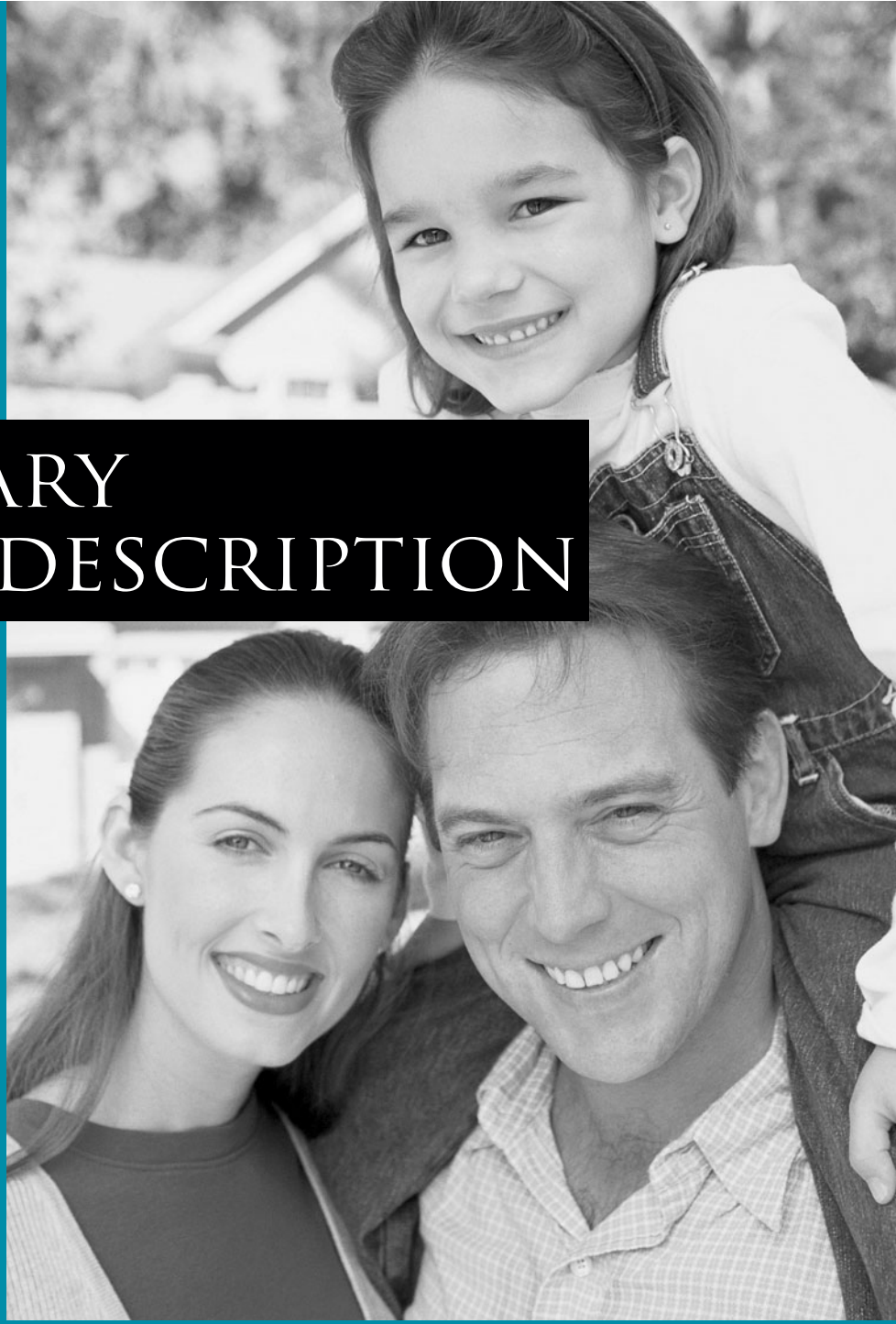


Summary Plan Description

The Pennsylvania Employees Benefit Trust Fund (PEBTF)

January 2005

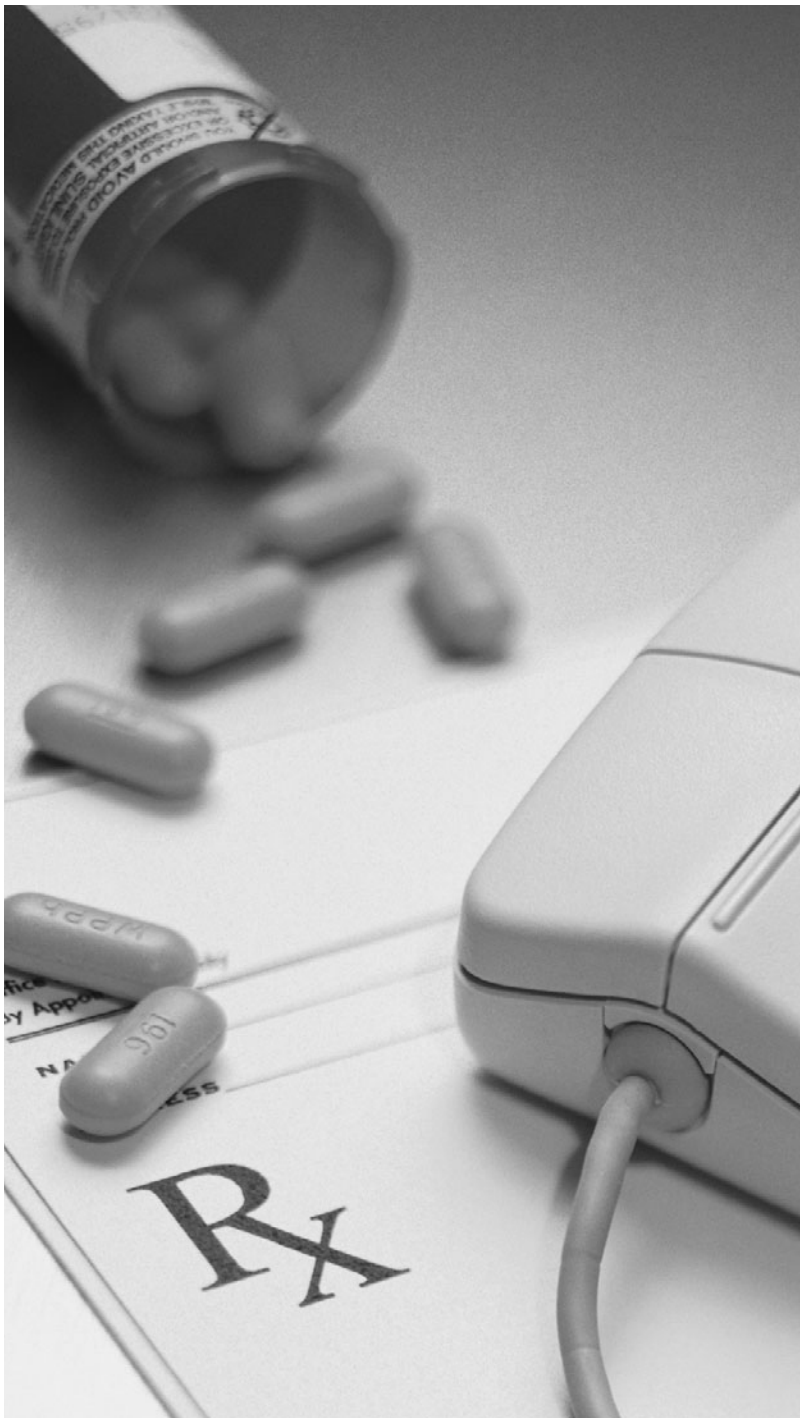
This Summary Plan Description (SPD) replaces all previous Summary Plan Descriptions and reflects the benefits provided to Members and their eligible Dependent(s) covered under the Pennsylvania Employees Benefit Trust Fund (PEBTF) as of January 1, 2005.

The SPD has been prepared to help you understand the main features of the health benefit coverage provided by the PEBTF. If there are any differences between this document and the Plan Document ("the Plan"), the Plan Document will control. If any questions arise that are not covered by this SPD, the Plan Document will determine how the questions will be resolved.

The SPD is not a contract between the PEBTF and its Members. 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 Dependent(s).

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 is responsible for the Plan provisions, as well as their interpretation and application.



Pennsylvania Employees Benefit Trust Fund (PEBTF)

150 S. 43rd Street, Suite 1

Harrisburg, PA 17111-5700

Phone: 717-561-4750

800-522-7279 In State

800-628-0174 Out of State

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 Eligible Members and their eligible Dependent(s). The level of benefits is determined by the Board of Trustees, seven of whom are designated by the Secretary of Administration of the Commonwealth of Pennsylvania and seven of whom are 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 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 Dependent(s) 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 source if you should have questions about your benefits.

The SPD does not include all of the details of your benefit coverage. The Plan Document, which is approved by the PEBTF Trustees, describes the terms and conditions of your benefit coverage. The Plan Document contains the details and provisions concerning the Plan's coverage for medical services, and all exclusions and limitations. If any questions arise which 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, amend 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 an Eligible Member covered by the PEBTF, the following options may be offered to you depending on your county of residence:

- Preferred Provider Organization (PPO) Option
- Health Maintenance Organization (HMO) Option
- Basic Option (No new enrollments)

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 Dependent(s) against the financial impact of illness and injury. Each year, during Open Enrollment, you have the opportunity to select a new medical and dental option.

The PEBTF also provides mental health and substance abuse coverage, prescription drug, vision, dental and hearing aid benefits for eligible groups.

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

Pennsylvania Employees Benefit Trust Fund (PEBTF)
150 South 43rd Street, Suite 1
Harrisburg, PA 17111-5700
(717) 561-4750
(800) 522-7279 (toll free in PA)
(800) 628-0174 (toll free outside of PA)
www.pebtf.org

In 2004, the Commonwealth of Pennsylvania implemented Employee Self Service (ESS) technology for employees under the Governor's jurisdiction and the Office of the Attorney General. ESS will allow employees to change their address, update personal information for Dependents, and enroll in medical and dental plans online. Employees can log onto ESS through the intranet at www.myworkingplace.state.pa.us or from the internet at www.workingsmart.state.pa.us. If you are unable to use ESS after its availability has been announced, please contact your local HR office.

If your agency does not participate in ESS, follow your agency's procedures to make any changes to your personal 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. These include physicians, dentists and other medical professionals, hospitals, psychiatric and rehabilitation facilities, birthing centers, mental or substance abuse Providers and all 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 yourself. The PEBTF Plan Option(s) 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. Coverage may be provided under the PPO Option, HMO Option, Basic Option, Mental Health and Substance Abuse Program or the Supplemental Benefits Plan. In each case, the PEBTF has contracted with independent Claims Payors to administer claims for coverage and benefits under these Plan Options. These Claims Payors, as well as the physicians and other medical professionals and facilities who 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 which 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 coverage 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.

Benefits at a Glance

Health Benefit Coverage Choices

- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Basic Option (No New Enrollments as of 8/1/03)

Mental Health and Substance Abuse Program

Prescription Drug Coverage

Vision Benefit

Dental Benefit

Hearing Aid Benefit

Eligibility

Summary

- Unless otherwise noted, you are eligible for medical and Supplemental Benefit coverage if you are a full-time permanent employee or part-time permanent employee working at least 50% of full-time hours of the Commonwealth (see section below for employees hired or re-hired on or after August 1, 2003)
- Temporary employees and permanent part-time employees working less than 50% of full-time hours are not eligible for PEBTF health benefit coverage. However, the time that an employee (first hired or rehired on or after August 1, 2003) works in a temporary 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 must live in a service area where the plan is approved
- You may elect coverage for your eligible Dependent(s) – see Eligibility Rules for New Hires or Re-hires – Hired on or After August 1, 2003
- You can change your coverage option during the Open Enrollment period and under certain other limited circumstances
- Coverage generally ends on your last day of employment or when you are no longer eligible

Eligibility Rules for New Hires or Re-hires – Hired on or After August 1, 2003

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

- Full-time and eligible part-time employees will receive single medical coverage only in the least expensive plan available in his or her county of residence
- Most employees must pay a biweekly employee share in the amount of 1% of biweekly base pay
- May purchase a more expensive plan in their county of residence by paying the cost difference, as determined by the PEBTF, in addition to the 1% employee contribution
- May purchase Dependent medical coverage for the first six months of employment as a new hire or re-hire
- May add eligible Dependents for medical coverage at no additional charge in the least expensive plan on the day immediately following the date the employee completes six months of employment as a new hire or re-hire (if a more expensive plan is chosen, the employee must pay the cost difference, as determined by the PEBTF)
- Employee and eligible Dependents receive Supplemental Benefits on the day immediately following the date the employee completes six months of employment as a new hire or re-hire
- Part-time employees must pay 50% of the cost in addition to the above-mentioned employee shares

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 14 calendar days, **will** be considered a new hire for purposes of the above described eligibility rules.

Furloughed Employee: Any employee who is recalled under the terms of their collective bargaining agreement will **not** be considered a new hire for purposes of benefit coverage.

Six Months of Employment: Eligibility for coverage is limited for the first six months of employment as a new hire or re-hire. 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 temporary 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 14 calendar days, then you will be required to satisfy a new six-month waiting period for full eligibility again.

Your full PEBTF coverage, including coverage for Supplemental Benefits, will begin on the day following the date you have worked six full months of employment as a new hire or re-hire.

Spousal Eligibility

Employees Hired or Re-hired on or After August 1, 2003: In order to enroll for coverage in the PEBTF, a Dependent spouse 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 share the spouse must pay and regardless of whether the spouse had been offered an incentive to decline such coverage. Coverage for such Dependent spouse in the PEBTF is limited to **secondary** coverage. This rule does not apply for those spouses who are self-employed.

Employees Hired Before August 1, 2003: In order to enroll for coverage in the PEBTF, if your Dependent spouse is offered medical or supplemental coverage through his or her own employer and he or she does not have to pay for coverage, your spouse must take his/her employer's coverage as primary. In that event, your spouse's coverage in the PEBTF is limited to **secondary** coverage. If your spouse has to pay for coverage or is offered an incentive not to take his/her employer's coverage, your spouse does not have to enroll in his/her employer's coverage and may remain as primary under the PEBTF.

A Declaration of Spouse Coverage (PEBTF-11) and a Coordination of Benefits (PEBTF-2A) Form must be completed any time there is a change to a spouse's health or Supplemental Benefit coverage. The PEBTF-2A must be completed any time there is a change in a Dependent's other coverage.

