
2022 PEBTF Open Enrollment

October 17 to November 4, 2022

Benefit Information for Permanent Part-Time and Non-Permanent Employees Working an Average of 30 Hours/Week (Employees who qualify for the Bronze Plan and other PEBTF plans)

The Affordable Care Act (ACA) requires employers to provide medical and prescription drug coverage to employees who average a minimum of 30 hours of service a week. You were recently notified by the commonwealth that you meet the criteria. As a result, you are eligible for:

- The Bronze Plan offered by Aetna and administered by the Pennsylvania Employees Benefit Trust Fund (PEBTF).
- Other PEBTF health benefits available to part-time employees.

Coverage is effective January 1, 2023. Information on all your options is listed below.

The Bronze Plan provides minimum essential coverage and is considered affordable under the ACA. Because you are eligible for the Bronze Plan, if you choose to purchase a private health plan through the Health Insurance Marketplace, you may not be eligible for a premium tax credit toward the cost of paying for coverage through the Marketplace. For more information on the Marketplace, visit www.healthcare.gov.

If you need help paying for your health insurance, please refer to the Additional Information section of the PEBTF's Summary Plan Description. The Summary Plan Description is available at www.pebtf.org.

Your Options: You may choose one of the following options (cost information appears on page 9)		
1. Bronze Plan, consisting of: <ul style="list-style-type: none">▪ Aetna medical▪ Prescription drug plan	2. Any combination of: <ul style="list-style-type: none">▪ Choice PPO, Basic PPO or PEBTF Custom HMO▪ Prescription drug plan▪ Supplemental benefits package of dental, vision and hearing aid benefits	3. Decline to enroll in coverage through the PEBTF.

This Open Enrollment supplement highlights the options available to you and provides a benefit summary of the Bronze Plan. If you are currently enrolled in benefits and do not want to change plans, you do not need to do anything. To enroll during Open Enrollment for an effective date of January 1, 2023, you must enroll by **November 4**, so take some time to review your options to determine if one of the plans is right for you. If you would like to enroll in health benefits, contact the HR Service Center at 1-866-377-2672 if your agency is supported by the HR Service Center. Please contact your local HR office if your agency is not supported by the HR Service Center. For questions about your benefits, you may contact the PEBTF at 1-800-522-7279. Health Advocate is another resource to help you locate doctors and providers that are part of the plan's network. Call 1-855-855-4238 or www.HealthAdvocate.com/PEBTF.

	Bronze (high deductible plan)	Choice PPO	Basic PPO	PEBTF Custom HMO (Referrals Required)
Cost (see page 9 for rate info)	You pay the biweekly employee contribution of 5% of your gross base pay ^A	You pay the biweekly employee contribution of 5% of your gross base pay ^A plus 50% biweekly rate, plus plan buy-up for the PPO ^B See page 9 for rate information	You pay the biweekly employee contribution of 5% of your gross base pay ^A plus 50% biweekly rate See page 9 for rate information	You pay the biweekly employee contribution of 5% of your gross base pay ^A plus 50% biweekly rate See page 9 for rate information
Get Healthy <i>Know Your Numbers</i>	If you participate in the Get Healthy <i>Know Your Numbers</i> Program, you pay 2.5% of your biweekly gross base pay instead of the 5% contribution The health care contribution and waiver are subject to change in July 2023			
In network deductible before plan pays	✓	✓	✓	
Visit network providers only				✓
May visit non-network providers (at additional cost)	✓	✓	✓	
Referrals needed for specialist care				✓
Preventive care covered 100% in-network – not subject to deductible. For a list of PEBTF preventive care services and immunizations, visit www.pebtf.org .	✓	✓	✓	✓
Copayment for primary care physician (PCP) office visit (Bronze plan – you pay the deductible before plan pays)	You pay the deductible before the plan pays	\$20	\$20	\$5
Copayment for specialist office visit		\$45	\$45	\$10
ER copayment (waived if admitted as an inpatient)		\$200	\$200	\$150
Urgent care copayment		\$50	\$50	\$50
Mental health and substance abuse benefits	✓	✓	✓	✓
Prescription drug coverage*	✓	✓	✓	✓
Dental, vision, and hearing aid *	no coverage	✓	✓	✓

*Shading indicates benefits separate from the medical plan. (Bronze Plan includes medical and prescription coverages.)

^A Please see your collective bargaining agreement for more information. The health care contribution and waiver are subject to change in July 2023.

