PEBTF

Summary Plan Description

Pennsylvania Employees Benefit Trust Fund (PEBTF)

April 2014

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 April 1, 2014. 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.

PEBTF

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

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 Trustees meet regularly to review the operations of the PEBTF. The Trustees establish PEBTF policies and determine the level of benefits and any changes to benefits. The Trustees are 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 PEBTF 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
- Consumer Driven Health Plan (CDHP) Option

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 Option.

The PEBTF also provides mental health and substance abuse coverage, as well as prescription drug, vision, dental and hearing aid benefits 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

Many employees at agencies under the Governor's jurisdiction and the Office of Attorney General and Office of the Auditor General can change their address and enroll in single medical coverage when newly eligible through employee self service (ESS) at www.myworkplace.state.pa.us. 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 PA State System of Higher Education 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 abuse 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 CDHP, each including the Mental Health and Substance Abuse Program. Additional coverage may be provided under the Supplemental Benefits Program. 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 PEBTF Board of Trustees set forth in the claims procedures described in this booklet.

Effect of Health Care Reform

The new health care reform law, known as the Patient Protection & Affordable Care Act, imposes various requirements on group health plans. Certain plans known as "grandfathered health plans" must comply with some of these requirements, but not all of them. The Board of Trustees of the PEBTF believes that the PEBTF is a grandfathered health plan and that the PEBTF may, therefore, preserve certain basic health coverage that was already in effect when health care reform was enacted. As a grandfathered health plan, the PEBTF may not include certain consumer protections of health care reform that apply to other plans. For example, the PEBTF is not required to provide coverage for specified preventive health care services without any copayments, deductibles or other cost sharing amounts (although it does, in fact, often provide that coverage). However, the PEBTF must comply with certain other consumer protections of health care reform, for example, the elimination of lifetime dollar limits on benefits.

You may direct questions about which protections do and do not apply to a grandfathered health plan and what might cause a change in a health plan's grandfathered status in writing to the PEBTF at 150 S. 43rd Street, Harrisburg, PA 17111. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Benefits at a Glance

Medical Plan Choices

- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Consumer Driven Health Plan (CDHP)

Mental Health and Substance Abuse Program

Durable Medical Equipment (DME), Prosthetics, Orthotics and Medical Supply Program

(Provided by DMEnsion Benefit Management except for Members enrolled in UnitedHealthcare CDHP)

Get Healthy Program

Supplemental Benefits Program

- Prescription Drug Benefit
- Vision Benefit
- Dental Benefit
- Hearing Aid Benefit

IMPORTANT NOTE: Under all Medical Plan Options and Supplemental Benefits Program, 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 and PPO options are always within Usual, Customary and Reasonable (UCR) limits or the Plan Allowance, but charges by Non-Network Providers may not be. You are responsible for all charges in excess of the Plan Allowance.

Section 1: Eligibility

1.1 Summary

- Unless otherwise noted, you are eligible for medical and supplemental benefit (prescription drug, dental, vision and hearing aid) coverage 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).
- Non-permanent employees and permanent part-time employees working less than 50% of full-time hours are not eligible for PEBTF medical coverage. However, the time that an employee (first hired or rehired on or after August 1, 2003) works in a non-permanent capacity or less than 50% of full-time hours will be credited toward the six-month waiting period for supplemental benefits and Dependent medical coverage, once he or she becomes eligible.
- You will not be denied coverage in the PEBTF if you have a pre-existing medical condition.
- You must live in a service area where the HMO is approved in order to enroll in the HMO option.
- 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.

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

Employees and eligible Dependents are eligible for PEBTF coverage as follows:

- May enroll in a medical plan available in his or her county of residence
- Shall receive supplemental benefits
- Must pay the applicable biweekly employee contribution (refer to your collective bargaining agreement, if applicable)

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 supplemental benefits on the first date of eligibility under the PEBTF and are not required to purchase health benefits for Dependents for the first six months of employment. Also, you are not subject to any medical plan buy-up.

Spouse/Domestic Partner Eligibility for Employees Hired Before August 1, 2003: To enroll for coverage in the PEBTF, if the Dependent spouse/domestic partner of an employee hired before August 1, 2003, is eligible for medical or supplemental benefit coverage through his or her own employer and does not have to pay for coverage, he or

she must take his or her employer's coverage as primary coverage. In that event, your spouse's/domestic partner's coverage in the PEBTF is limited to **secondary** coverage. If your spouse/domestic partner has to pay for coverage or is offered an incentive not to take his or her employer's coverage, your spouse/domestic partner does not have to enroll in his or her employer's coverage and the PEBTF will remain as primary.

Contact your health plan any time there is a change to a spouse's/domestic partner's medical or supplemental benefit coverage.

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

Employees hired or re-hired on or after August 1, 2003, will be eligible to enroll for PEBTF coverage as follows:

- May enroll in single medical coverage only in the least expensive option available in his or her county of residence.
- Must pay the applicable biweekly employee contribution (refer to your collective bargaining agreement, if applicable).
- May purchase a more expensive option in their county of residence by paying the cost difference, as determined by the PEBTF, in addition to the employee contribution.
- May purchase Dependent medical coverage for the first six months of employment.
- May add eligible Dependents for medical coverage at no additional charge in the least expensive option in their county of residence on the day immediately following the date the employee completes six months of employment (if a more expensive plan is chosen, the employee must pay the cost difference, as determined by the PEBTF).
- Will receive supplemental benefits on the day immediately following the date the employee completes six months of employment, if you are enrolled in a medical plan.
- Part-time employees must pay 50% of the cost in addition to the above-mentioned employee contributions

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 supplemental benefits on the first date of eligibility under the PEBTF and are not required to purchase health benefits for Dependents for the first six months of employment. Also, you are subject to any medical plan buy-up.

Spouse/Domestic Partner Eligibility for Employees Hired or Re-hired on or After August 1, 2003: To enroll for coverage in the PEBTF, a Dependent spouse/domestic partner of an employee hired on or after August 1, 2003, who is eligible for medical or supplemental benefit coverage through his or her own employer **must** take his or her employer's coverage as his or her primary coverage; regardless of any employee contribution the spouse/domestic partner must pay and regardless of whether the spouse/domestic partner had been offered an incentive to decline such coverage. Coverage for such Dependent spouse/domestic partner in the PEBTF is limited to **secondary** coverage. This rule does not apply for those spouses/domestic partners who are self-employed.

Contact your health plan any time there is a change to a spouse's/domestic partner's medical or supplemental benefit 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.

Six Months of Employment: For the first six months of employment as a new hire or re-hire, coverage is limited to employee medical coverage only. You also may purchase Dependent medical coverage during this six-month period. This six-month period is satisfied once your cumulative period that you are actively working as an employee reaches six months. Time that you may work in a non-permanent capacity will be credited toward the six-month requirement (although you must be a permanent full- or part-time employee to be eligible for PEBTF benefits). Time when you are furloughed or otherwise not actively working does not count toward the six-month requirement. If you leave employment and later return following a break in service of more than 180 calendar days, then you will be required to satisfy a new six-month waiting period for full eligibility again.

Eligibility for full PEBTF coverage, including coverage for supplemental benefits and Dependent benefits, will begin on the day immediately following the date you have worked six full months of employment.

1.5 When Coverage Begins – Hired After August 1, 2003

You are eligible for medical coverage on your first day of employment as an eligible permanent full-time or part-time employee. You are eligible to elect benefits at any time, but 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. To be covered, you must enroll by selecting a Medical Plan Option and completing and submitting a PEBTF Enrollment/Change Form to the HR Service Center or your HR office if your agency is not supported by the HR Service Center. The PEBTF Enrollment/Change Form may be downloaded from the PEBTF's website, www.pebtf.org, Resources/Forms or you may contact the HR Service Center or your HR office if your agency is not supported by the HR Service Center to complete the enrollment form and any other required documents.

Many employees at agencies under the Governor's jurisdiction and the Office of Attorney General and Office of the Auditor General can change their address and enroll in single medical coverage when newly eligible through employee self service (ESS) at www.myworkplace.state.pa.us. In addition, employees can make plan changes during Open Enrollment. 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 PA State System of Higher Education 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.

Coverage During the First Six Months of Employment:

- You are eligible for single coverage in the least expensive Plan Option in your county of residence
- You pay the appropriate employee contribution/cost through payroll deduction
- No supplemental benefits (prescription drug, vision, dental and hearing aid) are provided
- You may enroll in a more expensive Plan Option but you must pay the biweekly buy-up cost for that option in addition to your employee contribution
- Your eligible Dependents may be covered provided they are enrolled in the same health plan as you are enrolled and you pay the required cost of coverage

NOTE: The effective date of coverage cannot be more than 60 days prior to the date that the PEBTF 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. 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.

Coverage Beginning with the Seventh Month of Employment (begins the day following the date you complete six months of employment):

- You and your eligible Dependents shall be covered for medical benefits in the least expensive plan in your county of residence. Your Dependents must be enrolled to be covered by the Plan
- You and your eligible Dependents may elect to enroll in supplemental benefits
- You continue to pay the appropriate employee contribution/cost through payroll deduction for the least expensive plan
- You may elect to participate in a more expensive medical plan but you must pay the biweekly buy-up cost for that option in addition to your employee contribution

1.6 Eligibility

You are eligible for medical and supplemental benefits 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. Permanent part-time employees who work at least 50% of full-time hours must elect coverage for 1) both medical and supplemental or 2) decline coverage. Your cost for these benefits is taken through payroll deduction.

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, please see the Supplemental Benefits section.

If you are on a Leave Without Pay With Benefits (LWOPWB), 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, but will be responsible for payment regardless of whether an invoice is received.

1.7 Eligibility Documentation

Employees are required to present documentation verifying the eligibility status for their Dependents. Employees are required to disclose medical and supplemental coverage available to their 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).

1.8 Eligible Dependents

As an Employee Member, 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.
- Domestic partner. A Domestic Partnership Verification Statement and Application for Health Benefits (PEBTF-12) Form must be completed and the appropriate verification evidence must be presented.
- 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/domestic partner is the parent of the child
  - Child for whom you are the court-appointed legal guardian or legal custodian as demonstrated by the 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 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. The HR Service Center or your HR office will notify you of the documentation needed.

Coverage for Dependent Children to Age 26: As an Employee Member, 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 day before the child's 26th birthday 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.

1.9 Disabled Dependent

Your 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
- Was your or your spouse's/domestic partner's Dependent before age 26
- Depends on you or your spouse/domestic partner for more than 50% support
- Is claimed as a Dependent on your or your spouse/domestic partner's federal income tax return
- 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 he or she lives outside the Employee Member's 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 his or her support from an Employee Member or his or her spouse/domestic partner.

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 five 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 he or she is 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 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 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 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 Trustees to determine, without more, that the individual is not, or is no longer, Totally and Permanently Disabled.

1.10 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 or in a domestic partnership
- 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 PEBTF medical and supplemental benefits coverage in the same plan as the Employee Member and must pay a monthly premium for coverage to continue. Coverage ends if and when the Employee Member's 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.

1.11 Domestic Partnerships

A domestic partner is a same or opposite-sex partner of an Employee Member who, together with the Employee Member, meets the following criteria:

- The Employee Member and his or her partner are engaged in an exclusive committed relationship of mutual caring and support and are and have, for the six-month period immediately preceding the date on which the Employee Member applies to have the partner qualify as a domestic partner, been jointly responsible for their common welfare and living expenses;

- Neither the Employee Member nor his or her partner is married (within the meaning of the laws of the Commonwealth of Pennsylvania) to or legally separated from any individual;

- The Employee Member and his or her partner are each at least 18 years old and mentally competent to enter into a contract in the Commonwealth of Pennsylvania;

- The Employee Member and his or her partner are each the sole domestic partner of each other;

- The Employee Member and his or her partner have lived together in the same residence on a continuous basis for at least six months immediately prior to the date on which the Employee Member applies to have the partner qualify as a domestic partner under the Plan, and they have the intent to reside together permanently;

- The Employee Member and his or her partner are not related to each other by adoption or blood to a degree that, if they are of different sexes, prohibits or, if they were of different sexes, would prohibit marriage in the Commonwealth of Pennsylvania;

- The Employee Member and his or her partner do not maintain the relationship solely for the purpose of obtaining employment-related benefits;

- Neither the Employee Member nor his or her partner has been a member of another domestic partnership during the six-month period immediately preceding the date on which the employee applies to have the partner qualify as a domestic partner under the Plan (unless the prior domestic partnership ended as a result of the death or marriage of the domestic partner); and

- The Employee Member and, to the extent applicable, his or her partner, complete any application as may be required by the PEBTF for qualification of the partner as a domestic partner under the Plan and meet applicable documentation requirements.

An Employee Member and his or her partner must meet the above listed requirements and submit evidence for the partner to be treated as a domestic partner, and, therefore, as an eligible Dependent, whether or not any jurisdiction recognizes the couple as having a same-sex marriage, civil union, domestic partnership, or similar relationship. A domestic partner may not be enrolled in the CDHP Option.

Dependent Children of the Domestic Partner: Coverage for domestic partner's Dependent children is also available.