Eligibility

You are eligible for the 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 the full-time hours, as determined by the Commonwealth. Other groups of employees may be eligible based on their collective bargaining agreements. 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 share of the cost of these benefits is taken through payroll deduction.

Exception: Collective bargaining agreements supersede these rules for certain groups of Members (i.e. Intermittent Intake Interviewers, Energy Assistance Workers and Liquor Store Clerks).

Effective July 2004, the employee cost share for coverage will be made on a before-tax basis for federal and Pennsylvania income tax purposes (certain other states' income taxes also qualify. Check with your local Human Resource Office).

For any special eligibility provisions regarding Supplemental Benefits, please see Eligibility – Supplemental Benefits.

Eligibility Documentation

Effective August 1, 2003, all employee Members are required to present documentation verifying the eligibility status for their Dependents. Employee Members are required to disclose all group medical and supplemental coverage available to their Dependent(s). Failure to provide this information is grounds for denying coverage to the Dependent.

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 should be completed if an employee was married outside of the country and cannot produce a valid marriage certificate.
- Unmarried child under age 19, including
  - Your natural child (original birth certificate required)
  - Legally-adopted child, including coverage during the adoption probationary period (Court Adoption Papers or a new birth certificate required)
  - Stepchild who lives with you (50% residency or greater, with proof that you claim the stepchild as a dependent on your federal income tax return) and for whom you have shown an original marriage certificate and a birth certificate indicating that your spouse is the parent of the child
  - Child who lives with the you, is solely supported by you and for whom you are the court-appointed legal guardian as demonstrated by the appropriate court order
  - Foster child, age 18, who lives with you and is solely supported by you, if you were the child's foster parent before the child's 18th birthday and for whom you have provided documentation from Social Services
  - Child for whom you are required to provide medical benefits by a Qualified Medical Child Support Order or National Medical Support Notice

Coverage for an eligible Dependent child ends on the child's 19th birthday unless the child qualifies as a full-time student or a disabled Dependent. To determine whether a Dependent certification form is required, contact your local Human Resource Office.

Important: If your Dependent child will not be a full-time student so that his or her coverage ends at age 19, it is your responsibility to notify the PEBTF that coverage has or will end, **no later than 60 days following the child's 19th birthday**. If you or your Dependent fail to do so, your Dependent will not be able to elect COBRA continuation coverage. This notice can be provided by timely returning a PEBTF student certification form indicating your child will not be a full-time student.

- Child who is a **full-time** student attending an accredited educational institution if he or she meets all of the following criteria:
  - Is age 19 to 23
  - Is not married
  - Does not work full-time
  - Depends on you for more than 50% financial support and is claimed by you as a dependent on your federal income tax return. Your child also may be eligible if other evidence is provided to support child dependency status
  - Renews student certification twice a year in January and July. The PEBTF will send you a student certification form which **must be completed and returned within thirty (30) days for your child to be covered**. The January student certification period requires the completion of a Student Verification Form by the accredited institution

Coverage ends the day that your child no longer meets any **one** of these requirements. **It is your responsibility to notify the PEBTF immediately if your child no longer satisfies the conditions for Dependent coverage. If the PEBTF is not notified within 60 days of the loss of eligibility, your Dependent will not be able to elect COBRA.**

Full-Time Students

Dependents who are **aged 19 to 23 and are full-time students** attending an accredited educational institution remain eligible under the Plan as long as they continue to recertify twice a year with the PEBTF. **It is your responsibility to immediately notify the PEBTF if, at any time, the student Dependent does not attend college, drops below full-time student status, or otherwise no longer satisfies the requirements for being an eligible Dependent (e.g. if he or she gets married, works full time or no longer depends on you for more than 50% financial support). If the PEBTF is not notified within 60 days of such event, your Dependent will not be able to elect COBRA continuation coverage**.

Generally speaking, a student will be considered "full-time" if, and only if, he or she is currently enrolled in an accredited educational institution and is carrying a course load of at least 12 credit hours per semester. He or she must be unmarried and not working full time.

The U.S. Secretary of Education recognizes various Regional and National accrediting agencies as reliable authorities concerning the quality of education or training offered by institutions of higher education or higher education programs they accredit. The PEBTF uses this list of resources to determine if your Dependent Student's educational institution meets the criteria set up by the PEBTF's Board of Trustees.

Student Dependents remain covered throughout the summer break between spring and fall semesters as long as they timely file their student certification forms with the PEBTF and return to full-time attendance in the fall. Students who do not recertify before September 1 will be terminated retroactive to July 1.

For purposes of determining the qualifying event dates when students cease to be "full-time students," the PEBTF has adopted the following guidelines:

- Any student who is enrolled and attending full-time throughout the spring semester is assumed to be a full-time student until July 1
- Any student who timely recertifies and re-enrolls for the fall semester is assumed to be a full-time student up until he/she fails to actually attend full-time when classes resume
- If a student actually attends school full time after July 1 and does not return to school in the fall, the student's actual last date of full-time attendance is the qualifying event for COBRA
- Failure to recertify and re-enroll for the fall semester will result in termination retroactive to July 1 and not to any earlier date as long as the student completed the spring semester as a full-time student and did not have any other qualifying event. July 1 is the qualifying event date
- A student who has timely recertified and re-enrolled will be assumed to be a full-time student until the first day of fall classes. If he/she fails to attend, as long as the student did not have any other qualifying event, the first day of fall classes is the qualifying event date
- A student who does not recertify during the January Student Certification will result in termination retroactive to January 1

Important: You (or your Dependent) must advise the PEBTF **within 60 days** of the qualifying event date that your child will not be returning to full-time attendance. If you or your Dependent fail to do so, your Dependent will not be able to elect COBRA continuation coverage.

Student Medical Leave: Student Medical Leave is available for full-time college students, to age 23, who cannot return to college because of a serious illness. Contact the PEBTF for specific instructions on applying for Student Medical Leave. You should apply for COBRA coverage for your Dependent within 60 days of the last day your Dependent attended school on a full-time basis, in case your Dependent does not qualify for Student Medical Leave coverage. You must apply for Student Medical Leave coverage within six months of the date your Dependent last attends classes. If Student Medical Leave coverage is approved, you must continue to certify the illness or disability every six months in order for student Dependent coverage to continue.

Disabled Dependent

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

- Is totally and permanently disabled, provided that the Dependent became disabled prior to age 19
- Was your Dependent before age 19
- Depends on you for more than 50% support
- Is claimed as a Dependent on your federal income tax return
- Completes a Disabled Dependent Certification Form (must be completed by employee Member)

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

NOTE: If your Dependent is disabled and covered by Medicaid, coverage may be available provided the Dependent lives with you. A Coordination of Benefits Form (PEBTF-2A) must be completed to indicate that your Dependent is covered by Medicaid.

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.

Last Date of Coverage for Dependent Child

A Dependent child becomes ineligible the day he or she:

- Turns 19, loses full-time student status prior to age 23 or turns 23 while a student
- Becomes employed full time
- Marries
- No longer lives with you and depends on you for support
- Is determined by the Trustees to no longer be Totally and Permanently Disabled
- No longer meets the Dependent eligibility requirements of the PEBTF

Important: You (or your Dependent) must advise the PEBTF **within 60 days** of an event which causes a child to no longer be an eligible Dependent. If you or your Dependent fail to do so, your Dependent will not be able to elect COBRA continuation coverage.

Common Law Marriages

If you and your spouse are married at 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. On September 17, 2003, the Pennsylvania Commonwealth Court ruled that it will no longer recognize common law marriage in Pennsylvania. Therefore, the PEBTF will only recognize a Pennsylvania common law marriage entered into prior to September 17, 2003. Although 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, without first producing a valid divorce decree from a court of competent jurisdiction certifying your divorce from your prior common law spouse.

If you entered into a common law marriage prior to September 17, 2003, and would like to obtain coverage for a 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, a copy of the cover page (indicating filing status) and signature page (if different) of your federal income tax return indicating marital status as of 2002. Figures reflecting income and deductions may be redacted, i.e. blacked out. Additional documentation may be required as well.

No Duplication of Coverage

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

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

The only exception to these rules barring duplication of coverage is that if you are an Active employee and your spouse is a retired State Police member or retired REHP member, your retired spouse can be covered as a Dependent under the active PEBTF plan for Supplemental Benefits. The Retired Pennsylvania State Police Program (RPSP) or the Retired Employees Health Program (REHP) will be the primary payor for the retiree even if the retiree is a Dependent on the Active Member's Prescription Drug coverage.

Eligibility – Supplemental Benefits

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

- You may cover your spouse who is a member of the Retired Employees Health Program (REHP) for vision, dental, prescription drug and hearing aid. The retiree Member's REHP Prescription Drug Plan will be primary
- State Police cadets are not eligible for Supplemental Benefits
- Certain dependent parents may qualify for coverage under the Prescription Drug Program provided certain conditions are met. Please contact the PEBTF for further details
- 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

As described herein, if you are hired or re-hired after August 1, 2003, you must complete a six-month period of employment before you are eligible for Supplemental Benefits.

When Coverage Begins – Hired After August 1, 2003

Your medical coverage begins on your first day of employment as an eligible permanent full- or part-time employee or when you first become eligible, provided you timely enroll within 60 days as described below. To be covered, you must enroll by selecting a medical plan and completing and submitting with your local Human Resource Office, a PEBTF Enrollment/Change Form. The PEBTF Enrollment/Change Form is available at your local Human Resource Office or the form may be downloaded from the PEBTF's web site, www.pebtf.org, Publications/Forms. If you are required to pay a share of the cost of coverage, you must also authorize the making of payroll deductions. If you were hired or re-hired on or after August 1, 2003, you will become eligible for Supplemental Benefits and coverage for your Dependent(s) beginning on the day following the date you complete six months of employment (see Six Months of Employment on page 4). The effective date of coverage cannot be more than 60 days prior to the date that you file the PEBTF Enrollment/Change Form. If you enroll during the Open Enrollment period, coverage begins on the day specified as the first date of new coverage.

Your Dependent(s) must be enrolled to be covered by the Plan. If you are required to fulfill the six-month waiting period for Supplemental Benefits, you may add Dependent(s) beginning as of the day following the date you complete six months of employment. Generally speaking, you can only add coverage for a Dependent during the Open Enrollment period. However, you may add or drop a Dependent between Open Enrollment periods if you have a "change in life event." **If you wish to add or drop a Dependent, because of a change in life event, you should report the change in life event within 60 days of the event.** If you do so, and you are adding a Dependent, coverage will be retroactive to the date of the change in life event. If you wait for more than 60 days, you may enroll (or disenroll) a Dependent, prospectively only, provided the PEBTF determines your change in coverage to be on account of, and consistent with the change in life event.

Except in connection with a change in life event, you may not add or drop a Dependent until the next Open Enrollment period. A "change in life event" is one of the following:

- You gain a Dependent through birth, adoption or marriage
- You lose a Dependent through divorce or death or if your Dependent loses his or her status as an eligible Dependent under the rules of this Plan or your spouse's group health plan
- You or your spouse's or other Dependent's group health coverage is lost due to the termination of a spouse's/Dependent's employment or termination of the spouse's/parent's group health medical coverage
- You complete six months of employment and elect to enroll a Dependent for medical and/or Supplemental Benefits
- A newborn may be added to your coverage and you will be permitted a seven-month window in which to provide a birth certificate and Social Security Number. At the end of the six months, your Human Resource Office will notify you, in writing, and allow thirty additional days to provide the documentation. If the documentation is not provided within that time, the newborn will be retroactively terminated to the date of birth and you will be responsible to reimburse the PEBTF for claims paid

Important: If you wait more than 60 days to report your divorce from your spouse or your Dependent's loss of status an as eligible Dependent, your former spouse or Dependent will lose their right to continue coverage under COBRA**.**

Other certification, in addition to a completed enrollment form, may be required from the PEBTF if your Dependent is a common law spouse (recognized under Pennsylvania law prior to September 17, 2003), over age 19, disabled, a stepchild, foster child or a child for whom you are the court appointed legal guardian.

If your adding or dropping of a Dependent changes the amount you pay for coverage, any such change must conform to any additional requirements under the Internal Revenue Code for mid-year changes in before-tax contributions for coverage.

In 2004, the Commonwealth of Pennsylvania implemented Employee Self Service (ESS) technology for employees under the Governor's jurisdiction and the Office of the Attorney General. ESS will allow employees to change their address, update personal information for Dependents, and enroll in medical and dental plans online. Employees can log onto ESS through the intranet at www.myworkingplace.state.pa.us or from the internet at www.workingsmart.state.pa.us. If you are unable to use ESS after its availability has been announced, please contact your local HR office.

When Coverage Ends

Your coverage will generally end on the date when:

- Your employment ends
- Your employment status changes to leave without pay without benefits
- Your percent of time worked decreases to between 50% and 99%, and you do not elect health coverage as a part-time employee
- Your percent of time worked decreases to less than 50%
- You are furloughed
- You are suspended from PEBTF coverage for fraud and/or abuse 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

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
- You voluntarily drop coverage for your Dependent as permitted under PEBTF rules
- You or your Dependent is suspended from PEBTF coverage for fraud and/or abuse 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 such event, coverage may be canceled back to the date the individual was incorrectly enrolled)

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

Upon an employee's death, eligible Dependent(s) may qualify for continued coverage. See page 83 of this SPD. For further information, your Dependents may contact your local Human Resource Office or the PEBTF. If the employee’s death is a result of a work-related accident, eligible Dependents may qualify for paid coverage. See page 88 for more information.

Changing Coverage

You may change plan options during the Open Enrollment period. You may enroll in any PEBTF approved plan for which you are eligible which offers service in your county of residence. Any change in coverage is effective on the day specified as the first date of new coverage. If you were first hired or re-hired on or after August 1, 2003 and switch to a more expensive option, you will have to pay the cost difference (in addition to the 1% employee share). You must complete any documentation required by your employer to authorize the applicable payroll deduction.

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

- If the Primary Care Physician (PCP) in an HMO or Primary Dental Office (PDO) in the DHMO plan terminates affiliation with that HMO or DHMO
- You move out of your plan's service area or into the service area of a plan not offered in your prior county of residence
- You have complied with the grievance procedure of an HMO or DHMO but were unable to resolve the problem with that HMO or DHMO
- You relocate as a result of a furlough or to avoid a furlough
- A change in life status that causes a non-student minor Dependent to lose coverage

If you change plan options during non-Open Enrollment periods, the effective date of coverage cannot be more than 60 days prior to the date you sign your Enrollment/Change Form and any necessary accompanying documentation. You must contact your local Human Resource Office to initiate a change in coverage.

