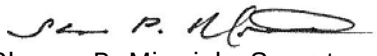
MANUAL

Commonwealth of Pennsylvania

Governor's Office

Subject:	***Number:***
Pennsylvania State Police Health Benefits Program Administrative Manual	Manual 530.15 Amended
By Direction of:  Sharon P. Minnich, Secretary of Administration	***Date:*** October 22, 2018
Contact Agency: Office of Administration, Office for Human Resources and Management, Bureau of Employee Benefits, Telephone 717.787.9872	

This manual has been updated to facilitate the enrollment of enlisted members and their dependents into the Pennsylvania State Police Health Benefits Program (SPHBP). Revisions to this manual include updates relative to the Office of Administration (OA), Human Resources (HR) Service Center procedures, claim forms and revised F-200 form.

This manual replaces, in its entirety, *Manual 530.15*, dated April 14, 2017.

STATE POLICE HEALTH BENEFITS PROGRAM
(SPHBP)

®

ADMINISTRATIVE MANUAL

Commonwealth of Pennsylvania
Office of Administration

Manual 530.15

NOTE

The State Police Health Benefits Program (SPHBP) 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 for State Police enlisted members and their dependents. The commonwealth, and SPHBP do not assume any legal or financial responsibility for the provision of those medical services, including without limitation the making of medical decisions, or negligence in the performance or omission of medical services. For a complete description of the SPHBP eligibility rules and benefits, reference should be made to State Police Health Benefits Handbook.

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PART 1 – ELIGIBILITY AND BEGINNING/END OF COVERAGE

Enlisted member Eligibility

Employees in the L1 and L3 bargaining unit and in an active pay status are eligible for the SPHBP.

When Does Coverage Begin?

Coverage begins on the date the employee becomes an enlisted member of the Pennsylvania State Police by graduating from Cadet to Trooper status.

When Does Coverage End?

Enlisted member and/or Dependent	Type of Coverage	Type of Qualifying Event	When Does State-Paid Coverage End
Enlisted member and Dependent	Medical, Dental, Prescription & Vision	Sick or Parental LWOPWB	At the end of the 1048 hours of leave entitlement plus 91 calendar days
Enlisted member and Dependent	Medical, Dental, Prescription & Vision	Family Care LWOPWB	At the end of the 480 hours of leave entitlement plus 91 calendar days
Spouse	Medical, Dental, Prescription & Vision	Divorce	On the date of divorce
Dependent Child (up to age 26)	Medical, Dental, Prescription & Vision	Reaches age 26	At the end of the month in which the Dependent Child reaches age 26
Enlisted member and Dependent	Medical, Dental, Prescription & Vision	Suspension WOP With Benefits	Coverage would end on the 92nd day of the suspension.
Enlisted member and Dependent	Medical, Dental, Prescription & Vision	Suspension WOP Without Benefits	Coverage would end on the 92nd day of the suspension.
Surviving Dependent and Furloughed Enlisted member	Medical, Dental, Prescription, & Vision	Employee's death (other than killed in the line of duty) or Furlough of Enlisted member	Date of Qualifying Event
Spouse and Eligible Dependent	Medical, Dental, Prescription & Vision	Enlisted member Killed in Line of Duty	Spouse: Remains covered until the spouse remarries or dies. Other Dependents: Continues as long as dependent eligibility requirements are met

PART 2 – ENROLLMENTS AND CHANGES

Cadet to Enlisted member.

NOTE: Cadets who graduate on/or after April 21, 2005 are eligible for the PPO Blue medical plan only. Per their collective bargaining agreement, enlisted members cannot decline SPHBP coverage.

1. When the cadet training is completed, the State Police Bureau of Human Resources and OA, Bureau of Employee Benefits meets with the cadet class in order for each graduating enlisted member to enroll in the SPHBP effective on their date of graduation. The enlisted member will be enrolled in SPHBP effective at 12:00 a.m. on the date of placement into the L1 bargaining unit. The State Police Bureau of Human Resources and OA, Bureau of Employee Benefits provides each enlisted member with a SPHBP Benefits Handbook. The enlisted member must sign a form stating that he/she received the handbook. The receipt of acknowledgement is then filed in the enlisted member's Official Personnel File (OPF).

2. The Public Safety HR Delivery Center will forward an Electronic Personnel Action Request (E-PAR) bundle with a spreadsheet of enlisted members graduating from Cadet to Trooper status to the Office of Administration (OA), HR Service Center for processing.

a. If an enlisted member is not adding a dependent to SPHBP coverage, OA, HR Service Center will automatically enroll the enlisted member in SPHBP employee only coverage.

b. If the enlisted member had dependents enrolled in Pennsylvania Employees Benefit Trust Fund (PEBTF) benefits as a Cadet and is not adding additional dependents to SPHBP coverage; the OA, HR Service Center will automatically enroll the enlisted member and applicable dependents in SPHBP multi-party coverage. NOTE: Domestic partners and domestic partner children are not eligible for SPHBP coverage.

c. If an enlisted member is adding a dependent at the time of graduation to trooper status and **no** eligibility documentation is required, the enlisted member will complete an F200 form (Refer to Attachment 10) at the pre-graduation benefits orientation. The State Police Bureau of Human Resources will forward the F200 form to OA, HR Service Center for processing. If the enlisted member is adding a dependent any time after graduation, he/she must contact OA, HR Service Center to add their dependent to SPHBP coverage.

d. If an enlisted member is adding a dependent to SPHBP coverage which requires eligibility documentation, the enlisted member must contact OA, HR Service Center to determine what supporting documentation must be provided. An F200 Form and all required supporting documentation must be forwarded to OA, HR Service Center for processing to add the dependent to SPHBP coverage.

3. Electronic interface files are sent to the health plans on a weekly basis. Enrollment information is not sent prior to the effective date. Enlisted members should allow five to ten business days to receive their identification cards.

4. The Public Safety HR Delivery Center will provide OA, Bureau of Employee Benefits (BEB) with a copy of the spreadsheet of enlisted members graduating from Cadet to Trooper status in order for the commonwealth to establish a Health Reimbursement Arrangement (HRA) account on behalf of the enlisted member.

Adding Dependents.

1. If an enlisted member would like to enroll a dependent in benefits and the enrollment does **not** require additional eligibility documentation, the enlisted member must contact OA, HR Service Center, Employee Services Division directly.

2. If an enlisted member is adding a dependent to SPHBP coverage which requires eligibility documentation, the enlisted member must contact OA, HR Service Center, Employee Services Division to determine what supporting documentation must be provided. An F200 Form and all required supporting documentation must be forwarded to OA, HR Service Center for processing to add the dependent to SPHBP coverage. Refer to Part 3 – Forms Required to Add/Remove Dependents.

3. OA, HR Service Center, Employee Services Division will mail a letter to all spouses newly added to coverage informing the individual of his/her rights to coverage under the *Consolidated Omnibus Budget Reconciliation Act (COBRA)* along with a copy of the "*COBRA* Continuation Coverage Rights: Important Notice of *COBRA* Continuation Coverage Rights" (Attachment 4). A copy of the cover letter mailed to the spouse shall be scanned and attached to a case in the case management application as proof that the COBRA Notice was mailed.

4. The SPHBP carriers receive data transmissions from SAP on a weekly, monthly and quarterly basis. The update files are sent weekly. This information contains updates to the enlisted members' information, if applicable. The eligibility files are sent monthly. On a quarterly basis, the carriers are sent match files to ensure that their records are accurate.

Changes.

1. The enlisted member must contact OA, HR Service Center, Employee Services Division for assistance with address or dependent changes.

2. Changes to benefit plans can only occur during the annual open enrollment period or with a qualifying event.

Other Coverage Data.

1. If enlisted members and/or their dependents undergo changes to their coverage by other medical/hospital or supplemental benefits insurance programs, enlisted members must contact the OA, HR Service Center, Employee Services Division to report the change for Coordination of Benefits purposes.

2. OA, HR Service Center will perform a PA30 copy action on Infotype 0167 – Health Plans under the "Other Dependent Information" section to reflect the details of the change indicated by the enlisted member.

3. The Coordination of Benefits data is transmitted to the insurance carriers via the weekly data transmission.

Dependents Turning 26.

Note: Dependent coverage ends at the end of the month in which the dependent turns 26.

1. SAP automatically terminates benefits for dependents who have turned 26 effective the end of the month in which the dependent reaches age 26; unless the dependent is considered a disabled dependent.

2. On a monthly basis, the OA, BEB will provide the PEBTF with a list of dependents who have reached their 26th birthday and are no longer eligible for SPHBP coverage. The PEBTF will notify the dependent of the option to purchase COBRA continuation coverage.

Disabled Dependents.

1. If an enlisted member wishes to apply for coverage for an unmarried disabled dependent (other than a spouse), the enlisted member must contact the medical insurance carrier's Customer Service Department.

2. The medical insurance carrier will mail the enlisted member a Disabled Dependent Certification Form. The form must be completed by the enlisted member and the treating physician and returned to the medical insurance carrier for review and approval.

3. If the disabled dependent is approved for coverage, the medical insurance carrier will notify the enlisted member of its decision.

4. The medical insurance carrier will notify OA, BEB of its decision for active enlisted members. For annuitants, the carrier will notify OA, BEB and the PEBTF.

5. If the dependent of an active enlisted member is approved for coverage, OA, HR Service Center, Employee Services Division will update SAP via PA30, copy on IT0021, and change the start date to the effective date.

Removing Dependents.

1. The enlisted member must contact OA, HR Service Center, Employee Services Division to remove a dependent from SPHBP coverage.

2. OA, HR Service Center, Employee Services Division will remove the dependent via SAP.

3. OA, HR Service Center, Employee Services Division will provide the PEBTF with a weekly report of dependents removed from SPHBP coverage. If deemed eligible for COBRA benefits, the PEBTF will forward COBRA enrollment materials to the dependent removed from SPHBP coverage.

4. Medical and supplemental plan carriers receive data transmissions from SAP on a regular basis. The medical and supplemental plan carriers will then remove the affected dependent from coverage.

Leave Without Pay With Benefits (LWOPWB).

NOTE: The effective dates in this section are used by the benefit carriers to begin and stop benefits.

Transactions. The Public Safety HR Delivery Center performs a PA40 action placing the enlisted member on LWOPWB.

Suspensions. An enlisted member who is placed on suspension will continue to receive benefits for the first 91 days.

