PEBTF BENEFIT NEWS for Retiree Members

New 2017 Medical Plan Options

There are changes to your retiree benefits which went into effect on January 1, 2017. Refer to the appropriate section of this article – Non-Medicare Eligible Retirees or Medicare Eligible Retirees.

Non-Medicare Eligible Retirees:

Your new medical plan began on January 1. Present your new plan's medical ID card at the time you receive medical services.

Copayment Amounts

The copayment amounts are listed on your medical ID card. Copayments are paid at the time of service.

	PPO Option	PEBTF Custom HMO Option
PCP Office Visit	$20	$5
Specialist Office Visit	$40	$10
Urgent Care Visit	$50	$50
Emergency Room Visit (waived if admitted)	$150	$150

What's Inside

The REHP Custom HMO

As a reminder, the Custom HMO offers a limited network of providers. This limited network allows the PEBTF to offer low HMO copayments and no deductible. Make sure you visit a provider who is in the Custom HMO network. The HMO does not pay for services at an out-of-network provider.

PPO Option – Annual Deductible

The PPO plans both include annual in-network deductibles. The deductible amounts differ by plan, as follows:

- Choice PPO: $300 single/$600 family
- Basic PPO: $1,000 single/$2,000 family

So, what is a deductible? It is the amount that you owe for health care services before the plan begins to pay. The PPO in-network deductible applies to all services except preventive care, office visits and outpatient therapy copayments, emergency room and urgent care copayments and blood tests done at a Quest Diagnostics or LabCorp.

You pay the deductible directly to the doctor or the facility. The deductible is applied to the PPO's discounted rate. Some providers may check with your plan ahead of time to see what deductible you owe and you may be asked to pay the deductible at the time of service. Other providers may bill you for any deductible amount once the services are submitted to your plan. After you met your annual deductible, services will be covered 100% for the

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remainder of the year. Of course, you will continue to pay any office visit copayments.

An example of when you would pay the PPO in-network deductible is with a surgical procedure. You are responsible for any costs up to your annual deductible amount. The plan will then pay 100% of the remaining medically-necessary covered services.

Tips to get the most out of your Aetna health plan

This article focuses on the Aetna plans. See page 8 for an article on the Basic PPO. The Spring newsletter will feature tips on using the Custom HMO offered by Geisinger.

Custom HMO

It's a member-centered approach where you are the center of a care team that works to keep you healthy or improve your health, not just treat you when you're sick or injured.

Accessing care starts with your participating primary care physician (PCP). You choose your PCP from the Custom HMO network. Think of your PCP as the quarterback of your care team — keeping your care connected across other facilities and specialists. Your primary doctor can:

- Make sense of various visits and tests
- Guide you on important health decisions
- See you for yearly wellness exams and screenings, not just when you're sick

Important reminders for the Custom HMO include:

- All care (with the exception of medical emergencies) must be provided within the Pennsylvania Custom HMO network. No out-of-network services are available.
- Be sure to check that all referrals are made within the Custom HMO network. Your PCP will work with you to coordinate referrals to the appropriate in-network specialist.

Choice PPO

- The Choice PPO network offers nationwide access to participating providers.
- Care may be provided by an in or out-of-network provider. To save money, choose an in-network PPO provider for lower out-of-pocket costs.
- If you use Quest or LabCorp for lab services, the deductible does not apply.
- You can estimate the cost of care in advance of your appointment by using the "Cost of Care" tool under "Coverage & Benefits" on Aetna Navigator (www.aetnanavigator.com). Please note: First time users will be required to register for the Aetna Navigator secure member portal.

How to request ID cards or locate a participating Custom HMO or Choice PPO provider:

- To print additional ID cards go to www.aetnanavigator.com and from the menu on the left hand side under "I want to…" click on View/Print an ID Card.
- It's easy to find a participating doctor — just visit: www.aetna.com/PEBTF
- Or you can call member services at 1-800-991-9222 (8:00 a.m. – 6:00 p.m. Monday through Friday). This number is located on the back of your ID card.