If Eligibility is Denied

The Board of Trustees has established the PEBTF's eligibility rules**. If eligibility for you or one of your Dependent(s) is denied, you have the right to appeal to the Board of Trustees. Your written appeal must be postmarked to the PEBTF within 60 days of the denial. A failure to appeal within this 60 day period will result in an automatic denial of your appeal.**

Your letter of appeal should include information as to why you believe that the eligibility rules were not correctly applied. Address your letter to the PEBTF Board of Trustees, Attention: Executive Director, 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 additional information.

Benefits Under All Health Plan Options

See PPO and HMO Option sections for more detail.
Basic Option members: You may refer to the Basic Option information that you received as a separate document.

Important – Please Read

The PEBTF offers several plans of medical benefits. You choose the Option – PPO, HMO or Basic Option – that best fits your needs. Not all Options are available in all areas, and there are no new enrollments in the Basic Option. In addition, the PEBTF offers mental health and substance abuse benefits, as well as Supplemental Benefits, including coverage for prescription drugs, vision care, dental care and a hearing aid benefit.

In each case, the PEBTF has contracted with one or more outside professional Claims Payors to administer benefits under the several Options and Supplemental Benefit programs. For example, the PPO Option in the Philadelphia area is administered by Independence Blue Cross under its "Personal Choice" program.

To understand the benefits available to you, you should read this section, which describes information which applies under all medical benefit Options, as well as the description in this booklet of the particular medical benefit Option that covers you (or Supplemental Benefit program, as the case may be). In addition, you should read the section "Services Excluded from All Medical Benefit Options" for a description of limitations applicable to all 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 benefit Option or Supplemental Benefit program has the authority to interpret and construe the Plan, and apply its terms and conditions with respect to your fact situation. In doing so, the Claims Payor may rely on its medical policies which are consistent with the terms of the Plan.
- No benefits are paid unless a service or supply is Medically Necessary (see the "Glossary of Terms"). The Claims Payor is empowered to make this determination, in accordance with its medical polices.
- With respect to certain Options, if you use 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.

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 pre-certification 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 pre-condition. 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.

Physician Services

Covered Services in a doctor's office include:

- Diagnosis and treatment of injury or illness
- Periodic health evaluation and routine check-up (routine or periodic adult physical exams excluded under the Basic Option)
- Pediatric immunizations for Members under age 21
- Allergy diagnosis and treatment (excluding serum which may be covered by the Prescription Drug Plan)
  - Basic Option – Inpatient allergy testing limited to one series of each of the following: percutaneous, intracutaneous and patch (each series must consist of 30 or more tests); the inpatient stay cannot be solely for the purpose of performing allergy testing. Patch and Scratch covered on an Outpatient basis only
  - Basic Option – Outpatient allergy testing limited to RAST/MAST/FAST, to a Maximum of 15 tests per year
- 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
- Emergency care in your physician's office
- Routine diabetic footcare 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 previously received lenses within the 24-month period preceding the prescription change

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

Hospital Services

Covered inpatient services at a network (participating) hospital 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 PPO)

The following outpatient services are also covered at a network (participating) 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
- 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, respiration, occupational, speech (due to a medical diagnosis), 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 Option) but they are subject to an annual Deductible and coinsurance.

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 for your health plan. 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, and that other means of transportation could have been used such as a wheelchair van or litter van.

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.

Failure to precertify out-of-network, non-emergency services may result in a 20% reduction in benefits payable for non-emergency ambulance services.

Care Outside of the Country

There may be instances where a medical facility in a foreign country will recognize your medical plan ID card. This may occur with a Blue Cross/Blue Shield plan. If the out-of-country medical facility does not recognize your health plan, you will be required to pay for medical services. You may then submit your claim to your health plan when you return home. You should ask for an invoice that includes your diagnosis and is translated into American dollars.

Disease Management

PPO & Basic Option Members: The PEBTF, through its Disease Management vendor, offers PPO and Basic Option Members the added benefit of disease management. It is available at no additional cost to Members with diabetes, heart disease or chronic lung disease. The program is specifically designed to help Members manage these conditions so they can stay healthy and enjoy life to the fullest. Disease Management may also be available for other medical conditions.

One of the most valuable features of the Disease Management Program is the support provided by a team of health care professionals led by registered nurses. The health care team will answer any questions a Member may have about a Chronic condition, and consult with the Member and the Member's doctor regarding the Treatment Plan. The program helps the Member follow his or her doctor's instructions with personalized

attention to fit the Member's needs and lifestyle. Program participants also receive educational materials including a periodic newsletter on topics related to diabetes, heart disease or chronic lung disease, and reminders about important tests and exams.

For HMO Members: The HMO plans offer Members the added benefit of disease management. It is available at no additional cost to Members with a variety of Chronic diseases such as diabetes, heart disease or chronic lung disease (programs vary by health plan). The program is specifically designed to help Members manage these conditions so they can stay healthy and enjoy life to the fullest. The Disease Management Program offered by your HMO may include periodic mailings, telephone calls from Disease Management nurses or interaction between the Disease Management nurses and your physician (services vary by health plan).

Emergency Medical Services

The plan covers emergency medical care as a result of an accident or severe illness 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 with 72 hours of the onset of the medical emergency. **For Personal Choice Members**: Emergency care must begin within 48 hours of the onset of the medical emergency.

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

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

For PPO and HMO Members: Emergency room Copayment is $50, which is waived if admitted. 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.

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

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.

Home Health Care

Benefit Limits Under all Plans:

PPO Option	HMO Option	Basic Option
Covered 100% in network. No day limit for In-Network care. You must precertify for both In-Network and Out-of-Network Home Health Care Services. Failure to precertify Out-of-Network services may result in a reduction in benefits payable for Home Health Care services in accordance with the Precertification/ Preauthorization policies of the PPO. **Out-of-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.	Subject to Deductible and coinsurance. Services must be ordered by your attending physician. You will be subject to any balances if non-participating Home Health Care Agency is used. Lifetime Benefit Maximum is $25,000 (for services rendered on or after October 1, 2003).

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 respiration therapy
- Medical or surgical supplies and equipment
- Prescription drugs and medications
- Oxygen and its administration
- Dietitian services
- Hemodialysis
- Laboratory services
- Medical social services consulting
- Antibiotic intravenous drug treatment
- Durable medical equipment
- Well mother/well baby care following release from an inpatient maternity stay

You must be essentially homebound. Benefits are also provided for certain other medical services and supplies when provided along with a primary service. To be eligible for coverage, your physician must submit 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 required preauthorization for payment for Home Health Care services, you must follow the Claims Payor's procedures.

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.

Hospice Care

(See the PPO section for information on Personal Choice 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. For Basic Option Members, Hospice Care is subject to your annual Deductible and coinsurance. You may contact your health plan 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 as well.

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

Human Organ and Tissue Transplant

If a human organ or tissue transplant is provided from a living donor to a human transplant recipient, the Facility and Professional Provider Services described above 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.

Mastectomy & Breast Reconstruction

Mastectomies are covered if Medically Necessary and performed on an inpatient basis (mastectomies 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.

Maternity Services

Childbirth services, including pre- and post-natal care, are covered for employee Members and the spouses and Dependent daughters of employee Members. If you are in the PPO Option, maternity services must be coordinated by a network OB/GYN. Under the HMO Option, services must be coordinated by an OB/GYN or your PCP. If pregnancy is confirmed and the Member chooses to continue receiving care from the network OB/GYN, the OB/GYN will obtain proper authorization from the Claims Payor for appropriate care. 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 or has a pecuniary or proprietary interest in the abortion, coverage is available only if there is provided 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.

Mental Health and Substance Abuse Services

Mental health and substance abuse treatment and services are not covered by your medical plan. Please see the section on the Mental Health and Substance Abuse Program. The **first claim** for an office visit incurred with a non-mental health and substance abuse professional and coded with a psychiatric diagnosis will be covered by your medical plan.

Medical Detoxification Treatment for Substance Abuse: The medical plan covers detoxification as an inpatient or outpatient, whichever is determined to be medically appropriate by your Claims Payor. **For Personal Choice PPO Members**: Coverage for detoxification is limited to a Maximum of seven days per admission and four admissions per lifetime. **For Basic Option Members**: Non-participating substance abuse treatment facilities are not covered.

Special Medical/Behavioral Health Care Benefits: Both your medical and managed behavioral health plans 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 health 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.

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 – $25 specialist visit Copayment (PPO & HMO)
- Dental Services – Removal of fully and partially bony-impacted teeth is covered – $25 specialist Copayment (PPO & HMO)
- Human organ and tissue transplant
- Podiatric care for treatment of disease or injury – $25 specialist Copayment (PPO & HMO)
- Diabetic education, syringes, chem. strips and other diabetic supplies (check with your Claims Payor for specific procedures)
- Durable Medical Equipment (rental or purchase). Coverage of Durable Medical Equipment may be determined by the Claims Payor in accordance with its medical policies, subject to limitations or exclusions as provided by the PEBTF
- Artificial limbs and eyes, orthopedic braces and prosthetic devices (replacement of these devices are not covered except for Dependent children and for breast prostheses due to mastectomy)
- Repair of equipment, devices and supplies

Skilled Nursing Facility (SNF)

Benefit Limits Under all Plans:

PPO	HMO	Basic
Covered 100% in network. You may receive 240 days at a participating facility. You must precertify for both In-Network and Out-of-Network services. Failure to precertify may result in a reduction of benefits. Benefit renews 12 consecutive months from the first date of admission to a SNF. **Out-of-Network**: 70% plan payment after Deductible, up to 240 days. Non-participating Providers may balance bill for the difference between Plan Allowance and actual charge.	Covered 100% in network. You may receive 180 days per year at participating facility. Benefit renews 12 consecutive months from the first date of admission to a SNF.	Subject to Deductible and coinsurance. Must be ordered by your attending physician. The Claims Payor must concur with the attending physician's certification that the skilled care requiring the services of a professional nurse is Medically Necessary on a daily basis. Lifetime Benefit Maximum is $100,000 for services rendered on or after October 1, 2003

Benefits are provided for a Skilled Nursing Care Facility (SNF), when Medically Necessary. The Member must require treatment by skilled nursing personnel which can be provided only on an inpatient basis in a SNF. Admission must be for the continued treatment of the same or a related condition for which you had been hospitalized.

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.

Intermediate care includes any care that is ordered by and provided under the direction of a physician. Intermediate care is provided on a continuous 24-hour basis to Members who, because of their mental or physical disabilities, do not require the degree of care and treatment in a hospital or SNF. Your plan **does not** provide coverage for intermediate care.

Custodial care is provided primarily for the maintenance of the Member or is designed to assist the Member in performing activities of daily living. Custodial care includes, but is not limited to, assistance in walking, bathing, dressing, eating, preparation of special diets and supervision of self-administered medications, which do not require the constant attention of trained medical personnel. Your Plan **does not** provide coverage for custodial care.

Surgical Treatment for Morbid Obesity

The Plan generally does not provide benefits for the surgical or nonsurgical treatment of obesity or to control or manage weight. The Plan does provide a limited benefit for the surgical treatment of Morbid Obesity (see Glossary of Terms), if such condition is determined to exist by the Claims Payor and the Member has not responded, in the determination of the Claims Payor, to conservative measures (such as dietary or lifestyle changes. The following gastric restrictive procedures are the only eligible covered procedures for the treatment of Morbid Obesity.

- Gastric bypass using a Roux-en-Y anastomosis
- Vertical banded gastroplasty
- Gastric stapling

However, coverage is **not** provided for any of the following:

- Components for the treatment of Morbid Obesity, including but not limited to, nutritional counseling, nutritional supplements, commercial weight loss programs, exercise equipment or gym memberships).
- The performance of a panniculectomy (a surgical procedure to remove an unwanted fatty abdominal apron or panniculus) or other surgical procedure to remove excess skin as a result of weight loss, regardless of the reason or reasons such a procedure is recommended

- Any surgical procedure considered Experimental/Investigative and the services and supplies in connection therewith, including but not limited to, the following:
  - Gastric bypass using a Billroth II type of anastomosis, including the Mini Gastric Bypass
  - Laparoscopic adjustable gastric banding
  - Biliopancreatic bypass
  - Biliopancreatic bypass with duodenal swith

Wellness Benefits

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

PPO Option

Summary

- PPO Option covers medical services designated in the PEBTF Plan Document
- PPO Option offers both an In-Network and an Out-of-Network benefit
- In order to receive the highest level of benefits, you must choose one of the In-Network physicians or facilities
- You may self refer for Medically Necessary care, as defined by the Plan
- $15 Copayment for office visits during regular hours – $20 Copayment for PCP office visits after hours, if the physician chooses to charge an after hours Copayment (for general practitioners, family practitioners, internists and pediatricians)
- $25 specialist office visit Copayment
- $50 Copayment for emergency room visit (waived if admitted to a hospital)
- Coverage percentages for services rendered by Non-Network Providers are based on the UCR Charge or Plan Allowance, as determined by the Claims Payor. Payment of amounts in excess of the UCR Charge or Plan Allowance is your responsibility

Benefit Highlights

	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. Certain non-network facilities continue at 70%	Does not apply	$1,500 per person $3,000 per family (plus the Deductible)
PREVENTIVE CARE		
Adult routine physical exams and preventive care (age 18 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
• Pediatric immunizations (under age 21) • Annual mammogram (age 40 and over) • Annual Pap Smear	Covered in full	70% plan payment; Member pays 30% Deductible waived

	Network Providers	Non-Network Providers
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%
OTHER PROVIDER SERVICES		
• Outpatient physical, occupational & speech therapy (due to a medical diagnosis, not developmental)	$15 Copayment per office visit	70% plan payment; Member pays 30%
• Manipulation therapy (restorative, chiropractic – 15 Medically Necessary visits, then Treatment Plan submitted if required by the PPO; not for maintenance of a condition) • Cardiac rehabilitation (18 visits per year) • Pulmonary rehabilitation (12 visits per year) • Respiratory Therapy	$15 Copayment per office visit	70% plan payment; Member pays 30%
• 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)	Covered in full	70% plan payment; Member pays 30%
OUTPATIENT HOSPITAL SERVICES		
• Professional fees & facility services, including: lab, x-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis, anesthesia & surgery	Covered in full	70% plan payment; Member pays 30%
• Outpatient Diabetic Education	Covered in full	Not covered

	Network Providers	Non-Network Providers
INPATIENT HOSPITAL SERVICES		
Professional fees & facility services including: room & board & other Covered Services (precertification is required for most services)	Covered in full (365 days per benefit period)	70% plan payment; Member pays 30% (70 days per calendar year)
EMERGENCY CARE		
• Emergency treatment for accident or medical emergency	Covered in full; $50 emergency room Copayment (waived if admitted)	
• 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 in full	Covered in full
DURABLE MEDICAL EQUIPMENT		
Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics (replacements covered for prosthetics and orthotics only for Dependent children & replacements for breast prostheses due to mastectomy)	Covered in full	70% plan payment; Member pays 30%
LIFETIME MAXIMUM BENEFIT	Unlimited	$1,000,000

IMPORTANT NOTE: Participating (Network) Providers agree to accept the Plan's Allowance as payment in full – often less than their normal charge. If you visit a non-Network Provider that does not participate, you are responsible for paying the Deductible, coinsurance and the difference between what the Provider charges and the maximum charge (called the UCR Charge or Plan Allowance) determined by the Claims Payor for the service provided (see Out-of-Network below). The Plan does not pay any percentage of amounts in excess of the UCR Charge or Plan Allowance, as applicable.