1. If the enlisted member **has not** been charged with a felony or misdemeanor under the laws of the United States, Commonwealth of Pennsylvania, or any other state(s) of the United States, and/or subdivisions thereof:

a. Benefits will continue during the period of suspension for a period of no less than 91 days (in accordance with the *Patient Protection and Affordable Care Act (PPACA)*). Coverage will end on the 92nd day of the suspension.

b. The Public Safety HR Delivery Center will notify the enlisted member, via written correspondence, that he or she is being placed on a long-term suspension without pay with benefits and the date when his or her benefits will terminate.

c. If the enlisted member exhausts his or her benefit entitlement, and the *COBRA* Administrator (the PEBTF) determines that the enlisted member is entitled to elect *COBRA* continuation coverage, the enlisted member will receive a notice to elect *COBRA* continuation coverage from the PEBTF.

2. If the enlisted member **has** been charged with a felony or misdemeanor under the laws of the United States, Commonwealth of Pennsylvania, or any other state(s) of the United States and/or subdivisions thereof:

a. Benefits will continue during the period of suspension for a period of no less than 91 days (in accordance with the *PPACA*). Coverage will end on the 92nd day of the suspension.

b. The Public Safety HR Delivery Center will notify the enlisted member, via written correspondence, that he or she is being placed on a long-term suspension without pay with benefits and the date when his or her benefits will terminate.

c. If the PEBTF, as the COBRA Administrator, determines that the enlisted member is entitled to elect COBRA continuation coverage, the enlisted member will receive a notice to elect COBRA continuation coverage from the PEBTF. COBRA continuation coverage will not be provided if the PEBTF determines that there was "gross misconduct." "Gross misconduct" is not specifically defined by law and is something that must be determined by the PEBTF, as the COBRA Administrator, on a case-by case basis.

3. If an enlisted member files a grievance challenging the suspension that is resolved in the member's favor, SPHBP coverage will be reinstated in accordance with the resolution of the grievance. Insurance carriers reinstate enlisted member benefits effective retroactively via transmission from the SAP system. If claims were

incurred during the period of suspension without pay without benefits and were originally denied for payment by the insurance carriers, they can be reprocessed after the enlisted member is made whole.

4. OA, HR Service Center, Employee Services Division will run a PA40 report on a weekly basis to determine which enlisted members have been placed on long-term suspension without pay without benefits. If an enlisted member is placed on long-term suspension without pay without benefits, OA, HR Service Center, Employee Services Division will provide the PEBTF with a weekly list of the enlisted members.

Military Leave.

1. The commonwealth provides leave benefits that exceed the requirements of the *Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)*. For *PPACA* purposes, employees who are on military leaves of absence will continue to be eligible for benefits, regardless of whether or not the military leave of absence is covered by USERRA, except for employees who enlist in the regular branches of the U.S. Armed Forces.

2. The employee will be placed on leave without pay without benefits effective the 92nd day of absence. Reference: *Management Directive 530.26, Military Leaves of Absence*.

Leave without Pay Without Benefits (LWOPWOB).

1. The Public Safety HR Delivery Center performs a PA40 action placing the enlisted member on LWOPWOB.

2. OA, HR Service Center, Employee Services Division will run a PA40 report on a weekly basis to capture LWOPWOB actions entered in SAP.

3. OA, HR Service Center, Employee Services Division will provide the PEBTF, the COBRA Administrator, with a weekly report of enlisted members who have been placed on LWOPWOB. Upon receipt of the weekly report, the PEBTF will provide the enlisted member and covered dependents with the opportunity to enroll in COBRA continuation of coverage.

4. OA, HR Service Center, Employee Services Division will capture the return to active duty or separation action via the PA40 report.

Enlisted Member Killed in the Line of Duty.

In the event an enlisted member is killed in the line of duty, all SPHBP benefits will continue for the eligible dependents of the deceased enlisted member for the life of the spouse or until the spouse remarries, and for other dependents as long as they meet the SPHBP eligibility requirements.

1. The Public Safety HR Delivery Center will prepare an E-PAR and forward to OA, HR Service Center to separate the enlisted member effective the date he or she was killed in the line of duty. OA, HR Service Center Agency Services performs a PA40 separation action in SAP.

2. A Transaction and Benefit Notice is circulated throughout the Public Safety HR Delivery Center so it can process appropriate transactions regarding this matter.

3. The Public Safety HR Delivery Center completes an F200 Form. If the deceased enlisted member has a surviving spouse, he/she will become the contract holder. If the deceased enlisted member has other dependents and no surviving spouse, then the oldest dependent becomes the contract holder.

4. The Public Safety HR Delivery Center forwards the completed F200 Form to OA, BEB notifying them of surviving family enlisted members who are eligible for continuation of coverage. A copy of the F200 Form is placed in the Killed in the Line of Duty file maintained by the Public Safety HR Delivery Center.

5. OA, BEB contacts the insurance carriers to ensure the eligible surviving family enlisted members are placed in survivor group # 02861602 (ClassicBlue) or group # 02861607 (PPOBlue).

6. The insurance carriers will issue new identification cards to surviving family enlisted members with the new survivor group number and new Unique Member Identifier (UMI).

7. Each January, the Public Safety HR Delivery Center will mail a letter to the survivor spouse along with the "Affirmation for Continued Medical Benefits for the Spouse, Child/Children of a State Police Officer Killed in the Line of Duty" (Attachment 3), for the spouse to sign indicating he or she has not remarried. This establishes the continued eligibility of the spouse and children for the survivor group coverage. If there are benefit changes, the Public Safety HR Delivery Center will notify OA, BEB of those benefit changes. The OA, BEB will notify the carriers of the changes.

8. When surviving dependents of the deceased enlisted member turn 26, the Public Safety HR Delivery Center will notify OA, BEB. OA, BEB notifies the carriers to ensure benefits are terminated effective at 12:00 a.m. on the first day of the month following the month in which the dependent reaches age 26.

Non-Work Related Deaths.

For spouses and dependents of deceased enlisted members (for non-work related deaths), benefits (medical, prescription drug, dental and vision) coverage will cease effective at 12:00 a.m. on the date of the qualifying event.

1. OA, HR Service Center, Agency Services Division will input a separation action via SAP effective the enlisted member's date of death.

2. OA, HR Service Center, Employee Services Division will run a PA40 report on a weekly basis to capture any separations entered via SAP.

3. If the deceased enlisted member has eligible covered dependents under his/her SPHBP coverage, OA, HR Service Center, Employee Services Division will send the PEBTF a weekly report of eligible covered dependents in order for the PEBTF to expedite the mailing of *COBRA* enrollment information to the deceased enlisted member's eligible covered dependents.

Spouse Turning 65 (During Enlisted Member's Active Employment).

If an enlisted member's spouse turns 65 and is Medicare eligible during the enlisted member's active employment, the spouse is not required to enroll in Medicare.

1. If the spouse elects to enroll in Medicare while he/she is covered under the SPHBP active plan, the enlisted member must contact OA, HR Service Center to provide their spouse's Medicare enrollment information.

2. OA, HR Service Center, Employee Services Division will update SAP via PA30, copy action on IT0167 – Health Plans under the Other Coverage for Dependents section using an effective date which reflects the beginning of Medicare coverage. This information is transmitted to the various carriers via a weekly data transmission.

Separation.

1. When the Public Safety HR Delivery Center is notified of an enlisted member's separation from the Pennsylvania State Police, an E-PAR is prepared with the pertinent information.

2. OA, HR Service Center, Agency Services performs a PA40 action via SAP to separate the enlisted member.

3. OA, HR Service Center, Employee Services Division will run a PA40 report on a weekly basis to capture any separations entered via SAP.

4. If the separation is due to resignation or dismissal, OA, HR Service Center, Employee Services Division will send the PEBTF a weekly report of enlisted members who have separated. The PEBTF will then offer the enlisted member and covered dependents COBRA continuation coverage.

5. If the separation is due to retirement, no notification is required. The State Employees Retirement System (SERS) will process the Retired Pennsylvania State Police Program (RPSPP) enrollment information for the enlisted member.

COBRA.

All enlisted members of the Pennsylvania State Police are covered by the provisions of *COBRA,* which requires that enlisted members and their dependents be offered the opportunity for a temporary extension of health coverage in certain instances where coverage would otherwise end.

1. Who is Eligible?

a. Eligibility is based upon participation in the SPHBP.

b. Dependents on an enlisted member's contract at the time of the qualifying event and children born to or placed for adoption with covered *COBRA* enrollees during *COBRA* coverage are eligible for *COBRA* continuation of coverage.

c. If a qualified beneficiary (including a covered employee or any dependent who is a qualified beneficiary) is determined by the Social Security Administration to be disabled and the PEBTF is notified within 60 days of the determination

and before the end of the 18-month *COBRA* continuation coverage, the 18 months may be extended to 29 months.

d. Additional dependents may be added to a *COBRA* enrollee's contract in accordance with commonwealth eligibility requirements.

2. Initial Notice of COBRA Rights.

a. *COBRA* requires that all new enlisted members enrolling in the SPHBP and the enlisted member's enrolled spouse, if any, must receive an initial notice of *COBRA* rights.

b. The Public Safety HR Delivery Center will provide each newly appointed enlisted member an initial *COBRA* notice and SPHBP Handbook at benefits orientation which occurs shortly before his/her graduation to Trooper status. The enlisted member signs the preprinted receipt in front of the handbook and the receipt is filed in the enlisted member's OPF.

c. If an enlisted member elects to add a spouse, OA, HR Service Center, Employee Services Division shall mail an initial *COBRA* notice to the spouse's home address. A copy of the cover letter mailed to the enlisted member and/or spouse, shall be scanned and attached to a case in the case management application as proof that the "Initial Notice of COBRA Rights" was mailed. Refer to "Important Notice of *COBRA* Continuation Coverage Rights" (Attachment 4).

3. What Coverages Are Available?

a. Enlisted members and dependents enrolled in the SPHBP may elect medical and/or supplemental benefits. The supplemental benefits package includes dental, vision and prescription drug coverage. A separate election may be made by the enlisted member and/or each dependent.

b. *COBRA* continuation coverage is available as long as premium payments are made timely, unless one of the following occurs: the enlisted member or dependent becomes covered under another group health plan; the employer no longer provides group health coverage to any of its enlisted members; or the individual becomes entitled to Medicare benefits after the *COBRA* qualifying event date. Note: The SPHBP portion of *COBRA* continuation of coverage may be elected to supplement other group health coverage only if that coverage predates the *COBRA* qualifying date.

