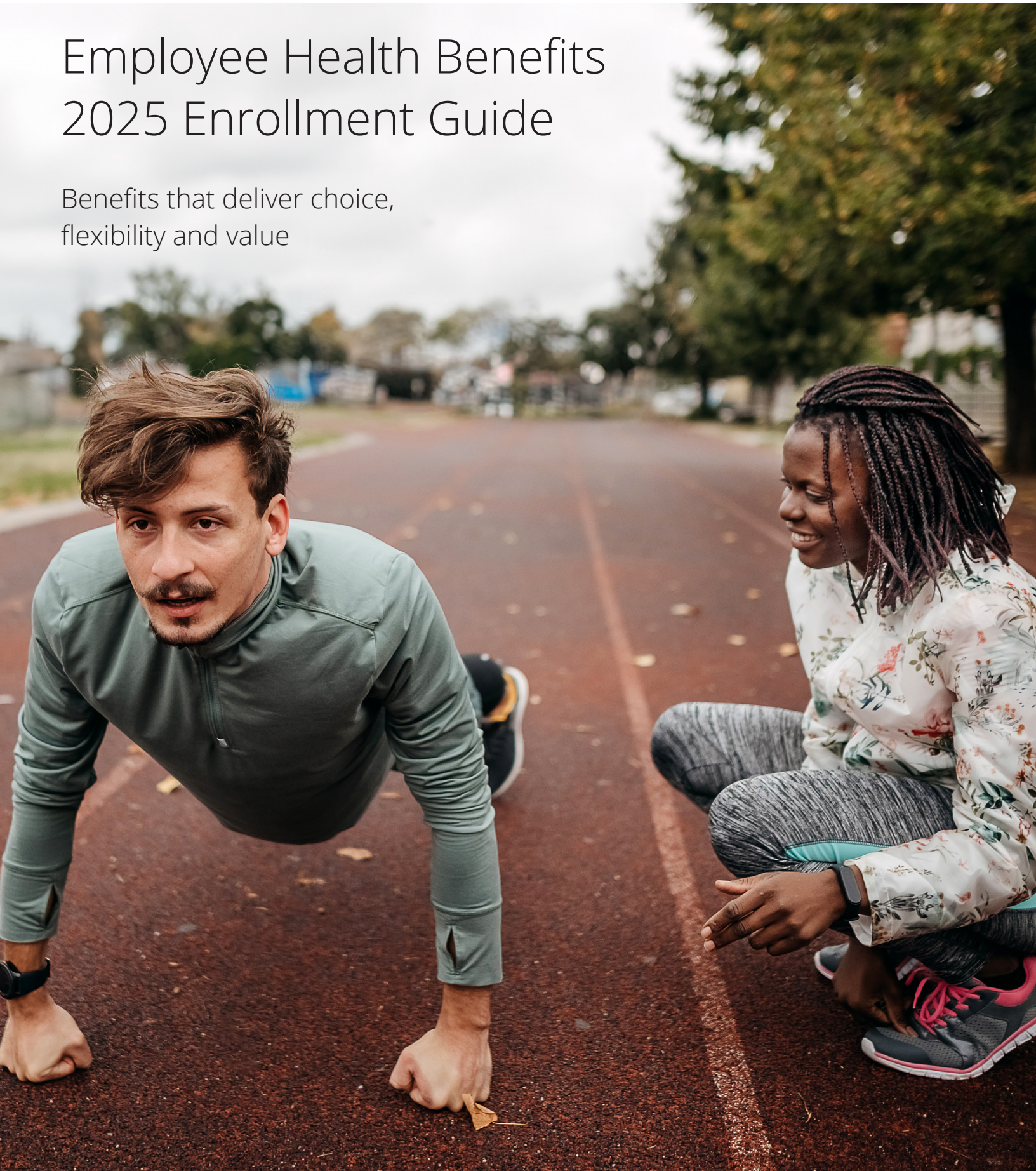
pebc
PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

Employee Health Benefits 2025 Enrollment Guide

Benefits that deliver choice, flexibility and value



Choice.
Flexibility.
Value.

