Elizabethtown College

2023 Open Enrollment Guide
College Retirees

November 7th through November 18th, 2022

Table of Contents

General Information 3

Open Enrollment Checklist 4

Healthcare Updates for 2023 5

Retiree Premiums for 2023 6

PPO Core $500 **(FULLY INSURED RETIREES ONLY)** 7

PPO Choice Blue $500 **(FULLY INSURED RETIREES ONLY)** 8

Signature 65 **(Medicare Supplement Plan)** 9

BlueRx PDP **(Medicare Prescriptions)** 10

Dental – Basic Plan 11

Dental – Enhanced Plan 12

Blue365 Vision Discount Plan 13

The information in this brochure is intended as an overview, only, of the employee benefit programs offered by Elizabethtown College. Every attempt has been made to ensure its accuracy. The provisions of each benefit program will govern if there is any inconsistency between the information in this brochure and Elizabethtown College's formal plans, programs, policies or contracts or any subsequent change in such plans, programs, policies or contracts.

General Information

Elizabethtown College is pleased to offer benefit-eligible retirees a comprehensive and valuable healthcare plan. During Open Enrollment, you can enroll in or change benefits. The changes you make during Open Enrollment will be effective January 1, 2023, and will remain in effect for the entire year, January 1, 2023, through December 31, 2023, unless you have a qualified life event. Qualified life events include:

- Marriage
- Legal Separation
- Birth or adoption of a child
- Death of a spouse, child or other qualifying dependent
- Divorce
- Employment Status Change
- Change in child's dependent status
- Change in spouse's benefits or employment status

Open Enrollment begins November 7 and ends November 18, 2022. During this time, you may do the following:

- Enroll in or change coverage
- Add and/or remove an eligible dependent from your coverage

This year, all retirees will enroll online through the Benelogic online enrollment system. Etown College staff will be available to assist you through the online enrollment process.

Contact Jess at 717-361-1425 or frontzj@etown.edu with questions regarding your benefits.

Open Enrollment Checklist

Evaluate

- ☐ Think about your health history and your health care needs.

Engage

- ☐ Read through this Enrollment Guide to make sure you understand the full spectrum of benefits available to you.
- ☐ Choose to attend one of the open labs on campus for enrollment assistance:
  (THURS) November 10th from 11-12PM
  (MON) November 14th from 3-5PM
  Both labs will be held in Hoover 108. Login credentials will be provided to you upon arrival.
  Be sure to bring Medicare ID information, Social Security numbers, dates of birth, addresses and phone numbers for you and your dependents!
- ☐ Contact Jess in Human Resources with any questions that you have.
  Ph: 717.361.1425 | E: frontzj@etown.edu

Enroll

- ☐ Login to Benelogic at **https://etown.benelogic.com/signin/nosso** beginning November 7th through November 18th to complete and submit your 2023 benefit elections.

Healthcare Updates for 2023

New Online Enrollment Vendor and Process

Elizabethtown College has chosen **Benelogic** as its new online enrollment vendor. Etown is excited to invite our retirees to use this platform to enroll and manage their benefits moving forward!

Medical Plan Options

IMPORTANT!! FULLY INSURED (Under 65 Retirees) ONLY!!

The PPO $0 and the PPO $250 plans will end December 31, 2022. If you are enrolled in one of these plans and want to continue enrollment in a medical plan, you will need to make a new medical plan election for January 1, 2023.

Dental Benefit Carrier – Sun Life

Elizabethtown College has moved to Sun Life for dental insurance – offering a larger network of participating providers! In addition, you can elect from two coverage levels – basic and enhanced – to cover your dental needs.

Virtual Dental Care

For dental emergencies, retirees now have access to virtual dental care via TeleDentistry. Call the hotline at 866.410.9849 or visit the web at teledentistry.com/sunlife to get started.

Retiree Premiums for 2023

All medical rates below reflect the MONTHLY premium amount.