4. Election Notices.

a. Upon receipt of the 26-year-old dependent monthly report, the PEBTF will mail an election notice to the eligible dependent for COBRA continuation coverage. (See "Notice of COBRA Election Rights & COBRA Continuation of Coverage Election/Waiver" form, Attachment 9, and "Important Notice of COBRA Continuation Coverage Rights", Attachment 4)

b. The COBRA Election Notice will specify the available coverages and the premium rates applicable to the SPHBP. Premiums will be provided only for the programs which may be elected. Premiums will equal the costs of the various programs for similarly situated enlisted members and dependents plus an additional two percent administrative fee.

c. Enlisted members and dependents will have 60 days from the date of notification as stated on the Notice of COBRA Election Rights form to elect COBRA continuation coverage by signing and returning the election notice to the PEBTF. The PEBTF will then bill the enlisted member/dependent the applicable premium rates. Coverage will be effective from the date that commonwealth coverage terminated. The PEBTF will provide the COBRA enrollee with a coupon booklet from which monthly payments should be made.

PART 3 – FORMS

Forms Required to Add/Remove Dependents

Dependent	Required Forms
Spouse	Adding – Enlisted member must contact OA, HR Service Center, Employee Services Division. Marriage certificate is not required. Removing – Enlisted member must contact OA, HR Service Center, Employee Services Division. OA, HR Service Center, Employee Services Division will send the PEBTF a spreadsheet on a weekly basis for COBRA enrollment information.
Domestic Partner	Adding – not eligible for SPHBP coverage Removing – not applicable
Common-Law Spouse	Adding – F200 and Common-Law Marriage Affidavit (Note: Common-Law Marriage must have been entered into prior to January 1, 2005) Removing – F200 and Divorce decree. OA, HR Service Center, Employee Services Division will send the PEBTF a spreadsheet on a weekly basis for issuance of Certificate of Creditable Coverage and COBRA enrollment information.
Dependent Child (up to age 26)	Adding – Enlisted member must contact OA, HR Service Center, Employee Services Division. No birth certificate is required. Removing – Enlisted member must contact OA, HR Service Center, Employee Services Division. OA, HR Service Center, Employee Services Division will send the PEBTF a spreadsheet on a weekly basis for COBRA enrollment information.
Dependent reaching age 26	Adding – no longer eligible for SPHBP coverage Removing – automatic process. OA, BEB will send the PEBTF a spreadsheet monthly for COBRA enrollment information.
Newborn Child	Adding – Enlisted member must contact OA, HR Service Center, Employee Services Division. No birth certificate is required. Enlisted member must provide newborn's Social Security Number within 6 months of date of birth. Removing – Enlisted member must contact OA, HR Service Center, Employee Services Division. OA, HR Service Center, Employee Services Division will send the PEBTF a spreadsheet on a weekly basis for COBRA enrollment information.
Stepchild	Adding – Enlisted member must contact OA, HR Service Center, Employee Services Division. No birth certificate is required. Removing – Enlisted member must contact OA, HR Service Center, Employee Services Division. OA, HR Service Center will send the PEBTF a spreadsheet on a weekly basis for COBRA enrollment information.
Adopted Child	Adding – F200 and Adoption papers or legal documentation placing the child in the adoptive parent's custody pending the issuance of the final adoption papers is required. No birth certificate is required. Removing – Enlisted member must contact OA, HR Service Center, Employee Services Division. OA, HR Service Center, Employee Services Division will send the PEBTF a spreadsheet on a weekly basis for COBRA enrollment information.

Dependent	Required Forms (Continued)
Foster Child	Adding – F200 and Affidavit of guardianship and support and/or documentation from the foster care agency is required. Foster children under 18 are not eligible. No birth certificate is required. Removing – Enlisted member must contact OA, HR Service Center, Employee Services Division. OA, HR Service Center, Employee Services Division will send the PEBTF a spreadsheet on a weekly basis for COBRA enrollment information.
Brother/Sister Cousin Grandchild Niece/Nephew Other Dependent Related by Blood or Marriage	Adding – F200 and Affidavit of guardianship and support is required. Dependent must be under the age of 19. No birth certificate is required. (Orders will expire upon the child's 19th birthday. Enlisted member can choose to allow dependent to remain enrolled in SPHBP benefits up to age 26.) Removing – Enlisted member must contact OA, HR Service Center, Employee Services Division. OA, HR Service Center, Employee Services Division will send the PEBTF a spreadsheet on a weekly basis for COBRA enrollment information.
Disabled Dependent	Adding – Disabled Dependent Certification Form (Attachment 7) is required. Forms are obtained from and filed with the medical carrier. Removing – Enlisted member must contact OA, HR Service Center, Employee Services Division. OA, HR Service Center, Employee Services Division will send the PEBTF a spreadsheet on a weekly basis for COBRA enrollment information.

Completing an F-200 Form.

1. Check Highmark Classic Blue or Highmark PPO Blue

2. Check type of action requested (check all that apply)

3. Enter effective date of action requested

4. Enter enlisted member's Last Name, First Name, Middle Initial

5. Enter enlisted member's social security number and employee number

6. Enter enlisted member's Date of Birth (MMDDYYYY)

7. Check sex (female or male)

8. Check single or married

9. If applicable, enter date of marriage (if applicable)

10. Enter enlisted member's street address

11. Enter enlisted member's local municipality

12. Enter enlisted member's city/state/zip code

13. Enter enlisted member's county

14. Enter enlisted member's mailing address (if different than street address)

15. Enter enlisted member's city/state/zip code for mailing address

16. Enter enlisted member's home phone number

17. Enter enlisted member's cell number

18. If applicable, check add or remove under Spouse Data

19. Enter spouse's last name, first name, middle initial

20. Enter spouse's social security number

21. Check female or male

22. Enter spouse's date of birth

23. Answer Yes or No to question: Does your spouse have other PA State Police Coverage?

24. Enter spouse's address and telephone number, if different than the employee

25. If applicable, check add or remove under Dependent Data

26. Enter dependent's last name, first name, middle initial

27. Enter dependent's social security number

28. Check female or male

29. Enter dependent's date of birth

30. Check daughter; son or other, explain relationship:

a. If other, add type of relationship, i.e. stepchild

31. Enter dependents' address and telephone number, if different than the employee

OTHER COVERAGE DATA- MEMBER (if applicable)

32. Enter Name of Policy Holder

33. Enter Identification/Policy Number

34. Enter Group Number

35. Enter Employer

36. Enter Name of Plan

OTHER COVERAGE DEPENDENT *(if applicable)*

37. Enter Name of Policy Holder

38. Enter Identification/Policy Number

39. Enter Group Number

40. Enter Employer

41. Enter Name of Plan

42. Enter covered dependents

MEDICARE MEMBER/DEPENDENT (if applicable)

43. Enter Member Name

44. Check Part A Only (Hospital), Part B Only (Medical) or Parts A and B

45. Enter effective dates for Medicare Part A and/or B

46. Enter Medicare Health Insurance Claim Number

47. Enter Dependent Name

48. Check Part A Only (Hospital), Part B Only (Medical) or Parts A and B

49. Enter effective dates for Medicare Part A and/or B

50. Enter Medicare Health Insurance Claim Number

51. Answer Question for Additional Medicare Information (End-Stage Renal Disease)

MEMBER AUTHORIZATION

52. Enter Employee Name

53. Employee Signature

54. Date of Employee Signature

55. Enter HR Remarks as applicable

56. Enter HR Service Center or HR Office Name

57. HR Service Center or HR Office Signature

58. HR Use Only – Enter the date the enrollment form was received

59. HR Use Only-Enter date the enrollment form was processed

Forms/Sample Letters/Affidavits.

All SPHBP forms can be accessed via ESS.

Below is a list of forms, sample letters, affidavits, etc., which are used in the SPHBP. Samples of these documents can be found in Part 5, Attachments:

1. Affidavit Attesting to the Existence of Common Law Marriage

2. Affidavit Attesting to Guardianship and Support

3. Affirmation for Continued Medical Benefits for the Spouse, Child/Children of a State Police Officer Killed in the Line of Duty

4. Important Notice of COBRA Continuation Coverage Rights

5. Dental Claim Form

6. Disabled Dependent Certification Form

7. Health Reimbursement Arrangement (HRA) Claim Form

8. Medical Insurance Claim Form

9. Notice of COBRA Election Rights/ COBRA Continuation Coverage Election/Waiver Form

10. Pennsylvania State Police Health Program F-200

11. Prescription Drug Claim Form

12. Prescription Drug Mail Order Envelope

13. Vision Direct Reimbursement Claim Form

Prescription Drug Claim Form

1. The Prescription Drug Claim Form must be used to request reimbursement for out-of-pocket prescription drug expenses which occur for the following reasons:

   a. Newly graduated enlisted member has not yet received their prescription drug identification card;

   b. Enlisted member uses an out-of-network pharmacy provider; or

   c. Enlisted member or covered dependents do not show eligible in the prescription drug carrier's system at the time the prescription drug is needed.

2. Enlisted member or covered dependents must pay for their prescription drug at the pharmacy.

3. Enlisted member or covered dependent must save their pharmacy receipt indicating the details and the cost of the prescription drug which was paid out-of-pocket.

4. Enlisted member obtains Prescription Drug Claim Form via ESS, or the prescription drug carrier's Web site.

5. Completes Prescription Drug Claim Form and attaches pharmacy receipt.

6. Mails Prescription Drug Claim Form to address listed on the claim form.

7. Prescription drug carrier reimburses enlisted member the same amount that would normally be paid to the pharmacy, less the applicable copayment. In some cases, the reimbursement will be less than the amount the enlisted member paid out-of-pocket for the prescription drug at the pharmacy.

8. Any remaining out-of-pocket expense incurred by the enlisted member after the prescription drug carrier provides the reimbursement can be submitted to the enlisted member's HRA Account.

Prescription Drug Mail Order Form

If an enlisted member or covered dependent is prescribed a medication for the maintenance of a medical condition, the treating physician can issue a prescription in quantities up to a 3-month (90 day) supply.