^BApplies to employees hired on or after August 1, 2003.

PEBTF Medical Benefit Options

You must select a plan that is available in your county of residence. Please see the Benefit Comparison on www.pebtf.org to learn what plans are offered by county.

This summary provides a general overview of the types of plans available. Detailed information may be found at www.pebtf.org.

PEBTF Medical Benefit Options for Permanent Part-Time and Non-Permanent Employees Working Average 30-Hour Weeks	
<p>Bronze Plan (High deductible plan)</p>	<ul style="list-style-type: none"> ▪ You pay the employee contribution, which is 5% of your biweekly gross base pay or 2.5% if you participate in the Get Healthy <i>Know Your Numbers</i> Program, (you will receive information on the Get Healthy Program after you enroll); refer to your collective bargaining agreement. The health care contribution and waiver are subject to change in July 2023 ▪ Annual in-network deductible of \$9,100 for single and \$18,200 for family and out-of-network deductible of \$9,200 for single and \$18,400 for family ▪ Plan pays at 100% of plan allowance once you have reached your deductible ▪ See page 6 for a summary plan design ▪ Out-of-network services subject to an annual deductible and coinsurance. In addition, you are responsible for the difference between the provider’s charge and the plan allowance ▪ No dental, vision or hearing aid coverage; only medical and prescription drug
<p>Choice PPO (Preferred Provider Organization)</p>	<ul style="list-style-type: none"> ▪ You pay the employee contribution, which is 5% of your biweekly gross base pay or 2.5% if you participate in the Get Healthy <i>Know Your Numbers</i> Program, (you will receive information on the Get Healthy Program after you enroll); refer to your collective bargaining agreement. The health care contribution and waiver are subject to change in July 2023 ▪ Plus you pay the 50% of the cost of benefits biweekly rate ▪ If hired on or after 8/1/03, you pay a plan buy-up for the PPO ▪ More flexibility — may visit a network or non-network provider ▪ Low network copayments: \$20 for primary care physician office visits; \$45 for specialist office visits; \$50 urgent care copayment; \$200 ER copayment (waived if admitted) ▪ Annual in-network deductible of \$400 single/\$800 family applies to all services except preventive care, office visits and outpatient therapy copayments, emergency room and urgent care copayments and labs done at a Quest Diagnostics or LabCorp ▪ Annual out-of-network deductible – \$800 single/\$1,600 family. You must satisfy the deductible first and then the plan pays 70% of the plan allowance. If you visit an out-of-network provider, you are responsible for the deductible, coinsurance and all amounts in excess of the plan allowance

Chart continues on page 4

<p>Basic PPO (Preferred Provider Organization)</p>	<ul style="list-style-type: none"> ▪ You pay the employee contribution, which is 5% of your biweekly gross base pay or 2.5% if you participate in the Get Healthy <i>Know Your Numbers</i> Program, (you will receive information on the Get Healthy Program after you enroll); refer to your collective bargaining agreement. The health care contribution and waiver are subject to change in July 2023 ▪ Plus you pay the 50% of the cost of benefits biweekly rate ▪ More flexibility — may visit a network or non-network provider ▪ Low network copayments: \$20 for primary care physician office visits; \$45 for specialist office visits; \$50 urgent care copayment; \$200 ER copayment (waived if admitted) ▪ Annual in-network deductible of \$1,500 single/\$3,000 family applies to all services except preventive care, office visits and outpatient therapy copayments, emergency room and urgent care copayments and labs done at a Quest Diagnostics or LabCorp ▪ Annual out-of-network deductible – \$3,000 single/\$6,000 family. You must satisfy the deductible first and then the plan pays 70% of the plan allowance. If you visit an out-of-network provider, you are responsible for the deductible, coinsurance and all amounts in excess of the plan allowance
<p>PEBTF Custom HMO Plan (Health Maintenance Organization)</p>	<ul style="list-style-type: none"> ▪ You pay the employee contribution, which is 5% of your biweekly gross base pay or 2.5% if you participate in the Get Healthy <i>Know Your Numbers</i> Program, (you will receive information on the Get Healthy Program after you enroll); refer to your collective bargaining agreement. The health care contribution and waiver are subject to change in July 2023 ▪ Plus you pay the 50% of the cost of benefits biweekly rate ▪ Limited network of providers and facilities. You must visit a network provider; no out-of-network services are available. You need a referral from your network PCP before you can see any other network provider, except in an emergency. If you seek services outside of the network, you are responsible for the full cost ▪ Low network copayments: \$5 for primary care physician office visits; \$10 for specialist office visits; \$50 urgent care copayment; \$150 ER copayment (waived if admitted) ▪ Except for emergencies, care is covered by the HMO only when arranged by the PCP. If you seek services outside the network or without the required referrals, you are typically responsible for the full cost



Bronze Plan

It is important to remember that the Bronze Plan is a high-deductible PPO plan. You must pay the deductible and maximum out-of-pocket expense before the plan begins to pay. Please be prepared to pay the doctor at the time of your visit.