Tax Implications: Although employees who cover domestic partners will be charged the same applicable contribution rates as those who cover other Dependents, the IRS requires that the contribution for the domestic partner's coverage be taken on a post-tax basis if the domestic partner is not the employee's tax-code dependent. In addition, employees must pay federal and FICA taxes on the value of the benefits provided to domestic partners (known as imputed income). The value of the benefits may change on an annual basis. Taxes will be withheld biweekly from your paycheck if you add a domestic partner. There are no additional taxes for employees who already have family coverage; for

example, an employee who covers his or her own child will not incur additional charges if the employee adds a domestic partner or for employees who were married in a state or jurisdiction that recognizes same-sex marriage.

1.12 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 him or her from coverage, you will not be permitted to subsequently add someone else as your spouse, common law or otherwise, or as your domestic partner 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.

1.13 No Duplication of Coverage

If you and your spouse/domestic partner 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/domestic partner'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/domestic partner's coverage, but not both.

The only exception to these rules barring duplication of coverage is if you are an Active Employee and your spouse/domestic partner is an active or retired Pennsylvania State Police enlisted member or retired REHP Member, your retired spouse/domestic partner can be covered as a Dependent under the PEBTF Plan for Active Employees for supplemental benefits only. The Retired Pennsylvania State Police Program (RPSPP) or

the REHP will be the primary payor for the retiree even if the retiree is a Dependent on the Active Member's Prescription Drug coverage. Active Pennsylvania State Police Health Benefits Program (SPHBP) and RPSPP Members may enroll in a Medicare Supplemental plan.

1.14 Eligibility – Supplemental Benefits

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

- Pennsylvania State Police cadets are not eligible for supplemental benefits
- You may cover your spouse/domestic partner who is a Member of the Retired Employees Health Program (REHP) or the Retired Pennsylvania State Police Program (RPSPP) for prescription drug, vision, dental and hearing aid. The Retiree Member's coverage under the Retiree Prescription Drug Plan will be primary
- Part-time employees must enroll in both medical and supplemental benefits to be covered by the PEBTF. If enrolling Dependents, they must be enrolled in both medical and supplemental benefits, as well
- If you are placed on workers' compensation as a result of a commonwealth work-related injury, you are required to use your prescription drug ID card to obtain prescription drugs relating to your injury

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 must complete a six-month period of employment before you are eligible for supplemental benefits.

1.15 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.

You will have six months to provide an original birth certificate (or decree or other proof of adoption or placement for adoption) and Social Security number in order for your New Child to be enrolled for coverage under the Plan. If you fail to provide the required documentation before the end of the six month period, the PEBTF will notify you in writing of the expiration of the period for providing the documentation. You will have until the end of the seventh month to provide the documentation. If the Social Security number is not provided by that time, the New Child will cease to be covered under the Plan at the end of the seventh month. If you fail to provide a birth certificate or equivalent proof that the child who incurs the claims is yours, you will be deemed to have misrepresented that the child is yours, and coverage will be terminated retroactively to the date of birth (or adoption or placement of adoption). You will be responsible for reimbursing the PEBTF for any claims paid for this child.

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 drop a Dependent due to a Qualifying Life Event or during the annual Open Enrollment. Refer to the Glossary on page 121 for a description of Qualifying Life Event.

If you wish to drop 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/termination of domestic partnership from your spouse/domestic partner or your Dependent's loss of status as an eligible Dependent), you, your former spouse/domestic partner or other 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/domestic partner, your child(ren) or your spouse's/domestic partner'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.

1.16 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

Employees of the Pennsylvania State System of Higher Education (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, termination of domestic partnership, etc.)
- You lose a Dependent through divorce, termination of domestic partnership, 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)

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

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. If the Plan pays benefits for 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 within 60 days of the date that you are notified of the amount due, 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 within 60 days of a divorce being finalized. 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, 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. Your ex-spouse's PEBTF coverage will be terminated on the actual date of divorce.

If your coverage ends, in certain circumstances you and your eligible Dependents 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 97 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 the employee's death is a result of a work-related accident, eligible Dependents may qualify for paid coverage.

1.17 Last Date of Coverage for Child

A child becomes ineligible as of the day he or she:

- Turns 26 (if not disabled)
- Is determined by the Trustees to no longer be Totally and Permanently Disabled if age 26 or older
- No longer meets the Dependent eligibility requirements of the PEBTF

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.

1.18 Changing Coverage

You may enroll for coverage and/or change Plan Options during the Open Enrollment period. You may enroll in any PEBTF-approved Plan Option 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 Plan Option, 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 bi-weekly 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 your Qualifying Life Event causes you to lose eligibility for a Plan Option but not lose eligibility for the Plan (such as a move outside of the relevant service area for your coverage), you may elect to change your coverage option. If you do not make an election, you will be enrolled in the PPO Option by default. If you were hired on or after August 1, 2003, you will be responsible for the biweekly buy-up cost for the PPO (in addition to the employee health care contribution).

You may change Plan Options 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 you must notify the HR Service Center or your HR office if your agency is not supported by the HR Service Center of the Qualifying Life Event by submitting the required documentation (PEBTF or Employee Self Service) within 60 days of the event. You may contact the PEBTF or Employee Self Service with questions.

If you change Plan Options during non-Open Enrollment periods, the effective date of coverage cannot be more than 60 days retroactive from the date the PEBTF Enrollment Change Form (and any necessary accompanying documentation) is received by the HR Service Center or your HR office if your agency is not supported by the HR Service Center. You must contact the HR Service Center or your HR office if your agency is not

supported by the HR Service Center to initiate a change in coverage and to inquire about any additional employee costs.

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

Many employees at agencies under the Governor's jurisdiction and the Office of Attorney General and Office of the Auditor General can change their address and enroll in single medical coverage when newly eligible through employee self service (ESS) at www.myworkplace.state.pa.us. 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 PA State System of Higher Education 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.

1.19 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 102 for a description of the Claims and Appeals Process.

Section 2: Benefits Under All Medical Plan Options

See PPO, HMO and CDHP Option sections for more detail.

Important – Please Read

The PEBTF offers several Plan Options for medical benefits. You choose the option – PPO, HMO or CDHP Option – that best fits your needs. Not all options are available in all areas. The PEBTF covers mental health and substance abuse benefits under each Plan Option. The PEBTF also offers supplemental benefits, including coverage for prescription drugs, vision care, dental care and a hearing aid benefit. Supplemental benefits are separate from your medical plan.

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 Program.

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 information about the prescription drug plan, vision care, dental care and hearing aid 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 Program 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 a Non-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.

2.1 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. 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 a Member has 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 the convenience of the Member, 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 CDHP Options: Failure to precertify Out-of-Network, non-emergency services may result in a 20% reduction in benefits payable for non-emergency ambulance services. Also, you will be reimbursed at the Out-of-Network rate for eligible Medically Necessary, non-emergency ambulance transports if you use an Out-of-Network Provider. 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 (CDHP) 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.

2.2 Care Outside of the Country

The Plan will cover some 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.

2.3 Case Management

Case management is a standardized medical assessment process that focuses on providing a Member with the appropriate types of health care services in a cost-effective manner when the Member is experiencing a high cost or specialized episode of care. The Member's needs are assessed by a case manager, who then coordinates the overall medical needs of the Member. This could involve such things as arranging for services to be provided in the Member's home or a setting other than the hospital. The services are provided to Members at no additional cost through the medical plans.

2.4 Chiropractic Care/Spinal Manipulations

Benefits:

PPO Option	HMO Option	CDHP Option
• Six Medically Necessary visits per year, then a Treatment Plan must be submitted for additional visits • $15 Copayment for Network chiropractic care • Non-Network care is subject to a $400 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 a Non-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 (due to a medical diagnosis or the diagnosis of Autism Spectrum Disorders and not developmental), cardiac rehabilitation, pulmonary rehabilitation and respiratory • $15 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; some plans may require a referral from your Primary Care Physician (PCP)	• Six Medically Necessary visits per year, then a Treatment Plan must be submitted for additional visits • Non-Network care is subject to the 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 a Non-Network chiropractor

2.5 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.

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

Does Not Apply to CDHP Members

DMEnsion Benefit Management, a licensed third party administrator, provides Durable Medical Equipment (DME), prosthetics, orthotics, medical supply and diabetic supply services to PEBTF Members under the Medical Plan Options.

- DME includes equipment such as wheelchairs, oxygen, hospital beds, walkers, crutches and braces, 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 (Members should obtain insulin under the Prescription Drug Plan)

You must show your medical ID card when receiving medical equipment alerting the provider that benefits should be provided by DMEnsion Benefit Management.

The Plan offers both a Network and a Non-Network benefit. If you choose a Network Provider, you are eligible to receive covered benefits at no cost. To find a Network Provider, contact DMEnsion Benefit Management at **1-888-732-6161** or log on to its website at www.dmension.net. The Network is extensive and it includes most major DME/P&O Providers.

Preauthorization is required for the rental of any DME item and the purchase of all DME and P&O devices.

If you use a Non-Network Provider, you will be responsible for 30% of the allowable amount plus the difference between the actual amount billed by the Provider and the DMEnsion Benefit Management allowed amount.

The Plan follows Medicare guidelines in determining whether DME, prosthetics, orthotics, medical supplies and diabetic supplies are covered. These nationally-recognized standards are used throughout the country. Most Providers and medical facilities are familiar with these guidelines.

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 continue to be paid by the Medical Plan Option, provided it is billed by the Provider and not by a DME supplier, and will not be subject to the DMEnsion Benefit Management Program. Your Provider may dispense the equipment and will bill your medical plan. For example, if you receive a knee brace or crutches at the emergency room, it may be billed to your medical plan, if it is billed by the facility and not a separate DME Provider. If your doctor writes a prescription for a DME item, you should obtain it from a DMEnsion Network Provider in order to get the highest level of benefits.

2.7 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:

Emergency Accident Care: Hospital services and supplies for the treatment of traumatic bodily injuries resulting from an accident.

Emergency Medical Care: Hospital services and supplies are covered only if the condition meets the following definition of emergency: The sudden onset of a medical condition manifesting itself by Acute symptoms of sufficient severity, which would cause the prudent layperson, with an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention could reasonably result in:

- Permanently placing your health in jeopardy
- Causing other serious medical consequences
- Causing serious impairment to bodily functions
- Causing serious and permanent dysfunction of any bodily organ or part

Emergency care must begin within 72 hours of the onset of the medical emergency.

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 and PPO Emergency Room Copayment is $50, 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.

Emergency treatment charges that do not meet the above criteria, as determined by the Claims Payor, are not covered.

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. Observation services generally do not exceed 24 hours. In rare cases, observation care could extend to 24 to 48 hours.

Therefore, if you are in observation care from an ER visit, you will be required to pay your $50 ER copayment.

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

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 $50 Member Copayment 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 $15 copayment.

Dental Services Related to Accidental Injury: Emergency dental services rendered by a physician or dentist are covered, provided the services are performed within 72 hours of an accidental injury (unless the nature of the injury precludes treatment within 72 hours, in which event treatment must be provided as soon as the Member's condition permits). Services are provided 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.

2.8 Facility and Professional Provider Services

Covered inpatient services at a participating Network facility include:

- 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)
- Oxygen and administration of oxygen
- Therapy services
- Administration of blood and blood plasma (**NOTE:** You pay 20% of the cost for blood products that are not replaced, or any other limit as may be imposed by the Claims Payor)

The following outpatient services also are covered at a participating Network facility:

- Emergency care
- Pre-admission testing
- Surgery (when referred by a PCP for HMO Members)
- 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
- Services of your Network physician or specialist
- Diagnostic Services (when referred by your PCP or specialist for HMO Members)
- Drugs, dressings, splints and casts
- Chemotherapy, radiation and dialysis services
- Physical, respiratory, occupational, speech (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental), cardiac and pulmonary rehabilitation therapies, including spinal manipulation (see charts under each option for the annual Maximums)

Medically Necessary services are also covered Out-of-Network (PPO and CDHP Option) 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.

2.9 Home Health Care

Benefits:

PPO Option	HMO Option	CDHP Option
• Covered 100% In Network • No day limit for In-Network care. You must precertify for both In-Network and Non-Network Home Health Care Services. Failure to precertify Non-Network services may result in a reduction in benefits payable for Home Health Care services in accordance with the preauthorization policies of the PPO • **Non-Network**: 70% plan payment after Deductible. Non-Participating Providers may balance bill for the difference between Plan Allowance and actual charge	• 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	• Covered 100% In Network • No day limit for In-Network care. You must precertify for both In-Network and Non-Network Home Health Care Services. Failure to precertify Non-Network services may result in a reduction in benefits payable for Home Health Care services in accordance with the preauthorization policies of the CDHP • **Non-Network**: 70% plan payment after Deductible. Non-Participating Providers may balance bill for the difference between Plan Allowance and actual charge

Benefit Limits Under all Plan Options:
Medically Necessary Home Health Care benefits will be provided for the following services when provided and billed by a licensed Home Health Care Agency:

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

If the Claims Payor requires preauthorization for payment for Home Health Care services, you must follow the Claims Payor's procedures.

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 home infusion 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.

2.10 Hospice Care

Hospice care offers a coordinated program of home care and inpatient Respite Care for a terminally ill Member and the Member's 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 up to a Maximum lifetime payment of $7,500. 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 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 services except for Respite Care

Respite Care is limited to a Maximum of ten days of facility care or 240 hours of in-home care throughout the treatment period. This is a non-renewable Lifetime Maximum and counts toward the lifetime dollar Maximum of $7,500.

