2022 PEBTF Open Enrollment

October 17 to November 4, 2022

Benefit Information for Non-Permanent Employees Working an Average of 30 Hours/Week

(For employees who only qualify for Bronze Plan)

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 to elect the Bronze Plan offered by Aetna and administered by the Pennsylvania Employees Benefit Trust Fund (PEBTF) on behalf of the commonwealth with coverage effective January 1, 2023.

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.

1. Bronze Plan, consisting of Aetna medical and prescription drug coverage.
2. Decline to enroll in coverage through the PEBTF.

This Open Enrollment newsletter provides a benefit summary of the Bronze Plan. If you are enrolled and want to remain enrolled for 2023, 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 this plan to determine if it 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.

Your Benefit Option – At a Glance	
	Bronze (high deductible plan)
Cost	You pay the employee contribution, which is 5% of your biweekly gross base pay. If you participate in the Get Healthy ***Know Your Numbers*** Program, you will pay 2.5% of your biweekly gross pay. Please see your collective bargaining agreement for more information. The health care contribution and waiver are subject to change in July 2023. You will also pay a dependent buy-up if you include your dependents during your first 90 days of employment.
In network high deductible before plan pays	**Yes**
Visit network providers only	No
May visit non-network providers (at additional cost)	**Yes**
Referrals needed for specialist care	No
Preventive care covered 100% in-network — not subject to deductible. For a list of PEBTF preventive care services and immunizations, visit www.pebtf.org.	**Yes**
Mental health and substance abuse benefits	**Yes**
Prescription drug coverage	**Yes**
Dental, vision, and hearing aid	No coverage

PEBTF 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. If you participate in the Get Healthy ***Know Your Numbers*** Program, you pay 2.5% of your biweekly gross base pay. Please see your collective bargaining agreement for more information.

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 may 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 Non-Permanent Employees Working an Average of 30 Hours/ Week

	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		
▪ 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 the out-of-pocket maximum; If not available in-network, full cost shall be covered without any cost sharing
MATERNITY SERVICES		
▪ Office visits	100% for the first prenatal visit; 100% plan allowance after deductible and out-of-pocket maximum for subsequent maternity charges including hospitalization and delivery charges	70% plan allowance after deductible; 100% plan allowance after the out-of-pocket maximum
▪ Hospital and newborn care	100% plan allowance after deductible and out-of-pocket maximum	70% plan allowance after deductible; 100% plan allowance after the out-of-pocket maximum
PHYSICIAN VISITS		
▪ Office visits (family practice, general practice, internal medicine and pediatrics) ▪ Specialist office visits ▪ Lab tests, X-rays, inpatient visits, surgery and anesthesia	100% plan allowance after deductible and out-of-pocket maximum	70% plan allowance after deductible; 100% plan allowance after the out-of-pocket maximum

	Network Providers*	Non-Network Providers**
OUTPATIENT THERAPIES		
▪ 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 the out-of-pocket maximum
OTHER PROVIDER SERVICES		
▪ 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 the out-of-pocket maximum
OUTPATIENT HOSPITAL FACILITIES		
▪ 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 the out-of-pocket maximum
▪ Outpatient diabetic education	100% plan allowance after deductible and out-of-pocket maximum	Not covered
INPATIENT HOSPITAL SERVICES		
▪ 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 the out-of-pocket maximum Limit: 70 days per calendar year
EMERGENCY CARE		
▪ 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
▪ Ambulance services for emergency care	100% plan allowance after deductible and out-of-pocket maximum	70% plan allowance after deductible; 100% plan allowance after the out-of-pocket maximum

	Network Providers*	Non-Network Providers**
INVISIBLE PROVIDERS AT A NETWORK FACILITY		
▪ 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		
▪ 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	Unlimited
PRESCRIPTION DRUG BENEFIT ▪ 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 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 for contribution and waiver amounts. 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).

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 or to remove dependents. 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.

10-2022