver of this contribution. The amount that you are required to contribute for medical and prescription drug coverage and the amount of the waiver for these benefits are set forth in the collective bargaining agreements negotiated between the Commonwealth and the various unions.

Get Healthy Program Participation Rules

You will be regarded as meeting the requirements for successful participation in the Get Healthy Program if you and, if applicable, your spouse or other Dependent satisfies the standards established by the Board of Trustees under the program. The standards for an employee may be the same as or different from the standards for Dependents and the standards for different classes of Dependents may be the same or vary as the Board of Trustees determines.

The Board of Trustees also shall determine the period during which performance under the Get Healthy Program will be measured for purposes of assessing successful participation. You are responsible for reviewing your payroll information for purposes of determining whether such successful participation has been appropriately taken into account. You may contact the PEBTF if you believe your successful participation has not been appropriately reflected in your pay.

For more information about the Get Healthy Program, visit www.pebtf.org.

Please see page 116 for information on the Get Healthy Appeals Process.

Section 9: Prescription Drug and Supplemental Benefits

Summary

- Prescription Drug
- Supplemental Benefits (Vision, Dental, and Hearing Aid)

Full-time employees: You and your Dependents may enroll in the Prescription Drug Plan and supplemental benefits at no cost if you are enrolled in medical coverage.

Most PEBTF Members are eligible for prescription drug and the supplemental benefits (vision, dental and hearing aid services). The medical plan you choose does not affect your prescription drug and supplemental benefits. Bronze Plan Members have medical and prescription drug coverage only (See Section 5 for more information).

You may enroll your Dependents in supplemental benefit coverage only if you enroll in supplemental benefit coverage. For full-time employees, no additional cost will be charged for prescription drug and supplemental benefits.

You will pay the applicable biweekly employee contribution when enrolled in any PEBTF benefits (refer to your collective bargaining agreement, if applicable).

You may elect prescription drug benefits and/or supplemental benefits (vision, dental and hearing aid) and not enroll in a PEBTF medical plan. If you choose to enroll in prescription drug benefits only, you must certify with the PEBTF that you and any enrolled Dependents are enrolled in a group medical plan that provides Minimum Value Coverage (unless you already have such a certification in effect).

PEBTF prescription drug and supplemental benefits (vision, dental and hearing aid) are administered through contracts with various vendors. Appropriate identification cards and other information regarding these benefits are distributed to eligible PEBTF Members periodically.

If enrolled in a medical plan, you may also participate in the reimbursement account, which is described in Section 14.

Eligibility

The eligibility rules that apply to prescription drug and supplemental benefits are identical to those for medical benefits, with the following exceptions:

- If you are hired on or after August 1, 2003, you and your eligible Dependents may enroll in prescription drug benefits and supplemental benefits (vision, dental and hearing aid) effective the date of hire (See the Eligibility Section for more information).
- You may cover your spouse who is a member of the REHP or the RPSPP for supplemental benefits (vision, dental and hearing aid).
- Pennsylvania State Police Cadets are not eligible for supplemental benefits (vision, dental and hearing aid). Cadets are eligible to enroll themselves and eligible dependents in medical coverage which includes Preventive Care prescription drug coverage. Cadets may purchase full prescription drug coverage (either single or family coverage) for 180 days (6 months).
- Permanent part-time employees may make the same elections as permanent full-time employees (except for certain groups who through collective bargaining are not eligible for medical, prescription drug and/or supplemental benefits). If enrolling Dependents, they must be enrolled in the same medical plan as the employee.
- Bronze Plan Members have prescription drug coverage only (in addition to medical coverage).
- If you have workers' compensation claims that resulted from Commonwealth employment and are administered by the Commonwealth's workers' compensation claims administrator, you are required to use the prescription drug card provided at the time of injury or provided by the workers' compensation claims administrator to obtain medications used to treat their work-related injuries. If you do not have a workers' compensation prescription drug card, contact your claims adjuster. You may continue to use your Commonwealth prescription drug card and present it to a participating pharmacy and pay the usual Copayment. The Commonwealth will automatically reimburse you for any prescription drug Copayments incurred for treatment of work-related injuries within 45 days. PASSHE and PHEAA employees should contact their local HR office regarding coverage for work-related injuries.

If you are hired or re-hired on or after August 1, 2003 with a break in service of more than 180 calendar days, you are eligible for medical, prescription drug and supplemental benefits (vision, dental and hearing aid) at time of re-hire.

A brief description of each Supplemental Benefit Option is found on the following pages.

Section 10: Prescription Drug Plan

Summary

- Prescription drug benefits may be elected separate from the supplemental benefits (vision, dental and hearing aid)
- Three-tier Copayment plan
- Retail and maintenance programs
- Bronze Plan Members: You pay 100% of your prescription drug costs up to the Maximum Out-of-Pocket; then the plan then pays at 100% for medications covered under the plan. You do not need to submit claims as long as you use your prescription drug card – the Prescription Drug Plan works with your medical plan to total all expenses

You may obtain up to 30-day supplies at a network retail pharmacy and 90-day supplies at mail order, CVS Maintenance Choice Network (CVS, Costco, or Kroger Pharmacy) Pharmacy.

Through the Prescription Drug Plan, you may obtain your required medications at Participating pharmacies throughout Pennsylvania and the United States at a reduced, prenegotiated cost.

If you use a pharmacy that does not participate in the pharmacy Network, or you do not present your prescription drug ID card at a Participating pharmacy, you pay the full cost of your prescription. You must then file a claim with the Prescription Drug Plan in order to receive reimbursement. See “Filing a Prescription Drug Claim Form” for more information. You also may need to apply for reimbursement if you need to fill a prescription for yourself or a Dependent after you or your Dependent is eligible for Prescription Drug Coverage but before the Prescription Drug Plan has entered you or your Dependent on its records.

To find out if your pharmacy participates in the plan’s network, call the telephone 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) a 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.

OUT-OF-POCKET MAXIMUM
(per calendar year)
When the In Network Out-of-Pocket Maximum is reached under the medical plan, mental health and substance use benefits and the Prescription Drug Plan, the plan pays at 100% until the end of the benefit period.

For 2026, the Out-of-Pocket Maximum is $10,600 for single coverage/$21,200 for family coverage.

The Out-of-Pocket Maximum 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.

Three Tier Copayment Plan

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 name drug 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 uses a three-tier system, by which 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 the formulary are called "preferred." Drugs not on that list are called "non-preferred." The following details the Copayments under your Prescription Drug Plan.

Bronze Plan Members – See Section 5 for Copayment information.

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

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

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 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.

Ways for 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 Maintenance Choice Network (CVS, Costco, or Kroger Pharmacy)

CVS Maintenance Choice Network (90-day supplies obtained at a retail pharmacy) availability may vary by state.

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.

Generic Equivalents

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 must 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 PrudentRx program does not apply if you are enrolled in the Bronze Plan.

The specialty care pharmacy is a mail order service and 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 a 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 pharmacy and may result in significant Out-of-Pocket costs.

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 compound includes a drug excluded by the Prescription Drug Plan)
- Insulin or other prescription injectables
- Federal legend oral contraceptives – (no Copayments)
- Genetically engineered drugs (with prior authorization)
- Infused medicine (with prior authorization)

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 only 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 may be 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.

Preventive Care Covered Medications for Members Enrolled in Medical Only: If you and your eligible Dependents are enrolled for coverage in a medical plan but not in the prescription drug benefits, your medical benefits shall be supplemented to provide you and your eligible Dependents with coverage, without cost-sharing, for the Preventive Care prescription drugs listed above. You will receive a CVS Caremark Preventive Drug Plan ID card which you should use at a CVS Pharmacy to obtain preventive prescription drugs without any Deductible, Copayments or Coinsurance.

Flu Vaccine: 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 Copayment.
2. ***At a CVS Caremark Flu Shot network pharmacy***: For 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.

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

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 with regard to a Preventive Care medication under the Plan shall apply to such medication.