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.

2.11 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, 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 Non-Member 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.

2.12 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. The PEBTF 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.

2.13 Maternity Services

Childbirth services, including pre- and post-natal care, are covered for all female members (including covered Dependents of Employee Members). 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 mother, as certified by the mother's physician.
- The abortion is performed in the case of pregnancy caused by rape or incest reported within 72 hours to a law enforcement agent. Incest must be reported within 72 hours from the date when the female first learns she is pregnant.

Where the certifying physician who will perform the abortion has a pecuniary or proprietary interest in the abortion, there shall be a separate certification from a physician who has no such interest in accordance with the PA Act 1982-138.

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.

2.14 Mental Health and Substance Abuse Services

Mental health and substance abuse treatment and services are not covered under the Medical Plan, except as described below. Please see the section describing the Mental Health and Substance Abuse Program. **Only the first claim (one visit per lifetime)** for an office visit incurred with a non-mental health and substance abuse professional and coded with a psychiatric diagnosis will be covered by the Medical Plan.

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

Special Medical/Behavioral Health Care Benefits: Both the Medical Plan and the Mental Health and Substance Abuse 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 health plan. For more information, see the section on Mental Health and Substance Abuse Program.

Coverage for Autism Spectrum Disorders: Benefits for autism spectrum disorders are provided under all Medical Plan Options, the Mental Health and Substance Abuse Program and the Prescription Drug Plan. Coverage is provided for Dependents to age 21 who have a diagnosis of autism spectrum disorders. The coverage is in accordance with Pennsylvania's 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).

The PEBTF will provide coverage for the diagnostic assessment and treatment of autism spectrum disorders, which includes:

- Prescription drugs and blood level tests;
- Services of a psychiatrist and/or psychologist (direct or consultation);
- Applied behavioral analysis; and
- Other rehabilitative care and therapies, such as services provided by speech and language pathologists, occupational and physical therapists.

Benefits, up to an annual maximum per year, will be provided as follows:

- The Dependent is being treated for an autism spectrum disorder;
- Services must be Medically Necessary and must be identified in a Treatment Plan;
- Services must be prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner; and
- Services must be provided by an autism service Provider or a person, entity or group that works under the direction of an autism service Provider.

Coverage will be provided by the PEBTF medical plans, the Mental Health and Substance Abuse Program and the Prescription Drug Plan. Coverage will not exceed an annual maximum under all benefits combined.

NOTE: The annual maximum amount is subject to change. The Pennsylvania Insurance Commissioner, on or before April 1 of each calendar year, may publish in the Pennsylvania Bulletin an adjustment to the maximum benefit equal to the change in the U.S. Department of Labor Consumer Price Index for all Urban Consumers in the preceding year, and the published adjusted maximum benefit shall be applicable to the following calendar years.

2.15 Other Covered Medical Services

Your health plan also covers the following Medically Necessary services when ordered by your physician and authorized by your Claims Payor:

- Sterilization – No Copayment for the surgery
- Dental Services – Removal of fully and partially bony-impacted teeth is covered – PPO and HMO Members have a $25 Specialist Copayment and must use a health plan Network dentist or oral surgeon; HMO Members must also receive a referral from their Primary Care Physician (PCP) for HMO plans that require a referral
- Podiatric care for treatment of disease or injury – PPO and HMO Members have a $25 Specialist Copayment
- Diabetic education and diabetic foot care. Routine diabetic foot care with a diagnosis of diabetes (coverage is not provided to women with gestational diabetes). Coverage is provided up to four times per calendar year. Syringes, needles, lancets and test strips are covered under the DME benefit – see the Durable Medical Equipment section.
- Durable Medical Equipment (rental or purchase) – see the Durable Medical Equipment section

2.16 Preventive Benefits

Adults:

Adult Routine Physical Exams and Preventive Care (age 19 and over)

Bone Mineral Density Screening: Benefits are provided for one screening every two years for women age 65 and older (for women before age 65, coverage is limited to individuals determined by the physician to be at high risk based on individual risk factors).

Colonoscopy: Limited to members age 50 and over, once every 10 years.

Fasting Cholesterol/Lipid Profile Screening: Benefits are provided for one screening per calendar year for Members age 19 and over.

Fasting Glucose Screening: Benefits are provided for one screening every three years for Members age 45 and older.

Fecal Occult Blood Test: Limited to members age 50 and over, once every 12 months.

HPV Screening: Benefits are provided for one screening per calendar year for females age 30 and over.

Mammography: Females over age 40 are eligible for one routine mammography screening per calendar year.

Prostate Specific Antigen (PSA) Testing: Limited to members age 50 and over, once every 24 months.

Routine Pap Smear and Gynecological Care: Benefits are provided for one routine pap smear and gynecological exam per calendar year.

Sigmoidoscopy: Limited to members age 50 and over, once every 5 years.

Immunizations (member over age 21)
The Plan covers the following adult immunizations:

- Chickenpox (Varicella)
- Human Papillomavirus (HPV) – for females and males to age 26
- Hepatitis B
- Influenza (may also receive the vaccine under the Prescription Drug Plan – see the Prescription Drug Plan section for more information
- Measles/Mumps/Rubella (MMR)
- Tetanus/Diphtheria/Pertussis (Tdap), Tetanus/Diphtheria (Td) or Tetanus (due to an injury) – limited to once every 10 years; a post-exposure Tetanus prophylaxis shot is covered following an injury, if no Tdap or Td had been received during the preceding ten years
- Immunizations that combine two or more component immunizations to the extent the component immunizations are covered under the Plan

Children:

Pediatric Preventive Care and Immunizations: All Dependent children age 18 years and under are covered for certain pediatric preventive services at stated intervals. Pediatric immunizations are covered for Members and Dependents up to age 21. Pediatric immunizations, along with periodic routine visits and certain laboratory expenses, are included under the Preventive Program available to PEBTF Members.

Pediatric Cholesterol Screening/Lipid Profile: Benefits are provided for one screening per calendar year, for Members age 2 to 18.

Pediatric Hemoglobin/Hematocrit: Benefits are provided for one screening per calendar year for Members age 18 or younger.

Pediatric Lead Screening: Benefits are provided for Members age 18 and younger, one screening every two years.

Pediatric immunizations are covered up to age 21:

- Chickenpox (Varicella)
- Diphtheria/Tetanus/Pertussis (DTaP) or Tetanus/Diphtheria/Perstussis (Tdap)
- Human Papillomavirus (HPV) – for females and males ages 9 to 21
- Hemophilus influenza type b (Hib)
- Hepatitis A
- Hepatitis B
- 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)
- Rotavirus
- Tetanus/Diphtheria (Td)
- Immunizations that combine two or more component immunizations to the extent the component immunizations are covered under the Plan

2.17 Private Duty Nursing

Outpatient private duty nursing services are covered under the PPO Option and the CDHP Option only under limited conditions when ordered by a physician and deemed Medically Necessary for the improvement of a medical condition. Private duty nursing that is primarily for the maintenance of a condition or for the convenience of a family member is not covered. The Member 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 the Member's home or is a member of the Member's immediate family are not covered. Private duty nursing will be case managed.

2.18 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
- Certain pediatric immunizations for Members under age 21 and certain immunizations for adult Members (see Preventive Benefits section 2.16)
- Allergy diagnosis and treatment (excluding serum which may be covered by the Prescription Drug Plan)
- Gynecological care and services (HMO Members may self refer)
- Maternity/obstetrical care (PPO and HMO Copayment applies to first prenatal care visit; no charge for all others)
- Family planning consultation
- Diagnosis of the need for mental health or substance abuse treatment – first visit only (see Mental Health & Substance Abuse Program section)
- Emergency care in your physician's office
- Routine diabetic foot care with a diagnosis of diabetes (coverage is not provided to women with gestational diabetes). Coverage is provided up to four times per calendar year
- Diabetic educational training when administered by a nutritionist or dietitian. Diabetic educational training is covered at the initial diagnosis of diabetes, when your self-management changes due to significant changes in your symptoms or conditions (self-management must be verified by a physician) or when your physician decides a new medication or therapeutic process is Medically Necessary

- Enteral formula when administered under the direction of a physician. Oral administration is limited to the treatment of the following metabolic disorders: phenylketonuria, branched chain ketonuria, galactosemia and homocystinuria
- Replacement of cataract lenses for adults and Dependent children following surgery is covered only when new cataract lenses are needed because of a prescription change and you have not previously received lenses within the 24-month period of the current prescription change

2.19 Skilled Nursing Facility (SNF)

Benefits:

PPO	HMO	CDHP
• Covered 100% In Network • You may receive 240 days at a Participating Facility. You must precertify for both In-Network and Non-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 • **Non-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	• Covered 100% In Network • You may receive 240 days at a Participating Facility. You must precertify for both In-Network and Non-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 • **Non-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

Benefit Limitations:

Benefits are provided for a Skilled Nursing Care Facility (SNF), when Medically Necessary, if:

- You were an inpatient of a hospital for a stay of at least three consecutive days (overnight and not including day of discharge), and, in most cases, must have been transferred to the SNF within 30 days of hospital discharge
- Services must be needed for a condition that was treated during the three-day hospital stay or for a condition that you were previously treated for in the hospital
- The physician must certify that you need skilled care and the PEBTF agrees that skilled services were Medically Necessary on a daily basis

- You must require and receive skilled nursing or skilled rehabilitation services, or both, on a daily basis. Skilled nursing and skilled rehabilitation services are those that require the skills of technical or professional personnel such as registered nurses, physical therapists and occupational therapists. In order to be deemed skilled, the services must be so inherently complex that they can be safely and effectively performed only by, or under the supervision of, professional or technical personnel

Examples of Skilled Nursing or Skilled Rehabilitation Services include:

- Development, management and evaluation of a Member'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

- 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.

2.20 Wellness Benefits

See the Get Healthy section for information about wellness benefits.

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

Section 3: Preferred Provider Organization (PPO) Option

3.1 Summary

- PPO Option covers medical services as set forth in the PEBTF Plan Document
- PPO Option offers both an In-Network and Non-Network benefit
- In order to receive the highest level of benefits, you must choose one of the In-Network facilities or providers
- You may self refer for Medically Necessary care, as defined by the Plan
- $15 Copayment for PCP office visits during regular hours (for general practitioners, family practitioners, internists and pediatricians); $20 Copayment for PCP office visits after hours, if the physician chooses to charge an after hours Copayment
- $25 Copayment for specialist office visit
- $50 Copayment for emergency room visit (waived if the visit leads to an inpatient admission to the hospital)
- Plan coverage for services rendered by Non-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

3.2 Benefit Highlights PPO Option

	Network Providers	Non-Network Providers * **
DEDUCTIBLE (per calendar year)	None	$400 per person
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.	Does not apply	$1,500 per person $3,000 per family Plus the Deductible
PREVENTIVE CARE		
• Adult routine physical exams and preventive care (age 19 and over)	$15 Copayment per office visit	70% plan payment; Member pays 30%
• Pediatric routine physical exams & preventive care (includes well-child care)	$15 Copayment per office visit	70% plan payment; Member pays 30%
• Annual gynecological exam	$15 PCP/$25 Specialist Copayment per office visit	70% plan payment; Member pays 30% Deductible waived

	Network Providers	Non-Network Providers * **
• Pediatric immunizations (under age 21) – See the Preventive Benefits section • Annual mammogram (age 40 and over) • Annual Pap Smear	Covered in full	70% plan payment; Member pays 30% Deductible waived
• Adult immunizations – See the Preventive Benefits section • Preventive benefits for Members age 50 and over – See the Preventive Benefits section	Covered in full	70% plan payment; Member pays 30%
MATERNITY SERVICES		
• Office visits	$15 PCP/$25 Specialist Copayment first office visit	70% plan payment; Member pays 30%
• Hospital and newborn care	Covered in full	70% plan payment; Member pays 30%
PHYSICIAN VISITS		
• Office visits (family practice, general practice, internal medicine and pediatrics)	$15 Copayment per office visit; $20 after hours if the physician chooses to charge an after hours Copayment	70% plan payment; Member pays 30%
• Specialist office visits	$25 Copayment per office visit	70% plan payment; Member pays 30%
• Lab tests, X-rays, inpatient visits, surgery and anesthesia	Covered in full	70% plan payment; Member pays 30%
OUTPATIENT THERAPIES		
• Outpatient physical & occupational therapy • Speech therapy (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental) • Cardiac rehabilitation (18 visits per year) • Pulmonary rehabilitation (12 visits per year) • Respiratory therapy • Manipulation therapy (restorative, chiropractic – 6 Medically Necessary visits, then Treatment Plan submitted; not for maintenance of a condition)	$15 Copayment per visit	70% plan payment; Member pays 30%

	Network Providers	Non-Network Providers * **
OTHER PROVIDER SERVICES		
• Radiation therapy, chemotherapy, kidney dialysis (not covered at a Non-Network freestanding dialysis center) • Home Health Care • Hospice ($7,500 benefit lifetime Maximum) • Outpatient Private Duty Nursing (240 hours per year) • Skilled Nursing Facility (240 days per year)	Covered in full	70% plan payment; Member pays 30%
OUTPATIENT HOSPITAL FACILITIES		
• Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis (not covered if provided in a Non-Network freestanding dialysis center – is covered at a Non-Network rate if it is a Non-Network hospital), anesthesia & surgery	Covered in full	70% plan payment; Member pays 30%
• Outpatient Diabetic Education	Covered in full	Not covered
INPATIENT HOSPITAL SERVICES		
• Professional fees & facility services including: room & board & other Covered Services (preauthorization is required for most services)	Covered in full (365 days per benefit period)	70% plan payment; Member pays 30% Non-Network: 70 days per calendar year
EMERGENCY CARE		
• Emergency treatment for accident or medical emergency	$50 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital); Deductible waived	
• Ambulance services for emergency care	Covered in full	Covered in full; Deductible waived
INVISIBLE PROVIDERS AT A NETWORK FACILITY		
• Includes radiologists, anesthesiologists, pathologists and emergency room physicians operating in a Network facility	Covered same as Network Provider; Covered in full	

	Network Providers	Non-Network Providers * **
DURABLE MEDICAL EQUIPMENT		
• Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics. The Plan follows Medicare guidelines for the coverage of DME, prosthetics, orthotics and supplies	Not covered by the medical plan; covered by DMEnsion Benefit Management, in accordance with PEBTF's DME policy (See page 25 for more information)	
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited

* Benefits provided by the following Non-Participating inpatient and outpatient Providers are not covered: Ambulatory surgical facilities, freestanding dialysis facilities, long-term Acute care hospitals, pharmacy/medical suppliers and substance abuse treatment programs.