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

Here is a simple example. You obtain a covered service from a non-Network Provider who charges $1,000. However, the Claims Payor determines that the Usual, Customary and Reasonable (UCR) Charge/Plan Allowance for the services is $950. This is your first non-Network covered service for the year so the Deductible applies. You are responsible for paying both the deductible ($400) and the amount charged in excess of the UCR Charge/Plan Allowance ($50). Of the remaining $550, the plan pays 70%, or $385, and you are responsible for paying the remaining 30% or $165. Total out-of-pocket expense is $615.

If you or your Dependent receive or plan to receive services from a non-PPO network Provider who recommends one of the services listed under Care or Treatment Requiring Prior Authorization, it is your responsibility to obtain prior authorization from your plan. 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

Out-of-Network

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

After the Deductible, the PPO plan will pay 70% of the next $5,000 of most Out-of-Network covered expenses. Once you reach the Out-of-Pocket Maximum, the plan pays 100% of your 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 UCR Charge or Plan Allowance (as applicable).

NOTE: Covered expenses do not include charges in excess of the UCR (Usual, Customary and Reasonable) Charge/Plan Allowance for a service or supply as determined by the PPO. The percentage reimbursement described in the chart above for non-Network Providers is based on the UCR Charge/Plan Allowance. For example, a "70% plan payment" for non-Network Providers means 70% of the UCR Charge/Plan Allowance. You are responsible for paying the entire amount of the charge in excess of the UCR Charge or Plan Allowance (as applicable), in addition to any Deductible or coinsurance.

For Out-of-Network care, there is a $1,000,000 lifetime Maximum.

All claims for Out-of-Network services must be filed on forms provided by the PPO. All claims must be received by the PPO no later than one year from the date of service.

Care or Treatment Requiring Preauthorization

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

In-Network precertification is performed automatically for you by your physician or the network specialist providing the care.

It is your responsibility to obtain precertification for those Out-of-Network services requiring it. For Out-of-Network Care, such as hospitalization, be sure to follow the precertification guidelines for your plan. Contact your health plan for specific preauthorization guidelines. The procedures and services that require preauthorization may vary depending on the policies of the PPO. In an emergency, the hospital should call, but it is your responsibility to ensure that the call is made. Contact your PPO for specific information about services that require precertification.

If you present your ID card to a participating Provider and the participating Provider fails to obtain or follow preauthorization requirements, you will not be subject to penalties.

If you use a non-participating Provider, it is your responsibility to make sure that preauthorization is received.

If prior approval is not obtained or the requirements not followed and you undergo the procedure, then benefits will be provided for Medically Necessary and appropriate services. However, in this instance, the amount of the allowance will be reduced by 20%.

Preauthorization of scheduled elective admissions and selected outpatient services should be obtained at least seven days prior to the date of service. If services are provided on an emergency basis, notification should occur within 48 hours or within two business days following such services.

Preauthorization requirements do not apply to services provided by a hospital emergency room Provider. In the event an inpatient admission results from an emergency room visit, notification must occur within 48 hours or two business days of the admission. If the hospital is a participating Provider, they are responsible for performing the notification.

For Personal Choice Members: If services requiring prior authorization are received outside of the Personal Choice Network without obtaining prior authorization from Personal Choice's Patient Care Management Department, benefits will be reduced by $1,000 for inpatient hospital facility care and 20% for all other services. This means that if you use a non-Personal Choice Network Provider and do not obtain prior authorization for those services requiring such prior authorization, the amount you will have to pay for inpatient care will be increased by $1,000 and the amount you will have to pay for other services will be increased by 20%, possibly more if your Provider is not a Blue Cross and Blue Shield participating Provider.

Hospice Care for Personal Choice Members

See page 22 for Hospice benefit for all other plans.

Respite Care, of a Maximum of seven days every six months is covered at 100% In-Network. Out-of-Network services are covered at 70% of the UCR Charge or Plan Allowance, whichever is applicable. Precertification is required for all In-Network and Out-of-Network Hospice care. Failure to precertify Out-of-Network services may result in a 20% reduction in benefits payable for Hospice Care services.

You are eligible for Hospice Services when your attending physician certifies that you have a terminal illness with a medical prognosis of six months or less and when you elect to receive care primarily in your home to relieve pain and to enable you to remain at home rather than to receive other types of care.

You are also eligible for short-term inpatient care in a Medicare-certified Skilled Nursing Facility when the Hospice considers such care necessary to relieve primary caregivers in your home. Up to seven days of such care every six months will be covered.

Hospice benefits are subject to Personal Choice precertification.

No Hospice Care benefits will be provided for:

- Services and supplies for which there is no charge
- Research studies directed to life lengthening methods of treatment
- Services or expenses incurred in regard to the patient's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property)
- Care provided by family members, relatives and friends
- Private duty nursing

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 Blue Card 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.

Blue Card 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.

NOTE: You are still required to contact the PPO for preauthorization when outside the PPO's service area.

Grievance – Appeal Process

You must comply with the written grievance and appeal procedures of your PPO. Each PPO has a grievance procedure available to you. The PPO will reject any appeal which is not timely filed with the PPO as outlined in the grievance procedures.

Except as described in the following sentence, the PEBTF will accept the PPO's determination that you are entitled to benefits in accordance with the PPO's grievance procedure. The PEBTF may decline to accept the PPO's determination if the Board of Trustees determines 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 results of the PPO's grievance process, you have the final right of appeal to the PEBTF Board of Trustees, Attn: Executive Director, 150 S. 43rd Street, Harrisburg, PA 17111. The appeal to the Trustees must be postmarked within 30 days of the PPO's final decision. The Trustees will review your appeal, including such other pertinent information as you may present and will notify you of their decision, and the reasons therefore, within 60 days of the date of the appeal.

All appeal decisions rendered by the Trustees are final.

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

HMO Option

Summary

- HMOs cover medical services designated in the PEBTF Plan Document
- Treatment for medical services is coordinated by a Primary Care Physician (PCP) – some HMOs may not require PCP referrals (check with your plan)
- $15 Copayment for PCP office visits during regular hours; $20 Copayment for PCP office visits after hours, if the physician chooses to charge an after hours Copayment
- $25 specialist office visit Copayment
- $50 Copayment for emergency room visit (waived if admitted to hospital)

HMO Provider Networks

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

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

Primary Care Physician

You must choose a Primary Care Physician (PCP) from the network of HMO doctors. Your PCP acts as your personal physician, 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 of the HMOs may not require PCP-referral (check with your health plan). Women may self refer for all gynecological care in all HMO plans.

You may choose a general or family practitioner, internist or pediatrician as your PCP. 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 office of your HMO. You may request to change your PCP by calling or writing your HMO's member services office. You must notify your local Human Resource Office of any PCP change. The effective date of the change will depend on the date you notify member services.

Failure to receive authorization for services from the HMO and/or your PCP will result in non payment of those services.

Benefit Highlights

	Network Providers
DEDUCTIBLE (per calendar year)	None
OUT-OF-POCKET MAXIMUM	Does not apply
PREVENTIVE CARE	
Adult routine physical exams and preventive care (age 18 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) • Annual mammogram (age 40 and over) • Annual Pap Smear	Covered in full
MATERNITY SERVICES	
• Office visits	$15 PCP/$25 specialist Copayment first office visit
• Hospital and newborn care	Covered in full
PHYSICIAN VISITS	
• Office visits (PCPs include family practice, general practice, internal medicine and pediatrics)	$15 Copayment per office visit ($20 after hours)
• 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 & speech therapy (due to a medical diagnosis, not developmental) • Manipulation therapy (restorative, chiropractic Medically Necessary visits; not for maintenance of a condition) • Cardiac Rehabilitation • Pulmonary Rehabilitation • Respiratory Therapy	$15 Copayment per office visit Combined Maximum of 60 visits per year for all outpatient therapies
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

	Network Providers
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 admitted)
• Ambulance services for emergency care	Covered in full
DURABLE MEDICAL EQUIPMENT	
Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics (replacements covered for prosthetics and orthotics only for Dependent children & replacements for breast prostheses due to mastectomy)	Covered in full
LIFETIME MAXIMUM BENEFIT	Unlimited

Care or Treatment Requiring Preauthorization

Precertification, also called preauthorization, is an advance review of your proposed treatment to ensure it is Medically Necessary. Precertification does not verify that you are covered by the health plan or guarantee payment. All inpatient admissions and certain outpatient referrals and procedures require approval before they are performed. Failure to precertify in accordance with your HMO's procedures will result in non payment for services.

Care Outside of the HMO Area/Student Benefits

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

Grievance – Appeal Process

You must comply with the written grievance and appeal procedures of your HMO. Each HMO has a grievance procedure available to you. The HMO will reject any appeal that is not timely filed with the HMO as outlined in the grievance procedure.

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 Board of Trustees determines 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 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 Board of Trustees 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 Board of Trustees, Attn: Executive Director, 150 S. 43rd Street, Harrisburg, PA 17111. The appeal to the Trustees must be postmarked within 30 days of the Department's advisory opinion. The Trustees will review your appeal, including the Department of Health's recommendation and such other pertinent information as you may present, and will notify you of their decision and the reasons therefore, within 60 days of the date of the appeal.

All appeal decisions rendered by the Trustees are final.

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

Mental Health & Substance Abuse Program

Summary

The PEBTF contracts with United Behavioral Health (UBH) to provide mental health and substance abuse rehabilitation treatment services, whether inpatient or outpatient. **(Inpatient detoxification services will be coordinated by UBH but services are provided through your PPO, HMO or Basic Option when clinically necessary.)**

UBH provides a specialized network of professional Providers and treatment facilities, which have been thoroughly evaluated according to comprehensive guidelines. UBH Network Providers have fulfilled specific selection and credentialing criteria and are committed to your health and well-being.

With the Mental Health and Substance Abuse Program you should experience minimal out-of-pocket expenses and no claim forms as long as you use UBH In-Network Providers. However, you have the freedom to receive eligible mental health services from Out-of-Network Providers, but at a lower level of benefit coverage.

Covered Services

Service	Network	Non-Network
Mental Health		
Outpatient	100% after $15 Copayment Annual max: 60 visits (network/non-network combined)	100% of Usual, Customary and Reasonable (UCR) Charges after $200 annual Deductible (outpatient/inpatient combined) up to a max of $35 paid/visit; annual max: 60 visits (network/non-network combined) Limited to licensed psychiatrists, psychologists, social workers and nurses. Subject to retrospective review.

Service	Network	Non-Network
Inpatient & Intermediate* Note: $300 penalty for non-notification	100% Annual max: 60 days (Network/non-network combined) One physician visit per covered day unless covered by per diem	70% of Usual, Customary and Reasonable (UCR) Charges after $200 annual Deductible (outpatient/inpatient combined); annual max: 60 days (network/non-network combined); one physician visit per covered day paid at 70% of UCR after annual $200 Deductible is met. Subject to retro review.
Substance Abuse		
Outpatient Note: Additional visits available through benefit substitution: 1 substance abuse inpatient day = 2 outpatient visits	100% Annual max: 60 visits Lifetime max: 120 visits	Not Covered
Inpatient Note: Additional days available through benefit substitution: 2 outpatient substance abuse visits = 1 inpatient substance abuse day; 15 additional days max allowable. Intermediate* levels of care are available through benefits substitution.	100% Annual max: 30 days Lifetime max: 90 days	Not Covered
Ambulatory Detoxification	100%	Not Covered
Medical Detoxification	Not covered; medical detox covered by medical plan	Not covered; medical detox covered by medical plan
* Intermediate care includes partial hospitalization, day treatment and intensive outpatient. With the exception of state mandated benefits, the standard UBH benefit substitution ratios will be used.		

Network Care

To take advantage of the benefits that are available through the Mental Health and Substance Abuse Program you should follow these steps:

- **Call 1-800-924-0105**. 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 the best-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.
- After your initial meeting(s), the mental health or substance abuse professional will discuss your needs and treatment goals with a UBH 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 must contact your UBH counselor for a new referral**.
- Your treatment will be based on the individual Treatment Plan developed by you, your mental health or substance abuse professional and the UBH 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 UBH care manager will monitor your progress and work with your Provider to ensure that your needs are met.

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 UBH to determine the clinical necessity. Members will receive non-network benefits only for those services deemed clinically necessary. You are responsible for submitting charges to UBH for review and payment. To obtain a claim form, call a UBH Member Services Representative at 1-800-924-0105, prompt 3. Representatives are available Monday through Friday, 9:00 a.m. to 8:00 p.m.

UBH Members who receive inpatient care from a non-Network facility must notify UBH within 24 hours of admission to any inpatient, residential, partial or structural outpatient program or risk a penalty of $300 for non-notification.

Special Medical/Behavioral Health Care Benefits

Both your medical and managed behavioral health plans 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 health plan, physicians may diagnose any of these conditions, and prescribe and monitor medications. No counseling benefits are available under the medical health plan.

Under the managed care behavioral health plan, Members **must** call for precertification to a network psychiatrist who may diagnose any of these conditions, develop and implement a Treatment Plan and prescribe and monitor medications. Additionally, the managed behavioral health plan provides benefits for counseling services to both the Member and other family Members.