Source: Aetna

Get Lower Cost Lab Testing and More From One of Our Preferred Labs

If you are enrolled in one of the Non-Medicare PPO plans your diagnostic testing done at a Quest Diagnostics or LabCorp is covered 100% and is not subject to a deductible.

Using Quest Diagnostics

Below are some tips on how to use Quest Diagnostics to save money.

As a preferred in-network lab for PEBTF members, Quest can help lower your out-of-pocket costs. When you visit your doctor, tell them you prefer Quest Diagnostics.

Tips for using Quest Diagnostics

- If your doctor will collect the specimen at his or her office, ask your doctor to send your test to Quest Diagnostics.
- Your doctor can either send your order electronically to Quest Diagnostics or give you a print order form.
- If your doctor doesn't have an account with Quest Diagnostics, they can call **1.866.MYQUEST (1.866.697.8378)** to set up an account.
- Quest Diagnostics can send a courier to pick up your sample from your doctor's office.
- To visit a Quest Diagnostics Patient Service Center:
    1. Obtain an order from your doctor.
    2. Find a Quest Diagnostics location near you. Go to **QuestDiagnostics.com/Appointment or call 1.888.277.8772**.
    3. Minimize your wait time by scheduling an appointment*. Walk-ins are welcome.
    4. Bring the following to your visit:
        - If your doctor does not send your lab orders electronically, bring a print copy of your lab order from your doctor
        - Photo identification
        - Current health insurance information and your ID card

Using LabCorp

By choosing LabCorp you have the opportunity to maximize your laboratory testing benefits and lower your out-of-pocket costs.

Offering you convenient access for specimen collection

- If your doctor collects the specimen in his/her office, please ask your doctor to send the specimen to LabCorp for testing.
- LabCorp also operates a network of conveniently located patient service centers (PSCs) for specimen collection.
- Visit our website at www.labcorp.com to locate the PSC nearest you and make an appointment. Appointments are not required, and walk-ins are welcome.

TIPS to be prepared at a PSC:
Bring the following information with you:

- The LabCorp test request form from a health care professional requesting laboratory testing
- A current insurance identification card
- A photo ID (for example, a driver's license or employee identification badge)

You can also securely manage your test results 24/7 by enrolling in LabCorp Beacon: Patient.

Why join?

- Make an appointment with a lab 24 hours a day
- Receive lab results as easily as checking email
- Share your lab test results securely and privately
- Manage health information for the entire family

Medicare - Eligible Retiree Members

Medicare Part B Premium

For some Medicare enrollees, the 2017 Medicare Part B premium usually deducted from your monthly Social Security benefit is $109.00, compared to $104.90 for the past four years.

For those who paid $121.80 in 2016 or are enrolling in Medicare Part B for the first time in 2017, you will pay a monthly Part B premium of $134.00.

If you make more than $85,000 (single) or $170,000 (joint tax return), your monthly premium will be higher.

Aetna Medicare PPO Deductible Amounts

The Medicare PPO deductible is based on the Medicare Part B deductible. For 2017, your annual in-network deductible is $183. The annual out-of-network deductible is $366. After you meet the annual deductible, you pay low copayments.

Copayment Amounts

Copayments for primary care physician (PCP) and specialist office visits increased under the Medicare PPO and Medicare HMO in 2017. Here are the copayments for common services:

	Medicare PPO Option	Medicare HMO Option
PCP Office Visit	$15	$15
Specialist Office Visit	$20	$20
Outpatient/inpatient therapies (change for HMO only)	$15	$15
Urgent Care Visit	$50	$50
Emergency Room Visit (waived if admitted)	$50	$50

New Medicare HMO Plan Offered in Southcentral Pennsylvania

BlueJourney HMO, offered by Capital Blue Cross, is available to members who reside in Southcentral Pennsylvania. It replaces Geisinger Gold Classic (HMO) in that area. Members affected by the change received a letter in fall 2016 and could enroll in this new plan during the Medicare Open Enrollment which ended on November 11, 2016. If you enrolled in this new plan, use the new medical ID card that you received.