The Public Employee Benefits Cooperative (PEBC) offers a variety of benefits and programs to help you manage your health while keeping benefit costs affordable. In this guide, you'll find information on your 2025 health plan benefits to help you choose the coverage that works best for you.

Questions?
Please contact your Human Resources department.

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What's changing for 2025

In ongoing efforts to provide benefits and programs that are comprehensive and cost effective for employees, we consider many different factors. With the goal of maintaining the current benefit plan offerings, we're pleased to announce the medical and pharmacy plans will be administered by Blue Cross and Blue Shield of Texas (BCBSTX) and Prime Therapeutics, effective 1/1/2025. EAP, FSA and HSA providers are also changing for 2025. Please carefully review the enrollment guide for important transition information and learn about the new tools available to help you manage and make the most of your benefits.

New Medical Plan: Blue Cross and Blue Shield of Texas

As a BCBSTX member, you will enjoy access to a large health care provider network and an array of resources to help you manage your health care and make informed health care decisions.

Whether you are trying to improve your health or reach the next level of wellness, BCBSTX is here to help.

You will get a member ID card in the mail. Be sure to show this card when you receive care beginning January 1, 2025. The cards have only the subscriber's name, but can be used by each covered family member.

The BCBSTX networks include doctors, hospitals and other health care providers. Whether you are choosing PPO or HDP, you have access to independently contracted in-network providers. Find out if your provider is in-network. Use Provider Finder as a guest to look for doctors, hospitals and other health care providers before you get your member ID card.

1. Go to **bcbstx.com**.
2. Click **Find Care** and select **Find a Doctor or Hospital**.
3. Scroll down to **Basic Guest Search** and click **Search for Doctors as a Guest**.
4. Enter the city and state or ZIP code where you want to search.
5. Select **Employer Plans** for type of plan to search and confirm your State.
6. Choose **PPO** and **Blue Choice PPO℠ (BCA)** and click on **Search Selected Plan for Doctors. The network is the same for both the PPO and HDP plans.**
7. Click **View Profile** to get more details about the provider.

After you get your member ID card, register for Blue Access for Members℠ and log in there for personalized search results.

BCBSTX knows the importance of a strong doctor-patient relationship. Changing health care providers can be stressful. This is especially true if you have a serious or chronic medical condition. If you are getting care from a doctor who is not part of your PPO medical plan, you may be able to continue treatment with that doctor temporarily. Treatment can continue until the end of the current course of treatment. To learn more, contact Customer Service at BCBSTX as soon as possible to discuss what continuation of care options are available.

For more information on continuation of care or other questions, please call **888-306-5753** from 8:00 a.m. to 8:00 p.m. CT.

New Pharmacy Benefit Coverage: Prime Therapeutics, LLC

Prime Therapeutics LLC (Prime) will administer your plan's pharmacy benefits. Your new Performance Select drug list covers many of the same prescription drugs as your current plan. You can fill your prescriptions at any network retail pharmacy or the Express Scripts® Pharmacy home delivery service. Specialty meds can be filled at Accredo or another network pharmacy. Be sure to use your Member ID at the pharmacy to take advantage of MedsYourWay® discount card pricing. With MedsYourWay, you'll pay the lower available cost on eligible prescriptions, whether your plan's cost share amount or an available drug discount card price.

New Flexible Spending Account (FSA) and Health Savings Account (HSA) Administrator: HealthEquity®

HealthEquity will be the new administrator for FSA and HSA accounts. A health care FSA is a way to set aside money from your earnings before taxes are withheld to pay eligible out-of-pocket health care expenses and qualifying dependent daycare expenses. An HSA is a savings account that you can use to help cover qualified health care expenses. You must be enrolled in a high-deductible health plan (HDP) to participate in an HSA.

High Deductible Plan (HDP) deductibles

For 2025, the HDP deductible for network services is $1,650 for individuals and $3,300 for families. The out-of-network HDP deductible is $3,000 for individuals and $6,000 for families, plus you pay charges exceeding the plan payment.

Health Savings Account (HSA) contributions

The maximum contribution to an HSA for 2025 is $4,300 for individuals and $8,550 for families, with deposits made through payroll deduction. If you are age 55 or older, you can make an extra catch-up deposit of $1,000 in 2025.