1. The enlisted member can obtain a Prescription Drug Mail Order Envelope by contacting the prescription drug carrier or by calling OA, HR Service Center.

2. Completes the New Patient Home Delivery Form which is attached to the envelope and encloses the original prescription from the treating physician along with applicable copayment.

3. Mails the prescription drug mail order envelope to the address preprinted on the front of the envelope.

4. The prescription drug carrier will fill the prescription and mail the medication to the enlisted member's home address.

5. Refills can be obtained either by mail order, online ordering or by phone to the prescription drug carrier.

6. Out-of-pocket expenses for prescription drug copayments can be submitted to the enlisted member's HRA Account for reimbursement.

PART 4 – GENERAL INFORMATION

Administration.

Benefit administration for the SPHBP is handled by the OA, BEB. OA, BEB contracts with vendors for each of the following programs: PPOBlue, Traditional ClassicBlue, dental plan, prescription drug plan, vision plan, disease management and wellness and the health reimbursement arrangement (HRA).

The carriers (contracted vendors) receive weekly updates on benefit transactions processed. The dental carrier receives updates from the medical insurance carrier.

1. OA, BEB is responsible for:

a. Administering the benefits for State Police Enlisted members and their covered dependents.

b. Assisting OA, HR Service Center, Employee Services Division in resolving eligibility questions and policy clarifications.

c. Determining restitution of SPHBP and RPSPP benefit overpayments.

d. Maintaining communication with the various carriers.

e. Ensuring all dependents are properly removed upon their 26th birthday.

f. Assisting the State Police Bureau of Human Resources with new Cadet Orientation and Newly Appointed Enlisted Member Orientation.

2. OA, HR Service Center, Employee Services Division is responsible for:

a. Assisting enlisted members with SPHBP enrollment paperwork.

b. Explaining eligibility requirements and benefits to enlisted members.

c. Collecting outstanding documentation relevant to enlisted member's benefit transactions.

d. Enrolling enlisted members and dependents in the SPHBP.

e. Assisting enlisted members in resolving eligibility problems.

f. Transacting enlisted member enrollments and changes into SAP.

g. Maintaining communication with OA, BEB.

3. BCPO is responsible for collecting claim overpayments from State Police enlisted members.

4. The Public Safety HR Delivery Center is responsible for:

a. New Cadet Orientation.

b. Newly Appointed Enlisted Member Orientation.

c. Killed in the Line of Duty Counseling.

Dual Enrollments.

If an enlisted member's spouse is also an active State Police enlisted member who is eligible to participate in the SPHBP, he/she must enroll as a single enlisted member under his/her own coverage and cannot be enrolled under the spouse's benefits.

The following are three examples of dual enrollments that are prohibited:

1. Two State Police enlisted members are married to one another and list each other as a dependent under his/her medical benefits.

2. Two State Police enlisted members are married to one another and both list the same dependent child for SPHBP coverage.

3. An active duty State Police enlisted member is married to a retired State Police enlisted member and list each other as a dependent under his/her medical benefits

The following are two examples that are not dual enrollments because two separate contracts are involved:

1. Husband is employed by Department of Human Services, lists himself, wife, and son on PEBTF-2 Form for medical and supplemental benefits administered by PEBTF. Wife is a State Police enlisted member, lists herself, husband and son for SPHBP coverage.

2. Husband and wife are both State Police enlisted members. Each has their own SPHBP contract. Husband lists two sons for SPHBP coverage and wife lists two daughters for SPHBP coverage.

Highmark Blue Shield Split Contracts.

A split contract occurs in the following situations:

1. At least one subscriber is enrolled in either Traditional ClassicBlue or PPOBlue and at least one subscriber is enrolled in Signature 65; or

2. The enlisted member and spouse are both over 65 and Medicare eligible. For identification purposes, Highmark Blue Shield assigns a separate unique member identification (UMI) number to each subscriber and mails a separate set of identification cards. When services are obtained, the patient must be sure to present his or her own identification card to the provider. If the incorrect identification card is shown, the claim might be rejected. In such cases, the claim should be resubmitted using the correct identification number.

Identification Cards.

1. The enlisted member will receive identification cards from each of the carriers-medical, prescription drug, dental and vision plans.

2. The identification cards will not contain the enlisted member's social security number. The plan carriers assign a UMI number for each enlisted member contract. The medical plan carrier will provide a separate identification card for each family member enrolled on the enlisted member's contract. The prescription drug, dental and vision plan carriers will each provide two identification cards containing the enlisted member's name. These cards should be used to obtain services for the enlisted member and their covered dependents.

3. If identification cards are lost, stolen or damaged, the enlisted member should contact the customer service number of the insurance plan carrier directly to request replacement card(s). Customer service numbers are listed on the identification cards or can be obtained on the insurance plan carrier's Web site.

SPHBP Handbook Replacement.

If an enlisted member misplaces his or her SPHBP Handbook, the enlisted member should contact OA, Bureau of Employee Benefits (BEB) to request a replacement and indicate whether the enlisted member needs just the page inserts or the entire handbook including the binder. If the enlisted member is requesting a new handbook, a charge of 25 cents per page will be charged for providing copied material. The costs must be paid in advance. Monies received for handbooks are deposited into the SPHBP Restricted Receipts Account.

PART 5 - ATTACHMENTS

1. Affidavit Attesting to Existence of Common Law Marriage.

Affidavit Attesting to the Existence of Common Law Marriage

We, _____ and _____, the undersigned do hereby affirm, under penalty of perjury, that we have expressly agreed to and entered into a common law marriage.

Pursuant to this common law marriage, we established the relationship of husband and wife.

We hold ourselves out to the community as husband and wife and have cohabitated for _____ years.

We each sign this affidavit as evidence of our mutual agreement, and with the understanding that it may be used as evidence of our marriage contract. We agree to provide the Commonwealth with any additional information that may be required as proof of our marriage.

_____
Employee's Signature

_____
Spouse's Signature

On this _____ day of _____, 20___, before me appeared _____ and _____, the affiants who being duly sworn, affirm that the facts contained therein are true and correct and acknowledge that they executed in the same for the purpose therein recited.

_____
Notary Public

A valid common law marriage is a legal marriage, having all the legal consequences of a ceremonially performed marriage, but not all jurisdictions continue to recognize the legal validity of common law marriage. If the employee and "spouse" live in a state other than Pennsylvania, it must be a state which recognized common law marriage for the parties to have a valid common law marriage. If there is not a valid common law marriage, the employee may not enroll the intended "spouse" as a "dependent common law spouse."

While individuals may become legally married by "common law" in states which recognize common law marriage, there is no similar way to become "common law divorced." And since a valid common law marriage is legally recognized to be a valid as a ceremonially performed marriage, there must be a valid legal divorce before either of the parties can legally re-marry. For these reasons, the Commonwealth must be provided with a divorce decree for either party who has been previously married.

pennsylvania
OFFICE OF ADMINISTRATION

updated June 2016

2. Affidavit Attesting to Guardianship and Support.

Affidavit Attesting to Guardianship and Support

I, _____, the undersigned, do hereby affirm that I am the
(Member's Name)
guardian/legal guardian of and provide sole support to my _____,
(Circle one) (Relationship)

_____, whose date of birth is _____. I also affirm that
(Dependent's Name)

_____ resides with me.
(Dependent's Name)

_____ _____
Employee's Signature Employee's Printed Name

_____
Employee's Social Security Number

Commonwealth of Pennsylvania:
: SS
County of _____ :

On this _____ day of _____, 20____, before me appeared
_____, the affiant who being duly sworn affirms that the facts
(Employee's Name)
contained therein are true and correct and acknowledges that he/she executed the same for the purposes therein recited.

_____
Notary Public

pennsylvania
OFFICE OF ADMINISTRATION

updated June 2016

3. Affirmation for Continued Medical Benefits for the Spouse, Child/Children of State Police Officer Killed in the Line of Duty.

DATE

ANNUAL AFFIRMATION FOR CONTINUED MEDICAL BENEFITS FOR THE SPOUSE, CHILD/CHILDREN OF A STATE POLICE OFFICER WHO DIED IN THE LINE OF DUTY

Deceased State Police Officer _____

Date of Death _____

Social Security Number _____

Name of Spouse _____

Social Security Number _____

Check appropriate block:

_____ I have not remarried, all medical benefits will continue.

_____ I remarried on _____, and my present married name is _____.
date

I understand, since I have remarried, that all medical benefits previously granted to me will terminate on the date I remarried.

I realize that these provisions are in accordance with Interest Arbitration Award dated December 22, 2004, between the Commonwealth of Pennsylvania and the Pennsylvania State Troopers Association.

_____
Signature of Spouse

COMMONWEALTH OF PENNSYLVANIA:
: SS
County of _____:

On this _____day of _____2016, before me appeared _____, the affiant who being duly sworn, affirms that the facts herein are true and correct.

_____
Notary Public

4. Important Notice of COBRA Continuation Coverage Rights

150 South 43rd Street, Suite 1
Harrisburg, PA 17111-5700
717.561.4750 | 800.522.7279
www.pebtf.org

IMPORTANT NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

FOR EMPLOYEES AND THEIR COVERED DEPENDENTS UNDER THE HEALTH PLANS ADMINISTERED BY THE PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND (PEBTF) OR THE STATE POLICE HEALTH BENEFITS PROGRAM

What is COBRA Continuation Coverage?

A federal law passed in 1986, titled the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that employees and their families covered under most group health plans be offered the opportunity for temporary extension of health coverage (known as COBRA continuation coverage) in certain instances where coverage under the plan would otherwise end. This Notice summarizes your rights and obligations under COBRA law. You and your family members should read this Notice carefully. For additional information about your rights and obligations under the group health plan and under federal law, PEBTF members should refer to their Summary Plan Description. State Police enlisted members should refer to their State Police Health Benefits Program Handbook. If you have any questions, contact the PEBTF at the address or telephone number shown above.

COBRA continuation coverage is temporary self-paid coverage available for active employees and their enrolled dependents through the PEBTF when one of the qualifying events listed below occurs which would result in a loss of coverage. Each individual entitled to COBRA continuation coverage because of a qualifying event is referred to as a qualified beneficiary. You do not have to show that you are insurable to elect COBRA continuation coverage.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed below. You can also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

There may be other coverage options for you and your family. You also may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

When is COBRA Continuation Coverage Available?