Psychological Testing

Members and their eligible Dependent(s) are entitled to receive four hours of psychological testing on an annual basis from a UBH network Provider. **This service requires precertification**. When Medically Necessary, additional hours of psychological testing may be covered under the network managed behavioral health outpatient benefit. Non-network or non-precertified outpatient psychological testing services must be Medically Necessary (as determined by UBH) to be covered by the outpatient non-network mental health and substance abuse benefit plan.

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 rehabilitation benefits administered by UBH. Ask the facility or the person providing your care to contact UBH at 1-800-924-0105 as soon as possible so that UBH can effectively coordinate with your medical doctor the mental health or substance abuse treatment you will need.

Mental Health Appeal Process

If you disagree with the individual Treatment Plan proposed by UBH and the mental health or substance abuse professional to whom you were referred, call UBH Member services at 1-800-924-0105 and tell the representative that you would like to appeal your Treatment Plan. You can also ask UBH about how a claim was processed or paid. If after discussing your situation with UBH Member services, the matter has not been satisfactorily resolved or the Treatment Plan altered, you can submit a formal request for review. This request should be submitted to Member/Provider Relations Department at 1600 Market Street, Suite 2050, Philadelphia, PA 19103-7220. UBH will provide a written response to the appeal within 30 days.

If you have had an In-Network or non-network claim denied, you must submit a written request for review to UBH postmarked within 60 days of the effective date of the denial. The request for review should be submitted to the address specified above. UBH will provide a written response to the appeal within 30 days.

There are additional levels of appeal available, if necessary. You may contact UBH or the PEBTF for further information.

Services Excluded From All Medical Benefit Options

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

- Abortions, unless necessary to save the life of the mother or in the case of rape or incest (documentation will be requested)
- Activity therapy, mainstreaming and similar treatment
- Acupuncture
- Adult immunizations and immunizations for travel or employment
- Adult replacement prostheses and cranial prostheses except for replacement breast prostheses due to mastectomy
- 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 autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation that extends beyond traditional medical management, or for inpatient confinement for environmental change
- Charges associated with transportation of blood, blood components or blood products
- Charges for blood donors with blood donation
- Charges in excess of UCR Charge or Plan Allowance as determined by the Claims Payor
- Cognitive rehabilitative therapy
- Copayments for prescription drugs

- Correction of myopia or hyperopia 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); **For Personal Choice Members**: For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body and from which no improvement in physiologic function can be expected

- 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 that does not meet the definition of Durable Medical Equipment in accordance with the [Claims Payor's] or [PEBTF's] medical policy, including personal hygiene or convenience items (air conditioner, air cleaner, humidifiers, adult diapers, fitness equipment, etc.)

- Estimates to repair a DME item

- Examinations or treatment ordered by the court in connection with legal proceedings unless such examinations or treatment otherwise qualify as covered services

- Exams for employment, school, camp, sports, licensing, insurance, adoption, marriage, driver's license, foreign travel, passports or those ordered by a third party

- Expenses directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apiocoectomy (dental root resection), root canal treatments, soft tissue impaction, alveolectomy and treatment of periodontal disease; emergency dental services from an accidental injury are covered under all medical plans

- 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 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 your plan's wellness programs

- Mental health and substance abuse treatment services not covered by the managed Mental Health and Substance Abuse Program

- Morbid Obesity: Services and supplies for the surgical treatment of Morbid Obesity which are not approved under the PEBTF's limited coverage of such procedures (see Benefits Covered Under All Medical Options), as well as services and supplies with respect to the non-surgical treatment of obesity and the control or management of weight (including the non-surgical components of eligible surgical treatment), including without limitation nutritional counseling, nutritional supplements, commercial weight loss programs, exercise equipment or gym memberships. 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

- 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)

- 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)

- 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

- 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 his 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, naturopaths or homeopaths including those working under the direct supervision of an approved Provider

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

- Services for which you have no legal obligation to pay

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

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

- Services paid for by any government benefits

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

- Services performed by a Professional Provider enrolled in an educational training program when such services are related to the education and training program and provided through a hospital or university (charges are usually part of the facility charges and can not 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

- Tinnitus Maskers

- 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

- 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

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

Exclusions Under the Basic Option Only

- Adult Routine or periodic physical examinations, including charges in excess of the allowance for non-participating Provider charges, except for an annual routine screening mammography or a routine annual gynecological exam

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 for the PEBTF.

Supplemental Benefits

Summary

- Prescription Drug
- Vision
- Dental
- Hearing Aid

Most PEBTF Members are eligible for Supplemental Benefits: Prescription Drug, Vision, Dental, and Hearing Aid services. Coverage and services offered by Supplemental Benefits for prescription drug, vision and hearing aid are not affected by the annual PEBTF Open Enrollment for medical plans. The medical plan option you choose does not affect your Supplemental Benefits. You will be able to change dental options during the annual Open Enrollment.

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.

Eligibility

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

- Employees and their eligible Dependent(s) hired after August 1, 2003, will become eligible for Supplemental Benefits immediately following the date you complete six months of employment (See “Six Months of Employment” on page 4).

- State Police Cadets are not eligible for Supplemental Benefits.

- You may cover your spouse who is a retiree covered under the Retired Employees Health Program (REHP) for prescription, vision, dental and hearing aid. The Retiree Member’s coverage under the REHP Prescription Drug Plan will be primary.

- Certain Dependent parents may qualify for coverage under the Prescription Drug Program provided certain conditions are met. Please contact the PEBTF for further details.

- Employees who have workers' compensation claims, which resulted from Commonwealth employment and are administered by the Commonwealth's workers' compensation carrier, are required to use their prescription drug card to obtain medications used for their work-related injuries. Present your prescription drug ID card to a participating pharmacy and pay the usual Copayment. The Commonwealth will automatically reimburse you for any prescription drug Copayments incurred for treatment of work-related injuries within 45 days.

- Part-time employees must enroll in Medical and Supplemental Benefits.

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

Prescription Drug Plan

Summary

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

The prescription drug benefit gives you and your eligible Dependent(s) the opportunity to obtain most Medically Necessary medications at the Prescription Drug Plan's **participating pharmacies** throughout Pennsylvania and the United States.

Coverage also is available for a dependent parent(s) of an Eligible Member who has no spouse or other Dependent enrolled for Supplemental Benefits. In order to apply for this coverage, the parent(s) must be totally dependent upon the employee Member for support, according to Internal Revenue Service qualifications, and be able to substantiate this dependency to the PEBTF. The dependent parent must be ineligible to receive prescription drug coverage from any other source, including federal, state or local governments. Proper certification forms and guidelines for determination of eligibility for this coverage can be obtained through the PEBTF.

If you use a pharmacy that does not participate in the Prescription Drug Plan's network, or you do not present your prescription drug 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 may also 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.

In each case where you pay up front and file a claim for reimbursement, the Prescription Drug Plan will make reimbursements based on the cost of the drug as determined by the plan. The pharmacy charge in excess of the cost of the drug, if any, is your responsibility. This reimbursement amount may be less than the amount that would have been paid if you had used your prescription drug card at a participating pharmacy. The copays applicable to card users are not available if you do not present your card.

To find out if your pharmacy participates with your Prescription Drug Plan, call your pharmacy or contact the plan. The telephone number appears on your Prescription Drug ID Card.

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 plus the cost difference between the brand 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, where the plan includes a list of generic and brand-name drugs called a formulary. The formulary summary is available at www.pebtf.org. Drugs included on that list are called "preferred." Drugs not on that list are called "non-preferred." The following details the Copayments under your Prescription Drug Plan.

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 Designated Pharmacy – up to 90 Day Supply	**Your Copayment**
Tier 1: Generic drug	$20
Tier 2: Preferred brand-name drug	$36, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug	$72, plus the cost difference between the brand and the generic, if one exists

Retail Prescriptions – up to a 30-day supply

- Present your identification 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.

Maintenance Prescriptions – up to a 90-day supply
Two Options – Mail Order or Designated Pharmacy

The Prescription Drug Plan includes two options for obtaining long-term maintenance prescriptions (up to a 90-day supply). The mail order option is available through the mail order facility. Or, if you prefer you may use the Plan's designated pharmacy for your maintenance supplies. There are Copayment differences between the two maintenance feature options. See the chart on the preceding page for Copayment amounts.

Covered Drugs

- Federal legend drugs
- State restricted drugs
- Compound prescriptions
- 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)

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
- Medication for a patient confined to a rest home, nursing home, sanitarium, extended care facility, hospital, or similar entity (except for participating nursing homes). Basic Option Members: Prescription drug claims incurred in non-participating nursing homes should be submitted to your medical plan
- Medications lawfully obtainable without a prescription (over the counter items)
- Non-sedating antihistamines
- Medications for weight reduction
- Prescription drugs administered while you are at an outpatient facility
- Refill prescriptions resulting from loss, theft or damage
- Smoking cessation drugs
- Syringes, needles and chem strips
- Unauthorized refills
- Any other exclusions as determined by the Board of Trustees

Quantity Limitations

There are certain prescription drugs that are subject to quantity limits. The Quantity Limit List is posted on the PEBTF web site, www.pebtf.org, Publications/Forms.

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

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, SSRI's which are used for depression, PPI's which are used to control Gastroesophageal Reflux Disease and COX-2 or NSAID drugs which are used for pain and arthritis.

If you have tried a first-line therapy without success, your physician may contact the Prescription Drug Plan. The telephone number appears on your Prescription Drug Plan ID card.

Proton Pump Inhibitors Supply Limits

Proton Pump Inhibitors are drugs used for Gastroesophageal Reflux Disease (GERD) and other gastrointestinal conditions. The Prescription Drug Plan will cover a 90-day lifetime supply. To qualify for additional supplies, your physician must demonstrate that you have a condition for which one of these drugs is recommended. Your physician will be required to submit information such as results of an endoscopic examination to the Prescription Drug Plan to continue coverage of the drugs under this plan. Your physician may contact the Prescription Drug Plan. The telephone number appears on your Prescription Drug Plan ID card.

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).

If you try to purchase medications listed on the Prior Authorization List (the Prior Authorization List is on the PEBTF web site – www.pebtf.org), you will be advised at the pharmacy that verification of a diagnosis for the condition being treated will be necessary. To obtain verification, your treating physician should contact the Prescription Drug Plan. The telephone number appears on your Prescription Drug Plan ID card.

If the request is approved for coverage, you will receive written correspondence from the Prescription Benefit Manager (PBM). 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 will receive written correspondence from the PBM explaining the reason for the denial. If you are not satisfied with the PBM's decision, you have the right to appeal to the PEBTF via telephone or mail. Once you have contacted the PEBTF to start your appeal process, the PEBTF will forward a questionnaire that you and your attending physician must complete and return to the PEBTF. The PEBTF will forward your information to an outside medical consultant for review.

If the medical consultant agrees that the medication should not be approved for coverage, the PEBTF will notify you, in writing, of the denial. You then have the right to a final appeal to the PEBTF's Board of Trustees, Attn: Executive Director, 150 S. 43rd Street, Harrisburg, PA 17111. Any such appeal must be postmarked to the Board of Trustees within 60 days of the initial denial. If the Board of Trustees approves the appeal, the PEBTF will notify you and the Prescription Drug Plan of the approval. If the Board of Trustees denies the appeal, you will be notified of the denial. **The decision of the Board of Trustees is final**.

Filing a Drug Claim Form

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

- Use a pharmacy that is not part of the Prescription Drug Plan's network
- Do not use the Prescription Drug Plan ID card when filling a prescription
- Purchase allergenic extracts from a physician – use Allergenic Extract Claim Form
- Purchase a prescription drug from a physician

Prescription Drug Claim Forms are available from the Prescription Drug Plan or the PEBTF. The Prescription Drug Plan will accept Prescription Drug Claim Forms completed in their entirety along with the receipt that must include:

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

All Prescription Drug Claim Forms must be received within one year from the date the prescription was filled.

You will be reimbursed based on the amount a participating 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.

Allergenic Extract Serum

Allergenic extracts purchased from a physician or pharmacy are eligible for coverage under the Prescription Drug Plan. However, if an allergenic extract serum contains a drug that is excluded from the Prescription Drug Plan, it will not be covered. To apply for reimbursement, the physician or facility and the Member must complete and submit an Allergenic Extract Claim form for each vial of allergenic extract purchased. Allergenic Extract Claim Forms are available from the Prescription Benefits Manager (PBM) and the PEBTF. The cost of the extract is the physician or facility's charge for each vial. The cost for the office visit is not eligible under the Prescription Drug Plan – check with your Health Plan. Plan reimbursement to the Member is calculated as follows:

1. If the cost of each vial of extract is equal to or less than the amount indicated below, the Member's cost is the actual cost of each vial and no reimbursement is due.

Generic Drug	$10.00
Formulary Brand Name Drug	$18.00
Non-Formulary Brand Name Drug	$36.00

2. If each vial of extract is a Generic Drug, and the cost is in excess of $10,00 the Member's cost is limited to $10.00 for each vial.
3. If each vial of extract is a Formulary Brand Name Drug, and the cost is in excess of $18.00 per vial, the Member's cost is limited to $18.00 for each vial plus, if a generic equivalent is available, the difference between the cost of the Formulary Brand Name Drug and the Generic equivalent, as determined by the PBM.
4. If each vial of extract is a Non-Formulary Brand Name Drug and the cost is in excess of $36.00 per vial, the Member's cost is limited to $36.00 for each vial plus, if a generic equivalent is available, the difference between the cost of the Non-Formulary Brand Name and the Generic equivalent, as determined by the PBM.

Filing a Claim for Residents of Nursing Homes – Basic Option Members Only

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 Drug Plan, claims should be submitted to the Basic Option plan for payment consideration.

Eligible prescription drug claims will be reimbursed through the Basic Option, subject to your annual Deductible and coinsurance. The Basic Option timely filing limitation will also be enforced.

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

Using your Prescription Drug Card for Workers' Compensation Related Prescriptions

Employees who have workers' compensation claims, which 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 for their work-related injuries. Benefit limitations, such as Step Therapy, Prior Authorization, Quantity Limits, etc. under the Prescription Drug Plan do not apply to prescription drugs needed for workers' compensation injuries. Present your Prescription Drug Plan ID card to a participating pharmacy and pay the usual Copayment. The Commonwealth will automatically reimburse you for any prescription drug Copayments incurred for work-related injuries within 45 days and will also reimburse the PEBTF for the prescription expense.