Flexible spending account (FSA) contributions

You must elect an FSA every year you intend to participate. The maximum amount you can set aside for 2025 is $3,200 — including general-purpose FSAs and limited-purpose FSAs (LP-FSAs). Employer contributions do not count toward the annual limit. To help pay for qualifying daycare expenses, you can set aside up to $5,000 in the dependent care FSA in 2025, which cannot be used for medical expenses.

Life insurance open enrollment

There is a reduction to Optional Term Life (TLF) and Spouse Optional Term Life (SLF) insurance rates for 2025.

During this year's annual enrollment period, you have a one-time opportunity to enroll or increase your coverage on the Optional Life (TLF) plan without medical questions! You may also enroll your spouse in up to $25,000 of Spouse Optional Life (SLF) without medical questions even if you've waived coverage on your spouse in the past.

New Employee Assistance Program (EAP): ComPsych

ComPsych GuidanceResources is an Employee Assistance Program included with your BCBSTX plan. You and your family members have access to a suite of EAP services — no copays or deductibles attached. Your benefits include up to five free therapy sessions per issue. Once you've used these free sessions, you can use your BCBSTX network benefits to keep seeing the same therapist in many cases.

ID card and debit card information

Medical plans

You will receive an ID card in the mail in late December, 2024. Please note that your medical ID card will indicate your level of coverage, but it will not list your dependents by name. You can also print a temporary ID card, if needed, at **bcbstx.com** and access a digital card in the BCBSTX App.

Dental plans

DeltaCare USA DHMO and Delta Dental PPO — you will not receive a new ID card unless you are new to the plan and/or changed plans for 2025. Members with an existing card who are not changing plans can continue to use their existing ID card. If you need a new card, you can contact customer service and request one or log in to your online account and download an electronic version.

For new DeltaCare members, your assigned provider will be listed on your welcome letter.

Vision plan

ID cards are not necessary to obtain services. If you prefer to carry an ID card, you can register on **vsp.com** to download and print an ID card.

HealthEquity Visa® card

You will receive a HealthEquity Visa® card in the mail in about 7–10 days after your account is opened. This card works for both flexible spending accounts and health savings accounts. A PIN number is not required, and the card does not have an annual card fee.

Did you move?

Be sure to provide your Human Resources department/ Benefits Office your new address as soon as possible. This will help avoid delays in receiving your ID cards, EOB forms and other information.

If you do not receive your ID card by late January, print a temporary ID card or call the plan's Customer Service department.

Providers can confirm eligibility by contacting the appropriate plan. As long as you are enrolled in a plan, a provider can electronically confirm your eligibility and that of your covered dependents.

Dependent eligibility

Who is an eligible dependent?

Your dependent can be enrolled in a plan only if they are an eligible dependent residing in the United States. If both you and your spouse work for the same employer, your dependents can be covered by only one of you.

Eligible spouse

- Your lawful spouse (you must have a valid certificate of marriage considered lawful in the State of Texas or a signed and filed legal Declaration of Informal Marriage considered lawful in the State of Texas)
- A surviving spouse of a deceased retiree, if the spouse was covered at the time of the retiree's death

Eligible children

- Your natural child under age 26
- Your natural, mentally or physically disabled child, if the child has reached age 26 and is dependent upon you for more than one-half of their support as defined by the Internal Revenue Code. To be eligible, the disability must occur before or within 31 days of the child's 26th birthday.
- Your legally adopted child, including a child who is living with you who has been placed for adoption or for whom legal adoption proceedings have been started, or a child for whom you are named permanent managing conservator
- **Your newborn is not automatically enrolled in your medical plan. You are responsible for contacting your Human Resources department and completing the required enrollment paperwork to add your newborn.**

If you enroll your newborn within 31 days from the date of birth, coverage is effective on the date of birth. If you do not add your newborn within 31 days from the date of birth, you cannot add your newborn until the next annual enrollment period.