** Participating Providers agree to accept the PPO Plan Allowance as payment in full, often less than their normal charge. If you visit a Non-Participating 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.

There are no additional charges for In-Network pediatric immunizations for Members under age 21, injections (except allergy serum), Diagnostic Services (x-ray, lab, pathology) or surgical procedures.

Inpatient admission and certain other services may require preauthorization. When care is rendered by a Network Provider, it is the responsibility of the hospital or physician to obtain preauthorization if it is required for the service being provided. Neither you nor your eligible Dependent is required to obtain preauthorization when being treated by a Network physician or in a PPO Network hospital or other PPO Network facility.

Benefits provided by the following Non-Participating inpatient and outpatient facility Providers are not covered: Ambulatory surgical facilities, freestanding dialysis facilities, long-term Acute care hospitals, pharmacy/medical suppliers and substance abuse treatment programs.

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 a Non-Network Provider, you are responsible for the Deductible, applicable coinsurance and all amounts in excess of the Plan Allowance.

3.3 Non-Network or Out-of-Network Services

Each year, you pay the first $400 (the Deductible) of covered Non-Network expenses for each covered person.

After the Deductible, the PPO plan will pay 70% of the next $5,000 of most Non-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 Out-of-Pocket Maximum is $1,500 per person plus your Deductible, or $3,000 for a family, plus the Deductibles. 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 PPO. The percentage reimbursement described in the Benefit Highlights Chart for Non-Network Providers is based on the Plan Allowance. For example, a "70% plan payment" for Non-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 Non-Network care, there is an unlimited Lifetime Maximum benefit.

All claims for Non-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.

3.4 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 a Non-Participating Provider or a BlueCard Participating Provider, 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.

3.5 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. With the BlueCard Program, PPO Members can enjoy In-Network coverage anywhere in the United States when they use participating Blue Cross and/or Blue Shield PPO Providers.

To access BlueCard Providers, call 1-800-810-BLUE (2583). The telephone number is printed on the back of your ID card.

BlueCard Language from the Blue Cross Blue Shield Association
The following are specific provisions provided by the Blue Cross Blue Shield Association:

When a Member obtains Covered Services through BlueCard outside the geographic area the PPO serves, the amount a Member pays for Covered Services is calculated on the **lower** of:

- The billed charges for a Member's Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to the PPO

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with a Member's health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with a Member's health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount a Member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method or require a surcharge, the PPO would then calculate a Member's liability for any Covered Services in accordance with the applicable state statute in effect at the time a Member received care.

3.6 Care Outside of the Country

BlueCard Worldwide provides Members with access to network health care services around the world. Members traveling or residing outside of the United States have access to doctors and hospitals in more than 200 countries and territories.

Members who are traveling outside the United States should remember to always carry their PPO identification card. If non-emergency care is needed, Members may call 1-800-810-BLUE (2583). A medical coordinator, in conjunction with a medical professional, will assist Members in locating appropriate care. The BlueCard Worldwide Service Center is staffed with multilingual representatives and is available 24 hours a day, 7 days a week. Also, Members may call the plan to obtain preauthorization if services require preauthorization. BlueCard Participating Providers are not obligated to request preauthorization of services. Obtaining preauthorization, where required, is the Member's responsibility (the preauthorization telephone number is on the back of your medical ID card).

Members who need emergency care should go to the nearest hospital. If admitted, Members should call the BlueCard Worldwide Service Center, 1-800-810-BLUE (2583).

To locate BlueCard Participating Providers outside of the United States, Members may call BlueCard Worldwide Service Center, 1-800-810-BLUE (2583), 24 hours a day, 7 days a week, or visit www.bcbs.com.

3.7 Filing a PPO Option Claim

All claims for Non-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 102 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

4.1 Summary

- HMOs cover medical services as set forth in the PEBTF Plan Document
- Treatment for medical services must be coordinated by a Primary Care Physician (PCP)
- $15 Copayment for PCP office visits during regular hours (for general practitioners, family practitioners, internists and pediatricians); $20 Copayment for PCP office visits after hours, if the physician chooses to charge an after hours Copayment
- $25 Copayment for specialist office visit
- $50 Copayment for emergency room visit (waived if the visit leads to an inpatient admission to the hospital)

4.2 Benefit Highlights HMO Option

	Network Providers
DEDUCTIBLE (per calendar year)	None
OUT-OF-POCKET MAXIMUM	Does not apply
PREVENTIVE CARE	
• Adult routine physical exams and preventive care (age 19 and over)	$15 Copayment per office visit
• Pediatric routine physical exams & preventive care (includes well-child care)	$15 Copayment per office visit
• Annual gynecological exam	$15 PCP/$25 Specialist Copayment per office visit
• Pediatric immunizations (under age 21) – See the Preventive Benefits section • Adult immunizations – See the Preventive Benefits section • Annual mammogram (age 40 and over) • Annual Pap Smear • Preventive benefits for Members age 50 and over – See the Preventive Benefits section	Covered in full
MATERNITY SERVICES	
• Office visits	$15 PCP/$25 Specialist Copayment first office visit
• Hospital and newborn care	Covered in full

	Network Providers
PHYSICIAN VISITS	
• Office visits (PCPs include family practice, general practice, internal medicine and pediatrics)	$15 Copayment per office visit; $20 after hours if the physician chooses to charge an after hours Copayment
• Specialist office visits	$25 Copayment per office visit
• Lab tests, X-rays, inpatient visits, surgery and anesthesia	Covered in full
OUTPATIENT THERAPIES	
• Outpatient physical & occupational therapy • Speech therapy (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental) • Cardiac Rehabilitation • Pulmonary Rehabilitation • Respiratory therapy • Manipulation therapy (restorative, chiropractic Medically Necessary visits; not for maintenance of a condition)	$15 Copayment per visit Combined Maximum of 60 visits per year for all outpatient therapies (Therapy services are considered visits. If the same provider performs different types of therapies on the same date, to the same Member, it counts as one visit for each type of therapy performed.)
OTHER PROVIDER SERVICES	
• Radiation therapy, chemotherapy, kidney dialysis • Home Health Care (60 visits in 90 days) • Hospice ($7,500 benefit lifetime Maximum) • Skilled Nursing Facility (180 days per calendar year)	Covered in full
OUTPATIENT HOSPITAL SERVICES	
• Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis, anesthesia & surgery • Outpatient Diabetic Education	Covered in full
INPATIENT HOSPITAL SERVICES	
• Professional fees & facility services including: room & board & other Covered Services	Covered in full (365 days per calendar year)
EMERGENCY CARE	
• Emergency treatment for accident or medical emergency	$50 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital)
• Ambulance services for emergency care	Covered in full

	Network Providers
DURABLE MEDICAL EQUIPMENT	
• Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics. The Plan follows Medicare guidelines for the coverage of DME, prosthetics, orthotics and supplies	Not covered by the medical plan; covered by DMEnsion, in accordance with the PEBTF's DME policy. (See page 25 for more information)
LIFETIME MAXIMUM BENEFIT	Unlimited

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

4.3 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.

4.4 Primary Care Physician

You must choose a Primary Care Physician (PCP) from the network of HMO doctors. Your PCP acts as your personal physician, providing treatment or referring you to a network specialist or network hospital when needed. Care provided or coordinated by your PCP is considered **In-Network**. Some HMOs do not require PCP-referral (check with your particular HMO). Women may self refer for all gynecological care in all HMO plans.

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 or a referral to a specialist in the network, 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 and/or your PCP will result in nonpayment of those services.

4.5 Care or Treatment Requiring Preauthorization

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

4.6 Care Outside of the HMO Area/Student Benefits

Some HMO plans may offer "guest privileges" to a Member's Dependents temporarily residing outside of their service area. Please contact your HMO Member Services Department for information on guest privileges.

4.7 Care Outside of the Country

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.

4.8 Filing an HMO Option Claim

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

If your claim for benefits is denied, see page 103 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: Consumer Driven Health Plan (CDHP) Option

5.1 Summary

- There are two parts to the Consumer Driven Health Plan (CDHP)
  - Health Reimbursement Account (HRA) funded with dollars provided by the PEBTF
  - Medical benefit plan – a PPO Plan providing different coverage for benefits depending on Network or Non-Network care
- HRA is an account of funds that you may use to pay for medical expenses you normally would pay for out of your pocket
- Annual Deductible is $1,500 single/$3,000 family but the PEBTF credits your Health Reimbursement Account (HRA) with $1,000 single/$2,000 family – Maximum annual out-of-pocket expense is $500 single/$1,000 family
- Unused amounts in your HRA can be carried forward and used in future years as long as you continue to participate in the CDHP
- Many preventive care services are covered at 100% In-Network up to annual $500 single/ $1,000 family, with each family member limited to $500 – see the Preventive Benefits section
- In order to receive the highest level of benefits, you must choose one of the In-Network Providers or Facilities
- You may self refer for Medically Necessary care, as defined by the Plan
- The CDHP is not available to cover a domestic partner because the tax laws governing the associated Health Reimbursement Account will not permit its use for the payment of expenses incurred for the domestic partner in the majority of cases

The Consumer Driven Health Plan (CDHP) is designed to encourage you to seek and obtain the most appropriate and cost-effective health care. It combines a "high Deductible" PPO-type plan with PEBTF contributions on your behalf to a Health Reimbursement Account (HRA) which you may use to cover your out-of-pocket costs. The CDHP offers the advantage of a high-quality comprehensive medical plan with many preventive services covered.

A key component of the plan is the HRA. The PEBTF credits your account with amounts you can apply to your medical expenses. You can save these amounts for the future. Unused amounts in your HRA roll over for use in the following year. These amounts can be used to reduce future out-of-pocket costs or used to pay for medical expenses which are not covered by the PEBTF Plan of Benefits. Typical medical expenses for which you may be reimbursed include dental and vision care expenses. You also can be reimbursed for prescription drug Copayments. See page 56 for a list of additional medically-necessary items that can be paid from your HRA.

The CDHP also covers preventive care services. You receive up to $500 single/$1,000 family per year in preventive care services, which encourages you to take the steps needed to stay healthy and perhaps even reduce the cost of health care services in the future.