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)
- Investigational or Experimental 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 tests 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)
- Prescription drugs for which coverage is provided under a plan option for medical benefits
- Refill prescriptions resulting from loss, theft or damage
- Syringes, needles and test strips
- Unauthorized refills

This is a partial list of exclusions. If you have any questions about whether a particular expense is covered, you may contact the Prescription Benefit Manager or the PEBTF.

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.

Utilization Controls

Quantity Limitations, Step Therapy, and Maintenance Day Supplies allow the Prescription Benefit Manager to better manage your use of prescription drugs to ensure that drugs are not over prescribed or under prescribed or that you are not taking medications that can cause serious side effects or counteract each other.

Quantity Limitations

There are certain prescription drugs that are subject to quantity limits. The quantity limit list is posted on the PEBTF website, www.pebtf.org/Publications.

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 benefits for 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

Maintenance Day Supplies

Maintenance medications are prescription drugs that you need to take regularly. Medications that treat ongoing conditions like high blood pressure, high cholesterol and asthma are usually considered maintenance medications. The Prescription Drug Plan allows you to obtain up to a 90-day supply at mail order or at a CVS Maintenance Choice Network pharmacy (CVS, Costco or Kroger Pharmacy). CVS Maintenance Choice Network (90-day supplies obtained at a retail pharmacy) availability may vary by state. See the Copayment chart earlier in the section.

Prior Authorization Appeals

Your Prescription Drug Plan requires prior authorization for benefits to be paid for certain medications. This requirement helps to ensure that 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.

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 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 117 for the Appeals Process.

The prior authorization list is on the PEBTF website at www.pebtf.org.

Filing a Prescription Drug Direct Claim

File a prescription drug claim with the Prescription Drug Plan if you or a covered Dependent:

- Use a pharmacy that is not part of the pharmacy Network
- Do not use the Prescription Drug Plan 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.

Filing a Claim for Residents of Nursing Homes

To obtain reimbursement for prescription drug claims incurred while you or a Dependent are a resident of a nursing home whose pharmacy does not participate with the Prescription Benefit Manager, 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 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 Prescription Benefit Manager. You will save money by choosing generic drugs.

Using your Prescription Drug Card for Workers' Compensation Related Prescriptions

If you have workers' compensation claims that 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 workers' 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 workers' compensation prescription drug card, contact your claims adjuster. You may continue to use your CVS Caremark prescription drug 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. PASSHE and PHEAA employees should contact their local HR office for information regarding coverage for work-related injuries.

Coordination of Benefits

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

See page 105 of this SPD for complete Coordination of Benefits information.

Section 11: Vision Plan

Summary

- Yearly vision exam allowance
- Standard lenses allowance (spectacle or contact lenses every year
- Frames (every two years)
- Not available to Bronze Plan Members

You may get a vision exam and lenses every year.
Frames allowance is covered every two years.

The vision plan provides you and your eligible Dependents with an allowance for a vision examination, lenses and frames or contact lenses in order to achieve normal visual acuity.

The plan uses a panel of participating Providers, including ophthalmologists, optometrists and opticians. Services and materials may be provided at minimal cost to you by a participating Provider. If you select a non-participating Provider, payment will be made directly to you according to the established fee schedule.

Covered Services

Vision Examination – Covered in full at a participating Provider

Routine vision analysis and glaucoma test for you and your eligible Dependents every year (365 days from the date of last covered examination service).

Lenses (spectacle lenses and contact lenses)

Standard Glass/Plastic – Covered in full at a participating Provider – once per year (365 days) from last covered spectacle lens or contact lens service.

Transition Lenses

- Maximum of $65.00 (single vision) and $70 (bifocal or trifocal).

Contact Lenses – Maximum plan payment of $150 every year (365 days) for the routine examination and purchase of contact lenses. Participating Provider's charge for lenses is limited to the retail charge minus 10% (for disposable contact lenses) and 15% (for all other non-disposable lenses).

Frames – Covered in full to a Maximum $175 allowance

You and your eligible Dependents – every two years (730 days) from the last covered vision plan's frame service. You may choose either an American or foreign-made frame.

Plan Limitations

The items below are, to a limited extent, available under the Plan. However, if you select any of these items, you must pay the additional cost for these options over and above the benefit allowance for the standard materials:

- Frames in excess of $175.00
- Photochromatic extra lenses

- Solid tints (other than pink #1 or #2), gradient tints or fashion tints
- Coated lenses, including ultraviolet, anti-reflective, anti-scratch or edge coating
- Progressive multifocals – plan pays trifocal allowance
- No-line (seamless) bifocals – plan pays bifocal allowance

A participating Provider may only charge the wholesale cost for the lens option plus 25%.

How To Obtain Vision Benefits

Use your vision plan ID card when obtaining vision care services. The Provider will telephone the vision plan or obtain information via the vision plan's secure website to verify your vision care eligibility.

You may contact the vision plan to obtain information on your eligibility for services. The phone number appears on page 152. You also may link to the vision plan's website from www.pebtf.org.

NOTE: Participating Providers will accept the vision plan's allowance as full payment for a spectacle lens examination and lenses. You must pay for any lens options you select (see list of limitations) and the difference between the actual wholesale cost of a frame and the Plan Allowance.

Use of Non-Participating Vision Providers

If the Provider you select is not a participating optometrist, ophthalmologist or optician, you will be responsible for payment of the full amount at the time of service. After you submit a claim form, reimbursement to the plan Maximum will be made directly to you from the vision plan. You must submit a copy of the itemized receipt with your signature, ID number and patient's name.

IMPORTANT: The vision plan cannot process receipts for payment without your signature. Mail your receipt to the vision plan at the address on the back of your vision plan ID card.

If you go to a Provider who is non-participating, reimbursement will be made to you by the vision plan to the Maximum allowances as shown on the NVA website (you'll find that information under the View Eligibility section after you log in to e-nva.com.

Any additional cost must be paid by you.

Claims must be postmarked within one year from the date of service.

Plan Exclusions

- Medical, surgical or laser treatment of the eyes
- Replacement of broken, lost or scratched spectacle or contact lenses or frames
- Vision services provided by federal, state or local government
- Vision services or materials compensated under workers' compensation laws
- Sunglasses or Polaroid lenses
- Industrial (3 mm) safety lenses and safety frames with side shields

If your claim for benefits is denied, see page 116 for a description of the Appeals Process.

Section 12: Dental Plan

Summary

The dental plan permits you and your eligible Dependents to obtain required dental treatments through a Dental PPO Plan. The dental plan is not available to Bronze Plan Members.

Your routine dental exam and cleaning is covered in full every six months at a participating dentist.

The Dental PPO Plan uses a panel of participating dentists. You have the choice of using a participating or non-participating dentist. You will save more Out-of-Pocket when you use a participating dentist. You can go to a non-participating dentist, but you may be balance billed for any charges above the Dental PPO's allowance. You may contact the Dental PPO Plan to obtain claim forms for those services which were provided by a non-participating Provider. The dental plan also accepts any standard dental claim form. Your dentist will complete an examination and recommend needed treatment.

Covered Services

The Dental PPO Plan has a **$50 annual Deductible** per family Member on all basic and major restorative services. The Deductible **does not apply** to preventive, diagnostic or orthodontic services.

Diagnostic: Procedures to assist a dentist in evaluating existing conditions and required dental care – to include office visits, exams, diagnosis and X-rays (exams and bitewing X-rays once in any six-month period, full mouth X-rays once in any 36-month period). Annual Deductible does not apply.

Preventive: Prophylaxis (cleaning once in any six-month period), fluoride treatments (limited to persons under age 19), space maintainers (limited to persons under age 19), sealants (under age 15, limited to once in 36 months on unfilled permanent first and second molars). Annual Deductible does not apply.

Basic Restorative: Amalgam, silicate, acrylic and composite fillings.

Major Restorative: Crowns, inlays, onlays where above materials are not adequate, limited to once every five years.

Oral Surgery: Simple extractions, surgical extractions, soft tissue impactions, surgical exposures, tooth reimplantation of an accidentally-avulsed tooth, alveolectomy, frenectomies, (see exclusions). Full or partially bony extractions may be covered under the medical plan. You receive the highest level of benefits if you use a PPO Network dentist.