Vision Plan

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) – American or foreign-made frames

The Vision Program provides you and your eligible Dependent(s) 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 which includes ophthalmologists, optometrists and opticians. Services and materials may be provided at minimal cost to you by a participating Provider. If you select a non-participating Provider, payment will be made directly to you according to the established fee schedule.

Covered Services

Vision Examination – Covered in full at a participating provider

Routine vision analysis and glaucoma test for you and your eligible Dependent(s) 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 Dependent(s) (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 Dependent(s) (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 PEBTF 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 Dependent(s) – 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.

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

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%.

Special Limitations

Cosmetic Contact Lenses – Maximum plan payment of $50 (in lieu of all other benefits including Vision Analysis). 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

How To Obtain Vision Benefits

Use your Vision Plan ID card when obtaining vision care services. When making your appointment with a participating Provider, please notify them that your coverage is administered by NVA and provided by the PEBTF, Sponsor #013. The Provider will telephone the Vision Plan to verify your vision care eligibility.

You may contact NVA at 1-800-672-7723 to obtain information on your eligibility for services.

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

Use of Non-Participating Vision Providers

If the Provider you select is not a participating optometrist, ophthalmologist or optician, you will be responsible for payment of the full amount at the time of service. 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 Bifocals Ex-Bifocals Trifocals Aphakic	 $15.00 $24.50 $26.50 $31.00 $60.00
Additional Allowance – per pair Plastic Lenses	Single Vision $ 1.00 Multifocal $ 4.00
Pink #1 or #2 Tint	Single Vision $ 3.00 Multifocal $ 4.00
Photo Gray Extra (Glass only) (Brown and Gray)	Single Vision $14.00 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 received within one year from the date of service.

Vision Plan Appeal Process

If a claim for benefits is denied in full or in part, you shall be notified of the denial in writing and you shall have an opportunity to appeal the denial. The notice of denial shall be sent to you by the Vision Plan and it will state the specific reason(s) for the denial.

Notice of denial shall be provided to you no later than 90 days after receipt of the claim by the Vision Plan unless special circumstances require an extension of time for processing the claim.

You have the right to appeal a fully or partially denied claim by filing a written request for review of the claim with the Vision Plan.

All appeals must be received within 60 days after the claim is denied. The Vision Plan will notify you of its decision within 60 days of the request.

If you are not satisfied after completing the appeal process with the Vision Plan, you have a right to a final appeal to the PEBTF Board of Trustees, Attn: Executive Director, 150 S. 43rd Street, Harrisburg, PA 17111. The appeal to the Trustees must be postmarked within 30 days of the date of the Vision Plan's claim denial. The Trustees will review the appeal and will notify you of their decision within 60 days of the date that the Trustees received the appeal.

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 of the Board of Trustees are final.**

Dental Plan

Summary

Options:
- Fee-for-service Dental Plan
- Managed care Dental Plan

The Dental Program permits you and your eligible Dependent(s) to obtain required dental treatments through either a traditional fee-for-service Dental Plan or through a managed care Dental Plan. A change between options may be made only during the annual Open Enrollment. All Members of a family must be enrolled in the same option.

Fee-for-Service Dental Plan

The fee-for-service Dental Plan uses a panel of participating dentists. You have the choice of using a participating or non-participating dentist. Claim forms are available at a participating Provider office. 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.

Covered Services

The fee-for-service Dental 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).

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).

Basic Restorative: Amalgam 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 are covered under your medical plan.

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.

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

Orthodontic: Procedures for straightening teeth. Orthodontics is a benefit for eligible employees, spouses and Dependent(s) to age 19 (to age 23 for a full-time student). One-half of the payment shall be paid to the Member the first year; one-half will be paid the second year 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.

Dental Benefits Payment Schedule (Participating Providers)

All payments are based on a Usual, Customary and Reasonable (UCR) or Maximum Plan Allowance fee schedule as determined by the Dental Plan. Charges in excess of the UCR/Maximum Plan Allowance amount are your responsibility.

Benefit	Plan Payment	Member Payment
Diagnostic/Preventive • Exam, diagnosis, x-rays • Cleaning	100% UCR	0%
All Basic/Major Restorative Services		Annual $50 Deductible per family Member
Basic Restorative • Amalgam and composite fillings • Oral surgery • Palliative emergency services • General anesthesia • Endodontics (root canal and root canal filling) • Denture repair of existing dentures	90% UCR (after Deductible)	10%
Major Restorative • Crowns, inlays, onlays • Periodontics (surgical and non-surgical treatment of gums and supporting structures of the teeth) • Fixed bridges • Partial or complete dentures • Repair of fixed bridges • Adding new tooth or clasp to dentures • Denture relining or rebasing • Guided tissue regeneration	60% UCR (after Deductible)	40%
Orthodontic	70% UCR; lifetime Maximum of up to $1,250 per person	30%
Annual Plan Maximum	$1,000 per person	

The above covered percentages 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 for prosthodontics, including dentures, crowns and bridges is applied to the calendar year in which the impression was made even if the final delivery or fitting is in the subsequent calendar year. The Maximum lifetime orthodontic benefit is $1,250 per person.

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

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

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

Predetermination of Benefits

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

Payment of Dental Services

Services performed by participating dentists are paid on a modified UCR/Maximum Plan Allowance 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 UCR/Maximum Plan Allowance, 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 modified UCR Copayments, charges where Maximums have been exceeded, or charges for services not covered by the plan.

Payment for services performed by a non-participating dentist is also calculated on a modified UCR basis 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 calculated modified UCR and services not covered by the plan.

Coordination of Benefits

If separate dental benefits are available to you or your eligible Dependent(s) under other programs, there are specific conditions applicable to a determination of the amount of payment. The ratio of each carrier's liability to the total cost incurred is reviewed.

Payment is made according to the "birthday" rule adopted by most insurance carriers, but in no case does the dental Provider pay in excess of its total contractual obligation, even if it is the only carrier involved.

If the other carrier determines its benefits first, the PEBTF's dental Provider will pay any difference between the amount paid by the other carrier and the charge for the Covered Service to the extent of the Member's benefit for that given procedure.

Dental Service Claims

Claims for dental services must be **submitted 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 considers itself liable for a procedure once the procedure irrevocably begins (other than orthodontics); for example, if the tooth is prepared and impressions are taken for a crown or bridge.

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

Fee for Service Dental Plan Appeal Process

If a claim for benefits is denied in full or in part, you shall be notified of the denial in writing and you shall have an opportunity to appeal the denial. The notice of denial shall be sent to you by the Dental Plan and it will state the specific reason(s) for the denial.

Notice of denial shall be provided to you no later than 90 days after receipt of the claim by the Dental Plan unless special circumstances require an extension of time for processing the claim.

You have the right to appeal a fully or partially denied claim by filing a written request for review of the claim with the Dental Plan.

All appeals must be received within 60 days after the claim is denied. The Dental Plan will notify you within 60 days of the request of its decision.

If you are not satisfied after completing the appeal process with the Dental Plan, you have a right to a final appeal to the PEBTF Board of Trustees, Attn: Executive Director, 150 S. 43rd Street, Harrisburg, PA, 17111. The final appeal to the Trustees must be postmarked within 30 days of the date of the Dental Plan's final denial. The Trustees will review the appeal and will notify you of their decision within 60 days of the date that the Trustees received the appeal.

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 of the Board of Trustees are final.**

Managed Care Dental Plan

As a managed care participant, you must select the dentist or dental group you wish to provide dental services to you and your eligible Dependent(s). You may select a Primary Dental Office for you and each of your family Members. You may check if your dentist participates with the managed care Dental Plan by logging on to the PEBTF web site, Publications/Forms section.

With the exception of some Copayments, the managed care Dental Plan covers, in full, the eligible dental services you receive, including the services of a specialist, if such services are authorized by your primary dentist.

NOTE: You must receive all care from your primary dentist or from specialists authorized by your primary dentist to perform services for you (written referrals must be obtained). Any services obtained by a dentist other than your primary dentist, or by a referral coordinated by someone other than your primary dentist, will not be eligible for payment.

Services Which Have Copayments

Because the philosophy of a managed care plan is to encourage regular dental visits, all preventive routine care, diagnostic and restorative services (fillings) are covered at 100% of the managed care Dental Plan's allowed charge for such dental services.

Other non-routine services such as single, unconnected inlays, onlays and crowns, and fixed and removable prosthetics are covered at 80%. Orthodontic services are covered at 60%. The difference between the percentages listed and the 100% is a Copayment which you must pay to your dentist. Terms and payments must be arranged with your dentist.

Out-of-Area Emergency Treatment

The managed care Provider will pay for emergency dental services needed when you are traveling out of the area (more than 50 miles from your dentist's office), up to a Maximum of $50 for each occurrence.

In order to receive payment for out-of-area emergency dental services, you must submit to your primary dentist a receipted bill which itemizes the charges and services performed.

Managed Care Dental Plan Benefit Coverage

	Plan Payment
Preventive Dental Care Routine dental examinations Oral prophylaxis (cleanings) Topical fluoride applications (under age 19) Nutritional counseling Plaque control program Space maintainers Sealants (under age 15, posterior teeth)	100%
Diagnostic Services Oral diagnosis and Treatment Planning Dental x-rays, including bitewings, full mouth, panographic and other dental x-rays	100%
Restorative Services (under local anesthesia) Amalgam, silicate, acrylic, synthetic, porcelain (porcelain veneers for restorative purposes only; not for cosmetic purposes) and composite restorations Single, unconnected inlays, onlays and crowns	100% 80%
Periodontic (treatment of disease of the gums and other tissues of the mouth) – under local anesthesia – nonsurgical and surgical – contact the Dental Plan regarding limitations	100%
Endodontics, including pulp treatment, root canal treatment and apicoectomy (under local anesthesia)	100%
Oral Surgery (under local anesthesia) Simple extractions Surgical extractions Soft tissue impactions Tooth replantation of an accidentally-avulsed tooth (reinserting a tooth dislodged in an accident) Surgical exposures Alveolectomies (shaping of bone after tooth extractions) Operculectomies (removal of gum tissue over unerupted teeth) Removal of odontogenic cysts (a tooth-related cyst) Frenectomies (removal or cutting of the tissue attachments)	100%
Palliative emergency dental treatment	100%
Medications provided while in the managed care Dental Plan participating dentist's office	100%

	Plan Payment
Prosthetics (under local anesthesia) Fixed bridges, including abutment inlays, onlays, crowns and pontics Removable complete dentures Removable partial dentures Relining and rebasing of removable dentures	80%
Repairs to single crowns, fixed prosthetics and removable prosthetics Office Laboratory	 100% 80%
Orthodontics (Treatment must be initiated under the managed care dental program) Special orthodontic diagnostic procedures Orthodontic appliances Functional and myofunctional therapy when provided by the primary or referral dentist in conjunction with appliance therapy	60%
Guided Tissue Regeneration	100%

Plan Exclusions/Limitations

The managed care Provider either limits or excludes the following:

- Services of dentists who are not your managed care primary dentist, except referral services arranged by a participating dentist or required in a covered emergency
- Additional covered dental services which require a Copayment from the patient if the patient has a previously unresolved Copayment balance that has been outstanding for 60 or more days, unless special payment arrangements have been made with your managed care dentist
- Dental services or supplies that are cosmetic in nature, including personalized or specialized techniques (bleaching)
- Dental services performed prior to the effective date of coverage or after the termination date of coverage
- Prosthetic devices (including bridges), crowns, inlays and onlays and the fitting thereof, which were prescribed while the patient was not covered under the managed care program, or which were finally inserted more than 30 days after termination of coverage
- Replacement of a lost or stolen prosthetic device (such as a denture) or replacement or repair of orthodontic braces
- Spare or duplicate prosthetic devices or appliances
- Dental services or supplies which are unnecessary or Experimental, according to accepted standards of dental practice
- Appliances (other than full dentures) or fillings primarily used to alter vertical dimension or restore occlusion

- Surgical implants
- Prescription medications, pre-medications, relative analgesia
- Periodontal splinting
- Gnathological recordings
- Equilibration
- Any dental service for which you are eligible under workers' compensation, or other federal, state or local government programs. Dental services for which, in the absence of any health services or insurance program, no charge would be made to the individual.
- Dental services in a hospital unless directed by your managed care participating dentist or required in a covered dental emergency
- Charges for broken appointments
- Dental services other than those specifically listed in the Plan Document
- Services related to the treatment of temporomandibular joint dysfunctions (TMJ)
- Full or partial bony extractions
- Services, the cost of which has been or is later recovered in an action at law or in compromise or settlement of any claim.
- Charges for additional treatment necessitated by lack of Member cooperation or failure to follow a professionally-prescribed Treatment Plan
- General anesthesia or intravenous sedation
- General anesthesia, sedation or medications provided in a referred specialist's office
- A fixed bridge or a case that is more complicated requiring precision prosthetics or attachments when a satisfactory result can be achieved with a cast chrome or acrylic partial denture. The obligation of the plan will be any of the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. If you and the dentist select a more complex procedure, the Copayment for the plan's approved lesser procedure plus any additional charges for the more complex procedure are your responsibility
- Consultations provided by other than your primary dental office

Managed Care Dental Plan Appeal Process

If a claim for benefits is denied in full or in part, you shall be notified of the denial in writing and you shall have an opportunity to appeal the denial. The notice of denial shall be sent to you by the Dental Plan and it will state the specific reason(s) for the denial.

Notice of denial shall be provided to you no later than 90 days after receipt of the claim by the Dental Plan unless special circumstances require an extension of time for processing the claim.

You have the right to appeal a fully or partially denied claim by filing a written request for review of the claim with the Dental Plan.

All appeals must be received within 60 days after the claim is denied. The Dental Plan will notify you within 60 days of the request of its decision.

If you are not satisfied after completing the appeal process with the Dental Plan, you have a right to a final appeal to the PEBTF Board of Trustees, Attn: Executive Director, 150 S. 43rd Street, Harrisburg, PA 17111. The final appeal to the Trustees must be postmarked within 30 days of the date of the Dental Plan's claim denial. The Trustees will review the appeal and will notify you of their decision within 60 days of the date that the Trustees received the appeal.

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 of the Board of Trustees are final**.

Hearing Aid Plan

Summary

The hearing aid benefit plan offers you and your eligible Dependent(s) the opportunity to apply for a hearing aid reimbursement allowance.