REHP May Cancel Your Coverage For Fraud or Intentional Misrepresentation

IMPORTANT: If you intentionally provide false or misleading information about eligibility for coverage under the REHP Plan (or about a claim) or you fail to make a required contribution on time, your coverage may be terminated retroactively. This may occur, for example, if you file a false claim, fail to notify us promptly of a divorce or fail to submit timely proof of birth or adoption that verifies your relationship with a new child whom you have added as a dependent.

All Retirees – Prescription Drug Benefit

The Open Enrollment Newsletter included information about prescription drug copayment changes effective January 1, 2017. To save money, ask your doctor about generic drugs.

	Copayment 1/1/2017
Prescriptions at a Network Pharmacy Up to a 30 Day Supply	
Tier 1: Generic drug	$10
Tier 2: Preferred brand-name drug	$20*
Tier 3: Non-Preferred brand-name drug	$40*
Mail Order or Retail Maintenance at a CVS Pharmacy Up to 90 Day Supply	
Tier 1: Generic drug	$15
Tier 2: Preferred brand-name drug	$30*
Tier 3: Non-Preferred brand-name drug	$60*
Retail Maintenance at a Rite Aid Pharmacy (non-Medicare) Retail Maintenance at a Preferred or Non-Preferred Network Retail Pharmacy (Medicare) Up to 90 Day Supply	
Tier 1: Generic drug	$20
Tier 2: Preferred brand-name drug	$40*
Tier 3: Non-Preferred brand-name drug	$80*

*plus the cost difference between the brand and the generic, if one exists

There may be some formulary changes for 2017. Some medications may have moved from preferred to non-preferred which could result in a higher cost to you. Visit www.pebtf.org to view the formulary. Formularies may be found under Publications & Forms.

Other Benefits

For Non-Medicare Eligible Retirees:
Mental Health & Substance Abuse Benefit: Optum continues to administer the mental health and substance abuse benefits. **PPO Members:** Your outpatient mental health office visit copay is $20. Inpatient services are subject to the PPO medical deductible. You may visit out-of-network providers at higher out-of-pocket costs. **Custom HMO Members:** Your outpatient mental health office visit copay is $5. You must visit an Optum network provider. If you go out-of-network, you will not have coverage.

Durable Medical Equipment (DME), Prosthetics, Orthotic, Medical and Diabetic Supplies: DMEnsion continues to administer the durable medical equipment (DME), prosthetics, orthotics, medical and diabetic supply benefit. There are no changes to this benefit. Members previously enrolled in the CDHP must now use DMEnsion for these items.

For Medicare Eligible Retirees:
You receive the above-listed benefits as part of your Medicare HMO or Medicare PPO plan.

Obtaining Diabetic Supplies for Non-Medicare and Medicare Eligible Members

The following chart shows how you should obtain diabetic supplies. Effective January 1, 2017, there were changes to how non-Medicare eligible members obtain diabetic supplies.

Item	Non-Medicare Eligible Members	Medicare Eligible Members Enrolled in MHMO or MPPO
Insulin	CVS Caremark RX with copay	SilverScript RX with copay
Syringes/Needles	DMEnsion	SilverScript RX with copay
Pump		Contact medical plan
Glucometer		
Lancets		
Test Strips		
Non-Medicare: CVS Caremark – 1-888-321-3261; DMEnsion – 1-888-732-6161 ***Medicare:*** SilverScript – 1-866-329-2088; medical plan phone numbers appear on your medical ID card		

New Year – New You

Your medical benefits include an annual physical at no cost. Part of your annual physical may include a blood test as well as blood pressure screening and height and weight measurements.

Your doctor performs screening tests for factors that contribute to metabolic syndrome. Metabolic syndrome is a group of high risk factors – high blood pressure, high blood sugar, high cholesterol and abdominal fat. When all of these factors are combined, they set the stage for serious problems. These risk factors can double your risk for heart attack and strokes and increase your risk of diabetes by five times. According to the American Heart Association, 47 million Americans have metabolic syndrome – that's one out of every six people.

Once you know your risk factors, you should work with your doctor to make lifestyle changes to improve your health.

Source: WebMD

Ready to Improve Your Health?