You pay the employee contribution, which is 5% of your biweekly gross base pay or 2.5% if you participate in the Get Healthy **Know Your Numbers** Program, (you will receive information on the Get Healthy Program after you enroll); refer to your collective bargaining agreement for contribution and waiver amounts

Here is how the Bronze Plan works:

- **Annual Deductible:** You are responsible for the first **\$9,100** of in-network covered medical and prescription drug expenses for single coverage or **\$18,200** for family coverage. This is known as the annual deductible. For example, if you visit your doctor in January for treatment of bronchitis, you will have to pay the entire cost of the office visit and any prescription drug costs.
- **Plan Coverage:** Once you pay the annual deductible, the plan will pay 100% of the allowable amount for medically-necessary services that are covered under the plan. For example, if you have heart bypass surgery and you have single coverage, you will be responsible for \$9,100 of in-network services and the plan will pay 100% of the allowable amount for covered medically-necessary services after you meet this deductible. Any other covered, medically-necessary services and prescription drugs the remainder of the year will be covered at 100% of the allowable amount.
- **Preventive Care Services:** These are covered in-network at 100%. That means that you do not have to pay anything for these services and they are not subject to the annual deductible (visit www.pebtf.org for a list of preventive care services). For example, you can get an annual physical and any routine immunizations that are covered under the preventive benefits.
- **Prescription Drug Benefit:** Benefits are provided by CVS Caremark and are subject to the annual deductible and out-of-pocket maximum. You are responsible for paying the full cost of the medication until after you satisfy the annual deductible and maximum out of pocket for all medical, mental health and substance abuse benefits and prescription drug costs, and then the plan will pay at 100% for medications covered under the plan.
- **Out-of-Network Benefit:** You will have greater out-of-pocket costs if you go to a non-network provider — an annual deductible of \$9,200 for single coverage or \$18,400 for family coverage. The plan will then pay 70% of the plan allowance up to your annual maximum out-of-pocket of \$12,133 for single coverage/\$24,267 for family coverage. In addition, an out-of-network provider may bill you for the difference between their charge and the plan allowance.
- The Bronze Plan provides only medical, mental health and substance abuse and prescription drug coverage. The plan does **not** provide dental, vision or hearing aid benefits.

Bronze Plan for Permanent Part-Time and Non-Permanent Employees Working Average of 30-Hour Weeks

	Network Providers*	Non-Network Providers**
DEDUCTIBLE (Per Calendar Year) Includes costs for medical, mental health and substance abuse benefits and prescription drug costs.	\$9,100 single \$18,200 family	\$9,200 single \$18,400 family
OUT-OF-POCKET MAXIMUM When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the end of the benefit period. Out of Pocket Maximum includes costs for medical, mental health and substance abuse benefits and prescription drug costs. Includes deductibles, coinsurance, copayments and any other expenditure required of an individual, which is a qualified medical expense for the essential health benefits. Excludes balance-billing amounts for out-of-network providers and other out-of-network cost sharing.	\$9,100 single \$18,200 family	\$12,133 single \$24,267 family
PREVENTIVE CARE		
<ul style="list-style-type: none"> Preventive care services. For a list of PEBTF Preventive Care Services and Immunizations, visit www.pebtf.org. 	Covered in full – not subject to annual deductible	70% plan allowance after deductible; 100% plan allowance after out-of-pocket maximum; If not available in-network, full cost shall be covered without any cost sharing
MATERNITY SERVICES		
<ul style="list-style-type: none"> Office visits 	100% for the first prenatal visit; 100% plan allowance after deductible and out-of-pocket maximum for subsequent maternity charges including hospitalization and delivery charges	70% plan allowance after deductible; 100% plan allowance after out-of-pocket maximum
<ul style="list-style-type: none"> Hospital and newborn care 	100% plan allowance after deductible and out-of-pocket maximum	70% plan allowance after deductible; 100% plan allowance after out-of-pocket maximum
PHYSICIAN VISITS		
<ul style="list-style-type: none"> Office visits (family practice, general practice, internal medicine and pediatrics) Specialist office visits Lab tests, X-rays, inpatient visits, surgery and anesthesia 	100% plan allowance after deductible and out-of-pocket maximum	70% plan allowance after deductible; 100% plan allowance after out-of-pocket maximum