Applications for Hearing Aid Reimbursement may be obtained by contacting the PEBTF.

Hearing Aid Benefit

This benefit is limited to one hearing aid per ear per 36-month period (1,095 days), up to a Maximum of $350 for a monaural hearing aid, $475 for BiCROS or CROS aids and $600 for binaural aids. **The order date is used to determine the date of service.**

The allowance for a hearing aid includes coverage for a hearing aid evaluation test performed by a physician/audiologist or licensed dealer/fitter. The evaluation determines which make and model will best compensate for the loss of hearing acuity. The hearing aid evaluation test is only covered if the cost of the evaluation and hearing aid(s) does not exceed the allowance for hearing aid(s).

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

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

Application for Hearing Aid Reimbursement

A PEBTF Hearing Aid Benefit Application must be completed in its entirety and returned to the PEBTF. The form is located on the PEBTF web site – www.pebtf.org – Publications/Forms 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 physician or audiologist statement.
2. Itemized statements and paid receipts showing the purchase of the hearing aid and/or the charges for the hearing aid evaluation test, including the dates of service and/or purchase.

Plan Exclusions/Limitations

- Hearing aid evaluation tests or hearing aids for which there is no physician's certificate of Medical Clearance (medical waiver accepted for replacement aids obtained under the program)
- Otologic and/or audiometric examinations by a physician or audiologist and any audiometric examination billed separately and not included in the total dealer charge for the hearing aid
- Hearing aids for which the audiometric examination and/or hearing aid evaluation test took place more than six months before the most recent otologic examination of the ear by a licensed practitioner
- 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 Plan must be submitted (postmarked) to the PEBTF within one year of the date of service.

Hearing Aid Plan Appeal Process

If a claim for benefits is denied in full or in part, you shall be notified of the denial in writing and you shall have an opportunity to appeal the denial. The notice of denial shall be sent to you by the PEBTF and it will state the specific reason(s) for the denial.

Notice of denial shall be provided to you no later than 90 days after receipt of the claim by the PEBTF unless special circumstances require an extension of time for processing the claim.

You have the right to appeal a fully or partially denied claim by filing a written request for review of the claim with the PEBTF within 60 days after the claim is denied. The PEBTF will notify you within 60 days of the request of its decision.

If you are not satisfied after completing the appeal process with the PEBTF, you have a right to a final appeal to the PEBTF Board of Trustees, Attn: Executive Director, 150 S. 43rd Street, Harrisburg, PA 17111. The final appeal to the Trustees must be postmarked within 30 days of the date of claim denial. The Trustees will review the appeal and will notify you of their decision within 60 days of the date that the Trustees received the appeal.

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 of the Board of Trustees are final.**

Coordination of Benefits

Summary

- Benefits are coordinated with other plans. Benefits coordinated include medical, 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. The PEBTF requires spouses with other coverage to enroll for that coverage under the conditions described on page 4
- A Coordination of Benefits (PEBTF-2A) Form must be completed any time a Dependent(s) coverage changes

The PEBTF coordinates benefits with other group insurance plans under which you may be covered. For instance, your spouse 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.

When filing claims for medical, prescription, 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(s) participates. You may be entitled to be paid up to 100% of the reasonable expenses under the combined plans. In coordinating benefits, one plan, called the primary plan, pays first. The secondary plan adjusts its benefits so that the total amount available will not exceed allowable expenses. Failure to follow the compliance provisions of either the primary or secondary plan, shall disqualify a Member for coverage under this section.

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

1. A plan without a coordination of benefits provision is always the primary plan. If all plans have coordinating provisions, then:
    a. The plan covering a person other than as a dependent is primary and the plan covering a person as a dependent is secondary; and
    b. The plan covering a person as an active employee is primary and the plan covering a person as a retiree is secondary, unless the retiree is covered under the Retired Employees Health Program (REHP) or the Retired Pennsylvania State Police Program (RPSP), in which event the REHP or RPSP plan shall be primary and the PEBTF secondary.

2. **Child Covered Under More than One Plan**: The order of benefits when a Dependent child is covered by more than one plan is:
   a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married; or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents longer is primary.

   b. If the specific terms of a court decree state that one of the parents is responsible for the 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 claim determination periods or plan years commencing after the plan is given notice of the court decree.

   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the custodial parent;
      - The plan of the noncustodial parent; and then
      - The plan of the spouse of the noncustodial parent.

3. **Active or Inactive Employee**: The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under the rule labeled 1(a).

4. **Continuation Coverage**: If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, Member, subscriber or retiree (or as that person's Dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage**: The plan that covered the person as an employee, Member, subscriber or retiree longer is primary.

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

Medicare

Government regulations require that you have a choice of medical plans if you continue working beyond age 65. If you or a Medicare covered Dependent remain enrolled in the PEBTF Plan, the PEBTF coverage is primary. The same options are available to your spouse when he or she reaches age 65, regardless of your age. If you or a Dependent(s) becomes covered under Medicare, contact your local Human Resource Office to let them know the date Medicare begins.

Please notify the PEBTF if you or one of your eligible Dependent(s) are receiving Medicare before age 65, for instance because of end stage renal disease (ESRD) or other disability.

Your Choices

Active employees age 65 or older, up until the time they retire, may choose to have medical coverage provided through:

1. One of the PEBTF plans only
2. A PEBTF plan supplemented by Medicare
3. Medicare only

If you choose coverage under a PEBTF plan only or Medicare only, then that plan will pay its usual benefits. You are responsible for any additional costs.

If you choose both, the PEBTF plan will pay benefits first. If your expenses are greater than those paid under the plan, then Medicare will pick up the balance – up to its usual limits.

This choice is available until you retire.

Your Spouse's Choices

Regardless of your age, your spouse has the same choices as you do when he or she reaches age 65:

1. The PEBTF-sponsored medical coverage chosen by the employee only
2. A PEBTF-sponsored medical coverage chosen by the employee supplemented by Medicare
3. Medicare only

Your spouse's choice of coverage is available until you retire.

COBRA Coverage & Survivor Spouse Coverage Due to Work-Related Deaths

Summary

- If your medical or Supplemental Benefits coverage ends due to certain reasons, the PEBTF may continue your coverage for a limited period of time
- Federal law also allows you to continue coverage at your own expense under certain circumstances under the Federal law commonly known as COBRA

Continued Coverage as Provided by the PEBTF

In certain situations, medical coverage for you and your eligible Dependent(s) 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.

Notices

You or another qualified beneficiary in your family has the responsibility to inform the PEBTF of a divorce, legal separation or child's loss of Dependent status under the Plan. This information must be provided within 60 days of the date of the qualifying 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, it will notify you that you have the right to choose 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.

COBRA Continuation Coverage

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

The continuation coverage is available to you and your eligible Dependent(s) if coverage ends due to:

- Termination of your employment (for reasons other than gross misconduct)
- Reduction in your work hours
- Your death
- Your divorce or legal separation (in states that recognize legal separation)
- Your Dependent child no longer meets the eligibility requirements for coverage
- Your entitlement to Medicare

NOTE: If you voluntarily drop (disenroll) a Dependent from coverage 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 your 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.

Support Orders

Either the Employee Member or the Dependent spouse Member may elect COBRA coverage for the Dependent spouse Member. It should be noted that a court spousal support order which directs that an Employee Member provide medical coverage for his/her spouse does not, and cannot, require that the PEBTF do anything other than comply with the terms of the benefit Plan, including the Plan's provisions and procedures for continuation coverage under COBRA. Therefore, the Employee Member or spouse Member must duly elect, and timely pay for, COBRA coverage in accord with the Plan's COBRA requirements in order to fulfill the Employee Member's obligation under the court order. Such a court order for spousal support relates only to the Employee Member's obligation, as the PEBTF is not a party under the court's jurisdiction in such a legal action.

Cost of Continued Coverage

Continued coverage is available to you and your Dependents at your or your eligible Dependent's expense. The cost to you or your Dependent(s) 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 this 11-month period.

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

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 PETBF, in writing, within 60 days of a divorce or a child losing Dependent status**. Failure to notify the PEBTF of these events in a timely manner will cause COBRA coverage to be unavailable.

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 the PEBTF is timely notified of the qualifying event, it shall, within 14 days, send a COBRA election notice to you or your Dependent(s), by First Class Mail. You will have 60 days 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 have timely informed the PEBTF of a qualifying event, but are determined to be ineligible for COBRA coverage, the PEBTF will send you a notice of COBRA unavailability explaining the reason.

Within 45 days of the election of COBRA, you must pay an initial premium which will be billed by the PEBTF. This premium includes the period of coverage from the date of your qualifying event to the date of the election notice, and any regular monthly premium that becomes due between the election and the end of the 45-day period. **Thereafter, premiums must be paid monthly and must be postmarked to the PEBTF on or before the due date or your COBRA coverage will be terminated**. 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, your coverage will be terminated and you should receive a "termination notice" within two weeks. All notices are sent to your last known address according to PEBTF records. If COBRA subscribers change their address it is their responsibility to notify the PEBTF, in writing.

Effect of Waiving COBRA Coverage

If coverage is waived, COBRA may not later 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 Certification of Coverage (which protects an employee's right not to be affected by pre-existing medical condition requirements in obtaining new medical insurance, e.g., under a new employer's plan of benefits).

Length of Continued Coverage

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

- At the end of 18 months from the date COBRA coverage began, if the qualifying event is your termination of employment or reduction in hours (29 months if you or an eligible Dependent(s) are disabled). See "Special Disability Rules," below
- At the end of 36 months from the date COBRA coverage began for your Dependent(s) if the qualifying event is your death, divorce or separation, your child's loss of Dependent status, or the Member's entitlement to Medicare
- Your 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 not 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(s) become, after the date of the COBRA election, covered under another group health plan (as an employee or otherwise)
- 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 you a notice of early termination of COBRA explaining (1) the reason for termination, (2) the effective date and (3) an explanation of any rights you or your dependents may have to elect alternative coverage.

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

Special Disability Rules

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

- You or your Dependent(s) 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 Dependent(s)

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

Extension of COBRA Due to a Second Qualifying Event

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

A second qualifying event includes:

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

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

Qualifying Events for Student Dependents

Dependents who are aged 19 to 23 and are full-time students attending an accredited educational institution remain eligible under the Plan as long as they continue to recertify twice a year with the PEBTF. **It is your responsibility to immediately notify the PEBTF if, at any time, the student Dependent does not attend college, drops below full-time student status or otherwise no longer satisfies the requirements for being an eligible Dependent (for example, if your Dependent gets married, works full time or no longer depends on you for more than 50% financial support). If the PEBTF is not notified within 60 days, your Dependent will not be able to elect COBRA**. For information on Student Medical Leave coverage, refer to page 7.

Student Dependents remain covered throughout the summer break between spring and fall semesters as long as they timely file their student certification forms with the PEBTF and return to full-time attendance in the fall. Students who do not recertify before September 1 and who do not attend college on a full-time basis will be terminated retroactive to July 1. Students who do not recertify during the January Student Certification will be terminated retroactive to January 1.

For purposes of determining the qualifying event dates when students cease to be “full-time students,” the PEBTF has adopted the following guidelines:

- Any student who is enrolled and attending full-time throughout the spring semester is assumed to be a full-time student until July 1
- Any student who timely recertifies and re-enrolls for the fall semester is assumed to be a full-time student up until he/she fails to actually attend full-time when classes resume
- If a student actually attends school full time after July 1 and does not return to school in the fall, the actual last date of the student’s full-time attendance is the qualifying event for COBRA
- Failure to recertify and re-enroll for the fall semester will result in termination retroactive to July 1 and not to any earlier date as long as the student completed the spring semester as a full-time student and did not have any other qualifying event. July 1 is the qualifying event

- A student who has timely recertified and re-enrolled will be assumed to be a full-time student until the first day of fall classes which he/she fails to attend as long as the student did not have any other qualifying event. The first day of fall classes is the qualifying event
- A student who does not recertify during the January Student Certification will result in termination retroactive to January 1

NOTE: Remember that your child will cease to be a full-time student eligible for coverage if he or she stops attending classes on a full-time basis during a semester, even if previously certified with the PEBTF as a full-time student. In such event, **make sure you notify the PEBTF within 60 days** in order to preserve the student's COBRA rights. It is also important to remember that a full-time student may cease to be eligible under the requirements of the plan of benefits, e.g., marriage, full-time employment, ceasing to be financially dependent on the Employee Member.

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.

Work-Related Deaths

Surviving spouses and Dependent(s) of an employee who died in a work-related accident may also have a right to free continuation coverage of **medical and Supplemental Benefits (if the Dependent(s) 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 and Dependent(s) will receive continuation coverage, at no cost, until the surviving spouse remarries or becomes eligible for coverage under another employer's health plan. Dependent(s) will continue to receive continuation coverage until they no longer meet the eligibility rules of the Plan.

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.

Additional Information

Certificate of Coverage

The PEBTF issues Certificates of Coverage to all Members (employees, spouses and Dependents) whose coverage with the PEBTF is terminated. This Certificate helps to protect people who are affected by pre-existing medical conditions in obtaining new medical insurance. The Certificate of Coverage is good for 63 consecutive days during which the individual did not have any creditable coverage.

Motor Vehicle Insurance

If you or your Dependent(s) are injured as a result of a motor vehicle accident in Pennsylvania, 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 Plan. 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 Dependent(s) fail to obtain primary automobile insurance as required by Pennsylvania law, the first $5,000 of claims resulting from an automobile accident are excluded from PEBTF coverage.

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.

Benefits from Other Plans (Subrogation)

If you or any of your enrolled Dependent(s) 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.

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 Dependent(s) 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 Dependent(s) are involved in a matter in which the PEBTF is exercising its subrogation rights, you and they must cooperate fully and entirely to enable the PEBTF to pursue and exercise its full 100% subrogation rights. Failure to cooperate fully will result in your and their disqualification from all PEBTF benefits for a period of time as determined by the Trustees.

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 Dependent(s) sustained in a motor vehicle accident that occurred in Pennsylvania.

If the PEBTF makes a demand for reimbursement of benefits paid and you do reimburse or repay the money, or otherwise cooperate with the PEBTF in its recoupment of monies owed, you and your Dependent(s) 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 repayment when due, you and your Dependent(s) 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 to the Board of Trustees the PEBTF's demand that you reimburse amounts paid by the PEBTF in a subrogation situation. To do so, your written appeal must be postmarked within 60 days of the date of the notice or demand to you. If you file an appeal, the suspension of your and your Dependent(s) coverage will be stayed pending resolution of the appeal. The appeal will be considered by the Board of Trustees and you will be advised in writing of their decision.