COBRA continuation coverage is available to qualified beneficiaries when a qualifying event occurs which would normally end coverage. Qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Employees have a right to elect COBRA continuation coverage if coverage is lost because of:

1. A reduction in hours of employment, or
2. Termination of employment for reasons other than gross misconduct.

of:

1. Employee's death;
2. Employee's reduction in hours of employment or termination for reasons other than gross misconduct;
3. Divorce, legal separation from the employee in anticipation of divorce[1], or termination of a domestic partnership; or
4. Employee becomes entitled to Medicare benefits (Part A, Part B or both).

A covered dependent of an employee has a right to elect COBRA if coverage is lost because of:

1. Parent-employee's death;
2. Parent-employee's reduction in hours of employment or termination for reasons other than gross misconduct;
3. Parent-employee's divorce, legal separation from the employee in anticipation of divorce, or termination of domestic partnership;
4. Dependent's loss of dependent status (for example, over the eligible age) or
5. Parent-employee becomes entitled to Medicare benefits (Part A, Part B or both).

For PEBTF Members only, the domestic partner of an employee or his or her children will have rights similar to the spouse and stepchildren of an employee. For example, on the termination of a domestic partner relationship, the domestic partner may elect to continue coverage.

Who Notifies the PEBTF of a Qualifying Event?

The employer is responsible for notifying the PEBTF if the qualifying event is a reduction in hours, termination of employment, or death of the employee. **For other qualifying events (divorce, termination of domestic partnership, dependent child's losing eligibility for coverage as a dependent) you must notify the PEBTF in writing (to the above address) within 60 days after the event occurs. If you do not notify the PEBTF within that time period any rights to COBRA continuation coverage will be permanently lost. You should also report the qualifying event to the HR Service Center or, if you work in an agency not supported by the HR Service Center, your local HR Office.**

How is COBRA Continuation Coverage Provided?

After the PEBTF receives proper notice of a qualifying event it will send you or your family member(s) an election notice explaining your rights and applicable premium rates for coverage. You have 60 days from the date of the election notice or, if later, the date you would lose coverage because of the qualifying event, to notify the PEBTF that you wish to elect COBRA continuation coverage. A separate election may be made by each qualified beneficiary eligible for such coverage. Covered employees may elect coverage on behalf of their eligible dependents and parents may elect coverage on behalf of their children. **If you do not timely elect COBRA continuation coverage your coverage will end on the date of the qualifying event.**

If you elect COBRA continuation coverage you will be offered coverage which is the same as coverage provided under the plan to similarly situated employees or family members. Maximum coverage will be up to 36 months when the qualifying event is the death of the employee, divorce/termination of domestic partnership, or loss of a dependent child's eligibility. When coverage is lost because of a reduction in hours of employment or termination of employment (for reasons other than gross misconduct), coverage generally lasts for only up to 18 months.

When the qualifying event is the end of employment or a reduction in hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the Medicare entitlement. (For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA

[1] Under federal law a legal separation is a qualifying event if it causes a loss of coverage. For Pennsylvania residents, however, there is no legal separation recognized in the law. Moreover, neither plan provides that coverage will terminate in the event of legal separation. Therefore, mere separation is not a qualifying event entitling the spouse and children to COBRA coverage. There is a

continuation coverage for his eligible dependents can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event, since 36 minus 8 equals 28 months.)

There are two ways in which the 18-month period of COBRA continuation coverage can be extended: (1) a disability extension of the 18-month period to a maximum of 29 months, or (2) a second qualifying event extension of the 18-month period up to a maximum of 36 months.

Disability Extension

The 18 months may be extended to 29 months if a qualified beneficiary (including a covered employee or any dependent who is a qualified beneficiary) is determined by the Social Security Administration to be disabled and the PEBTF is so notified within 60 days of the determination and before the end of the 18-month COBRA continuation coverage period. The disability would have to have started before the 60th day of COBRA continuation coverage and must last until the end of the 18-month period of coverage. The affected individual must also notify the PEBTF within 30 days of any subsequent determination that the individual is no longer disabled.

Second Qualifying Event Extension

If your family experiences another qualifying event (if the second event would have caused eligible dependents to lose coverage under the benefit plan had the first qualifying event not occurred) during the 18 months of COBRA continuation coverage, the eligible dependent can get up to18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the PEBTF. This extension may be available to the eligible dependent if the employee or former employee dies, becomes entitled to Medicare benefits, or gets divorced or terminates domestic partnership or if the dependent child ceases being eligible under the plan.

Payment of COBRA Premiums

The amount of the applicable COBRA premium and due date for payment will be explained in the Election form sent to you. The premium may change during the COBRA period of coverage.[1] You do not have to send any payment for continuation coverage with the Election Form. However, **you must make your first payment for COBRA continuation coverage within 45 days after the date of your first invoice**. The PEBTF will send you coupons (which are sent the first week of the month), and the first coupon will be retroactive to the qualifying event date. This initial invoiced amount will include:

1. The period of coverage from the time your coverage under the Plan would have otherwise terminated up to the time of the billing month after COBRA was elected, and
2. Any regularly scheduled monthly premium that becomes due between your election and the end of the 45-day period. (If a regular monthly premium is received by the PEBTF prior to payment of this initial invoice amount, and during the 45-day period, the monthly premium will be applied to the initial invoice.)

If you do not make your first payment for COBRA continuation coverage within 45 days of the date of your first invoice, you will lose all continuation coverage rights under the Plan of Benefits.

Premium Due Dates and Grace Period

All monthly premiums are due by the first of each month. If you fail to pay the initial premium or any subsequent monthly premium in a timely manner, your coverage will terminate **and cannot be reinstated.** After you make your first payment for coverage you will be required to pay for coverage for each subsequent month of coverage and will be given a maximum grace period of 30 days to make each periodic monthly payment. If you fail to make a monthly payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the Plan of Benefits.

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[1] Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. However, the maximum amount a qualified beneficiary may be required to pay for coverage may not exceed 102 % (or 150 % in the case of an extension of coverage due to a disability) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

Can COBRA Continuation Coverage be Terminated Early?
Yes. The law provides that COBRA continuation coverage may be terminated prior to the end of the maximum coverage period for any of the following reasons:

1. The Employer no longer provides group health coverage to any of its employees;
2. The premium for your coverage is not paid timely;
3. You first become covered under another group health plan after the date of election; or
4. You become entitled to Medicare after the date of election; or
5. Coverage was extended for up to 29 months due to disability and subsequent determination finds that you are no longer disabled.

If you remain covered at the end of the COBRA period and are not Medicare eligible you may be allowed to convert to an individual health plan.

State Police enlisted members with questions about COBRA should consult their State Police Benefits Program Handbook or contact the PEBTF at one of the telephone numbers listed on this notice. PEBTF members with questions about COBRA should consult their Summary Plan Description or contact the PEBTF at one of the telephone numbers listed on this notice. **If you change your address you must promptly notify the HR Service Center or, if you work in an agency not supported by the HR Service Center, your local HR Office and the PEBTF.** You should also keep a copy of any notices you send to the PEBTF.

KEEP THIS NOTICE FOR YOUR RECORDS

PEBTF-1
Rev. 2-2018

Can COBRA Continuation Coverage be Terminated Early?
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2. The premium for your coverage is not paid timely;
3. You first become covered under another group health plan after the date of election; or
4. You become entitled to Medicare after the date of election; or
5. Coverage was extended for up to 29 months due to disability and subsequent determination finds that you are no longer disabled.

If you remain covered at the end of the COBRA period and are not Medicare eligible you may be allowed to convert to an individual health plan.

State Police enlisted members with questions about COBRA should consult their State Police Benefits Program Handbook or contact the PEBTF at one of the telephone numbers listed on this notice. PEBTF members with questions about COBRA should consult their Summary Plan Description or contact the PEBTF at one of the telephone numbers listed on this notice. **If you change your address you must promptly notify the HR Service Center or, if you work in an agency not supported by the HR Service Center, your local HR Office and the PEBTF.** You should also keep a copy of any notices you send to the PEBTF.

KEEP THIS NOTICE FOR YOUR RECORDS

PEBTF-1
Rev. 2-2018

5. Dental Claim Form.

MEMBER DENTAL CLAIM FORM

UNITED CONCORDIA
Insuring America's Dental Health

Please submit claim to:
Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

HEADER INFORMATION

1. Type of Transaction (*Mark all applicable boxes*)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (*Last, First, Middle Initial, Suffix*)

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐ M ☐ F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5
☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender ☐ M ☐ F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Reserve For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender ☐ M ☐ F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										

33. Missing Tooth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ____ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining:

43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI

50. License Number

51. SSN or TIN

52. Additional Provider ID

52a. Phone Number ( ) -

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number ( ) -

58. Additional Provider ID

5730 (4-13)

6. Disabled Dependent Certification.

HIGHMARK. BLUE SHIELD

DISABLED DEPENDENT CERTIFICATION

TO BE COMPLETED BY EMPLOYEE/PENSIONER

1. Name of Employee/Pensioner/Surviving Spouse (print - last, first & middle initial) | 2. Group Number | 3. Identification Number

4. Employee/Pensioner/Surviving Spouse Address (number, street, city, state, & zip code)

5. Disabled Dependent's Name | Disabled Dependent's Birthdate Month Day Year | Disabled Dependent's Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Disabled Dependent's Relationship to Employee/Pensioner | Disabled Dependent's Sex ❑ Male ❑ Female | Disabled Dependent's Age When Disability Occurred

6. Is dependent permanently residing in your household? ❑ Yes ❑ No If "No", please explain: _____

7. Do you provide 50% or more financial support to the dependent? ❑ Yes ❑ No If "No", please explain: _____

8. Is dependent listed as a dependent in your last Federal Income Tax Return? ❑ Yes ❑ No If "No", please explain: _____

9. Was the dependent certified as a student dependent at the time of the disability? ❑ Yes ❑ No

10. Current student status: ❑ Full time ❑ Part time ❑ Not Applicable

11. Was dependent ever employed? ❑ Yes ❑ No

12. Is dependent employed now? ❑ Yes ❑ No

13. If answer to question 11 or 12 is "Yes", give name(s) and address(es) of employer(s) and date(s) employed: _____

14. Was dependent covered under your (former) employer's program prior to age of deletion? ❑ Yes ❑ No

15. Disabled dependent's Social Security Number _____

16. Is dependent now covered under Medicare or any other hospital-medical coverage? ❑ Yes ❑ No If "Yes", please complete the following:

Medicare Health Insurance Claim Number _____ | Hospital Insurance (PART A) Effective Date _____ | Medical Insurance (PART B) Effective Date _____

If covered by other insurance, please print name of the employer, the insurance company name, and your certificate or agreement number on the reverse side hereof.