Fully Insured Medical Plans

Highmark	PPO Core $500				
Tier	100/0	70/60	85/30	50/0	Group
Retiree	$0.00	$305.54	$152.77	$509.24	$1,018.47
Retiree + Spouse	$1,068.26	$732.85	$900.55	$1,577.50	$2,086.73
Surviving Spouse	$1,068.26	$427.30	$747.78	$1,068.26	$1,068.26

Highmark	PPO Choice Blue $500				
Tier	100/0	70/60	85/30	50/0	Group
Retiree	$0.00	$293.42	$146.71	$489.04	$978.07
Retiree + Spouse	$1,026.98	$704.21	$865.60	$1,516.02	$2,005.05
Surviving Spouse	$1,026.98	$410.79	$718.89	$1,026.98	$1,026.98

Medicare Supplement Plans

Highmark	Signature 65 w BlueRx PDP				
Tier	Retirees Prior to 1996 (70/60)	Retirees 1996-1998 (85/30)	Retirees 1998-9/1/2004 (100/0)	Retirees 1998-9/1/2004 (50/0)	Retirees 9/1/2004 → (Group)
Retiree	$47.23	$23.61	$0.00	$78.72	$157.43
Retiree + Spouse	$110.20	$133.81	$157.43	$236.15	$314.86
Surviving Spouse	$62.97	$110.20	$157.43	$157.43	$157.43

Dental Plans

Sun Life	Basic Plan		Enhanced Plan	
Tier	Monthly	Annually	Monthly	Annually
Retiree	$26.00	$312.00	$31.52	$378.24
Retiree + Spouse	$44.18	$530.16	$67.92	$815.04

Vision Plan

Highmark	Blue365 Discount Plan
Tier	Monthly
ALL MEDICAL ENROLLMENTS	INCLUDED

PPO Core $500

Health Plan Provisions:

Administrator	Highmark Blue Shield www.highmarkblueshield.com **Phone**: 1-800-345-3806 **Group #:** 10628250	
Provisions	**In-Network**	**Out-of-Network**
Annual Deductible Individual: Family:	 $500 $1,000	 $1,000 $2,000
Total Maximum Out-of-Pocket Individual: Family:	 $8,700 $17,400	 N/A N/A
Copays: Primary Care Physician Telemedicine Services Urgent Care Center Specialist Emergency Room Visit	 $20 per visit $20 per visit $50 per visit $30 per visit $100 per visit (waived if admitted)	 80% after deductible Not covered 80% after deductible 80% after deductible $100 per visit (waived if admitted)
Routine Preventive Care: Physical Exams Immunizations Routine Gynecological Exam Mammograms, Routine	 100% (no deductible) 100% (no deductible) 100% (no deductible) 100% (no deductible)	 80% after deductible 80% after deductible 80% (no deductible) 80% after deductible
Hospital Inpatient	100% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Diagnostic Services & Advanced Imaging	100% after deductible	80% after deductible

Prescription Drug Plan Provisions:

	Participating Retail Pharmacy (31-day supply)	**Express Scripts Mail Order (90-day supply)**
Individual Annual Deductible	$25	
Generic Drugs	You pay 25% of the drug cost	You pay a $25 copay
Formulary Brand Drugs	You pay 25% of the drug cost	You pay a $75 copay
Non-Formulary Brand Drugs	You pay 45% of the drug cost	You pay a $125 copay
Specialty Drugs	You pay 25% of the drug cost $150 maximum per prescription	

PPO Choice Blue $500

Health Plan Provisions:

Administrator	Highmark Blue Shield www.highmarkblueshield.com Phone: 1-800-345-3806 Group #: 10628253		
Provisions	**In-Network Enhanced Value**	**In-Network Standard Value**	**Out-of-Network**
Annual Deductible Individual: Family:	 $500 $1,000	 $1,000 $2,000	 $2,000 $4,000
Total Maximum Out-of-Pocket Individual: Family:	 $8,700 $17,400		 N/A N/A
Copays: Primary Care Physician Telemedicine Services Urgent Care Center Specialist Emergency Room Visit	 $20 per visit $20 per visit $50 per visit $30 per visit $100 per visit (waived if admitted)	 $40 per visit $20 per visit $100 per visit $60 per visit $100 per visit (waived if admitted)	 60% after deductible Not covered 60% after deductible 60% after deductible $100 per visit (waived if admitted)
Routine Preventive Care: Physical Exams Immunizations Routine Gynecological Exam Mammograms, Routine	 100% (no deductible) 100% (no deductible) 100% (no deductible) 100% (no deductible)		 80% after deductible 80% after deductible 80% (no deductible) 80% after deductible
Hospital Inpatient	100% after deductible	80% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	80% after deductible	60% after deductible
Diagnostic Services & Advanced Imaging	100% after deductible	80% after deductible	60% after deductible

