PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND
ENROLLMENT IN PEBTF PRESCRIPTION DRUG PLAN
WITHOUT PEBTF MEDICAL PLAN COVERAGE

Notice

For various reasons under the Affordable Care Act, it is important that a group health plan provide minimum value. Minimum value coverage means that your health plan pays at least 60% of the total cost of medical services for a standard population. If you are enrolled in health coverage through the Marketplace, you have minimum value coverage. If you are enrolled in coverage through an employer (or other source), you should have received a notice about the Marketplace that shows your coverage is at least minimum value. If you do not have a Marketplace Notice, please contact your health plan administrator to confirm your coverage is at least minimum value.

If you would like to enroll in the Prescription Drug Plan only, you must certify that you are enrolled in another group health plan that does provide minimum value. Please attach a copy of your medical ID card to show you have other group health coverage.

Employee and/or Dependent Information

Employee Name:_____ Employee Number:_____ Employee Date of Birth:_____

Employee Name:
I am currently: ☐ Enrolled in a medical plan other than the PEBTF/REHP that provides minimum value under the Affordable Care Act
Spouse/Domestic Partner Name:
My spouse/domestic partner is currently: ☐ Enrolled in a medical plan other than the PEBTF/REHP that provides minimum value under the Affordable Care Act
Dependent Child(ren) Name:
My dependent child(ren) is currently: ☐ Enrolled in a medical plan other than the PEBTF/REHP that provides minimum value under the Affordable Care Act

Signature: I have read and understand the explanation set forth above. I hereby attest and certify that I have group health plan coverage that provides minimum value, as defined under the Affordable Care Act. I declare that the foregoing information is true and correct to the best of my knowledge, information and belief.

I understand that if I and/or my dependents ever cease to have group health plan coverage that provides minimum value that my coverage under the PEBTF Prescription Drug Plan may be discontinued. I agree to notify the HR Service Center (or my local HR Office for agencies not supported by the HR Service Center) and complete an Enrollment Change Form (PEBTF-2).

I understand that the PEBTF may suspend or terminate my PEBTF group health plan coverage if it concludes I have provided false or misleading information in this Declaration and that I may be held responsible for costs under the Prescription Drug Plan.

_____ _____

Employee Signature Date

PEBTF, 150 S. 43rd Street, Harrisburg, PA 17111