NOTE: If you have not already done so, it may be to your financial advantage to contact Social Security and apply for Social Security Disability payments and/or Medicare Health Insurance or Supplemental Security Income (SSI) and/or Medicaid on behalf of your disabled dependent.

I hereby certify that the above information is correct to the best of my knowledge and authorize release of any information requested with respect to this certification.

_____ Signature of Employee/Pensioner or Surviving Spouse | _____ Date Signed | ( ) _____ Home Phone # | ( ) _____ Work Phone #

17. OTHER HOSPITAL/MEDICAL INSURANCE

Policyholder name _____ Employer name & phone number _____

Insurance Carrier name & phone number _____

Policy and/or Social Security Number _____ Effective date of coverage _____

6235 D (R11-05)

Highmark Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association

TO BE COMPLETED BY ATTENDING PHYSICIAN

DIRECTIONS TO ATTENDING PHYSICIAN:

- **Please complete all areas of this form and then proceed to the Level of Impairment chart and circle one appropriate indicator per category.**
- **If the patient has a psychiatric related diagnosis, please complete the Brief Psychiatric Rating Scale and Global Assessment Scale.**
- **Your prompt completion of this form will expedite the disability application process.**
- **Any fee for completion of this form and other forms for dependent disability determination is the responsibility of the employee.**

Is dependent now incapable of self-support because of disability? ❑ Yes ❑ No

Has such disability existed continuously since before dependent attained age 19? ❑ Yes ❑ No

When did present illness begin or injury occur? Date: _____

Does the patient have a previous history of this illness? ❑ Yes ❑ No

If "Yes", please explain _____

Date disability commenced: _____

Subjective symptoms: _____

Objective findings (please provide dates of surgery, x-rays, or other tests): _____

Diagnosis description or medical history and medications (please give as much detail as possible): _____

Date of last office visit: _____ Frequency of visits: _____

PROGRESS: ❑ Recovered ❑ Improved ❑ Unimproved ❑ Regressed

Prognosis for employment: _____

NAME OF PHYSICIAN (print or type)	TELEPHONE NUMBER	DEGREE

ADDRESS OF PHYSICIAN (print or type)

PHYSICIAN'S SIGNATURE (print or type)	DATE

ADDITIONAL COMMENTS: _____

Global Assessment Scale (GAS)

Robert L. Spitzer, M.D., Miriam Gibbon, M.S.W., Jean Endicott, Ph.D.

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30) should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (e.g., 35, 58, 62). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

Name of Patient: _____ ID No. _____ Group Code: _____

Admission Date: _____ Date of Rating: _____ Rater: _____

G A S Rating: _____ PHYSICIAN'S SIGNATURE: _____

100
91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his/her warmth and integrity. No Symptoms.

90
81 Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and "everyday" worries that only occasionally get out of hand.

80
71 No more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.

70
61 Some mild symptoms (e.g., depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him/her "sick".

60
51 Moderate symptoms OR generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).

50
41 Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).

40
31 Major impairment in several areas such as work, family relations, judgement, thinking or mood (e.g., depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (e.g., speech is at times obscure, illogical or irrelevant), OR single suicide attempt.

30
21 Unable to function in almost all areas (e.g., stays in bed all day) OR behavior is considerably influenced by either delusions or hallucinations OR serious impairment in communication (e.g., sometimes incoherent or unresponsive) or judgment (e.g., acts grossly inappropriately).

20
11 Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

10
1 Needs consistent supervision for several days to prevent hurting self or others (e.g., requires an intensive care unit with special observation by staff), makes no attempt to maintain minimal personal hygiene, or serious suicide act with clear intent and expectation of death.

LEVEL OF IMPAIRMENT SCALE

NOTE: Any fee for the completion of this and other forms for dependent disability is the responsibility of the employee.

*	requires minimal help < 25% of the time.
* *	requires moderate help 25 - 50% of the time.
* * *	requires major help 50 - 75% of the time.

Dependent meets eligibility requirements of the groups as verified by completion of the Disabled Dependent Certification form. ❑ YES ❑ NO

If NO, refer: _____

GUIDELINES

A. Medical Diagnosis: _____

B. Level of Impairment: _____

CIRCLE A RATING FOR EACH CATEGORY	1	2	3	4	5
motor	self sufficient	needs minimal help *	needs moderate help **	needs major help ***	dependent
functional (ADLs)	self sufficient	needs minimal help *	needs regular help **	needs major help ***	dependent
mental capacity	no deficit	slight deficit	moderate deficit	mod/severe deficit	severe deficit
judgement	no deficit	slight deficit	moderate deficit	mod/severe deficit	severe deficit
rehab potential	excellent	good	good for partial restoration	condition static	condition will worsen
employment	excellent	good	good for part-time employment	good for low level employment	poor
Total	_____	_____	_____	_____	_____

Sum 1+2+3+4+5 _____

C. Mental Nervous Diagnosis: _____

D. Level of Impairment: _____

	1	2	3	4	5
intelligence	normal or better	mildly retarded	moderately retarded	severely retarded	profoundly retarded
perception	no deficit	slight deficit	moderate deficit	mod/severe deficit	severe deficit
thinking	no deficit	slight deficit	moderate deficit	mod/severe deficit	severe deficit
judgement	no deficit	slight deficit	moderate deficit	mod/severe deficit	severe deficit
affect	normal	slight problem	moderate problem	mod/severe problem	severe problem
behavior	normal	slight problem	moderate problem	mod/severe problem	severe problem
functional (ADLs)	self sufficient	needs minimal help	needs regular help	needs major help	dependent
intelligence potential	excellent	good	good for partial	condition static	condition will worsen
Total	_____	_____	_____	_____	_____

Sum 1+2+3+4+5 _____

Patient Name: _____ Agreement Number: _____

Physician Name: _____ Signature: _____

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
Alcohol Drug Abuse and Mental Health Administration
NIMH-PRB Collaborative Study of Maintenance
Drug Therapy in Affective Illness

BRIEF PSYCHIATRIC RATING SCALE

Overall and Gorham

FORM NO.	UNIT NO.	SUBJECT GROUP	STUDY NO.	RATER NO.	PERIOD NO.

FACILITY	SUBJECT'S ID NO.	INITIALS

RATER	DATE

Write in the appropriate number for each item, using the following key:

Not Present	Very Mild	Mild	Moderate	Moderately Severe	Severe	Extremely Severe
1	2	3	4	5	6	7

1. SOMATIC CONCERN (13) _____
Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not.

2. ANXIETY (14) _____
Worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms.

3. EMOTIONAL WITHDRAWAL (15) _____
Deficiency in relating to the interviewer and to the interviewer situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation.

4. CONCEPTIONAL DISORGANIZATION (16) _____
Degree to which the thought processes are confused, disconnected or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of patient's subjective impression of his own level of functioning.

5. GUILT FEELINGS (17) _____
Over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety, or neurotic defenses.

6. TENSION (18) _____
Physical and motor manifestations of tension "nervousness", and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient.

7. MANNERISMS AND POSTURING (19) _____
Unusual and unnatural motor behavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here.

8. GRANDIOSITY (20) _____
Exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation.

9. DEPRESSIVE MOOD (21) _____
Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints.

10. HOSTILITY (22) _____
Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not infer hostility from neurotic defenses, anxiety nor somatic complaints. (Rate attitude toward interviewer under "uncooperativeness").

11. SUSPICIOUSNESS (23) _____
Belief (delusional or otherwise) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances.

12. HALLUCINATORY BEHAVIOR (24) _____
Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people.

13. MOTOR RETARDATION (25) _____
Reduction in energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only; do not rate on the basis of patient's subjective impression of own energy level.

14. UNCOOPERATIVENESS (26) _____
Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on the basis of reported resentment or uncooperativeness outside the interview situation.

15. UNUSUAL THOUGHT CONTENT (27) _____
Unusual, odd, strange, or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of the thought processes.

16. BLUNTED AFFECT (28) _____
Reduced emotional tone, apparent lack of normal feeling or involvement.

17. EXCITEMENT (29) _____
Heightened emotional tone, agitation, increased reactivity.

18. DISORIENTATION (30) _____
Confusion or lack of proper association for person, place or time.

19. ELEVATED MOOD (31) _____
Happy, laughing, joking optimistic, with exaggerated sense of well-being.

Patient Name: _____ **Agreement Number:** _____

Physician's Signature: _____

7. Health Reimbursement Arrangement (HRA) Claim Form.

WageWorks
www.wageworks.com

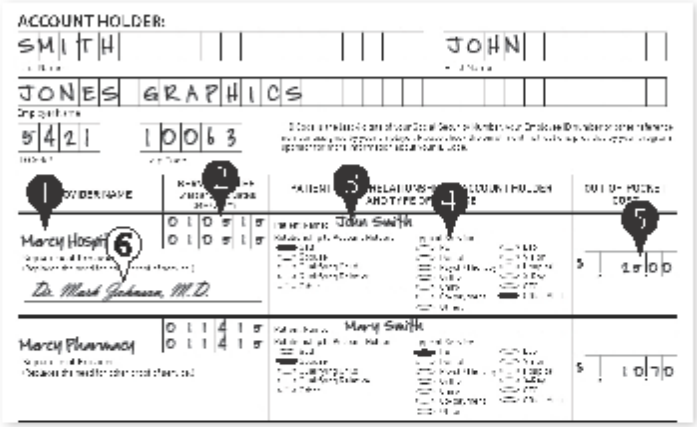
HEALTHCARE ACCOUNT
How to File a Claim for Approval

Claim Filing Options:

- **File claim online:** Log into your account at www.wageworks.com to submit your claim electronically.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. Fax: 877-353-9236 , US Mail: CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

Instructions to fill out this form:

- Complete ALL account holder information.
- Provide your employer name without abbreviation.
- Use your documentation to complete each section of the form, including the following:
  - ① Provider Name
  - ② Service Date(s)
  - ③ Patient Name and Relationship to Account Holder
  - ④ Type of Service
  - ⑤ Patient Responsibility
  - ⑥ Provider Signature is not required, but can replace need for other proof of service



Tips For Claim Submission

- An eligible dependent is defined as a spouse, qualifying child, or qualifying relative.
  - A qualifying child is defined as a tax dependent child up to age 26 or any age if permanently disabled.
  - A qualifying relative is someone who resides with you for more than half of the year.
  - Qualifying children and relatives must not provide more than half of his/her own support.
- For information to claim orthodontia expenses, refer to the guide located at: https://www.wageworks.com/employees/support-center/important-forms.aspx.
- For a complete list of eligible expenses specific to your plan, log in to your account at www.wageworks.com and select "Eligible Expense" from the left side of the screen. Only submit claims for eligible expenses.
- A letter of medical necessity is required for any expense listed as "Yes (Letter)" on the eligible expense list to establish medical necessity. Cosmetic surgery or procedures, e.g., teeth whitening, are not eligible expenses unless deemed as medically necessary by a licensed physician. A letter of medical necessity form can be obtained at: https://www.wageworks.com/employees/support-center/important-forms.aspx.