Palliative Emergency Treatment: Minor procedures for emergency treatment of dental pain.
Anesthesia Services: General anesthesia when performed in conjunction with surgical procedures covered by the dental plan. 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 an assistant at oral surgery. The medical plans (PPO, HMO and Bronze Plan) may provide coverage for anesthesia services for dental care rendered to a patient who is seven years 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.

Endodontic: Procedures for pulpal therapy (including but not limited to root canal, apicoectomy and pulpotomy) and root canal filling.

Periodontic: Surgical and non-surgical procedures for treatment of gums and supporting structures of teeth.

Prosthodontic: Procedures for construction of fixed bridges, partial or complete dentures limited to once every five years, or repair of fixed bridges, adding new tooth or clasp to dentures; denture relining or rebasing (limited to once in any 12-month period).

Denture Repair: Repair of existing dentures.

Porcelain Veneers: For restorative purposes only; not for cosmetic purposes.

Guided Tissue Regeneration: Surgical procedure that uses a barrier membrane placed under the gingival tissue and over the remaining bone to enhance regeneration of new bone.

Orthodontic: Procedures for straightening teeth. Orthodontics is a benefit for you, eligible spouses and Dependents. Quarterly payments shall be paid to you up to a Maximum benefit of up to $2,250 per person provided you remain eligible. The $2,250 benefit is a Lifetime Maximum; it is not renewable. Annual Deductible does not apply.

Dental PPO Plan Benefit Coverage (Participating Providers)

Benefit	Coverage %	Time Limitations
Routine Examinations	100%	Once every 6 months
Annual Deductible – All Basic/Major Restorative Services	Annual $50 per family member	
Cleanings (Prophylaxis)	100%	Once every 6 months
Fluoride Application (under age 19)	100%	Once every 6 months
Plaque Control Program	NOT COVERED	
Sealants (under age 15, unfilled permanent first and second molars)	100%	Once every 36 months on same tooth
Full Mouth X-rays	100%	Once every 36 months
Bitewing X-rays	100%	Once every 6 months
Root Canal Treatment	90%	
Apicoectomy (root surgery)	90%	
Basic Restorative Services (amalgam, silicate, acrylic and composite fillings)	90%	Once every 24 months on same tooth
Oral Surgery	90%	Limitations vary by procedure
Single Crowns (Benefit limited based on procedure codes)	60%	Once every 5 years on same tooth
Fixed Bridgework	60%	Once every 5 years on same arch
Repairs to Bridges	60%	Once in 12 months
Dentures	60%	Once in every 5 years on same arch
Denture Relines	60%	Once every 12 months
Periodontics	60% - limitations vary by procedure	
Implants	60%	
Extractions of Complete or Partial Bony impacted teeth	NOT COVERED – Covered by medical plan	
General anesthesia	90% - in conjunction with covered dental work	
Maximum	$2,000 per person for a calendar year (Payments made for diagnostic and preventive dental services do not count toward the annual maximum)	
Orthodontics	70% - up to $2,250 Lifetime Maximum	
Out-of-Area Emergency	Covered as above	
All PPO percentages are based on a Maximum Plan Allowance fee schedule as determined by the dental plan. A non-participating dentist can balance bill for any difference between their charge and the Maximum Allowable Charge (MAC).		

The covered percentages as listed in the chart are payable to participating Providers and are subject to limitations and exclusions as specified by the Plan.

The Maximum benefit for all services, except orthodontics, is $2,000 per person per calendar year (payments made for diagnostic and preventive dental services do not count toward the annual maximum). Payment is applied to the calendar year in which the service or procedure is completed, regardless of the date the service was started. For example: Payment for prosthodontics, including dentures, crowns and bridges, is applied to the calendar year in which the final delivery or fitting is made, not when the impression is initiated, even if the final delivery or fitting is in a calendar year subsequent to the calendar year in which the impression is made.

The Maximum lifetime orthodontic benefit is $2,250 per person.

Coverage for Services Received by a Non-Participating Dentist or Dental Group

If you receive dental services from a non-participating dentist or dental group, you must pay the non-participating Provider's charge for the services and file a claim for direct reimbursement with the dental plan. A standard dental claim form may be obtained from your dentist.

Plan Allowances for Covered Services of a non-participating dentist or dental group are made to the Member only and not to the non-participating dentist. The allowances for dental expenses are based on the Maximum Allowable Charge (MAC), as determined by the dental plan and in accordance with the Dental Benefits Payment Schedule. Any difference between the non-participating Provider's charge and the payment from the dental plan is your responsibility.

Predetermination of Benefits

If total charges for a Treatment Plan from either a participating or non-participating Provider are expected to exceed $300, a predetermination is strongly suggested before the services are started. You should request that your dentist submit the predetermination claim form in advance of performing services. The dental plan will act promptly in returning a predetermination voucher to the dentist and to you with verification of patient eligibility, scope of benefits and definition of a 60-day period for completion of services. Once the service is completed, the voucher should be submitted to the dental plan for payment. **NOTE: This is not a guarantee of benefits.**

Payment of Dental Services

Services performed by participating dentists are paid on a MAC basis which the participating dentist has agreed to accept as full payment for services covered by the Group Dental Service Contract.

The dental plan calculates the modified MAC, pays the participating dentist, and will advise you of any charges not payable by the dental plan which are your responsibility. These are generally your share of the cost, charges where Maximums have been exceeded (such as your annual Maximum), or charges for services not covered by the Plan.

Payment for services performed by a non-participating dentist is also calculated on a MAC and paid directly to you. You are responsible for payment of the non-participating dentist's total fee, which may include amounts in addition to your share of the MAC and services not covered by the Plan.

Dental Service Claims

Claims for dental services must be **submitted (postmarked) to the dental plan within one year of the date of service**. Claims received more than one year from the date of service will not be honored. The dental plan will pay benefits for a procedure only after the service is completed.

Plan Exclusions

- Prescription drugs, pre-medications, relative analgesia
- Facility and physician charges for hospitalization, including hospital visits
- Plaque control programs, including oral hygiene and dietary instruction
- Procedures to correct congenital or developmental malformations except for children eligible at birth
- Procedures, appliances or restorations primarily for cosmetic purposes (bleaching)
- Procedures, appliances or restorations necessary to alter vertical dimension and or restore or maintain the occlusion
- Replacing tooth structure lost by attrition
- Periodontal splinting
- Gnathological recordings
- Equilibration
- Treatment of dysfunctions of the temporomandibular joint (TMJ)
- Services incurred after eligibility ceases
- Full or partial bony extractions
- Services performed prior to the effective date of coverage or after termination of coverage
- All other dental service or treatment not listed as a Covered Service

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

If your claim for benefits is denied, see page 116 for a description of the Appeals Process.

Section 13: Hearing Aid Plan

Summary

The hearing aid benefit offers you and your eligible Dependents the opportunity to apply for a hearing aid reimbursement allowance. The Hearing Aid Plan is not available to Bronze Plan Members.

Your hearing aid benefit is limited to one hearing aid per ear per 36-month period.

Applications for Hearing Aid Reimbursement may be obtained by contacting the PEBTF, or you may download a Hearing Aid Claim Form from the PEBTF website, www.pebtf.org.

Hearing Aid Benefit

This benefit is limited to one hearing aid per ear per 36-month period (1,095 days). Eligibility for a replacement aid or aids becomes effective 36 months from the **order date** of the previous aid obtained under the program. Binaural aids or CROS aids will be considered with medical authorization.

Reimbursement Allowances

If it is medically substantiated that an aid is required, the program will allow reimbursement to you for one of the stated Maximums listed below:

- For a monaural aid (one) in either ear, the program will allow up to a Maximum of $900
- For binaural aids (an aid in each ear), the program will allow up to a Maximum of $1,800
- For a CROS aid, the program will allow up to a Maximum of $2,400

The order date is used to determine the date of service.