5.2 Benefit Highlights CDHP Option

	Network Providers	Non-Network Providers
DEDUCTIBLE (per calendar year)	$1,500 single ($1,000 HRA credit reduces this to $500) $3,000 family ($2,000 HRA credit reduces this to $1,000)	$1,500 single ($1,000 HRA credit reduces this to $500) $3,000 family ($2,000 HRA credit reduces this to $1,000)
OUT-OF-POCKET MAXIMUM	$1,500 single ($1,000 HRA credit reduces your out-of-pocket to $500) $3,000 family ($2,000 HRA credit reduces your out-of-pocket to $1,000)	$4,500 single ($1,000 HRA credit reduces your out-of-pocket to $3,500) $9,000 family $2,000 HRA credit reduces your out-of-pocket to $7,000)
PREVENTIVE CARE		
• Adult routine physical exams and preventive care (age 19 and over)	100% ($500 Maximum for single per year; $1,000 Maximum for family per year)	Not covered
• Pediatric routine physical exams & preventive care (includes well-child care)	100% ($500 Maximum for single per year; $1,000 Maximum for family per year)	Not covered
• Annual gynecological exam	100% ($500 Maximum for single per year; $1,000 Maximum for family per year)	Not covered
• Pediatric immunizations (under age 21) – See Preventive Benefits section • Adult immunizations – See Preventive Benefits • Annual mammogram (age 40 and over) • Annual Pap Smear • Preventive benefits for Members age 50 and over – See the Preventive Benefits section	100% ($500 Maximum for single per year; $1,000 Maximum for family per year) Amounts are cumulative for all preventive benefits combined	Not covered

	Network Providers	Non-Network Providers
MATERNITY SERVICES		
• Office visits • Hospital and newborn care	100% after Deductible	70% after Deductible
PHYSICIAN VISITS		
• Office visits (family practice, general practice, internal medicine and pediatrics) • Specialist office visits • Lab tests, X-rays, inpatient visits, surgery and anesthesia	100% after Deductible	70% after Deductible
OUTPATIENT THERAPIES		
• Outpatient physical & occupational therapy • Speech therapy (for a medical diagnosis or for the diagnosis of Autism Spectrum Disorders not for developmental) • Cardiac rehabilitation (18 visits per year) • Pulmonary rehabilitation (12 visits per year) • Respiratory therapy • Manipulation therapy (restorative, chiropractic – 6 Medically Necessary visits, then Treatment Plan submitted; not for maintenance of a condition)	100% after Deductible	70% after Deductible
OTHER PROVIDER SERVICES		
• Radiation therapy, chemotherapy, kidney dialysis • Home Health Care • Hospice ($7,500 benefit lifetime Maximum) • Outpatient Private Duty Nursing (240 hours per year) • Skilled Nursing Facility (240 days year)	100% after Deductible	70% after Deductible

	Network Providers	Non-Network Providers
OUTPATIENT HOSPITAL SERVICES		
• Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis, anesthesia & surgery • Outpatient Diabetic Education	100% after Deductible	70% after Deductible
INPATIENT HOSPITAL SERVICES		
• Professional fees & facility services including: room & board & other Covered Services (preauthorization is required for some services)	100% after Deductible	70% after Deductible
EMERGENCY CARE		
• Emergency treatment for accident or medical emergency • Ambulance services for emergency care	100% after Deductible Covered in full	
DURABLE MEDICAL EQUIPMENT		
• Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics. The Plan follows Medicare guidelines for the coverage of DME, prosthetics, orthotics, supplies and diabetic supplies	100% after Deductible	70% after Deductible
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited

NOTE: In the above 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 Claims Payor with respect to the CDHP Option. You are responsible for all costs in excess of the Plan Allowance.

You can save money by using a CDHP Network Provider. Network Providers, sometimes called Participating Providers, have agreed to accept the CDHP'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 charges in excess of the Plan Allowance. If you use a Non-Network Provider, you are responsible for the Deductible, applicable coinsurance (30% of eligible expenses in many cases) and all amounts in excess of the Plan Allowance.

Inpatient admission and certain other services may require preauthorization. When care is rendered by a Network Provider, it is the responsibility of the hospital or physician to obtain preauthorization if it is required for the service being provided. Neither you nor your eligible Dependent is required to obtain preauthorization when being treated by a Network physician or in a Network hospital or other Network facility.

If you or your Dependents receive or plan to receive services from a Non-Network Provider who recommends services, it is your responsibility to obtain preauthorization from the Claims Payor. You must call the CDHP and provide the following information:

- Your name and the name of the person for whom the services will be rendered
- Your Medical 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

5.3 Care or Treatment Requiring Preauthorization

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

Preauthorization requirements do not apply to services provided 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 CDHP 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.

If the Participating Provider fails to obtain or follow the preauthorization requirement, the allowable amount 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.

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

The CDHP offers a national Network of Providers and facilities. To receive the highest level of benefits, call the telephone number that appears on your CDHP ID card if you should need medical services outside of your area.

5.5 Care Outside of the Country

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

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

Durable Medical Equipment (DME), prosthetics, orthotics, medical supplies and diabetic supplies that are ordered by a CDHP Network Provider or specialist, are covered if Medically Necessary, subject to payment of the Deductible and the PEBTF's DME policy.

DME includes equipment such as wheelchairs, oxygen, hospital beds, walkers, crutches and braces, 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.

Preauthorization is required for the rental of any DME and the purchase of all DME and P&O devices that exceed $100 (or such other dollar amount as the CDHP may establish under its preauthorization policies). Preauthorization is also required for all Out-of-Network services.

If you use a Non-Network Provider, or supplier, you will be responsible for 30% of the eligible expense (not in excess of the UCR Charge as determined by the CDHP), plus any amount billed by the Provider/supplier which is in excess of the Plan Allowance.

The Plan follows Medicare guidelines for the coverage of DME, prosthetics, orthotics, medical supplies and diabetic supplies.

5.7 Services Covered Under Your Health Reimbursement Account's Personal Care Account

A unique feature of the CDHP Option is the Health Reimbursement Account (HRA). You can use the amounts credited to your HRA to pay for Deductibles and coinsurance on services covered under the CDHP, or to pay for other Medically Necessary medical items or services which are not otherwise covered, as described below.

The PEBTF will establish and maintain an HRA for each PEBTF Member who elects to participate in the CDHP Option. All amounts are credited by the PEBTF - you are not permitted to contribute additional amounts to your HRA.

Your HRA is credited as of the first day of the plan year (January 1) with $1,000 for an individual and $2,000 for a family, provided that you (and your covered Dependents) are enrolled in the CDHP Option as of the first day of the plan year. If you enroll in the CDHP Option **after** the beginning of the calendar year, your HRA will be credited with a pro-rata amount, in accordance with the following table:

Effective Date of Enrollment	Individual Credit	Family Credit
After January 1 but before April 1	$1,000	$2,000
On or after April 1 but before July 1	$750	$1,500
On or after July 1 but before October 1	$500	$1,000
On or after October 1	$250	$500

Provided you remain enrolled under the CDHP Option as of the end of the plan (calendar) year, the unused amounts in your HRA will carry over and be eligible for use to reimburse eligible expenses in the following year of your participation in the CDHP Option. **So long as you continue to participate in the CDHP Option, the funds remain available and there is no "use it or lose it" rule**. Use your HRA to help reimburse your current expenses, or save it for use in future years – it's your choice. If you had been a participant in the CDHP Option under the Active Plan immediately prior to your retirement, your unused HRA balance as an active employee will carry over and be added to your HRA account under the Retired Employees Health Program (REHP).

You can use your HRA to reimburse a variety of expenses incurred by you or your covered Dependent(s) during the plan year. The Maximum amount available for reimbursement at any given time is the amount credited to your HRA (including carried over amounts), less qualified medical expenses previously reimbursed from your HRA.

The Claims Payor for the CDHP Option maintains your HRA and provides all recordkeeping. Requests for reimbursement should be filed directly with the Claims Payor. The following is a list of Medically-Necessary items that may, generally, be reimbursed from your HRA under the current tax rules. All decisions regarding whether an item is reimbursable are made by the Claims Payor for the CDHP Option, which will require documentation regarding the date, nature and cost of the expenses, as well as the Provider and recipient of services. The expense must be incurred during a period of time in which you (or an eligible Dependent) are eligible for coverage under the CDHP Option.

- Alcoholics Anonymous, transportation costs to and from meetings
- Acupuncture
- Amounts over Plan Allowance
- Amounts in excess of any health coverage plan limits
- Braille books and magazines, the difference in cost compared to a regular printed edition
- Christian Science practitioners
- Contact lenses
- Eyeglasses
- Optometrists/ophthalmologists
- Contact lens solution
- Contraception (oral contraceptives and contraceptive services such as IUDs, Norplant, Depo-Provera injections)

- Dental treatment (does not include dental treatment which is for cosmetic purposes, i.e. teeth whitening)
- Dentures
- Diaper service needed to relieve the effects of a certain disease
- Difference between brand and generic prescription drugs (not variable)
- Experimental/Investigational treatments (services that do not meet the Claims Payor's Experimental definition in the health coverage)
- Full body scans
- Guide dog or other animal used by a visually or hearing-impaired person
- Hearing aids and hearing aid batteries
- Heart scan (EBCT)
- Home construction needed for the installation of special, Medically Necessary equipment
- Premiums for individual medical insurance plans
- Infertility treatments
- Laser eye surgery
- Lead-based paint removal to prevent a child from contracting lead poisoning
- Legal fees needed to authorize treatment for mental illness
- Lodging and meals while receiving medical care up to $50 per night
- Massage therapy, when determined to be Medically Necessary by a physician
- Medical information plans
- Modification of a car for use by a disabled Dependent
- Nursing home expenses for medical reasons
- Prescription drugs not covered under the health coverage
- Smoking cessation programs and prescription drugs
- Special home for a mentally disabled Dependent
- Special schools and education for mentally impaired or physically disabled person
- Special telephones or televisions for hearing impaired individuals
- Reversal of sterilization
- Transportation needed to obtain medical care; this may include bus or taxi fare, cost of gas, tolls, parking, etc.
- Tuition fees for Dependents with learning disabilities, when recommended by a physician
- Admission and transportation to a medical conference which concerns the Chronic illness of a Member
- Tutoring fees for Members with learning disabilities, when recommended by a physician
- Vision therapy
- Weight loss program when recommended by a physician to treat an existing disease, such as heart disease

5.8 Filing a CDHP Option Claim

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

If your claim for benefits is denied, see page 102 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 6: Mental Health & Substance Abuse Program (MHSAP)

6.1 Summary

The Mental Health & Substance Abuse Program (MHSAP) will provide mental health and substance abuse rehabilitation treatment services, whether Inpatient or Outpatient. **(Inpatient detoxification services will be coordinated by the MHSAP but services are covered under the PPO, HMO or CDHP Option when clinically necessary.)**

The MHSAP provides a specialized Network of professional Providers and treatment facilities, which have been thoroughly evaluated according to comprehensive guidelines established by the MHSAP. 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 MHSAP In-Network Providers. However, you have the freedom to receive eligible mental health and substance abuse services from Non-Network Providers, but at a lower level of benefit coverage.

Under mental health parity, psychological conditions must be treated the same as physical illnesses. Effective January 1, 2012, there are no visit limits under the MHSAP. Out-of-pocket costs are not higher under the MHSAP and there are no separate Deductibles. The MHSAP will work with your specific medical plan option to track any Deductibles that may apply to both medical and mental health and substance abuse treatment. You will not have two Deductibles to satisfy under the PPO and CDHP options. Medical and mental health and substance abuse benefits will both apply to the Deductibles.

The MHSAP benefit will continue to be separate from your medical plan but the MHSAP will be structured the same as your medical plan option. The following pages detail the MHSAP benefits for members under all medical plan options. Please refer to the applicable chart that highlights the mental health and substance abuse benefits for the medical plan option in which you are enrolled.

6.2 Benefit Highlights – MHSAP Benefit
For Members Enrolled in the PPO Option

Service	Network	Non-Network
DEDUCTIBLE (per calendar year)	None	$400 per person
OUT-OF-POCKET MAXIMUM	Does not apply	$1,500 per person ($3,000 per family)
MENTAL HEALTH		
Outpatient	100% after $15 Copayment	70% plan payment; Member pays 30% After Deductible Limited to licensed psychiatrists, psychologists, social workers and nurses Subject to retrospective review
Inpatient & Intermediate*	100% One physician visit per covered day unless covered by per diem	70% plan payment; Member pays 30% After Deductible Subject to retrospective review
SUBSTANCE ABUSE		
Outpatient	100%	70% plan payment; Member pays 30% After Deductible
Inpatient	100%	70% plan payment; Member pays 30% After Deductible
Ambulatory Detoxification	100%	70% plan payment; Member pays 30% After Deductible
Medical Detoxification	Covered by medical plan	
EMERGENCY ROOM	$50 Copayment, waived if the visit leads to an inpatient admission	
* Intermediate care includes partial hospitalization, day treatment and intensive outpatient		

Benefit Highlights – MHSAP Benefit
For Members Enrolled in the HMO Option

Service	Network	Non-Network
DEDUCTIBLE (per calendar year)	None	None
OUT-OF-POCKET MAXIMUM	Does not apply	Does not apply
MENTAL HEALTH		
Outpatient	100% after $15 Copayment	70% plan payment; Member pays 30% Limited to licensed psychiatrists, psychologists, social workers and nurses Subject to retrospective review
Inpatient & Intermediate*	100% One physician visit per covered day unless covered by per diem	70% plan payment; Member pays 30% Subject to retrospective review
SUBSTANCE ABUSE		
Outpatient	100%	70% plan payment; Member pays 30%
Inpatient	100%	70% plan payment; Member pays 30%
Ambulatory Detoxification	100%	70% plan payment; Member pays 30%
Medical Detoxification	Covered by medical plan	
EMERGENCY ROOM	$50 Copayment, waived if the visit leads to an inpatient admission	
* Intermediate care includes partial hospitalization, day treatment and intensive outpatient		

Benefit Highlights – MHSAP Benefit
For Members Enrolled in the CDHP Option

Service	Network	Non-Network
DEDUCTIBLE (per calendar year)	$1,500 (single) ($1,000 HRA credit reduces this to $500) $3,000 (family) $2,000 HRA credit reduces this to $1,000)	$1,500 (single) ($1,000 HRA credit reduces this to $500) $3,000 (family) $2,000 HRA credit reduces this to $1,000)
OUT-OF-POCKET MAXIMUM	$1,500 (single) ($1,000 HRA credit reduces this to $500) $3,000 (family) $2,000 HRA credit reduces this to $1,000)	$4,500 (single) ($1,000 HRA reduces your out-of-pocket to $3,500) $9,000 (family) ($2,000 HRA credit reduces your out-of-pocket to $7,000)
MENTAL HEALTH		
Outpatient	100% after Deductible	70% plan payment; Member pays 30% After Deductible Limited to licensed psychiatrists, psychologists, social workers and nurses Subject to retrospective review
Inpatient & Intermediate*	100% after Deductible One physician visit per covered day unless covered by per diem	70% plan payment; Member pays 30% After Deductible Subject to retrospective review

Service	Network	Non-Network
SUBSTANCE ABUSE		
Outpatient	100% after Deductible	70% plan payment; Member pays 30% After Deductible
Inpatient	100% after Deductible	70% plan payment; Member pays 30% After Deductible
Ambulatory Detoxification	100% after Deductible	70% plan payment; Member pays 30% After Deductible
Medical Detoxification	Covered by medical plan	
EMERGENCY ROOM	100% after Deductible	
* 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 MHSAP. You are responsible for all costs in excess of UCR Charges.