Tip for Over-the-Counter Expenses

- A prescription is required for any over-the-counter expense listed as "Yes (Rx)" on the eligible expense list. As a result of the Health Care Reform Law, in addition to the required detailed receipt, an actual prescription written by a doctor (on a prescription pad or form) dated on or before the date the expense was incurred is required to verify that the over-the-counter medicine is prescribed for a known medical condition.

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all 6 required pieces of information needed to approve your expense, and are not acceptable for submission.
- Explanation of Benefits (EOBs) are recommended, especially if your insurance covered a portion of the expense.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- Send only photocopies of your claim form and documentation—keep the originals for your records if submitting via US Mail.
- Your provider may sign the form confirming the date of services, charges and other service or product information in lieu of providing separate documentation or other proof of service.

Tips For Faxing

- Do not use a cover page when faxing the claim form and documentation.
- Submit only claims for your own account.

Tips for Viewing Claim Status

- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log into your account at www.wageworks.com and select "Profile" in the upper right corner of the screen).

3790 (02/2015)

8. Medical Insurance Claim Form.

HIGHMARK. BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

MEMBER SUBMITTED HEALTH INSURANCE CLAIM FORM

FILING INSTRUCTIONS

1. Complete **all** items below **including** your signature and date. **All** of the information is essential for prompt and accurate processing of your claim(s). Please do not highlight information or use red ink.
2. Submit the claim and attach an **itemized** statement of services from the healthcare provider to the address provided on the back of your ID card. Cancelled checks, cash register receipts or personal itemizations are not acceptable.
3. The itemized statement **must** include name of patient, date(s) of service, type of services performed, diagnosis and charge(s).
4. You must use a separate claim form for each patient. All expenses for one patient can be submitted with one claim form.

NOTE: YOU SHOULD MAKE A COPY OF YOUR COMPLETED CLAIM FORM AND ITEMIZED BILLS FOR YOUR RECORDS.

PATIENT INFORMATION

PATIENT'S NAME (first name, middle initial, last name)

PATIENT'S ADDRESS

Street

City State Zip Code

PATIENT'S DATE OF BIRTH (month, day, year)

PATIENT'S SEX ☐ MALE ☐ FEMALE

PATIENT'S RELATIONSHIP TO THE PERSON NAMED ON ID CARD

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

ID CARD INFORMATION

NAME ON ID CARD (first name, middle initial, last name)

IDENTIFICATION NUMBER ON ID CARD (including any letters)

GROUP NUMBER ON ID CARD

ADDRESS OF PERSON LISTED ON ID CARD

Street

City State Zip Code

If patient is covered by another insurance plan, please complete the following:

OTHER INSURANCE COVERAGE INFORMATION (*If you have an Explanation of Benefits, please attach.*)

INSURED'S NAME ON OTHER INSURANCE CARD

OTHER INSURANCE COMPANY POLICY NUMBER

OTHER INSURANCE COMPANY'S NAME

Street

City State Zip Code

IF SERVICE WAS A RESULT OF ACCIDENT, CHECK BELOW:

☐ AUTOMOBILE ACCIDENT ☐ WORK-RELATED ACCIDENT

☐ OTHER: _____

DATE OF ACCIDENT (month, day, year)

DISABILITY DATES _____ THRU _____

STUDENT INFORMATION

IS THE PATIENT A FULL-TIME STUDENT OVER 19 YEARS OLD?

☐ YES ☐ NO

SCHOOL NAME AND ADDRESS:

DATES OF CURRENT TERM:

_____ TO _____

EXPECTED DATE OF GRADUATION:

CERTIFICATION

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, Highmark may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named.

Signature _____ Date _____

1218 403 **REMEMBER TO ATTACH AN ITEMIZED STATEMENT OF SERVICES PERFORMED**

9. Notice of COBRA Election Rights / COBRA Continuation Coverage Election / Waiver Form

150 South 43rd Street, Suite 1
Harrisburg, PA 17111-5700
717.561.4750 | 800.522.7279
www.pebtf.org

Name
Address
City, State Zip

Notice of COBRA Election Rights

Notice for: Name

Qualifying Event:
No Longer Eligible as of:
Date of Notification:

The PEBTF has received information that you and/or your dependents have experienced the qualifying event stated above, which results in loss of coverage under the State Police Health and/or Supplemental Benefits Plan. Under the federal COBRA law, this qualifying event may entitle you and/or your dependents, if any, to elect self-paid continuation coverage under COBRA for up to 18 months from the date of the qualifying event. Persons eligible for COBRA continuation coverage are referred to as qualified beneficiaries.

How to Elect COBRA Continuation Coverage

The enclosed, completed election form must be postmarked by you for return to the PEBTF within 60 days of the Date of Notification stated above in order to qualify for COBRA continuation coverage. **If COBRA continuation coverage is not elected within this time period, it may not be elected at any later date.**

This Notice is addressed to both you and your spouse, if any; however, only one of you needs to elect continuation coverage for your spouse and any dependent child(ren) who wishes to continue coverage.

Because COBRA gives you the right to elect coverage independently, you, your spouse or dependent child(ren), if any, may elect coverage on an individual basis. Additional election forms may be obtained from the PEBTF office by calling one of the telephone numbers listed above, or you may copy the enclosed forms and submit the completed copies.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You can also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

There may be other coverage options for you and your family. You also may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

10. Pennsylvania State Police Health Benefits Program Form (F200).

PENNSYLVANIA STATE POLICE HEALTH PROGRAM F-200

☐ Highmark Classic Blue ☐ Highmark PPO Blue

Action requested (check all that apply):

Effective Date ____________________

☐ Enrollment	☐ Remove Dependents	☐ Begin LWOPWOB
☐ Dependent data change	☐ Add Dependents	☐ Return from LWOPWOB

MEMBER DATA

Name (Last, First MI)	SSN		Employee Number
Date of Birth (MMDDYYYY)	☐ Female ☐ Male	☐ Single ☐ Married	Date of Marriage (if applicable)
Street Address			Local Municipality
City/State/Zip Code			County
Mailing Address (if different than address listed above)			City/State/Zip Code
Home Phone #	Cell Phone #		

SPOUSE DATA

☐ Add ☐ Remove	Name (Last, First MI)	Spouse's SSN	☐ Female ☐ Male	Date of Birth

Does your spouse have other PA State Police coverage? ☐ Yes ☐ No

List address and telephone number if different than the employee:

DEPENDENT DATA

☐ Add ☐ Remove	Name (Last, First MI)	Dependent's SSN	☐ Female ☐ Male	Date of Birth

☐ Daughter ☐ Son ☐ Other, explain relationship:

List address and telephone number if different than the employee:

☐ Add ☐ Remove	Name (Last, First MI)	Dependent's SSN	☐ Female ☐ Male	Date of Birth

☐ Daughter ☐ Son ☐ Other, explain relationship:

List address and telephone number if different than the employee:

☐ Add ☐ Remove	Name (Last, First MI)	Dependent's SSN	☐ Female ☐ Male	Date of Birth

☐ Daughter ☐ Son ☐ Other, explain relationship:

List address and telephone number if different than the employee:

OTHER COVERAGE DATA — MEMBER

Name of Policy Holder	Identification/Policy Number	Group Number
Employer	Name of Plan	

OTHER COVERAGE — DEPENDENT

Name of Policy Holder	Identification/Policy Number	Group Number
Employer	Name of Plan	Covered Dependents

Continued on back

MEDICARE MEMBER/DEPENDENT

Member Name	☐ Part A Only (Hospital) ☐ Part B Only (Medical) ☐ Parts A and B	Effective Dates Part A Part B	Medicare Health Insurance Claim
Dependent Name	☐ Part A Only (Hospital) ☐ Part B Only (Medical) ☐ Parts A and B	Effective Dates Part A Part B	Medicare Health Insurance Claim

Additional Medicare Information (End-Stage Renal Disease)

Are you, your spouse, or dependents eligible for Medicare benefits due to end-stage renal disease? ☐ Yes ☐ No

MEMBER AUTHORIZATION: I request the above enrollment (or change) for health insurance coverage. I understand this application is subject to approval by the commonwealth and my coverage will be subject to the terms of the agreements between the commonwealth and the health plans. Any person or organization having provided or who may provide health care services to me or any person named on this application, either prior to or during the period of this contract, is authorized to furnish to the health plans, any information or records relating to these services. I further understand that if I, or any person named on this application, knowingly and with intent to defraud the commonwealth or the health plans, files an application for insurance or statement of claim containing materially false information, or conceals, for the purpose of misleading information concerning facts material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I further understand that, if at any time I fail to provide accurate information to the commonwealth or health plans, I will be required to repay any payments made as a result of such misinformation.

Employee Name	Employee Signature	Date

HR Remarks

HR Service Center or HR Office Name	HR Service Center or HR Office Signature	Date Enrollment Form Received	Date Enrollment Form Processed

11. Prescription Drug Claim Form.

EXPRESS SCRIPTS®

Commercial Prescription Drug Claims Form

Please refer to instructions on reverse side.