Reimbursement Allowance for the Hearing Aid Evaluation Test: The hearing aid evaluation test is performed by a physician/audiologist or licensed dealer/fitter and may determine which make and model will best compensate for the loss of hearing acuity. Inclusive with the Maximums stated above, the program will allow for the Usual, Customary and Reasonable cost of the test as long as the cost of the hearing aid(s) does not exceed the Maximums stated above. If the cost of the hearing aid(s) exceeds the Maximum, the program will **not** pay for the cost of the hearing aid evaluation test.

Under no circumstances is payment considered for a hearing aid unless the audiometric examination and the hearing aid evaluation test are performed within six months of the most recent otologic examination of the ear by licensed practitioners.

Application for Hearing Aid Reimbursement

A PEBTF Hearing Aid Claim Form must be completed in its entirety and returned to the PEBTF Program. The form is located at www.pebtf.org/ Publications and Forms or you may contact the PEBTF to request a form be sent to you.

The following information must be submitted to the PEBTF Program along with the claim form mailed to the address that is on the claim form:

1. Physician or audiologist statement of Medical Necessity. If you are requesting a replacement of an aid previously reimbursed under this program, you may submit a medical waiver in lieu of a certificate of medical clearance.

2. Itemized statements and paid receipts showing the purchase of the hearing aid and/or the charges for the hearing aid evaluation test, including the dates of service and/or purchase.

Plan Exclusions/Limitations

- Hearing aid evaluation tests or hearing aids for which there is no physician's certificate of Medical Clearance (medical waiver accepted for replacement aids obtained under the program)
- Otologic and/or audiometric examinations by a physician or audiologist and any audiometric examination billed separately and not included in the total dealer charge for the hearing aid
- Hearing aids for which the audiometric examination and/or hearing aid evaluation test took place more than six months before the most recent otologic examination of the ear by a licensed practitioner
- Hearing aids purchased outside of the United States
- Drugs or medications prescribed in conjunction with the hearing aid
- Replacement parts or batteries
- Any service for which coverage is available through a group medical plan covering the Member
- Replacement or repair of hearing aids that are lost or broken, unless at the time of replacement, 36 months (1,095 days) have elapsed since services were last rendered
- Charges billed for the completion of insurance forms
- Hearing aids purchased over-the-counter

Claims for reimbursement under the Hearing Aid Program must be submitted (postmarked) to the PEBTF Program within one year of the date of service.

If your claim for benefits is denied, see page 116 for a description of the Appeals Process.

Section 14: Reimbursement Account

Reimbursement Account

From time to time, the Board of Trustees may establish a voluntary cost-saving initiative for Members. As an incentive for you to participate in such program, the PEBTF may establish an account for each participating Employee Member and contribute a specified amount to such account. The criteria for participation, the amount to be contributed to the account, and the uses to which funds in the account may be applied shall be determined by the Board of Trustees when it establishes the cost-saving initiative, subject to the following rules:

(a) Qualification for a contribution to the account shall be limited to Employee Members enrolled in an option described in Sections 3, 4 and 5 and shall otherwise be based solely on the participation of the Employee and their Dependents, as applicable, in the cost-saving program.

(b) The funds in your account will be available to pay only Qualified Medical Expenses of you and your Dependents, and shall be limited to Copayments, Coinsurance, and Deductibles under the medical plan chosen by you or Qualified Medical Expenses that are not essential health benefits. The Board of Trustees may further limit application of the funds in the account, as it determines.

(c) You must submit claims for payment from your account within twelve months after the date of the notice (as set forth in the notice) provided to you that you have qualified for the contribution to the account. Amounts remaining in the account after all such claims have been adjudicated and paid shall be forfeited.

(d) The funds in your account will be forfeited when you and your Dependents cease to be enrolled in any of the options described in Sections 3, 4 and 5. Your Dependent who continues coverage under one of these options after the your coverage has ceased shall be treated as an Employee Member for purposes of this Section.

(e) If you have funds in such an account, you may elect to permanently waive and forfeit the amounts in the account any time you make a change in your enrollment election under the Plan.

Section 15: Coordination of Benefits

Summary

- Benefits payable under the PEBTF are coordinated with benefits payable from other plans. Benefits coordinated include medical, DME, mental health and substance use services, prescription drug, vision, dental and hearing aid services.
- You cannot receive duplicate payment for the same service.
- Other coverage must be reported any time there is a change in coverage. The PEBTF requires spouses with other coverage to enroll for that coverage under the conditions described on pages 7 and 8.
- You must notify your medical plan any time a Dependent's coverage changes.

Your PEBTF Plan coordinates with other heatlh plans under which you may be covered. You will not receive duplicate payments for a service under two or more plans.

The PEBTF coordinates benefits with other health 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.

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 PEBTF as a Dependent. To prevent duplicate payments for any given service under two or more plans, the PEBTF coordinates benefits with other group insurance plans under which Members may be covered.

When filing claims for medical, prescription drug, vision, dental or hearing aid services, Members are required to indicate and identify any other insurance or group health plan(s) in which the Member 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 follow the coordination of benefits provisions of the primary or secondary plan shall disqualify you for coverage under the Plan.

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 or Dependent**. The plan that covers the person other than as a Dependent is the primary plan and the plan that covers the person as a Dependent 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 and primary to the plan covering the person as other than a Dependent (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 (member, policyholder, subscriber or retiree) is the secondary plan and the other plan is the primary plan.

2. **Dependent Child Covered Under More Than One Plan**. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan, the order of benefits is determined as follows:

    a. For a Dependent 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 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 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 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 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 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 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 of an active employee and that same person is a Dependent 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 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 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.

Medicare

This Plan will pay benefits secondary to Medicare where permitted by law. Government regulations require that the Plan pay benefits primary to Medicare for a Member who is an active employee and who continues working beyond age 65. The same rules apply to a Member's spouse when they reach age 65, regardless of the Employee Member's age.

Employee's Choices: Active employees aged 65 or older, up until the time they retire, may choose to have medical coverage provided through:

- One of the PEBTF plans only, or
- A PEBTF plan supplemented by Medicare, or
- Medicare only.

If the Employee Member chooses coverage under a PEBTF plan only or Medicare only, then that plan will pay its usual benefits and the Employee is responsible for any additional costs. If the Employee Member chooses both, then the PEBTF plan will pay benefits first. If the Employee's expenses are greater than those paid under the Plan, then Medicare will follow its rules for payment.

Employee's Spouse's Choices: Regardless of the Employee Member's age, and up until the Employee Member's retirement, the Employee Member's eligible spouse has the same choices as the Employee Member when they reach age 65:

- The PEBTF-sponsored medical coverage chosen by the Employee Member only; or

- PEBTF-sponsored medical coverage chosen by the Employee Member supplemented by Medicare; or
- Medicare only.

Section 16: COBRA Coverage & Survivor Spouse Coverage Due to Work-Related Deaths

Summary

- If you or your Dependent's medical, prescription drug or supplemental benefits (vision, dental and hearing aid) coverage ends due to certain reasons, the PEBTF may continue your coverage for a limited period of time

If your PEBTF coverage ends, you may elect COBRA coverage and continue to pay the monthly cost.

- You also may continue coverage at your own expense under certain circumstances under the Federal law commonly known as COBRA

Continued Coverage as Provided by the PEBTF

In certain situations, medical coverage for Members may be extended. If coverage would end while you are in the hospital, coverage continues for you until discharged from that facility or benefits are exhausted, whichever occurs first.

In considering whether to elect continuation coverage, you should take into account 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 Life 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 new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, Deductibles, and Out-of-Pocket costs will be before you make a decision 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.healthcare.gov.

COBRA Continuation Coverage

As provided by the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you and your eligible Dependents have the right to continue benefits under the PEBTF if coverage ends

for certain specified reasons which are referred to as "Qualifying Life Events:"

- Termination of your employment (for reasons other than gross misconduct)
- Reduction in your work hours
- Your death
- Your divorce or legal separation (in states that recognize legal separation) – PEBTF must be notified within 60 days of the date of divorce in order to issue a COBRA Election Notice
- Your Dependent child no longer meets the eligibility requirements for coverage
- Your entitlement to Medicare

NOTE 1: If you voluntarily drop (disenroll) a Dependent from coverage during an Open Enrollment Period as permitted by the PEBTF rules, who would otherwise be an eligible Dependent if not disenrolled, this is not a COBRA Qualifying Life Event. Likewise, if you or your Dependent's coverage is suspended by the PEBTF 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 Life Event.