6.3 Network Care

To take advantage of the benefits that are available through the MHSAP, you should follow these steps:

- **Call the MHSAP phone number that appears on your medical ID card.** You will speak to a trained counselor who will gather basic information to understand your situation and needs.

- Based on the information you provide, the counselor will refer you to a qualified mental health or substance abuse professional located near your place of work or home. You will be able to get an in-person appointment, normally within 72 hours or sooner if your condition warrants.

- After your initial meeting(s), the mental health or substance abuse professional will discuss your needs and treatment goals with a Network counselor and an individual Treatment Plan will be developed. **If, after your initial appointment, you decide that you would like to see a different mental health or substance abuse professional, you should inform the MHSAP of your desire for a new referral**.

- Your treatment will be based on the individual plan developed by you, your mental health or substance abuse professional and the MHSAP care manager. It may include short-term outpatient counseling; more intensive, structured outpatient counseling; day-treatment programs; inpatient residential care; or hospital care. During your treatment, a care manager will monitor your progress and work with your Provider to ensure that your needs are met.

6.4 Non-Network Care

You may receive mental health services from a Non-Network Provider who is a licensed social worker, nurse, psychologist or psychiatrist. All Non-Network services are subject to retrospective clinical review by the plan to determine the clinical necessity. You will receive Non-Network benefits only for those services deemed clinically necessary. You are responsible for submitting charges to the plan for review and payment. To obtain a claim form, call the plan's Member Services Department.

Members who receive inpatient mental health care from a Non-Network facility must notify the MHSAP within 24 hours of admission to any inpatient, residential, partial or structured outpatient program**. PPO and CDHP Members: If you use a Non-Network or Non-Participating Provider and preauthorization is not obtained, the amount that would be paid for the clinically necessary service is subject to a reduction of 20 percent as a penalty for failure to preauthorize.**

6.5 Special Medical/Behavioral Health Care Benefits

Both your Medical Plan Option and MHSAP provide outpatient benefits for the diagnosis and medical management of the following diagnostic 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.

Under the MHSAP, Members **must** call for preauthorization to a Network psychiatrist who may diagnose any of these conditions, develop and implement a Treatment Plan and prescribe and monitor medications. Additionally, the MHSAP provides benefits for counseling services to both the Member and other family members.

Coverage for Autism Spectrum Disorders: Benefits for autism spectrum disorders will be provided by the PEBTF medical plans, the Mental Health and Substance Abuse Program and the Prescription Drug Plan. Benefits will not exceed an annual maximum benefit amount under all coverage combined.

Coverage is provided for Dependents to age 21 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).

6.6 Psychological Testing

Members and their eligible Dependents are entitled to receive four hours of psychological testing on an annual basis from a Network Provider. **This service requires preauthorization**. When clinically necessary, additional hours of psychological testing may be covered under the Network managed behavioral health outpatient benefit. Non-Network or non-preauthorized outpatient psychological testing services must be clinically necessary (as determined by the MHSAP) to be covered by the outpatient Non-Network MHSAP.

6.7 Emergency Services

If you or an eligible Dependent experience a mental health or substance abuse emergency, immediately proceed to the nearest emergency room or medical facility. You or a family Member should advise the facility that you are a PEBTF Member with mental health and substance abuse benefits administered separately from your medical plan. Ask the facility or the person providing your care to contact the MHSAP as soon as possible so that the plan can effectively coordinate with your medical doctor or facility the mental health or substance abuse treatment you will need.

6.8 Filing an MHSAP Option Claim

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

If your claim for benefits is denied, see page 103 for a description of the Appeals Process.

Section 7: Services Excluded From All Medical Plan Options

NOTE: If you participate in the Consumer Driven Health Plan, some of the exclusions listed below may be reimbursable from your Health Reimbursement Account. See that section for a list of covered items.

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
- Acupuncture
- 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
- 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 above the annual limit and for Members age 21 and over, 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 (CDHP Members: May be submitted to the HRA)

- 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)

- Cranial prostheses (wigs)

- 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, registration of domestic partnership, civil union or similar relationship, driver's license, foreign travel, passports or those ordered by a third party

- Expenses directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impaction, alveolectomy and treatment of periodontal disease; emergency dental services rendered within 72 hours of an accidental injury are covered under all medical plans (see Emergency Medical Services in Section 2).

- 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
-
- 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

- 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 Abuse 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

- Mental health and substance abuse treatment services not covered by the managed Mental Health and Substance Abuse Program; the first visit to a non-mental health provider (one such visit per lifetime) is covered under the medical plan

- Morbid Obesity: All services and supplies for the surgical treatment of obesity, including Morbid Obesity. Also excluded are services and supplies for panniculectomies and other surgical procedures to remove excess skin as the result of weight loss, regardless of the reason or reasons such a procedure may be recommended. Also excluded is the non-surgical treatment of obesity and the control or management of weight. Non-surgical components for the treatment of Morbid Obesity, include but are not limited to, nutritional counseling, nutritional supplements, commercial weight loss programs, exercise equipment or gym memberships

- 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)

- Nutritional counseling (except for diabetic educational training)

- 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, except for gestational diabetes, is covered under all medical plans)

- PPO Option: Notwithstanding anything in the Plan to the contrary, no benefits shall be payable under the PPO Option for care provided by a non-contracted Provider. For these purposes, a non-contracted Provider is a Provider that has no agreement with (i) the Claims Payor that has established the applicable Network for the PPO Option, relating to payment for care rendered by that Provider, whether or not that agreement pertains to the Network; or (ii) any Blue Cross or Blue Shield Plan that would qualify the Provider for participation in the BlueCard Program

- 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)

- 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: Nutritionists, 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/domestic partner, 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

- Transsexual surgery and charges for any treatment leading to or in connection with transsexual surgery

- Travel, 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 for tobacco dependency, except as provided under the Get Healthy Program

- 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

8.1 Summary

- The Get Healthy Program is a program that promotes health and wellness to employees and covered spouses/domestic partners 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/domestic partner or other Dependent to participate in the Get Healthy Program shall be determined by the Board of Trustees.

8.2 Get Healthy Incentive

Employees are required to contribute a certain percentage of their gross biweekly pay for PEBTF benefits (refer to collective bargaining agreements). The Get Healthy Program offers the employee an incentive to participate – a health care contribution waiver. The health care contribution amount and the health care contribution waiver are set forth in the collective bargaining agreement as negotiated between the commonwealth and the various unions.

8.3 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/domestic partner 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 and the period for which a partial waiver of contributions under the Plan shall apply. 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.

Please see page 104 for information on the Get Healthy Appeals Process.

Section 9: Supplemental Benefits

9.1 Summary

- Prescription Drug
- Vision
- Dental
- Hearing Aid

Most PEBTF Members are eligible for supplemental benefits: Prescription drug, vision, dental and hearing aid services. The Medical Plan Option you choose does not affect your supplemental benefits.

PEBTF supplemental benefits are administered through contracts with various vendors. Appropriate identification cards and other information regarding supplemental benefits are distributed to eligible PEBTF Members periodically.

9.2 Eligibility

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

- Employees and their eligible Dependents hired after August 1, 2003 will become eligible for supplemental benefits immediately following the date the employee completes six months of employment (See the Eligibility Section for more information).

- You may cover your spouse/domestic partner who is a Member of the REHP or the RPSPP for prescription drug, vision, dental and hearing aid. The Retiree Member's coverage under the REHP Prescription Drug Plan will be primary.

- Pennsylvania State Police Cadets are not eligible for supplemental benefits.

- Part-time employees must enroll in both medical and supplemental benefits to be covered by the PEBTF. If enrolling Dependents, they must be enrolled in both medical and supplemental benefits, as well.

A brief description of each supplemental benefit is found on the following pages.

Section 10: Prescription Drug Plan

10.1 Summary

- Prescription drug coverage for you and your eligible Dependents
- Three-tier Copayment plan
- Retail and maintenance programs

Through the Prescription Drug Plan, you and your eligible Dependents 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.

10.2 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.

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.

Prescriptions at a Network Pharmacy – up to a 30 Day Supply	**Your Copayment**
Tier 1: Generic drug	$10
Tier 2: Preferred brand-name drug	$18, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$36, 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	$15
Tier 2: Preferred brand-name drug	$27, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$54, plus the cost difference between the brand and the generic, if one exists
Retail Maintenance at a CVS or Rite Aid Pharmacy– Up to 90 Day Supply	**Your Copayment**
Tier 1: Generic drug	$15 CVS / $20 Rite Aid
Tier 2: Preferred brand-name drug	$27 CVS / $36 Rite Aid, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$54 CVS / $72 Rite Aid, plus the cost difference between the brand and the generic, if one exists

10.3 Retail Prescriptions – up to a 30-day Supply

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

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

10.4 Three Ways for Obtaining Prescriptions for up to a 90-day Supply

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

- Mail Order
- CVS Pharmacy
- Rite Aid Pharmacy

There are Copayment differences between the two retail pharmacy maintenance feature options. See the chart on the preceding page for Copayment amounts.

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.

10.5 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, CVS pharmacy or Rite Aid pharmacy. If you use a pharmacy other than a specialty care pharmacy, CVS pharmacy or Rite Aid 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.

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.

Contact the PEBTF for information on the specialty care pharmacy.

10.6 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
- Allergy extract serums (will not be covered if the serum includes a drug excluded by the Prescription Drug Plan)
- Federal legend oral contraceptives
- Genetically engineered drugs (with prior authorization)

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 copay.

2. ***At a CVS Caremark Flu Shot network pharmacy***: For members age 18 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, Weis Markets and Rite Aid, in addition to CVS pharmacies and many independent pharmacies. Call or stop by your local pharmacy to make sure they have the flu shots in stock, and that they participate with CVS Caremark Flu Shot Program for insurance.

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

10.7 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)
- Infusion therapy drugs
- Investigational or Experimental drugs (non-FDA approved indications)
- Sexual dysfunction (MSD) drugs
- Medications lawfully obtainable without a prescription (over the counter items)
- Medications for weight reduction
- Non-sedating antihistamines
- Prescription drugs administered while you are an inpatient at a facility and billed by the facility (charges for such drugs may be considered for coverage under the applicable medical plan option)
- Prescription drugs for which coverage is provided under a plan option for medical benefits
- Refill prescriptions resulting from loss, theft or damage
- Smoking cessation drugs

- 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.

10.8 Utilization Controls

Step Therapy, Maintenance Day Supplies and Quantity Limitations 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.

10.9 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.

10.10 Limits on Certain Drug Classes

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

10.11 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 (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 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 104 for the Appeals Process.

The Prior Authorization List is on the PEBTF website at www.pebtf.org.

10.12 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 allergenic extracts from a physician
- 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. In the case of an allergy extract, you will be reimbursed for the full cost of the extract itself minus your Copayment amount. The balance, if any, is your responsibility and is not eligible for consideration under any medical plan.

10.13 Filing a Claim for Residents of Nursing Homes – PPO, HMO & CDHP Members

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.

10.14 Using your Prescription Drug Card for Workers' Compensation Related Prescriptions

Employees who have workers' compensation claims that resulted from commonwealth employment and are administered by the commonwealth's workers' compensation carrier are required to use their prescription drug ID card to obtain medications used to treat those work-related injuries unless the workers' compensation carrier has made other arrangements. Present your prescription drug ID card 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. Employees of PASSHE and PHEAA should contact their local HR office for information regarding coverage for work-related injuries.

10.15 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 92 of this SPD for complete Coordination of Benefits information.

Section 11: Vision Plan

11.1 Summary

- Yearly vision exam allowance
- Standard lenses allowance (spectacle or contact lenses every year for those under age 16; every two years for those over age 16)
- Frames (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.

11.2 Covered Services

Vision Examination – Covered in full at a participating Provider

Routine vision analysis and glaucoma test for you and your eligible Dependents every twelve months (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 (see the following page for Maximum benefits for contact lenses).

You and your eligible Dependents (children 16 years or older) – twenty-four months (730 days) from last covered spectacle lens or contact lens service.

If medically required as the result of diabetes or hypertension – you and your eligible Dependents (children 16 years and older) – twelve months (365 days) from last covered spectacle lens or contact lens service. Medical certification must be obtained from and authorized by the Vision Plan annually.

Child to age 16 – twelve months (365 days) from last covered spectacle lens or contact lens service.