STEP 1 CARDHOLDER/PATIENT INFORMATION *(to be completed by patient)*

Cardholder ID #

Cardholder's name *(Last)* *(First)* *(MI)*

Address

City State ZIP

Patient information *(Please list information for the patient submitting claims; allow one claim form for each patient.)*

Patient's name *(Last)* *(First)* *(MI)*

Relationship to cardholder? Self ☐ Spouse ☐ Dependent ☐ Gender M ☐ F ☐

Date of birth *(Month/Day/Year)*

STEP 2 CLAIM INFORMATION FROM PHARMACY RECEIPT *(to be completed by patient)*

Reason for submission? ☐ Forgot insurance card ☐ Processing error at pharmacy ☐ Out of network pharmacy ☐ Other _____

Is this a compound Rx? Y ☐ N ☐ *(If yes, please attach a compound claim form from the pharmacy.)*

Does the patient reside in an assisted living facility? Y ☐ N ☐ Is this for an allergy serum? Y ☐ N ☐

Is this claim for a diabetic supply? Y ☐ N ☐ Was a discount card used? Y ☐ N ☐

Was this prescription filled in a foreign country? Y ☐ N ☐ Country code ☐☐ Currency used _____

Foreign medication name _____

Foreign amount paid _____

Please include a pharmacy receipt with the following information:
Fill date, Rx number, National Drug Code (NDC), medication name (in English), strength, dosage, quantity, days supply, amount paid, prescriber name, and the prescriber NPI#

STEP 3 OTHER INSURANCE COVERAGE *(to be completed by patient)*

Is the patient eligible for primary prescription-drug coverage from another provider? Y ☐ N ☐

If yes, did the patient submit the claim to this other provider? Y ☐ N ☐ *(If yes, please attach the explanation of benefits from the other provider.)*

Did the prior insurance pay in error? Y ☐ N ☐

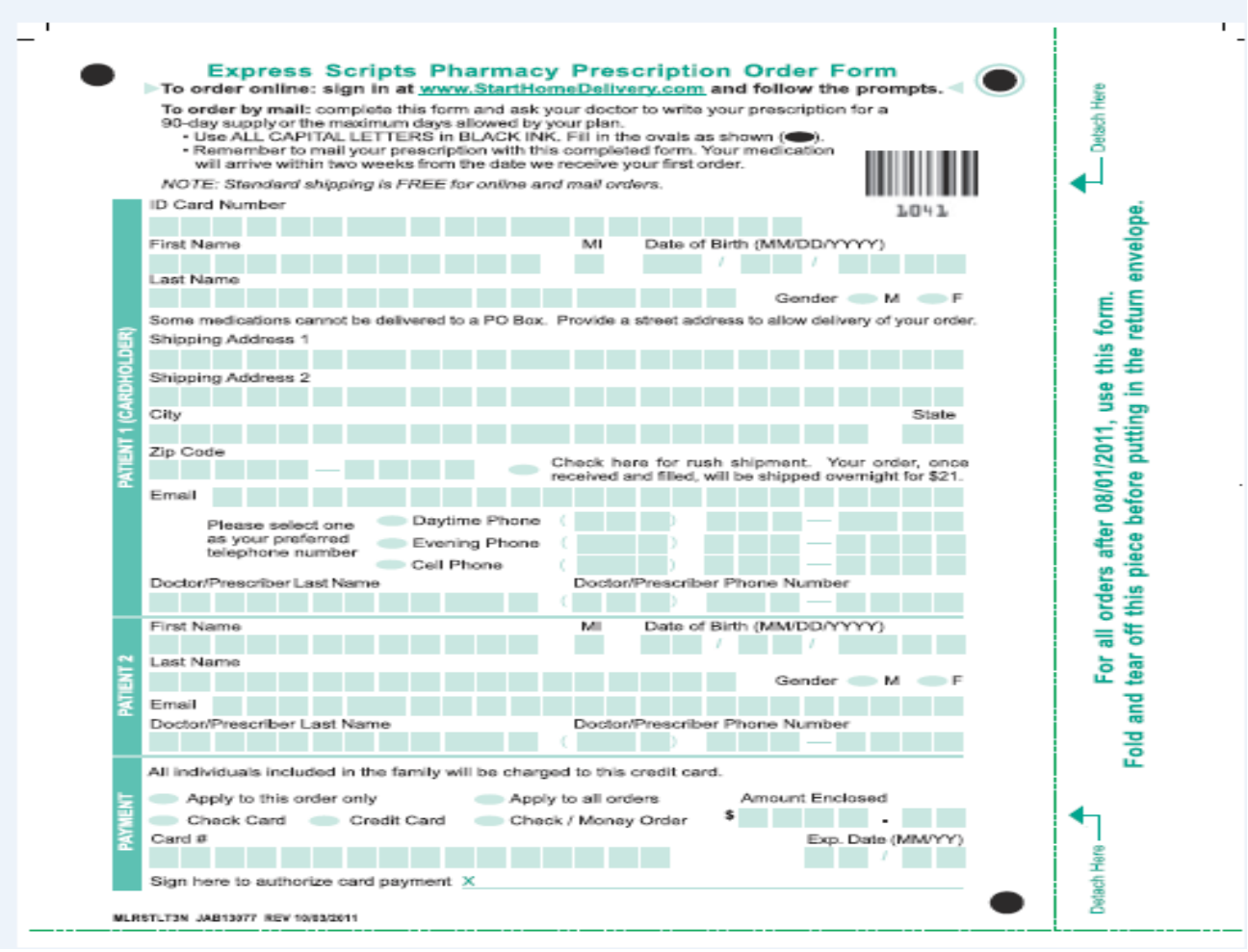
(Over)

12. Prescription Drug Mail Order Form.

MLRSTLT3N JAB13077 REV 10/03/2011

Postage Required
Post Office will not deliver without proper postage

EXPRESS SCRIPTS®
HOME DELIVERY SERVICE
PO BOX 66568
ST LOUIS MO 63166-6568



Express Scripts Pharmacy Prescription Order Form

To order online: sign in at www.StartHomeDelivery.com and follow the prompts.

To order by mail: complete this form and ask your doctor to write your prescription for a 90-day supply or the maximum days allowed by your plan.
- Use ALL CAPITAL LETTERS in BLACK INK. Fill in the ovals as shown (●).
- Remember to mail your prescription with this completed form. Your medication will arrive within two weeks from the date we receive your first order.

NOTE: Standard shipping is FREE for online and mail orders.

1041

PATIENT 1 (CARDHOLDER)

ID Card Number
First Name MI Date of Birth (MM/DD/YYYY)
Last Name
Gender M F
Some medications cannot be delivered to a PO Box. Provide a street address to allow delivery of your order.
Shipping Address 1
Shipping Address 2
City State
Zip Code
Check here for rush shipment. Your order, once received and filled, will be shipped overnight for $21.
Email
Please select one as your preferred telephone number: Daytime Phone ( ) — Evening Phone ( ) — Cell Phone ( ) —
Doctor/Prescriber Last Name
Doctor/Prescriber Phone Number ( ) —

PATIENT 2

First Name MI Date of Birth (MM/DD/YYYY)
Last Name
Gender M F
Email
Doctor/Prescriber Last Name
Doctor/Prescriber Phone Number ( ) —

PAYMENT

All individuals included in the family will be charged to this credit card.
Apply to this order only Apply to all orders
Amount Enclosed $.
Check Card Credit Card Check / Money Order
Card #
Exp. Date (MM/YY)
Sign here to authorize card payment X

MLRSTLT3N JAB13077 REV 10/03/2011

Detach Here

For all orders after 08/01/2011, use this form.
Fold and tear off this piece before putting in the return envelope.

Detach Here

13. Vision Direct Reimbursement Claim Form.

DAVIS VISION
EYECARE REFRAMED™

Pennsylvania State Police

FOR INTERNAL USE ONLY
Auth #: _____
Paid ☐ Denied ☐ Pended ☐

Direct Reimbursement Claim Form

Important Information:

1. Use this form to request reimbursement for services received from providers who do not participate in the Davis Vision network.
2. Expenses for both examinations and eyewear can be claimed on this form. Only services listed on this form will be considered for reimbursement.
3. **Make sure that all sections are completed, that you and the providers(s) have signed the form, and that all services, charges, and service dates have been entered. If the form is incomplete, additional information may be required. This may result in a delay of payment for eligible benefits.**
4. Please submit claim reimbursement for each patient on a separate claim form.
5. Please note that the **member's** (or employee's or authorized person's) signature is required on this form.
6. Mail completed claim form to: **Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.**
7. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your coverage with your benefits office or call **1-888-235-3251** or visit **www.davisvision.com**. The patient is responsible for the costs of all treatment and materials provided.

Member/Employee Information ** Your Member Identification No. is the number by which the company that sponsors your vision care benefits identifies you.*

(PLEASE PRINT CLEARLY)

Member Name: _____ (First / Middle Initial / Last) Member Identification No.*: _____

Mailing Address: _____ (Street / City / State / Zip)

Business Phone: _____ (Area Code) Home Phone: _____ (Area Code)

Patient Information

Patient Name: _____ (First / Middle Initial / Last)

Relationship: ☐ Member ☐ Spouse ☐ Child DOB: _____

Provider Information

Examiner	**Dispenser**
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: ____ Zip: _____	City: _____ State: ____ Zip: _____
State License Number: _____	State License Number: _____
Phone Number: _____	Phone Number: _____
Provider Signature: _____	**Provider Signature:** _____

Please complete the Date of Service, and the below General Standards sections for all services received. Incomplete information may result in significant delay of payment.

If lenses were prescribed, was one of the General Standards met according to the definition below.

☐ **YES** ☐ **NO**

General Standard: (1) There is a change of at least .50 diopter of sphere power in one eye. (2) There is a change of at least .50 diopter of sphere combined between the two eyes. (3) There is an increase in one line of snellen acuity (distance or reduced near) from the old Rx to the new Rx.

Service	Date of Service	Expense(s) Incurred
1. Eye Examination	(/ /)	$
2. Frames	(/ /)	$
3. Single Vision Lenses (one pair)	(/ /)	$
4. Bifocal Lenses (one pair)	(/ /)	$
5. Trifocal Lenses (one pair)	(/ /)	$
6. Lenticular (one pair)	(/ /)	$
7. Elective Contact Lenses	(/ /)	$
8. Medically Necessary Contact Lenses (prior approval required)	(/ /)	$
	Total	$

Member/Employee Certification

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim to plan provisions. Additionally, I have read and understand the fraud statement on the back of this form.

Required

_____ _____

Member/Employee or authorized person's signature **Date**

CL000572 2/3/14