NOTE 2: Federal law (COBRA) includes legal separation as a Qualifying Life 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 the HR Service Center or your HR office if your agency is not supported by the HR Service Center or the PEBTF of a divorce legal separation or child's loss of Dependent status under the Plan. This information must be provided within 60 days of the date of the Qualifying Life Event. Otherwise, the Member losing coverage will not be permitted to continue coverage under COBRA. The Employee Member's employer is responsible for notifying the PEBTF of other Qualifying Life Events (i.e., termination of employment, reduction in work hours or death).

When the PEBTF becomes aware of a Qualifying Life Event, the PEBTF will notify you that you have the right to elect COBRA continuation coverage. That notice will include more information about your rights under COBRA. As discussed above, you will have 60 days to elect COBRA coverage. If you fail to elect COBRA, your PEBTF coverage will terminate under the ordinary terms of the Plan. You should notify the PEBTF 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 spouse Member may elect COBRA coverage for the 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 PEBTF 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 your spouse must duly elect, and timely pay for, COBRA coverage in accordance with the Plan's COBRA requirements in order to fulfill the Employee Member's obligation under the court order. Such a court order for spousal support relates only to the Employee Member's obligation, as the PEBTF is not a party under the court's jurisdiction in such a legal action.

Cost of Continued Coverage

Continued coverage is available to you and your Dependents at your or your eligible

Dependent's expense. The cost to you or your Dependents for this continued coverage will not exceed 102% of the PEBTF's cost, as determined by the PEBTF. 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 PEBTF's cost during the 11-month extended period.

Applying for Continued Coverage

Employers have the responsibility to notify the PEBTF within 30 days of your death, termination of employment or reduction of hours. **You are obligated to notify the HR Service Center or your HR office if your agency is not supported by the HR Service Center or the PEBTF, in writing, within 60 days of a divorce or a child losing Dependent status**. If you do not notify the HR Service Center or your HR office if your agency is not supported by the HR Service Center or the PEBTF within 60 days of a divorce or loss of Dependent status, then you, the spouse or the former Dependent child will not be eligible to elect COBRA continuation coverage. Failure to notify the PEBTF of these events in a timely manner will cause COBRA coverage to be unavailable.

If the PEBTF is timely notified of the Qualifying Life Event, the PEBTF shall, within 14 days, send a COBRA Election Notice to you or your Dependents, by First Class Mail. You will have 60 days from the date of the notification to elect COBRA continuation coverage. You 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, you will not receive another opportunity to elect COBRA coverage**.

If you elect continued coverage within 60 days of losing coverage or the date you are notified, whichever is later, your coverage is effective as of the date you became ineligible. The COBRA coverage is reinstated retroactive to the Qualifying Life Event. Any denied medical expenses from that period must be resubmitted for payment.

If you have informed the PEBTF of a Qualifying Life 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 child after eligibility for PEBTF coverage is lost. Your employer is responsible for notifying the PEBTF of other Qualifying Life Events (i.e., your termination of employment, reduction in work hours or death). It is your responsibility to notify the PEBTF, in writing, of any address changes.

Paying for COBRA Coverage

Within 45 days of the date of your COBRA election, you must pay an initial premium amount. This premium includes the period of coverage from the date of your Qualifying Life Event to the date of the first payment. **Thereafter, premiums must be paid monthly and must be postmarked to the PEBTF on or before the due date or your 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 Members are sent to the address specified on the COBRA Election Form. It is the responsibility of the COBRA Member to

Effect of Waiving COBRA Coverage

If coverage is waived or the former Member fails to timely respond to the COBRA Election Notice, COBRA may not be elected after the 60-day election period.

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 Life Event is a result of your termination of employment or reduction in hours (29 months if you or an eligible Dependent are disabled). See "Special Disability Rules," below
- At the end of 36 months from the date COBRA coverage began for your Dependent if the Qualifying Life Event is a result of your death, divorce or separation, your Dependent child's loss of Dependent status, or the Member'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 due date. The PEBTF will issue a pro-rata refund for COBRA premiums if you are called back to work in the middle of the month or if you obtain other medical coverage
- You or your Dependent becomes, after the date of the COBRA election, entitled to Medicare
- You or your eligible Dependent becomes, after the date of the COBRA election, covered under another group health plan (as an employee or otherwise)
- The PEBTF terminates all of its health care plans
- The end of the period for which the premium was paid for the COBRA benefit

If your COBRA coverage is terminated prior to the end of the 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:

- You or your Dependents are determined by the Social Security Administration (SSA) to be totally disabled and the disability occurred within the first 60 days of COBRA coverage provided that:
  1) You notify 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, you or 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 you or your Dependent are 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 Life 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 Life Event includes:

- Death of a COBRA Employee Member
- Divorce
- Change in Dependent status
- Medicare entitlement of Employee Member

You must notify the PEBTF of a second Qualifying Life Event within 60 days.

COBRA Open Enrollment

During the Open Enrollment period, you may change Plan Options. As a COBRA participant, you may enroll in any PEBTF approved plan for which you are eligible 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 Offices are available through EBSA's website at www.dol.gov/ebsa.

Work-Related Deaths

Surviving spouses and Dependents of an employee who died in a work-related accident also may have a right to free continuation coverage of **medical, prescription drug and supplemental benefits (if the Dependents were enrolled in medical, prescription drug and/or supplemental benefits at the time of the employee's death)**, depending on the employee's collective bargaining agreement.

If eligible, the surviving spouse and Dependents will receive continuation coverage, at no cost, until the surviving spouse marries, remarries or becomes eligible for coverage under another employer's health plan. Dependents will continue to receive continuation coverage until they no longer meet the eligibility rules of the Plan.

A surviving Dependent, if eligible, will be transferred to the applicable annuitant group and coverage corresponding to that group when the deceased Employee Member would have reached the age qualifying that Member for retirement.

The PEBTF will annually certify all survivor Dependents to ensure that they remain eligible for survivor continuation coverage.

Section 17: Additional Information

Appeals – Right to Appeal Prior Authorization Determinations

If a claim for benefits is denied and you wish to appeal the claim denial, the PEBTF offers an appeal process.

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

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 PEBTF shall not review any of these prior authorizations or approval decisions, unless the following three conditions have been met:

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 Investigational nature of a service or product or on any other clinical or medical judgment. 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.

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.

Within 60 days of receipt of the appeal, the Board of Trustees will review the appeal and render to you, in writing, a final decision or request for additional information.

All appeal decisions rendered by the Board of Trustees are final.

Appeal Process – PPO, HMO, Bronze Plan, Vision, Dental and Hearing Aid Options

If your claim for benefits under the medical or supplemental benefits (vision, dental, hearing aid) 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 Claim 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 any additional appeal rights you may have. 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.

Except as described in the following sentence, the PEBTF will accept the Claims Payor's determination that you are entitled to benefits in accordance with the Claims Payor's grievance procedure. The PEBTF may decline to accept the Claims Payor's determination if the Board Trustees determine that your claim is not covered because it is subject to a specific exclusion under the PEBTF's Plan of Benefits.

You have the final right of appeal to the Board of Trustees, 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 Board of Trustees, as set forth below in the paragraph entitled "Final Appeal Process."

Appeal Process – Get Healthy

If you received a letter stating that you did not fulfill the obligations under the Get Healthy Program and you did not receive the contribution waiver, you have the right to appeal, in writing, by completing the Appeal Request Form, which may be found on www.pebtf.org.

The appeal to the Board of Trustees must be made in writing within 30 days after you receive the Get Healthy letter. The Board of Trustees will review your appeal, including such other pertinent information you may present, and will notify you of its decision, and the reasons therefore, within 60 days of the date of the appeal.

All appeal decisions rendered by the Board of Trustees are final.

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 under the Plan and received a final decision from the

Board of Trustees.