Prescription Drug Plan Provisions:

	Participating Retail Pharmacy (31-day supply)	**Express Scripts Mail Order (90-day supply)**
Individual Annual Deductible	$25	
Generic Drugs	You pay 25% of the drug cost	You pay a $25 copay
Formulary Brand Drugs	You pay 25% of the drug cost	You pay a $75 copay
Non-Formulary Brand Drugs	You pay 45% of the drug cost	You pay a $125 copay
Specialty Drugs	You pay 25% of the drug cost $150 maximum per prescription	

Signature 65

Health Plan Provisions:

Signature 65 is a complement to Medicare that fills in the coverage gaps and cost sharing of traditional Medicare (Medicare Part A and Medicare Part B).

To enroll into Signature 65, you must be enrolled in both Medicare Part A and Medicare Part B.

Administrator	Highmark Blue Shield www.highmarkblueshield.com Phone: 1-800-345-3806 Group #: 10628258		
Medicare Part A Covered Services			
Covered Services	**Medicare Pays**	**Plan Pays**	**Member Pays (1)**
Inpatient Hospital Days (1-60)	100% after deductible	Medicare deductible	$0
Inpatient Hospital Days (61-90)	100% after coinsurance	Medicare coinsurance	$0
Inpatient Hospital Days (91-150) may be used once per lifetime	100% after coinsurance	Medicare coinsurance	$0
Additional Inpatient Hospital Days	$0	100% of Medicare-eligible expenses for 365 additional days per benefit period, after the 60 Medicare inpatient hospital lifetime reserve days are exhausted	$0 for the first 365 additional inpatient hospital days per benefit period, 100% thereafter
Skilled Nursing Facility (1-20 days)	100%	$0	$0
Skilled Nursing Facility (21-100 days)	100% after coinsurance	Medicare coinsurance	$0
Skilled Nursing Facility (101+ days)	$0	$0	100%
Blood	$0 for the first 3 pints per cal. year, 100% thereafter	100% for the first three pints per cal. year, $0 thereafter	5% of Eligible Expenses
Inpatient Respite Care	95% of Eligible Expenses	$0	5% of Eligible Expenses
Medicare Part B Covered Services			
Covered Services	**Medicare Pays**	**Plan Pays**	**Member Pays (1)**
Outpatient Facility Provider Services	100% after deductible and coinsurance	Medicare deductible and coinsurance	$0
Outpatient Professional Provider Services	100% after deductible and coinsurance	Medicare coinsurance	Medicare deductible
Blood	$0 for the first 3 pints per cal. year, 80% after deductible thereafter	100% for the first 3 pints per cal. year, $0 thereafter	$0 for the first 3 pints per cal. year, 20% thereafter (after deductible)
Additional Benefits Not Covered by Medicare			
Covered Services	**Medicare Pays**	**Plan Pays**	**Member Pays**
Emergency Care in a Foreign Country	$0	80%	20%
(1) If the provider does not accept assignment from Medicare, any difference between the provider's charge and the combined Medicare/Highmark payment shall be the personal responsibility of the member.			

BlueRX Prescription Drug Plan

Prescription Drug Plan Provisions:

Administrator	Highmark Blue Shield www.highmarkblueshield.com Phone: 1-800-290-3914 Group #: 01983975
Enclosed – 2023 Benefit Summary Blue Rx	

2023 Benefit Summary

Elizabethtown College

Blue Rx

0198397

You pay the following until your total yearly drug costs reaches $4,660 Total yearly drug costs are the total drug costs paid by both you and your Part D Plan.