Frames – Covered in full to a Maximum $20 wholesale allowance

You and your eligible Dependents – twenty-four months (730 days) from the last covered vision plan's frame or contact lens service. You may choose either an American or foreign-made frame.

11.3 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 with a wholesale price in excess of $20.00. Your cost is the wholesale price minus the Maximum allowance ($20.00) plus 20%
- Photochromatic extra or Transitions 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%.

11.4 Special Limitations

Cosmetic Contact Lenses – Maximum plan payment of $50 for the routine examination and purchase of cosmetic contact. Participating Provider's charge for lenses is limited to the retail charge minus 25%.

Medically Required Contact Lenses or Subnormal Vision Aids – Maximum payment of $300, in lieu of all other benefits including vision analysis (no exam fee paid in addition to contact or subnormal vision aid allowance).

Payment for these items will be the usual and customary charge (as determined by the Vision Plan) or a Maximum of $300, whichever is less. For this benefit to be paid, Medical Necessity must be demonstrated as determined by the Vision Plan. Benefits for medically-required contact lenses or subnormal vision aids will be provided for the following medical conditions:

- Following cataract surgery (excludes surgically implanted contact lens)
- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses
- Anisometropia
- Keratoconus

11.5 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 128. 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.

11.6 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 below:

Vision Analysis – up to		$28.00
Glaucoma Test, if performed – up to		$ 3.00
Lenses – per pair		
Single Vision		$15.00
Bifocals		$24.50
Ex-Bifocals		$26.50
Trifocals		$31.00
Aphakic		$60.00
Additional Allowance – per pair	Single Vision	$ 1.00
Plastic Lenses	Multifocal	$ 4.00
Pink #1 or #2 Tint	Single Vision	$ 3.00
	Multifocal	$ 4.00
Photo Gray Extra (Glass only)	Single Vision	$14.00
(Brown and Gray)	Multifocal	$20.00
Oversize Blank Lenses	Single Vision	$ 6.00
	Multifocal	$ 9.00
Frames		$20.00

Any additional cost must be paid by you.

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

11.7 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 102 for a description of the Appeals Process.

Section 12: Dental Plan

12.1 Summary

The Dental Plan permits you and your eligible Dependents to obtain required dental treatments through a Dental PPO Plan.

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 PEBTF 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.

12.2 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.

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 eligible employees, spouses and dependents. Quarterly payments shall be paid to the Member up to a Maximum benefit of up to $1,250 per person provided the Member remains eligible. The $1,250 benefit is a lifetime Maximum; it is not renewable. Annual deductible does not apply.

12.3 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	
Extractions of Complete or Partial Bony impacted teeth	NOT COVERED – Covered by Medical Plan	
General anesthesia	90% - in conjunction with covered dental work	
Maximum	$1000 per person for a calendar year	
Orthodontics	70% - up to $1,250 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 his/her 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 $1,000 per person per calendar year. 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 $1,250 per person.

12.4 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.

12.5 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.**

12.6 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.

12.7 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.

12.8 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 102 for a description of the Appeals Process.

Section 13: Hearing Aid Plan

13.1 Summary

The hearing aid benefit offers you and your eligible Dependents the opportunity to apply for a hearing aid reimbursement allowance.

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.

13.2 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.

13.3 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.

13.4 Application for Hearing Aid Reimbursement

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

The following information must be submitted to the PEBTF along with 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.

13.5 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
- 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

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

If your claim for benefits is denied, see page 102 for a description of the Appeals Process.

Section 14: Coordination of Benefits

14.1 Summary

- Benefits payable under the PEBTF are coordinated with benefits payable from other plans. Benefits coordinated include medical, DME, mental health and substance abuse services, prescription drug, dental, vision 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/domestic partners with other coverage to enroll for that coverage under the conditions described on pages 8 and 9.
- You must notify your medical plan any time a Dependent's coverage changes.

The PEBTF coordinates benefits with other health plans under which you may be covered. For instance, your spouse/domestic partner may be covered under his or her 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/domestic partner is employed by a non-commonwealth employer, he or she may be covered under his or her 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 you or your Dependents may be covered.

When filing claims for medical, prescription drug, vision, dental or hearing aid services, you are required to indicate and identify any other insurance or group health plan(s) in which you or a Dependent 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 a Member for coverage under the PEBTF 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.

14.2 Medicare

This Plan will pay benefits secondary to Medicare where permitted by law. Government regulations require that a Member have a choice of medical coverage if he or she continues working beyond age 65. The same options are available to the Member's spouse/domestic partner when he or she reaches age 65, regardless of the Employee Member's age. If a Member becomes covered under Medicare, he must contact the HR Service Center or the Employee Member's local human resource office if their agency is not supported by the HR Service Center and let them know the date Medicare begins. An Employee Member must also notify the Fund office if he or any of his eligible dependents is receiving Medicare before age 65, e.g., because of end stage renal disease or other disability.

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/Domestic Partner's Choices: Regardless of the Employee Member's age, and up until the Employee Member's retirement, the Employee Member's eligible spouse/domestic partner has the same choices as the Employee Member when he or she reaches 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 15: COBRA Coverage & Survivor Spouse Coverage Due to Work-Related Deaths

15.1 Summary

- If you or your Dependent's medical or supplemental benefits coverage ends due to certain reasons, the PEBTF may continue your coverage for a limited period of time
- You also may continue coverage at your own expense under certain circumstances under the Federal law commonly known as COBRA

15.2 Continued Coverage as Provided by the PEBTF

In certain situations, medical coverage for you and your eligible Dependents 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.

15.3 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 events:"

- Termination of your employment (for reasons other than gross misconduct)
- Reduction in your work hours
- Your death
- Your divorce/termination of domestic partnership or legal separation (in states that recognize legal separation) – PEBTF must be notified within 60 days of the date of divorce/termination of domestic partnership 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 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 event.

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

15.4 Notices – Important

You or another qualified beneficiary in your family has the responsibility to inform the PEBTF of a divorce/termination of domestic partnership, 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 event. Otherwise, you (or your family member) will not be permitted to continue coverage under COBRA. Your employer is responsible for notifying the PEBTF of other qualifying events (i.e., your termination of employment, reduction in work hours or death).

When the PEBTF becomes aware of a qualifying 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.

You will also receive a notice from your Medical Plan Option indicating that your coverage has been terminated.

15.5 Support Orders

Either the Employee Member or the Dependent spouse/domestic partner Member may elect COBRA coverage for the Dependent spouse/domestic partner Member. It should be noted that a court spousal support order which directs that an Employee Member provide medical coverage for his/her spouse/domestic partner 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, the Employee Member or spouse/domestic partner Member 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.

15.6 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.

15.7 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/termination of domestic partnership or a child losing Dependent status**. If you, the spouse/domestic partner or Dependent child does 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/termination of domestic partnership or loss of Dependent status, then you, the spouse/domestic partner 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 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 event. Any denied medical expenses from that period must be resubmitted for payment.

If you have informed the PEBTF of a qualifying event within the 60 day time limit, but are determined to be ineligible for COBRA coverage, the PEBTF will send you a notice of COBRA unavailability explaining the reason.

PLEASE NOTE: The Employee Member will be responsible for any claims incurred by the Employee Member's former spouse/domestic partner or Dependent child after eligibility for PEBTF coverage is lost. Your employer is responsible for notifying the PEBTF of other qualifying events (i.e., your termination of employment, reduction in work hours or death).

15.8 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 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 notify the PEBTF, in writing, of any address changes.

15.9 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. In addition, if the employee experiences a gap in coverage as a result of a waiver of COBRA, the waiver of COBRA may affect an employee's Certificate of Coverage. The length of Creditable Coverage is credited against pre-existing medical condition requirements in new medical coverage, e.g., under a new employer's plan of benefits.

15.10 Length of Continued Coverage

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

- At the end of 18 months from the date COBRA coverage began, if the qualifying event is 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 event is a result of your death, divorce/termination of domestic partnership or separation, your 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.

15.11 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.

15.12 Extension of COBRA Due to a Second Qualifying Event

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

A second qualifying event includes:

- Death of a COBRA Employee Member
- Divorce/termination of domestic partnership
- Change in Dependent status
- Medicare entitlement of Employee Member

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

15.13 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.

15.14 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.

15.15 Work-Related Deaths

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

If eligible, the surviving spouse/domestic partner and Dependents will receive continuation coverage, at no cost, until the surviving spouse/domestic partner marries, remarries, establishes or re-establishes a domestic partnership 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 16: Additional Information

16.1 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.

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;

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.

16.2 Appeal Process – Eligibility Denied

Your written appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class) to the PEBTF within 60 days of the denial of eligibility. A failure to appeal within this 60 day period will result in an automatic denial of your appeal. Your letter should include information as to why you believe that the eligibility rules were not correctly applied. Address your letter to the PEBTF, Mailstop: APAED, 150 S. 43rd Street, Harrisburg, PA 17111.

Within 60 days of receipt of the appeal, the 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 Trustees are final.

16.3 Appeal Process – PPO, CDHP, Vision, Dental and Hearing Aid Options

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

Your written request for appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class) to the Claims Payor within 60 days after you receive notice of the denial (which may take the form of an Explanation of Benefits). You (or your authorized representative) can submit issues and comments in writing. The Claims Payor will advise you of its decision on appeal, including if you have the right (if your appeal is denied) to a second-level appeal to the Claims Payor. The Claims Payor will advise you of the specific reason(s) for its decision, including references to the provisions of the Plan (or the Claims Payor's policies and procedures) on which it is based. You have the final right of appeal to the PEBTF Board of Trustees, as set forth below in the paragraph entitled "Final Appeal Process."

16.4 Appeal Process – HMO Option

If your claim for benefits under the HMO Option has been denied, you must follow the written appeal procedure established by your HMO. You must request a review on appeal in writing, postmarked or actually received (if sent by other than U.S. Mail First Class) within 60 days after the HMO denies your claim (which may take the form of an Explanation of Benefits). The HMO will advise you of its decision on appeal, including the specific reason(s) for its decision and specific reference to the provisions of the Plan (or the HMO's policies and procedures) on which it is based.

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

If you are not satisfied with the result of the HMO's grievance process, you have the right to appeal postmarked within 30 days of the final decision of the HMO to the Pennsylvania Department of Health, Bureau of Managed Care, P.O. Box 90, Harrisburg, PA 17108-0090. Telephone: (888) 466-2787. The Department of Health will issue an advisory opinion (this is a recommendation only) – the PEBTF determines if the medical service is covered under the Plan.

When you receive the advisory opinion of the Pennsylvania Department of Health, you have the final right of appeal to the PEBTF's Board of Trustees, as set forth below in the paragraph entitled "Final Appeal Process."

16.5 Appeal Process – Mental Health and Substance Abuse Program (MHSAP)

You must comply with the written grievance and appeal procedures of the MHSAP. Your written request for appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class) to the Claims Payor within 60 days after you receive notice of the denial. 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 PEBTF's Board of Trustees, as set forth below in the paragraph entitled "Final Appeal Process."

16.6 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, to the PEBTF Board of Trustees, Mailstop: APAED, 150 S 43rd Street, Harrisburg, PA 17111.

The appeal to the Board of Trustees must be postmarked or actually received (if sent by other than U.S. Mail First Class) within 30 days of the date of the Get Healthy letter. The 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.

16.7 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.

16.8 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 PEBTF Board of Trustees. All final appeals must include copies of the Claims Payor's final denial(s), along with a letter and other supporting documentation explaining why you believe the Claims Payor's decision should be reconsidered. Mail your appeal to the PEBTF, Mailstop: APAED, 150 S. 43rd Street, Harrisburg, PA 17111 postmarked or actually received (if sent by other than U.S. Mail First Class) within 30 days of the Claims Payor's final decision. The Trustees will review the appeal and will notify you of its decision within 60 days of the date that the 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 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 PEBTF's 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.

16.9 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 his or her 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.

16.10 Benefits from Other Plans (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, and for six months thereafter.

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, your written appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class) within 60 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 PEBTF 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 event for self-pay continuation coverage under COBRA.

16.11 Certificate of Coverage

The PEBTF issues Certificates of Creditable Coverage to all Members (employees, spouses/domestic partners and Dependents) whose coverage with the PEBTF is terminated. This Certificate provides evidence of prior coverage that may be used to off-set pre-existing medical conditions in new medical coverage. The Certificate of Coverage identifies coverage from the PEBTF and may off-set a pre-existing condition exclusion to the extent that there is not a 63 consecutive day or more gap in coverage.

16.12 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.

16.13 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 are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. The states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying for their health premiums. Pennsylvania uses funds from its Medicaid program to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. (Pennsylvania does not have a premium assistance program for its Children's Health Insurance Program (CHIP), but offers CHIP coverage to eligible children on a free, low-cost, or at-cost basis.)

If you or your dependents are already enrolled in Medical Assistance (Medicaid) and you live in Pennsylvania, you may contact your state Medical Assistance office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medical Assistance, and you think you or any of your dependents might be eligible for either Medical Assistance or CHIP, you can contact your state Medical Assistance or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you may ask the state about its 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 six months 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)

Commonwealth employees who 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 their 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 HR office.