	Network Providers*	Non-Network Providers**
OUTPATIENT THERAPIES		
<ul style="list-style-type: none"> ▪ Outpatient physical and occupational therapy ▪ Speech therapy (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorder, not for developmental) ▪ Cardiac rehabilitation (18 visits per year) ▪ Pulmonary rehabilitation (12 visits per year) ▪ Respiratory therapy ▪ Manipulation therapy (restorative, chiropractic – 6 medically necessary visits then treatment plan submitted; not for maintenance of a condition) 	100% plan allowance after deductible and out-of-pocket maximum	70% plan allowance after deductible; 100% plan allowance after out-of-pocket maximum
OTHER PROVIDER SERVICES		
<ul style="list-style-type: none"> ▪ Radiation therapy, chemotherapy, kidney dialysis (not covered at a non-network freestanding dialysis center) ▪ Home health care (treatment plan required after 2 visits) ▪ Hospice ▪ Outpatient private duty nursing (240 hours per year/8 hours per day) ▪ Skilled nursing facility (240 days per calendar year) 	100% plan allowance after deductible and out-of-pocket maximum	70% plan allowance after deductible; 100% plan allowance after out-of-pocket maximum
OUTPATIENT HOSPITAL FACILITIES		
<ul style="list-style-type: none"> ▪ Professional fees and facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis (not covered if provided in a non-network freestanding dialysis center – is covered at a non-network rate if it is a non-network hospital), anesthesia and surgery 	100% plan allowance after deductible and out-of-pocket maximum	70% plan allowance after deductible; 100% plan allowance after out-of-pocket maximum
<ul style="list-style-type: none"> ▪ Outpatient diabetic education 	100% plan allowance after deductible and out-of-pocket maximum	Not covered
INPATIENT HOSPITAL SERVICES		
<ul style="list-style-type: none"> ▪ Professional fees and facility services including: room and board and other covered services (precertification is required for most services) 	100% plan allowance after deductible and out-of-pocket maximum Limit: 365 days per calendar year	70% plan allowance after deductible; 100% plan allowance after out-of-pocket maximum Limit: 70 days per calendar year
EMERGENCY CARE		
<ul style="list-style-type: none"> ▪ Emergency treatment for accident or medical emergency 	100% plan allowance after deductible and out-of-pocket maximum	100% plan allowance after deductible and out-of-pocket maximum
<ul style="list-style-type: none"> ▪ Ambulance services for emergency care 	100% plan allowance after deductible and out-of-pocket maximum	70% plan allowance after deductible; 100% plan allowance after out-of-pocket maximum

	Network Providers*	Non-Network Providers**
INVISIBLE PROVIDERS AT A NETWORK FACILITY		
<ul style="list-style-type: none"> Includes radiologists, anesthesiologists, pathologists and emergency room physicians operating in a network facility 	100% plan allowance after deductible and out-of-pocket maximum	
DURABLE MEDICAL EQUIPMENT		
<ul style="list-style-type: none"> Rental or purchase of durable medical equipment, supplies, prosthetics and orthotics, in accordance with the medical plan's DME policy. 	100% plan allowance after deductible and OOP MAX	70% plan allowance after deductible; 100% plan allowance after OOP MAX
LIFETIME MAXIMUM BENEFIT		
Unlimited		
PRESCRIPTION DRUG BENEFIT		
<ul style="list-style-type: none"> Provided by CVS Caremark 	You pay 100% of your prescription drug costs up to the maximum out-of-pocket; the plan then pays at 100% for medications covered under your plan. You do not need to submit claims – the prescription drug plan works with your medical plan to total all expenses	

*Participating providers agree to accept the Bronze Plan allowance as payment in full, often less than their normal charge.

**If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the provider's charges and the plan allowance.

This chart is intended as an easy-to-read summary. Benefits, limitations and exclusions are provided in accordance with the PEBTF Summary Plan Description. All benefits are limited to covered services that are determined by the Bronze Plan to be medically necessary.