	Deductible	**$0**	
	Out of Pocket Maximum	**Not applicable**	
Initial Coverage	**Retail Cost Sharing (Preferred Pharmacy)**	**Tier**	**Up to 31 Day Supply**
		Tier 1 (Preferred Generic)	**$0.00 Copay**
		Tier 2 (Generic)	**$8.00 Copay**
		Tier 3 (Preferred Brand)	**$35.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$65.00 Copay**
		Tier 5 (Specialty)	**33% of the cost**
	Retail Cost Sharing (Standard Pharmacy)	**Tier**	**Up to 31 Day Supply**
		Tier 1 (Preferred Generic)	**$5.00 Copay**
		Tier 2 (Generic)	**$13.00 Copay**
		Tier 3 (Preferred Brand)	**$40.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$70.00 Copay**
		Tier 5 (Specialty)	**33% of the cost**
	Mail Order Cost Sharing (Express Scripts)	**Tier**	**Up to 90 Day Supply**
		Tier 1 (Preferred Generic)	**$0.00 Copay**
		Tier 2 (Generic)	**$20.00 Copay**
		Tier 3 (Preferred Brand)	**$87.50 Copay**
		Tier 4 (Non-Preferred Drugs)	**$162.50 Copay**
		Tier 5 (Specialty)	**33% Coinsurance for a 31 day limit supply**
	Mail Order Cost Sharing (All other Mail Order Pharmacies)	**Tier**	**Up to 90 Day Supply**
		Tier 1 (Preferred Generic)	**$12.50 Copay**
		Tier 2 (Generic)	**$32.50 Copay**
		Tier 3 (Preferred Brand)	**$100.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$175.00 Copay**
		Tier 5 (Specialty)	**33% Coinsurance for a 31 day limit supply**

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660.01 until your costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap.

	Retail Cost Sharing (Preferred Pharmacy)	**Tier**	**Up to 31 Day Supply**
		Tier 1 (Preferred Generic)	**$0.00 Copay**
		Tier 2 (Generic)	**$8.00 Copay**
		Tier 3 (Preferred Brand)	**$35.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$65.00 Copay**
		Tier 5 (Specialty)	**33% of the cost**
	Retail Cost Sharing	**Tier**	**Up to 31 Day Supply**
		Tier 1 (Preferred Generic)	**$5.00 Copay**
		Tier 2 (Generic)	**$13.00 Copay**

Coverage Gap	**(Standard Pharmacy)**	**Tier 3 (Preferred Brand)**	**$40.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$70.00 Copay**
		Tier 5 (Specialty)	**33% of the cost**
	Mail Order Cost Sharing (Express Scripts)	**Tier**	**Up to 90 Day Supply**
		Tier 1 (Preferred Generic)	**$0.00 Copay**
		Tier 2 (Generic)	**$20.00 Copay**
		Tier 3 (Preferred Brand)	**$87.50 Copay**
		Tier 4 (Non-Preferred Drugs)	**$162.50 Copay**
		Tier 5 (Specialty)	**33% of the cost for a 31 day limit supply**
	Mail Order Cost Sharing (All other Mail Order Pharmacies)	**Tier**	**Up to 90 Day Supply**
		Tier 1 (Preferred Generic)	**$12.50 Copay**
		Tier 2 (Generic)	**$32.50 Copay**
		Tier 3 (Preferred Brand)	**$100.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$175.00 Copay**
		Tier 5 (Specialty)	**33% Coinsurance for a 31 day limit supply**
Catastrophic Coverage Description: After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $7,400.01, you pay the greater of: 5% of the cost or a $4.15 copay for generics and a $10.35 copay for all other drugs.			
Catastrophic Coverage	**the greater of: 5% of the cost or a $4.15 copay for generics and a $10.35 copay for all other drugs.**		

HM Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in HM Health Insurance Company depends on contract renewal. Your health benefits or health benefit administration may be provided by or through Highmark Health Insurance Company. Highmark Blue Shield provides post-sale administrative communications for these companies.

Highmark Blue Shield complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

Questions on BlueRx PDP benefits? Call 1-866-456-7739 seven days a week, from 8 a.m. to 8 p.m. (TTY users call 711).

Reference Code (Please have this number ready when you call): 23BRX0198397

EGHP_22_2409_C

Dental – Basic Plan

Plan Provisions:

Administrator	Sun Life www.sunlife.com/us **Phone**: 1-800-733-7879 **Policy #:** 956144 **Find a dentist** at www.sunlife.com/findadentist **Dental network**: Sun Life PPO dental network
Deductible (Only applies to Basic and Major Services)	$50 per person; $150 per family each calendar year
Types II and III Annual Maximum	$1,000 per person each calendar year
This dental plan also includes a Preventative Max Waiver which allows covered dental expenses for preventative services to not apply to the annual maximum.	