1. **Think about losing some weight.**

Weight loss helps reduce all the risk factors for metabolic syndrome.

2. **Focus on being more active.**

Regular exercise can help keep your heart and lungs healthy.

3. **Consider eating a heart-healthy diet.**

Eat plenty of fruits and veggies, whole grains, fat-free or low-fat dairy and protein foods.

4. **Try to quit smoking.**

Smoking can increase your risk for heart disease and stroke by 2 to 4 times (see page 7 for the smoking cessation programs).

5. **Talk with your doctor.**

If lifestyle changes aren't enough, your doctor may prescribe medicines that can help.

Source: ActiveHealth Management

Helping to Keep You Healthy

At the beginning of a New Year, many of us make resolutions to improve our health. While it's up to you to take the necessary steps, the Retired Employees Health Program (REHP) offers various resources to help you along your way. Consider participating in these programs in 2017.

Help to Quit Smoking

Non-Medicare Eligible Members: If 2017 is your year to quit smoking, you have help with the Quit For Life® Program. The PEBTF offers the program, free of charge to REHP non-Medicare eligible members and covered dependents (age 19 and older). Enrolling is easy! Call 1-866-QUIT-4-LIFE (1-866-784-8454) or register at www.quitnow.net/pebtf.

Medicare Eligible Members: Contact your Medicare HMO or PPO for information about smoking cessation programs.

Medical Plans Offer Discounts

Non-Medicare Eligible Members: Your medical plan offers discounts on gym memberships, nutrition counseling, alternative medicines and other services. Visit www.pebtf.org and click on Get Healthy Discount Programs. Then select your medical plan for more information. It's a great way to save money!!

Medicare-Eligible Members: Your Medicare HMO or PPO offers a fitness benefit which includes a free gym membership to gyms and health clubs in your plan's network. Contact your plan for more information.

2017 REHP Benefits Handbook Available

The 2017 REHP Benefits Handbook may be found on www.pebtf.org.

Important Information Needed to File Your 2016 Federal Taxes

Non-Medicare Eligible Members

Watch your mail for important tax information. The Affordable Care Act (ACA) requires that the PEBTF provides you with an annual notice summarizing your and your dependents' enrollment in the REHP health coverage.

You will receive a Form 1095-B from the PEBTF. The Form 1095-B is the Health Coverage Form. It has information you'll need to report on your tax return. The information basically shows whether or not you've had qualifying health insurance coverage.

Your tax preparer should be familiar with these forms. Please refer to your IRS Form 1040 (2016) line 61 Healthcare: individual responsibility. Within IRS Form 1040EZ (2016), see line 11. You may also want to refer to IRS Form 8962 Premium Tax Credit as well as Form 8965 Healthcare Exemptions.

Coverage for Autism Spectrum Disorder

Annual Amount Increased Effective January 1, 2017

Non-Medicare Eligible Members

Effective January 1, 2017, coverage for Autism Spectrum Disorder is increased to **$38,852** per year.

Nondiscrimination Statement

The Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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IMPORTANT BENEFIT INFORMATION

Tips on Using the Basic PPO offered by Highmark

The Basic PPO for non-Medicare eligible members offers both a network and an out-of-network benefit. Here are some tips to getting the most out of your plan:

- Use network providers when possible. You will save money! Visit www.highmarkblueshield.com and click on "Find a Doctor" at the top to search for providers. Select PPOBlue or BCBSPPO for the plan or enter OPB for the first 3 letters of your member ID card.
- The Basic PPO offers a nationwide network of providers through the BlueCard® program. If you are outside of the area, call the number on your medical plan ID card to find a network provider.
- Use Quest Diagnostics or LabCorp for blood work; the deductible does not apply.
- If you are in need of urgent/emergent care, try using an Urgent Care provider ($50 copay) instead of the Emergency Room ($150 copay).
- Create an online account at www.highmarkblueshield.com on your computer or smartphone to gain access to electronic EOBs, member discounts, printable ID Cards and much, much more!
- Traveling out of the country, no problem! Care can be coordinated through Blue Cross BlueShield Global Core. More information at www.bcbsglobalcore.com