Appeal Process – Prescription Drug Plan

Prior Authorization

Your Prescription Drug Plan requires prior authorization for certain medications. This requirement helps to ensure that 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 actually 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 – All Plans and Plan Options

If you are not satisfied with the Claims Payor's decision on appeal, you have the right to appeal to the Board of Trustees. 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 actually received (if sent by other than U.S. Mail First Class) within 30 days of receipt of the Claims Payor's final decision. The Board of Trustees will review the appeal and will notify you of its decision within 60 days of the date that the Board of Trustees received the appeal. There may be special circumstances where the Trustees need additional time to review your appeal and gather additional information. The PEBTF will contact you if additional time is needed.

Upon completion of the Board of Trustees' review, the PEBTF will forward written notice of the appeal's approval or denial to you.

All decisions rendered by the Board of Trustees are final and binding.

If you fail to file an appeal as set forth above and fail to exhaust the Plan's appeal process, then you shall be deemed to have forfeited your right to commence legal action against the Plan, the PEBTF or its Board of Trustees. You may not commence legal
action until after you have exhausted all claim and appeal rights under the Plan and received a final decision from the Board of Trustees.

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

The Board of Trustees 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 in order 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 Board of Trustees. The Board of Trustees 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.

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 on the basis of 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 her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough and take into account all of 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 on the basis of 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.

Recovery of Benefits (Subrogation)

If you or any of your enrolled Dependents receive benefits under the PEBTF 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 or on your or your Dependent'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 PEBTF. The “make whole” doctrine shall be inapplicable and shall not preclude such full recovery.

This right of subrogation 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 PEBTF 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 PEBTF, if you or your eligible Dependents are involved in a matter in which the PEBTF is exercising its subrogation rights, you and they and anyone acting on your or their 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 PEBTF, you accept that the PEBTF has an equitable lien against any amounts from a third party, to the extent that benefits have been paid or are payable under the PEBTF.

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 proceeding 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 Plan 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 PEBTF benefits for a period of time as determined by the Board of Trustees.

The PEBTF may commence or intervene in any litigation, arbitration or other proceeding in order to assert its subrogation rights. You and your Dependents, if applicable, may not oppose such participation and will assist the PEBTF in all matters relating to its subrogation 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 attorneys' fees, in such amounts as the court may allow.

To the extent required by law, this right of subrogation **does not apply** to any payments the PEBTF makes as a result of injuries to you or your Dependents sustained in a motor vehicle accident that occurred in Pennsylvania (exception is for 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 Board of Trustees and you will be advised in writing of their decision.

All decisions rendered by the Board of Trustees 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 against the Plan, the PEBTF or its Trustees. You may not commence legal action against the Plan, the PEBTF or the Trustees until after you have exhausted all claim and appeal rights and received a final decision from the Board of Trustees.

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

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

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 from the PEBTF. If you or your Dependents are acquitted of the felony charge, payment for medical expenses may 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 CFR 146.121(a)(1)(ii) and (b)(2).

Information about Help in Paying for Your Health Insurance Coverage Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

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.pennie.com (for residents of Pennsylvania) or **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 employees who are eligible for health insurance through the Pennsylvania Employees Benefit Trust Fund (PEBTF) are not eligible for the Children's Health Insurance Program (CHIP) administered by the Pennsylvania Insurance Department's Office of CHIP. There are a few exceptions for children of:

- Employees in their first 30 days of employment
- Employees who are not eligible to receive PEBTF family full coverage benefits
- Part time employees who are eligible to purchase the PEBTF benefits, but meet the hardship exception (PEBTF premiums and cost-sharing are more than 5% of the family's income during the year the child would be enrolled in CHIP)

If you have children who are **eligible** for PEBTF coverage and are currently enrolled in CHIP should immediately contact the HR Service Center at 1-866-377-2672 to enroll your children in PEBTF, then immediately contact their CHIP insurer to end CHIP coverage. Employees of agencies not supported by the HR Service Center should contact their local HR office.

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.gov 1-800-644-7730

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 July 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: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ 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	ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
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	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
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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	MAINE – Medicaid
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	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
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ 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)

NEW YORK – Medicaid	NORTH CAROLINA – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
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/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
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 July 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 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 PEBTF. 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 your Dependents fail to obtain primary automobile insurance as required by law, the first $5,000 of claims resulting from an automobile accident is excluded from PEBTF 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 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 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 by a 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 Employee Member/non-custodial parent, if not already enrolled). The NMSN, like other qualified medical support orders, may not order the PEBTF 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 711 :tty -800-1(522-7279-800-1) 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* សេវាកម្មជំនួយភាសា

ឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយជំសមរម្យ
ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។
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 children. The PEBTF must also 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 PEBTF Member.

A Qualified Medical Child Support Order (QMCSO) is a medical child support order that creates or recognizes an alternate recipient's right to receive benefits for which a 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 relates 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 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 (beginning and end dates) 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 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.

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. Members may request a copy of the Compliance Plan.

Privacy of Protected Health Information

The PEBTF is committed to protecting the privacy of your personal information. In accordance with applicable law, it has established policies and procedures for limiting the use and disclosure of personal health information under the Plan, and will take appropriate measures to keep your information confidential while satisfying your rights with respect to your own information.

Claims Payors and other professional Plan advisors are also required to take appropriate measures to maintain the privacy of your information and to make that information available to you.

The PEBTF has distributed to Members a Notice of Privacy Practices describing the protections of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and how these rules are applied. If you need another copy of the Notice of Privacy Practices, please contact the PEBTF or visit the PEBTF website, www.pebtf.org.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Members' Protected Health Information to the Commonwealth of Pennsylvania unless the Plan Sponsor (Commonwealth and all of the unions who have a collective bargaining agreement with the Commonwealth, except for the PA State Police) certifies that the Plan Documents have been amended to comply with certain HIPAA privacy requirements.

Receipt of Notices, Claims and Appeals

All other claims, notices and appeals must be submitted (postmarked) or actually received (if sent by other than U.S. Mail First Class) to the PEBTF or other Provider within the time indicated.

Spousal Support Orders

A court spousal support order which directs that an Employee Member provide medical coverage for their former spouse does not, and cannot, require that the PEBTF do anything other than comply with the terms of the Plan, including the Plan's provisions and procedures for continuation coverage under COBRA. Therefore, if eligible, your or your former spouse must duly elect, and timely pay for, COBRA coverage in accordance with the Plan's COBRA requirements in order to fulfill the Employee Member's obligation under the court order. A court order cannot require the Plan to cover an ex-spouse.

Termination or Suspension of Benefits

The PEBTF 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 any demand for repayment or suspension of benefits described in this Section by filing an appeal with the Board of Trustees. 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 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 coverage will be stayed pending resolution of the appeal. The appeal will be considered by the Board of Trustees and you will be advised in writing of its decision. **The decision of the Board of Trustees is final.**

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.

NOTE: Suspension of benefits in the event of a failure to repay is not a Qualifying Life Event for self-paid continuation coverage under COBRA.

Unauthorized Utilization

If you or your Dependent obtain or receive benefits when not eligible for such benefits (e.g., loss of benefits due to divorce, loss of dependent coverage, etc.), you will be

required to repay the PEBTF for the full amount paid by it. 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 any demand for repayment or suspension of benefits described in this Section by filing an appeal with the Board of Trustees. 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 that you receive the demand for repayment 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 coverage will be stayed pending resolution of the appeal. The appeal will be considered by the Board of Trustees and you will be advised in writing of its decision. **The decision of the Board of Trustees is final.**

NOTE: Suspension of benefits in the event of a failure to repay is not a Qualifying Life 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 PEBTF is repaid in full. You shall repay all amounts paid by the Fund 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:

a. The "Suspension Application Date" shall be the date of the notice to the Member (or the Employee Member) that benefits are being suspended, provided that, if the suspension arises from a 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).

b. Where the Member who is responsible for the false information is an Employee Member, the suspension shall apply to the Employee Member and all of their Dependents. The Employee Member shall be fully responsible for the repayment of benefits and collection costs resulting from the false statement for all such individuals.

c. Where the Member who is responsible for the false information is the Dependent of an Employee Member, the suspension shall apply to such Dependent.

d. 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.

e. For purposes of this Section, an individual shall be regarded as the Dependent of an Employee Member if the individual is or was covered under the Plan as the Employee Member's Dependent, whether or not the individual is or ever was such a Dependent.

f. A suspension of coverage resulting from the provision of false information will not be a Qualifying Life Event for self-pay continuation under COBRA.

g. For purposes of appropriate Plan administration, the Plan Administrator shall report the suspension of a Member's eligibility for coverage to the Commonwealth.