	In-Network	**Out-of-Network**
Type I Preventive Services Exams Cleanings X-rays Sealants	100%	100%
Type II Basic Services Fillings/Restorations Endodontics (root canals) Periodontics (gum treatment) Oral Surgery – Simple Extractions	80%	80%
Type III Major Services Crowns Inlays & Onlays Bridges Dentures Oral Surgery – Surgical Extractions	25%	25%
NO ORTHODONTIC BENEFIT		

*Participants who visit an out-of-network dentist will still receive coverage but will likely pay higher out-of-pocket costs since you will be responsible for the coinsurance listed above, plus all fees charged by your dentist in excess of Sun Life's normal reimbursement rates to in-network dentists.

Dental – Enhanced Plan

Plan Provisions:

Administrator	Sun Life www.sunlife.com/us **Phone**: 1-800-733-7879 **Policy #:** 956144 **Find a dentist** at www.sunlife.com/findadentist **Dental network**: Sun Life PPO dental network
In-network Deductible (Only applies to Basic and Major Services)	$50 per person; $150 per family each calendar year
Types II and III Annual Maximum	$1,500 per person each calendar year
This dental plan also includes a Preventative Max Waiver which allows covered dental expenses for preventative services to not apply to the annual maximum.	

	In-Network	Out-of-Network
Type I Preventive Services Exams Cleanings X-rays Sealants	100%	100%
Type II Basic Services Fillings/Restorations Endodontics (root canals) Periodontics (gum treatment) Oral Surgery – Simple Extractions	80%	80%
Type III Major Services Crowns Inlays & Onlays Bridges Dentures Oral Surgery – Surgical Extractions	50%	50%
Type IV Orthodontic Services Dependent children to age 26	50%	50%
Orthodontic Maximum	$1,000 Lifetime	$1,000 Lifetime

*Participants who visit an out-of-network dentist will still receive coverage but will likely pay higher out-of-pocket costs since you will be responsible for the coinsurance listed above, plus all fees charged by your dentist in excess of Sun Life's normal reimbursement rates to in-network dentists.

Vision Plan – Blue365 Vision Discount Plan

Plan Provisions:

	Service	Your Price
Eye Examinations	Routine Eye Exam Refraction Only (when exam is covered by Medicare) Retinal Imaging	*15% off Usual and Customary $20 --- $39
*Frames	Retail Frame	35% off Usual and Customary
Lenses (Uncoated Plastic)	Single Vision Bifocal Trifocal Lenticular	$45 $65 $95 $120
Lens Options *(Add to lens Prices Above)	Standard Progressive Premium / Ultra Progressive Polycarbonate Lenses Scratch-Resistant Coating Anti-Reflective (AR) Coating (Standard) Anti-Reflective (AR) Coating (Premium / Ultra) Ultraviolet Coating Tinting of Plastic Lenses (Solid / Gradient) Polarized Lenses High-Index Lenses Plastic Photochromic Lenses	$65 20% off Usual and Customary $35 $15 $45 20% off Usual and Customary $15 $15 $75 $65 $75
Contact Lenses	Contact Lens Evaluation, Fitting & Follow-Up Care (in lieu of eyeglasses) Conventional Lenses Disposable / Planned Replacement Lenses *Contact Lens Replacement Program	15% off Usual and Customary --- 15% off Usual and Customary 15% off Usual and Customary Up to 15% off Retail Prices

Locating a Network Provider

To find a network provider, please go to www.highmarkblueshield.com and click of "**Find a Doctor or Rx**." Click on "**Find an Eyecare Provider**." Enter your zip code and mile radius and then click on Search to see the most current listing of providers that will accept your discount plan.

* Usual and Customary (U&C): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar service.
* Special lens designs, materials, powers, and frames may require additional costs.
* Members should call 1.855.589.7911 or visit davisvisioncontacts.com with a current prescription.
Additional plan discounts may not be available at all provider locations in all states. Please confirm that discounts are accepted when making your appointment.