If it is determined that you or your Dependents are eligible for premium assistance under Medicaid, your employer's health plan is required to permit you and your Dependents to enroll in the plan – as long as you and your Dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

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
http://www.dpw.state.pa.us
1-800-644-7730

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

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, 2013. You should contact your State for further information on eligibility.

<table>
<tr><td>ALABAMA – Medicaid</td><td>COLORADO – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov

Phone: 1-855-692-5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/

Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website:
https://www.flmedicaidtplrecovery.com/

Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid

Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)

Phone: 1-800-869-1150</td></tr>
</table>

IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647

RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

OMB Control Number 1210-0137 (expires 10/31/2016)

16.14 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 the Employee Member's Dependents, whether or not such Dependents are legally permitted to drive. However, if the Dependent of an Employee Member has automobile insurance coverage that meets the requirements of applicable law independent of any automobile insurance coverage

that the Employee Member has or has 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.

16.15 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.

16.16 Qualified Medical Child Support Orders (QMCSOs)

Divorce/termination of domestic partnership 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.

16.17 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.

16.18 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.

16.19 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.

16.20 Spousal Support Orders

A court spousal support order which directs that an Employee Member provide medical coverage for his/her former spouse/domestic partner 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, the Employee Member or spouse/domestic partner Member 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/domestic partner.

16.21 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

You are obligated to repay amounts that the PEBTF has paid in error to you or your Dependent, or on your or your Dependent's behalf. A "payment in error" includes, but is not limited to, overpayments due to an administrative error. If you do not repay the money or otherwise fail to cooperate with the PEBTF in its recoupment of monies owed, your and your Dependent's benefits will be suspended 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. If you agree to a repayment plan and fail to make a timely payment under the repayment plan, your and your Dependent's benefits will be suspended (effective as of the paid-through date) until the money is repaid in full, and for six months thereafter. 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, your written appeal must be postmarked within 60 days of the date of the demand for repayment or notification of suspension. If you appeal a demand for repayment, the suspension of your and your Dependent's coverage will be stayed pending resolution of the appeal. The appeal will be considered by the PEBTF Board of Trustees and you will be advised in writing of its decision. **The decision of the PEBTF's Board of Trustees is final.**

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

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, your and your Dependent's benefits will be suspended until the money is repaid in full, or until the

PEBTF receives the initial repayment in accordance with the terms of a voluntary repayment agreed to between you and the PEBTF. If you agree to a repayment plan and you should fail to make a timely payment under the repayment plan, your and your Dependent's benefits will be suspended (effective as of the paid-through date) until the money is repaid in full, and for six months thereafter. 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, your written appeal must be postmarked within 60 days of the date of the demand for repayment or notification of suspension. If you appeal a demand for repayment, the suspension of your and your Dependent's coverage will be stayed pending resolution of the appeal. The appeal will be considered by the PEBTF Board of Trustees and you will be advised in writing of its decision. **The decision of the PEBTF's Board of Trustees is final.**

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

Misrepresentation or Fraud

Providing false or misleading information with respect to eligibility, benefits or any other aspect of the Plan will be considered fraud and an intentional misrepresentation of a material fact. If you obtain or receive benefits under the Plan as a result of false information or a misleading or fraudulent representation, your coverage will be suspended (possibly retroactively) and you must repay all amounts paid by the PEBTF, as well as all costs of collection, including attorney's fees. The repayment could include applying other eligible claim payments against any balance due. The suspension applies to your entire family. If you make full restitution, then you and your eligible Dependents must serve an additional six-month period without coverage before coverage will be reinstated. If your eligible Dependent is responsible for such misrepresentation or fraud, all coverage for your Dependent will be suspended immediately. If your Dependent makes full restitution, his or her benefits will remain suspended for an additional six-month period before being reinstated. In the event no amounts are owed to the PEBTF, the six-month suspension shall begin either on the date of the misrepresentation or the date the PEBTF first has knowledge of such misrepresentation, whichever is later.

A Member whose coverage is terminated or suspended for misrepresentation or fraud shall be reported to the commonwealth for such action as it may deem appropriate. Any suspension of benefits for misrepresentation or fraud may be appealed, in writing, to the PEBTF and must be postmarked within 60 days of the notification of the suspension. If the appeal is sustained, benefits will be paid retroactively to the date of the suspension. **The decision of the PEBTF's Board of Trustees is final.**

NOTE: Termination or suspension of benefits due to misrepresentation or fraud is not a qualifying event for self-paid continuation coverage under COBRA.

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 within 60 days of the date that you are notified of the amount due, 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.

16.22 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.**

16.23 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.

16.24 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 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 17: Glossary of Terms

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

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, MHSAP or the Plan of Supplemental Benefits.

When the PEBTF selects a PPO, HMO, CDHP, 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.

Consumer Driven Health Plan (CDHP): The CDHP is an option under the Medical Plan that is similar to that of a PPO, where there is both a Network and a Non-Network benefit. A Health Reimbursement Account (HRA), funded by the PEBTF is used to pay for medical expenses you normally pay for out of your pocket, up to the amount in the HRA. **NOTE**: The CDHP is not available for domestic partnerships because the tax laws governing the associated HRA will not permit its use in the majority of cases.

Copayment: Pre-established payment that must be made by you under the particular plan (e.g., for a doctor's office visit, for emergency care 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 any benefits.

Dependent: The spouse/domestic partner 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.

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 referred Network specialist (PPO, HMO, CDHP and Mental Health and Substance Abuse 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.

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/domestic partners (see also Eligible Member)

Mental Health and Substance Abuse Program: This program provides independent, stand-alone, mental health and substance abuse rehabilitation treatment services, whether inpatient or outpatient through a specialized Network of professional Providers and treatment facilities. Inpatient detoxification services will be provided through your Medical Plan Option as appropriate.

Network Providers: Medical Providers, such as doctors and hospitals, who have a contractual agreement with PPO, HMO or CDHP plans, or Mental Health and Substance Abuse Plan 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.

Non-Network (or Out-of-Network): Care provided by physicians or other medical professionals who have not contracted to provide services within the parameters established by a health or dental management company (PPO, HMO, CDHP or Mental Health and Substance Abuse Plan).

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-Pocket Maximum: The amount of eligible expenses you pay before the plan begins to pay at 100% (PPO or CDHP).

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.

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, termination of a domestic partnership, 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 his or her employer.

e. An Eligible Person changes his/her residence and, as a result, becomes ineligible for a Plan Option in which he/she is enrolled or eligible for a new plan or Plan Option.

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. A new Plan Option is added.

i. 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.

j. 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/domestic partner, former spouse/domestic partner, or other individual to provide accident or health coverage to the Eligible Retiree's child (and the coverage is actually provided).

k. 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.

l. An Eligible Person incurs a Special Enrollment Event.

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

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

Skilled Nursing Facility (SNF): Medicare-certified institution which is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for rehabilitation of injured, disabled or sick persons; and is duly licensed and regularly provides 24-hour skilled nursing care by and under the direction of licensed, qualified registered nurses (RN's), and which also provides therapeutic services by licensed, qualified therapists, acting within the scope of their licenses.

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.

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, CDHP, Mental Health and Substance Abuse Program 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 PEBTF 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 Trustees administer 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 Trustees may determine.

PEBTF Benefit Option Summary Comparison -- Active Members

BENEFIT	PPO OPTION		HMO OPTION	CONSUMER DRIVEN OPTION	
	No Referrals Needed		All care directed by	No Referrals Needed	
	In Network	Out-of-Network	Primary Care Physician (not all Plans)	In Network	Out-of-Network
Deductible	$0	$400 per person; 30% of the next $5,000; 0% in excess of $5,000. All services subject to Deductible unless otherwise noted.	$0	$1,500 single Deductible; $3,000 family per year. The PEBTF contributes $1,000 per individual and $2,000 per family per year into a Health Reimbursement Account (HRA). Therefore, the out-of-pocket maximum (in network) is $500 for an individual or $1,000 for a family per year.	
Out-of-Pocket Maximums	Not Applicable	$1,500 per person ($3,000 per family) PLUS the Deductible	Not Applicable	$1,500 single ($1,000 HRA reduces it to $500); $3,000 per family ($2,000 HRA reduces it to $1,000)	$4,500 single ($1,000 HRA reduces it to $3,500); $9,000 per family ($2,000 HRA reduces it to $7,000)
Physician Visits					
Primary Care Physician	100% after $15 Copayment ($20 after hours)	70%* after Deductible; Member pays 30%	100% after $15 Copayment ($20 after hours)	100% after Deductible	70%* after Deductible; Member pays 30%
Specialist	100% after $25 Copayment	70%* after Deductible; Member pays 30%	100% after $25 Copayment	100% after Deductible	70%* after Deductible; Member pays 30%
Preventative Care				All preventive care covered in network up to $500 a year ($1,000 for family)	Preventive care not covered out of network
Adult					
Routine Physical Examinations (Some Adult Immunizations are covered)	100% after $15 Copayment	70%* after Deductible ; Member pays 30%	100% after $15 Copayment		
Annual Routine Gynecological Exams including a PAP Test	100% after $25 Copayment (if visiting an OB/GYN)	70%*; Member pays 30% (Deductible waived)	100% after $25 Copayment (if visiting an OB/GYN)		
Annual Routine Mammograms	100%	70%*; Member pays 30% (Deductible waived)	100%		
Pediatric					
Routine Physical Examinations	100% after $15 Copayment	70%* after Deductible ; Member pays 30%	100% after $15 Copayment		
Pediatric Immunizations (contact the PEBTF)	100%	70%*; Member pays 30% (Deductible waived)	100% after $15 Copayment (for office visit)		
Emergency Room Services	$50 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	$50 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	$50 Copayment if considered a medical emergency as defined by the HMO (waived if admitted as an inpatient)	100% after Deductible	70% * after Deductible; Member pays 30%
Hospital Expenses (Inpatient & Outpatient)	100% (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)	100% after Deductible; Semi-private room (private room if Medically Necessary)	70%* after Deductible (up to 70 days per year); Member pays 30%
Medical/Surgical Expenses (Except Office Visits)	100%	70%* after Deductible; Member pays 30%	100%	100% after Deductible	70%* after Deductible; Member pays 30%
Skilled Nursing Facility Care (medically necessary)	100% (240 days per calendar year)	70%* (240 days) after Deductible; Member pays 30%	(180 days per calendar year at participating facility)	100% (240 days); after Deductible	70%* (240 days) after Deductible; Member pays 30%
Home Health Care (medically necessary)	100%	70%* after Deductible; Member pays 30%	100%; up to 60 visits in 90 days; may be renewed at the option of the HMO	100% after Deductible	70%* after Deductible; Member pays 30%
Chiropractic Care (restorative, medically necessary; not for maintenance of a condition)	100% after $15 Copayment (treatment plan must be submitted after 6 visits)	70%* after Deductible; Member pays 30% if Network Provider is not used; treatment plan must be submitted after 6 visits)	100% after $15 Copayment (combined maximum of 60 visits per year for all outpatient therapies)	100% after Deductible; (treatment plan after 6 visits)	70%* after Deductible; Member pays 30%; (treatment plan after 6 visits)
Mental Health & Substance Abuse Treatment	Provided by UBH	Provided by UBH	Provided by UBH	Provided by UBH	Provided by UBH
Durable Medical Equipment/Prosthetic	DMEnsion Benefit Management		DMEnsion Benefit Management	100% after Deductible	70%* after Deductible; Member pays 30%
Out of the Area Care	Urgent and Emergency Care Only, or as defined by the PPO	70%* after Deductible; Member pays 30% (Possible BlueCard)	Urgent and Emergency Care Only, or as defined by the HMO	Urgent and Emergency Care Only	70%* after Deductible; Member pays 30%
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

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

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.

Section 19: Your Rights as a PEBTF Member

As a Member of the PEBTF medical plan or supplemental benefits, you are entitled to certain rights and protections.

You are entitled to:

- Examine, without charge, at the PEBTF, all Plan Documents, including pertinent insurance contracts, trust agreements, annual reports and other documents filed with the Internal Revenue Service and the U.S. Department of Labor

- Obtain copies of all Plan Documents 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 a summary annual report of the PEBTF financial activities

- 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, CDHP Option 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 20: 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 Plan
Plan Number:	Not applicable
Plan Type:	Welfare plan
Plan Year:	Medical Plan Options: January 1 Mental Health and Substance Abuse Program: January 1 Supplemental Benefits: 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 Legal Process:	PEBTF 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, 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 PPO, HMO, CDHP, Mental Health and Substance Abuse Program or the supplemental benefits. 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, Mental Health and Substance Abuse Program, Prescription Drug, Dental, Vision, 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
www.pebtf.org	800-522-7279 (toll-free)
PPO Option	
Highmark PPO	888-301-9273
HMO Option	
Aetna HMO	800-991-9222
Geisinger Health Plan HMO	800-504-0443
Keystone Health Plan Central HMO	800-889-3863
Keystone Health Plan West HMO	888-301-9273
Consumer Driven Health Plan (CDHP)	
UnitedHealthcare Definity Health Reimbursement Account	866-270-5311
Mental Health & Substance Abuse Program	800-924-0105
State Employee Assistance Program	800-692-7459
Durable Medical Equipment (DME), Prosthetics, Orthotics and Medical Supplies	
DMEnsion Benefit Management	888-732-6161
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 plans' website addresses listed under the Links section.