A Member may appeal their suspension of benefits under this Section to the Board of Trustees (or its delegate). 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 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 Board of Trustees (or its delegate) is final.

NOTE: You must notify the HR Service Center or your HR office if your agency is not supported by the HR Service Center if your Dependent no longer qualifies for PEBTF coverage. You will be instructed to complete the necessary paperwork. If the Plan pays for benefits of an individual who was covered under the Plan as your Dependent when benefits are incurred after that individual ceases to be eligible for coverage, you will be required to repay the PEBTF the full amount of such benefits, unless alternative repayment arrangements are made with the PEBTF. An example is in the case of a divorce. You must notify the HR Service Center or your HR office if your agency is not supported by the HR Service Center immediately when the divorce is final. Your spouse's PEBTF coverage will be terminated on the actual date of divorce. If you delay, 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.

Recovery of Benefits for Ineligible Individuals

a. **Supplemental Benefits and Prescription Drug Benefits:** In the event that the Plan pays benefits under a Supplemental Benefits Option or Prescription Drug Benefits for the expenses of an individual who does not meet the Plan's definition of Eligible Person and is therefore not otherwise eligible to be covered under the Plan, the Employee Member shall be required to repay the PEBTF the full amount of such overpaid benefits within 60 days of the date that the Employee Member is notified of the amount due, unless alternative repayment arrangements are made with the PEBTF in accordance with the provisions of this Section.

b. **Medical Benefits:** 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 Person 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 Employee Member shall be required to repay the PEBTF the full amount

of such overpaid medical benefits within 60 days of the date that the Employee Member is notified of the amount due, unless alternative repayment arrangements are made with the PEBTF in accordance with the provisions of this Section.

c. **Repayment and Nonpayment of Amounts Owed to the Plan.** To address amounts owed a voluntary repayment plan agreed to between Member and the PEBTF can be arranged. Should the Employee 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 with the Board of Trustees. 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 Summary Plan Description (SPD) there are provisions regarding time limits for filing claims, paying COBRA premiums and notifying the PEBTF with regard to various matters. **These time limits must be strictly adhered to as they are strictly enforced by the PEBTF.** The time limits apply to receipt of appeals or other matters within the specified time periods as set forth in this SPD. 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. **Do not jeopardize your right 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.

Workers' Compensation

Any claims incurred as a result of a work-related injury or disease are the sole responsibility of workers' compensation. Such claims must be denied by the individual's workers' compensation plan prior to their submission to your medical plan for consideration. Use your workers' compensation prescription drug card or your CVS Caremark prescription drug ID card to obtain prescription drugs for an injury or illness related to your employment with the Commonwealth of Pennsylvania. Employees of PASSHE and PHEAA should contact their local HR office for information regarding coverage for work-related injuries.

Section 18: Glossary of Terms

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

Bronze Plan: The health and medical benefit coverage option under the Plan that is designed and identified to provide a level of coverage necessary to meet the Patient Protection and Affordable Care Act requirements for Minimum Essential Coverage and that has required participant contributions in an amount of no more than the Maximum amount that is considered affordable under the Patient Protection and Affordable Care Act.

Chronic: Slow onset and lasting for a long period of time; not Acute.

Claims Payor: The PEBTF or other organization that adjudicates claims under the authority of the Fund, including but not limited to, various third-party administrative service Providers selected by the Fund to adjudicate and pay claims under the medical plan options, Mental Health and Substance Use Program, Prescription Drug Plan or the Supplemental Benefits Options.

When the PEBTF selects a PPO, HMO Bronze Plan, durable medical equipment Provider, Prescription Benefits Manager, vision plan, dental plan or other third party administrator as the Claims Payor for a PEBTF 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/Investigative), to determine whether a service is Medically Necessary and to determine the applicable UCR Charge. The PEBTF 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.

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.

Dependent: The spouse or child of an Employee Member who meets the eligibility requirements of the Plan and has been enrolled by the Employee Member as an eligible Dependent (see Eligibility Section).

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

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.

Eligible Member: An Eligible Member means a Member enrolled in the PEBTF, whether as an Employee Member, a COBRA qualified beneficiary ("COBRA Member"), or the enrolled eligible Dependent of an Employee Member or COBRA Member. The term Member for purposes of this booklet, means, and is limited to, an Eligible Member. If you were previously enrolled for coverage but are not an Eligible Member, refer to the Summary Plan Description (SPD) 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 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.

Experimental or Investigative: Services or supplies which the Claims Payor for the health Plan Option you have selected determines are:

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

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 Member in the home for the purpose of restoring and maintaining Maximum levels of comfort, function and health of the patient.

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

Maximum: The greatest quantity or amount payable to or for a Member or available to a 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:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease, or injury; and
b. provided for the diagnosis, or the direct care and treatment of the Member's condition, illness, disease, or injury; and
c. in accordance with standards of good medical practice; and
d. not primarily for the convenience of a Member or the Member's Provider; and
e. the most appropriate supply or level of service that can safely be provided to the Member. When applied to hospitalization, this means that the Member requires Acute care as a bed patient due to the nature of the services rendered or the Member's condition, and the 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 PEBTF 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+Choice (Part C), Medicare Advantage Plans and Prescription Drug (Part D).

Member: Enrolled person eligible for benefits under the PEBTF, which includes eligible employees, their eligible Dependents, eligible COBRA beneficiaries and eligible surviving spouses (see also Eligible Member).

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 as appropriate.

Minimum Essential Coverage: Any insurance that meets the Patient Protection and Affordable Care Act requirement for having health coverage.

Minimum Value Coverage: Coverage in a group health plan that provides minimum value pursuant to section 36B(c)(2)(C)(ii) of the Internal Revenue Code.

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

New Child: A New Child means, with respect to any Eligible Employee or Dependent of an Eligible Employee, a child who is newly born to, newly adopted by, or newly placed for adoption with the Eligible Employee or Dependent, as applicable.

Open Enrollment: Period of time specified by the PEBTF during which Members may, in accordance with the established eligibility rules, change the Plan Option in which they are enrolled.

Out-of-Network (or Non-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, Bronze Plan or Mental Health and Substance Use Program). 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% (PPO, HMO or Bronze Plan).

Palliative: Relieves or alleviates without curing.

Plan Administrator: The Pennsylvania Employees Benefit Trust Fund (PEBTF).

Plan Allowance: Certain Claims Payors determine the Maximum covered expense 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:

a. 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 Non-Participating Providers will be paid by the Claims Payor, as amended from time to time.
b. For Participating Facility Providers, the Plan Allowance is the negotiated amount agreed to by the Provider and the Claims Payor. For Non-Participating Facility Providers, the Plan Allowance is the amount charged by the Facility Provider to all its patients, but not in excess of the Fee Schedule or other Maximum payment amount, if any, established by the Claims Payor with respect to Non-Participating Facility Providers.

PPO (Preferred Provider Organization): Offers both In-Network and Out-of-Network benefits. 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:

a. 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/;

b. 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;

c. With respect to infants, children and adolescents, evidence-informed Preventive Care https://www.hrs.gov/; and

d. screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") https://www.hrs.gov/; and

e. 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.

f. 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).

g. For Members between age 50 and 70 who have prostates, PSA testing for prostate cancer every other year.

h. 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.

i. 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.

j. 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.

k. 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 paragraph (e), items and services that constitute preventive care may be found at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

The PEBTF 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 Subsections (a)-(d) 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. PCP's are 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.