Important Cost Information for 2023

If you want to enroll in the Bronze Plan during Open Enrollment effective January 1, 2023:

You will pay the employee contribution, which is 5% of your biweekly gross base pay or 2.5% if you participate in the Get Healthy **Know Your Numbers** Program by completing a wellness screening, (you will receive information on the Get Healthy Program after you enroll); refer to your collective bargaining agreement. The health care contribution and waiver are subject to change in July 2023.

Employees already enrolled in PEBTF benefits must complete an annual wellness screening by December 31, 2022 to earn the waiver starting July 1, 2023.

A wellness screening includes a blood draw that tests for cholesterol and glucose (sugar) levels, blood pressure measurement and height and weight to calculate Body Mass Index (BMI).



If you want to enroll in the Custom PPO, Basic PPO or PEBTF Custom HMO that is offered to full-time employees:

You pay the employee contribution, which is 5% of your biweekly gross base pay or 2.5% if you participate in the Get Healthy *Know Your Numbers* Program in addition to the amounts listed below (you will receive information on the Get Healthy Program after you enroll); refer to your collective bargaining agreement for contribution and waiver amounts. The health care contribution and waiver are subject to change in July 2023.

After 90 days of service, you may elect to enroll in supplemental benefits.

Part-Time Employees – For Employees Hired on or After August 1, 2003

Cost for Health Coverage *in addition to the employee contribution*

2023 Costs - First 90 Days		
	Employee Only Biweekly Cost	Family Biweekly Cost
Choice PPO	\$143.52	\$573.67
Basic PPO	\$128.72	\$535.50
PEBTF Custom HMO	\$134.13	\$557.98
Prescription drug benefits	\$95.27	\$236.34
2023 Costs - After 90 Days		
INDIVIDUAL PLAN OPTIONS	Employee Only Biweekly Costs	Family Biweekly Cost
Choice PPO	\$143.52	\$358.60
Basic PPO	\$128.72	\$332.11
PEBTF Custom HMO	\$134.13	\$346.06
Prescription Drug Benefits	\$36.64	\$94.54
Supplemental Benefits	\$7.35	\$18.95
COMBINED PLAN OPTIONS	Employee Only Biweekly Cost	Family Biweekly Cost
Choice PPO and Prescription and Supplemental	\$187.51	\$472.09
Basic PPO and Prescription and Supplemental	\$172.71	\$445.60
PEBTF Custom HMO and Prescription and Supplemental	\$178.12	\$459.55
Choice PPO and Prescription	\$180.16	\$453.14
Basic PPO and Prescription	\$165.36	\$426.65
PEBTF Custom HMO and Prescription	\$170.77	\$440.60
Choice PPO and Supplemental	\$150.87	\$377.55
Basic PPO and Supplemental	\$136.07	\$351.06
PEBTF Custom HMO and Supplemental	\$141.48	\$365.01
Prescription and Supplemental	\$43.99	\$113.49

Employees are also responsible for the 5% of gross base pay employee contribution (2.5% if you participate in the Get Healthy Program) in addition to the rates listed above. The health care contribution and waiver are subject to change in July 2023.

Coverage does not begin automatically; you will need to enroll to begin coverage for yourself and, if you choose, your eligible dependents. Remember, you can enroll yourself or eligible dependents at any time during the year — you don't need to wait for a qualifying event or open enrollment.

Each year, you have an opportunity during open enrollment to decline coverage, remove dependents or change your medical plan. If you experience a qualifying event during the year, you may be eligible to make these changes in response to the event. Prior to enrollment, please contact your physician to confirm his or her participation in the plan's network.

Please be mindful that canceling coverage does require a qualifying event; otherwise, your opportunity to cancel would occur during the next open enrollment period.

Enrolling in health benefits will result in payroll deductions. Visit Employee Self Service at www.myworkplace.pa.gov to complete your enrollment. For questions about cost, visit www.employeeresourcecenter.oa.pa.gov.



Questions About Costs and How to Enroll in the Bronze Plan?

Call the HR Service Center at 1-866-377-2672 if your agency is supported by the HR Service Center.

Call your local HR office if your agency is not supported by the HR Service Center.



Questions About the Bronze Plan?

Visit www.pebtf.org. Select "2022 Open Enrollment" for links to the Bronze Plan's online provider directory.

Call the PEBTF at 1-800-522-7279 with any questions.

Call Health Advocate at 1-855-855-4238 to help locate network doctors and providers.