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

Qualified Medical Child Support Orders (QMCSOs)

Divorce situations often require the non-custodial parent to continue to provide health insurance coverage for their Dependent children. The PEBTF must also house the address of the custodial parent on its system so that the custodial parent receives important health care information relating to the child. To protect the privacy of the custodial parent, the address of the custodial parent is **never** disclosed to the non-custodial parent who is the PEBTF Member.

A Qualified Medical Child Support Order (QMCSO) is a medical child support which 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

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.

National Medical Support Notice (NMSN)

A National Medical Support Notice is a medical child support order transmitted by the state child support enforcement agency which is legally empowered to secure medical coverage for children under their non-custodial parent's group health plans. It is a standardized medical child support order used by the state child enforcement agencies to enforce medical child support obligations of non-custodial parents who are required to provide health care coverage through any employment related group health plan pursuant to a child support order.

A NMSN may be based on a court order (of this or another state) or an order of the state agency itself. A NMSN requires that the PEBTF immediately enroll the children, if eligible and if the NMSN meets the requirements of a qualified medical support order (and also to enroll the 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.

Spousal Support Orders

Either the Employee Member or the Dependent spouse Member may elect COBRA coverage for the Dependent spouse Member. It must be noted that a court spousal support order which directs that an Employee Member provide medical coverage for his/her spouse does not, and cannot, require that the PEBTF do anything other than comply with the terms of the benefit Plan, including the Plan's provisions and procedures for continuation coverage under COBRA. Therefore, the Employee Member or spouse Member must duly elect, and timely pay for, COBRA coverage in accord 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.

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.

You will receive an Explanation of Benefits (EOB) when these claims have been processed. If you receive any payment from the PEBTF in error, you are required to submit it directly to the VA facility. If you cash the check, you must refund the money to the PEBTF.

Felony Claims

If you or your Dependent(s) sustain injuries during the commission by you or them of a felony, the claims resulting from injuries are excluded from coverage. If you or your Dependent(s) are acquitted of the felony charge, payment for medical expenses will be provided on a retroactive basis.

Misrepresentation or Fraud

A Member who receives benefits under the Plan as a result of false information or a misleading or fraudulent representation shall be suspended and must repay all amounts paid by the PEBTF, as well as all costs of collection, including attorney's fees. The suspension applies to the entire family of a Member. If you make restitution, then you and your eligible Dependent(s) must serve an additional six-month period without coverage before benefits are reinstated.

If an eligible Dependent(s) abuses or defrauds the PEBTF, the Dependent(s) is immediately suspended from all benefits. If the Dependent(s) makes restitution, he/she will remain suspended for an additional six-month period without coverage before benefits are reinstated.

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

A Member whose benefits are terminated or suspended for misrepresentation or fraud shall be reported to the Commonwealth of Pennsylvania for such action as it may deem appropriate.

Any suspension of coverage for misrepresentation or fraud may be appealed to the Board of Trustees 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 Board of Trustees is final.**

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, without limitation, a payment made for services rendered at a time when you or a Dependent are ineligible for benefits under the Plan.

If the PEBTF demands repayment of amounts paid in error, and you do not repay the money or otherwise fail to cooperate with the PEBTF in its recoupment of monies owed, you and your Dependent(s) 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, make a payment so the coverage is reinstated, and then fail to make any subsequent payment when due, you and your Dependent(s) 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 to the Board of Trustees the PEBTF's demand that you reimburse amounts paid by the PEBTF in the above situation. To do so, your written appeal must be postmarked within 60 days of the date of the notice or demand to you. If you file an appeal, the suspension of your and your Dependent(s) coverage will be stayed pending resolution of the appeal. The appeal will be considered by the Board of Trustees and you will be advised in writing of their decision.

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

Use of Benefits

If you or your Dependent receive benefits when not eligible for such benefits, you will be required to repay the PEBTF for the full amount paid. The PEBTF will arrange a repayment schedule for you. The repayment schedule may take the form of: Payment in full, voluntary payroll deduction or repayment plan. If your benefits have been suspended, they will be reinstated when you make the first payment due under the repayment plan. However, if you subsequently fail to make a payment when due, you and your Dependent(s) will again be ineligible for all future benefits until the money is repaid in full and for six months thereafter.

Time Limits

Throughout this 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. Actual receipt of the claim notification or appeal within the specified time is the controlling factor. For PEBTF hearing aid claims, COBRA payments or appeals, the **postmark date** is the controlling factor. **Do not jeopardize your right to receive benefits by failing to observe the applicable time limits.**

Receipt of Notices, Claims and Appeals

All other claims, notices and appeals must be submitted (postmarked) to the PEBTF or other Provider within the time indicated.

Privacy of Protected Health Information

The PEBTF adheres to the medical privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and applicable state law, and has entered into agreements with the Claims Payors and other professional advisors to the PEBTF committing them to matching the confidentiality of personal health information as required by HIPAA. The PEBTF has distributed to Members a Notice of Privacy Practices describing the protections of HIPAA and how the Plan applies these rules. If you need another copy of the Notice of Privacy Procedures, please contact the PEBTF.

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 incorporate this section/article and agrees to abide by this section/article.

PEBTF Compliance Plan

The Trustees have adopted a Compliance Plan for the PEBTF. 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.

Glossary of Terms

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

Basic Option: Hospital and medical/surgical coverage for in- and outpatient facility care and medical/surgical and other professional Provider services provided by Highmark or your local Blue Cross plan.

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

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

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 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.

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 on or after October 1, 2003, 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 SPD in effect when your coverage ended.

Experimental/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.

Home Health Care: Equipment and services to the patient 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, DHMO 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) and Prescription Drug (Part D).

Member: Enrolled person eligible for benefits under the PEBTF, which includes eligible employees, their eligible Dependent(s), eligible COBRA beneficiaries and eligible surviving spouses (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 Basic, PPO or HMO Option as appropriate.

Morbid Obesity: A condition of consistent and uncontrollable weight gain, as determined by the Claims Payor, that is characterized by a weight which is at least one hundred (100) pounds or one hundred percent (100%) over ideal weight specified for frame, age, height and sex in the most recent Metropolitan Life Insurance or similar table or a body mass index (BMI) of 40 kg/m-2.

Network Providers: Medical Providers, such as doctors and hospitals, who have a contractual agreement with PPO or HMO plans, DHMO or UBH to provide medical services or mental health services to enrolled Members.

Non-participating Facilities - Basic Option: The plan pays covered expenses charged by a non-participating facility up to the Reasonable Charge for the service as determined by Blue Cross.

Charges made by the following Non-participating Facilities are **not** covered under Blue Cross:

- Hospice care facility
- Substance abuse treatment facility

Non-participating Providers - Basic Option: Covered expenses charged by a non-participating physician or another medical professional are paid according to the Reasonable Charge for the service as determined by Blue Shield or Blue Cross. You are required to pay the non-participating Provider's fee directly. A claim for a non-participating Provider must be submitted to Blue Shield or Blue Cross for reimbursement. Any difference between the covered expenses and actual fees is your responsibility.

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

Out-of-Network: 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, UBH or DHMO).

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

Palliative: Relieves or alleviates without curing.

Participating Facilities - Basic Option: Hospitals, psychiatric and rehabilitation facilities, skilled nursing facilities, freestanding outpatient surgical facilities, ambulatory surgical facilities, Home Health Care agencies, freestanding renal dialysis facilities, hospice care facilities, substance abuse treatment facilities and birthing centers where the Reasonable Charge is set by a contractual agreement with Blue Cross. Payment is made directly to the facility.

Participating Providers - Basic Option: Physician or other medical professional who is under a contractual agreement to accept the Blue Shield or Blue Cross allowance as payment in full.

Plan Administrator: The PEBTF.

Plan Allowance: Certain Claims Payors determines 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

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.

Reasonable Charge: Basic Option pays for Medically Necessary covered expenses that are "reasonable" as determined by Blue Cross or Blue Shield. Payments of Non-participating Providers' charges are limited to the reasonable fees of participating Providers.

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.

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, Basic, 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. Certain Claims Payors use the "Plan Allowance" in place of the UCR Allowance. Any reference to "UCR" or the "UCR Allowance" shall be deemed to refer to the "Plan Allowance" for those Plan Options which are administered by a Claims Payor that use the Plan Allowance.

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

2005 PEBTF Benefit Option Summary Comparison -- Active Members

Benefits Effective 1/1/05

BENEFIT	PPO OPTION		HMO OPTION	BASIC OPTION
	No Referrals Needed		All care directed by	(Effective 10/1/03)
	In Network	Out-of-Network	Primary Care Physician (not all Plans)	NO NEW ENROLLMENTS
Deductible	$0	$400 per person; 30% of the next $5000; 0% in excess of $5000. All services subject to deductible unless otherwise noted.	$0	$500 per person; Maximum 3 per family ($1,500) on all medical services. All services subject to deductible unless otherwise noted.
Out-of-Pocket Maximums	Not Applicable	$1500 per person ($3,000 per family) PLUS the deductible	Not Applicable	$3,000 per person, plus the deductible $9,000 per family, plus the deductible
Physician Visits				
Primary Care Physician	100% after $15 copayment	70%*; Member pays 30%	100% after $15 copayment ($20 after hours)	80% of plan allowance for par provider; Member responsible for 20%; Member responsible for remaining balance if non-par provider
Specialist	100% after $25 copayment	70%*	100% after $25 copayment ($30 after hours)	80% of plan allowance for par provider; Member responsible for 20%; Member responsible for remaining balance if non-par provider
Preventative Care				
Adult				
Routine Physical Examinations	100% after $15 copay	70%*	100% after $15 copayment	Not covered
Annual Routine Gynecological Exams including a PAP Test	100% after $25 copayment (if visiting an OB/GYN)	70%* (not subject to out-of-network deductible)	100% after $25 copayment (if visiting an OB/GYN)	80% of plan allowance (deductible waived)
Annual Routine Mammograms	100%	70%* (not subject to out-of-network deductible)	100%	80% of plan allowance (deductible waived)
Pediatric				
Routine Physical Examinations	100% after $15 copayment	70%*	100% after $15 copayment	80% of plan allowance
Pediatric Immunizations	100%	70%* (not subject to out-of-network deductible)	100% after $15 copayment (for office visit)	80% of plan allowance (deductible waived)
Emergency Room Services	$50 copayment, if considered a medical emergency as defined by the PPO (waived if admitted)	$50 copayment, if considered a medical emergency as defined by the PPO (waived if admitted)	$50 copayment if considered a medical emergency as defined by the HMO (waived if admitted)	80% of plan allowance
Hospital Expenses (Inpatient & Outpatient)	100% (up to 365 days per year)	70%* (up to 70 days per year)	100%; semi-private room (private room if medically necessary)	80% of plan allowance; semi-private room (private room if medically necessary)
Medical/Surgical Expenses (Except Office Visits)	100%	70%*	100%	80% of plan allowance
Skilled Nursing Facility Care (medically necessary)	100% (240 days)	70%* (240 days)	100% (180 days at participating facility)	80% of plan allowance; plus any balances if non-participating SNF is used ($100,000 lifetime maximum)
Home Health Care (medically necessary)	100%	70%*	100%; up to 60 visits in 90 days; may be renewed at the option of the HMO	80% of plan allowance; plus any balances if non-participating HHC Agency is used ($25,000 lifetime maximum)
Mental Health & Substance Abuse Treatment	Provided by UBH	Provided by UBH	Provided by UBH	Provided by UBH
Durable Medical Equipment/Prosthetic	100%	70% UCR	100%	80% of plan allowance
Out of the Area Care	Urgent and Emergency Care Only, or as defined by the PPO	70%* (Possible PPOBlueCard Cov.)	Urgent and Emergency Care Only, or as defined by the HMO	80% of plan allowance
Lifetime Maximum	Unlimited	$1,000,000	Unlimited	Unlimited (except as noted above)

*Non-participating 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.

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, 200 Constitution Avenue, N.W., Washington, D.C. 20210

- Obtain copies of all Plan Documents by writing to the PEBTF, Attention: Executive Director. 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, Basic 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 your and your Dependent(s) best interest.

If you have questions about this statement or how the PEBTF works, contact the PEBTF.

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 (800) 522-7279 (in PA) (800) 628-0174 (out of state) 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:	Basic Option: January 1 PPO and HMO 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
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., Blue Cross, Blue Shield, PEBTF, PPO, applicable HMO, 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 Basic, PPO, HMO, 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, etc.
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 NUMBERS

PEBTF

717-561-4750
800-522-7279 (in PA)
800-628-0174 (out-of-state)

PPO Plans

Blue Cross of Northeastern PA Access Care II PPO	888-338-2211
Capital Blue Cross PPO	800-889-3863
Highmark PPO Blue	800-386-4944
Personal Choice PPO	888-637-3283

HMO Plans

Aetna HMO	800-991-9222
First Priority Health HMO	800-822-8753
Geisinger Health Plan HMO	800-447-4000
HealthAmerica HMO	800-788-8445
HealthAmerica (Western PA) HMO	800-735-4404
HealthGuard of Lancaster HMO	800-822-0350
Keystone Health Plan Central/Lehigh HMO	800-622-2843
Keystone Health Plan East HMO	800-227-3115
Keystone Health Plan West HMO	800-386-4944
UPMC HMO	888-876-2756

Basic Plans

Capital Blue Cross	800-889-3863
Highmark Blue Cross/Blue Shield	800-386-4944
Northeastern Blue Cross/PA Blue Shield	800-829-8599

Mental Health & Substance Abuse Program

800-924-0105

State Employee Assistance Program

800-692-7459

Prescription Drug Benefits

ESI	866-841-2368
ESI Mail Order Facility	800-233-7139

Vision Benefits

National Vision Administrators (NVA)	800-672-7723

Dental Benefits

Delta Dental of Pennsylvania	800-932-0783
Concordia Plus	888-320-3321

Hearing Aid Benefits

PEBTF

800-522-7279 (in PA)
800-628-0174 (out-of-state)

For health plan web site addresses, log on to the PEBTF web site, www.pebtf.org. You will find the plans' web site addresses listed under the Links section.

Pennsylvania Employees Benefit Trust Fund

150 South 43rd Street, Suite 1

Harrisburg, PA 17111-5700