Qualifying Life Event: A qualifying life event means, subject to any restriction under applicable law or any Plan Option, any of the following events:

a. An individual becomes newly eligible for coverage under the Plan as an Eligible Employee's Dependent.

b. An Eligible Employee loses a Dependent through divorce or death.

c. An Employee's Dependent ceases to be eligible for coverage under the terms of the Plan or a Plan Option.

d. An Eligible Person 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.

e. An Eligible Person changes their residence and, as a result, becomes ineligible for a Plan Option in which they are enrolled.

f. The cost of coverage under a Plan Option to an Eligible Employee significantly changes.

g. An Eligible Person is enrolled in a Plan Option that ceases to be available to the Eligible Person 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.

h. An Eligible Person gains or loses group health coverage under another plan because of:

    i. 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;

    ii. 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.

i. 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 Employee'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).

j. An Eligible Person 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.

k. An Eligible Person incurs a Special Enrollment Event.

l. A Member's receipt of an order from a court or other authority directing the Member to disenroll the Member and/or Dependent.

m. 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 Member may be removed from PEBTF 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.

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

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 Health Insurance Portability and Accountability Active of 1996 (HIPAA), with respect to which the Plan is required to offer Eligible Employees and their Dependents an opportunity for coverage under Plan Options. A Special Enrollment Event is any of the following events:

a. The marriage of an Eligible Employee
b. The birth of a child, adoption of a child by or placement for adoption of a child with an Eligible Employee
c. An Eligible Person'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)
d. Another employer's termination of all employer contributions toward the cost of coverage (other than COBRA coverage)
e. In the case of an Eligible Employee who is not enrolled for coverage under the Plan or an Eligible Employee's Dependent 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.

Therapy Service means 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.

a. **Radiation Therapy** - The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.
b. **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents.
c. **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.
d. 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.
e. **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.
f. **Respiration Therapy** - Introduction of dry or moist gases into the lungs for treatment purposes.
g. **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.
h. **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.
i. **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 in excess of the UCR Charge are the sole responsibility of the Member. The UCR Charge is determined by the Claims Payor under the particular Plan Option you have selected (PPO, HMO, Bronze Plan, Mental Health and Substance Use Program, Prescription Drug or Supplemental Benefits), in accordance with the following factors:

- The usual fee which an individual Provider most frequently charges to the majority of 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 may differ 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 PEBTF

for purposes of determining the Maximum amount or expense eligible for coverage under the Plan.

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.

Reservation of Authority to Amend

The Board of Trustees reserves the right at any time to amend or modify any and all benefits under the Plan, including changing the cost for coverage, changing coverage for active employees and to removing or replacing service Providers, in its sole discretion or as required by law without notice to or consent of Members or their Dependents. Neither this SPD nor any other materials you may have received describing the PEBTF are intended to create any contractual or vested rights to employment or rights in the benefits described. The Board of Trustees administers the Plan and are empowered to establish rules and procedures under the PEBTF, which may have the effect of modifying or limiting benefits. Any such amendment, modification or limitation may be applied to all PEBTF Members, or to certain groups or classes of Members, as the Board of Trustees may determine.

2026 PEBTF Benefit Option Summary Comparison -- Active 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 SPD)	100%	70%* after Deductible; Member pays 30%	100%	70%* after Deductible; Member pays 30%	100%
Pediatric (see list in SPD)	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 PEBTF Plan Document.

1/1/26

Section 20: Your Rights as a PEBTF Member

As a Member of the PEBTF medical plan, prescription drug or supplemental benefits (vision, dental and hearing aid), you are entitled to certain rights and protections.

You are entitled to:

- Examine the Plan Document, without charge, at the PEBTF.
- Obtain copies of the Plan Document by writing to the PEBTF, Attention: Executive Director, 150 S. 43rd Street, Harrisburg, PA 17111. A reasonable charge for the copies may be made.
- Receive written notice if a claim for benefits is denied, for any reason, in whole or in part, and a right to appeal the decision in accordance with the provisions of the particular coverage (PPO, HMO, Bronze Plan, prescription drug or supplemental benefits).
- Receive a list of the Board of Trustees.

The Board of Trustees and other individuals who are responsible for the management of the PEBTF, are fiduciaries and are committed to acting prudently and in you and your Dependent's best interest.

If you have questions about this statement or how the PEBTF works, contact the PEBTF at 150 S. 43rd Street, Harrisburg, PA 17111.

Section 21: Administrative Information

This section of the SPD contains information on the administration of the PEBTF and information on its source of funds.

Basics of Your Plan

Plan Name:	Pennsylvania Employees Benefit Trust Fund (PEBTF) 150 S. 43rd Street, Suite 1 Harrisburg, PA 17111-5700 Phone: 717-561-4750 Toll-Free: 800-522-7279 www.pebtf.org
Identification Number:	52-1588740
Official Plan Name:	PEBTF Medical Plan/Supplemental Benefits Options Plan
Plan Number:	Not applicable
Plan Type:	Welfare plan
Plan Year:	Medical Plan Options: January 1 Mental Health and Substance Use Program: January 1 Prescription Drug Plan: January 1 Supplemental Benefits Options: January 1 (Subject to change)
Plan Fiscal Year:	July 1
Plan Sponsor:	Commonwealth of Pennsylvania (in addition to various affiliated agencies) and AFSCME Council 13 (in addition to other unions having a collective bargaining relationship with the Commonwealth of Pennsylvania)
Plan Administrator:	Board of Trustees of the PEBTF 150 S. 43rd Street, Suite 1 Harrisburg, PA 17111-5700 Phone: 717-561-4750 Toll-Free: 800-522-7279 www.pebtf.org All notices to the PEBTF should be sent to this address.
Plan Trustee:	Board of Trustees of the PEBTF
Agent for Service of	PEBTF

Legal Process:	Attention: Executive Director 150 S. 43rd Street, Suite 1 Harrisburg, PA 17111-5700
Plan Funding:	The PEBTF is funded by contributions by *participating* employers pursuant to the provisions of applicable collective bargaining agreements with the unions involved, in conjunction with contributions of like amounts on behalf of non-bargaining unit personnel. The Trust is tax qualified under Section 501(c)(9) of the Internal Revenue Code.
Determining Eligibility and Level of Benefits:	The Board of Trustees of the PEBTF is solely responsible for establishing the basic rules of eligibility for coverage and the overall level of benefits to be provided under the available options. The Board of Trustees is also responsible for interpreting and construing the Plan Options and the form of the PEBTF Plan Documents and its application. Specific eligibility for any one or more of the enumerated benefits and services is determined by the particular carrier (or plan) involved – e.g., PEBTF, PPO, applicable HMO, Bronze Plan, DME Claims Payor, Prescription Drug, Dental and Vision plans.
Claiming Benefits:	Benefits are normally paid automatically when you use *participating* or Network Providers for medical care, or when you get care through the PPO, HMO, Bronze Plan, Mental Health and Substance Use Program, prescription drug or supplemental benefits (vision, dental and hearing aid). You will have to file a claim form for all other types of care received, such as Out-of-Network care through the PPO option, Bronze Plan, Mental Health and Substance Use Program, prescription drug, vision, dental and hearing aid benefits.
Plan Termination and Amendment	The PEBTF reserves the right to discontinue or terminate any plan or option, to modify the plans to provide different cost sharing arrangements between the PEBTF and participants, or to amend the Plan Documents in any respect. This may be done at any time and without notice. Amendments may be made to any plan by action of the Board of Trustees. Benefits for claims occurring after the effective date of the plan modification or termination are payable in accordance with the revised Plan Documents. If a plan is terminated, all remaining assets will be distributed in accordance with the Agreement and Declaration of Trust of the PEBTF.

Important Phone Numbers

PEBTF	717-561-4750 800-522-7279 (toll-free)
Bronze Plan	
Aetna (Open Choice)	800-991-9222
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	800-924-0105
State Employee Assistance Program	800-692-7459
Prescription Drug Benefits	
CVS Caremark	888-321-3261
Vision Benefits	
National Vision Administrators (NVA)	800-672-7723
Dental Benefits	
United Concordia	888-320-3321
Hearing Aid Benefits	
PEBTF	800-522-7279

For health plan website addresses, log on to the PEBTF website, www.pebtf.org.

You will find the health plans' website addresses listed under the Links section.