Managing conservator

Dependents may be eligible if employee is the managing conservator with rights to make decisions about the child

- Your stepchild (natural or adopted child of current spouse)
- Your unmarried grandchild (child of your child) under age 26 who, at the time of enrollment, is your dependent for federal income tax purposes, without regard to income limitations
- A child for whom you are required to provide coverage by court order
- A surviving, eligible child of a deceased retiree, only if the child was covered as a dependent at the time of the retiree's death

Dependent verification

Valid proof of dependent eligibility is required before you can add a new dependent or spouse to the plan. Check with your Human Resources department for more information.

Who is not an eligible dependent?

Enrollment of an ineligible dependent can be considered fraud and subject you to penalties, including termination of employment, financial risk and criminal prosecution. Anyone eligible as an employee is not eligible as a dependent.

Ineligible spouse

- Your divorced spouse, or a person to whom you are not lawfully married, such as your significant other
- A surviving spouse who was not covered by the deceased retiree at the time of the retiree's death

Ineligible children

- Your natural, age-26-or-older child who is not disabled or whose disability occurred after the 26th birthday
- A child for whom your parental rights have been terminated
- A child living temporarily with you, including a foster child who is living temporarily with you or a child placed with you in your home by a social service agency, or a child whose natural parent is in a position to exercise or share parental responsibility or control
- Your current spouse's stepchild or the stepchild of a former spouse
- A surviving child of a deceased retiree who was not covered as a dependent at the time of the retiree's death
- A sibling, another family member or an individual not specifically listed by the plan as an eligible dependent

When a child's coverage ends

You may cover your child (natural child, stepchild, adopted child) in a medical, dental and/or vision plan until the last day of the month in which the child turns age 26, whether or not the child is a student, working, living with you and regardless of the child's marital status. This coverage does not extend to your child's spouse or their children. Your grandchild is eligible only if the grandchild is unmarried and your dependent for federal income tax purposes.

You must provide your Form 1040 to prove grandchild dependent status.

New hire enrollment

If you are a newly hired employee and selecting benefits for the first time:

- You must return your enrollment documents to your Human Resources department **within 14 days of the date you begin working**. If you miss that deadline, you'll automatically be enrolled in a default medical plan, employee-only coverage.
- The PPO is the default medical plan. You cannot change from PPO default plan enrollment until the next annual enrollment period unless you experience a qualified change in status event.
- Your coverage becomes effective on the first day of the month after 30 consecutive calendar days of active, regular employment
- If you select optional Term Life insurance (TLF) when you are newly hired and enrolling for the first time, you do not have to provide Evidence of Insurability (EOI).
- If you select Spouse optional Term Life (SLF) in an amount greater than $25,000, EOI is required. Instructions are found on the back of the enrollment form, available at **pebcinfo.com**. TLF coverage requirements vary by employer.

  Check with your employer to confirm your EOI requirements.

Change in status

IRS regulations state that unless you experience a qualified change in status event (described below), you cannot change your benefit choices until the next annual enrollment period.

The qualified change in status event must result in either becoming eligible for or losing eligibility under the plan. The change must correspond with the specific eligibility gain or loss. As long as the qualified change in status event is consistent, you may also change your corresponding FSA elections, dependent life insurance elections or your health benefit elections.

Required enrollment action

Spouse Medical Plan Surcharge Affidavit

If your employer requires it and your medical coverage includes your spouse, you must sign a "Spouse Medical Plan Surcharge Affidavit" during annual enrollment confirming their access to employer medical plan coverage through their employer — regardless of whether they enrolled in that coverage.

Verify submission requirements and deadlines with your employer.

Medical plan spouse surcharge

If your spouse's employer offers a medical plan, your spouse did not enroll in that plan and you cover your spouse in your employer PPO medical plan or HDP, **a $200 per month spouse surcharge** may apply to the cost of covering your spouse on your employer medical plan (deducted from your paycheck).

The surcharge may also apply if you fail to turn in the required Spouse Medical Plan Surcharge Affidavit or if you were late turning it in.

The medical plan spouse surcharge **will not** apply if:

- Your spouse is enrolled in dental and vision coverage
- Your spouse is enrolled in both their employer medical plan (proof of enrollment required) and your PPO plan or HDP
- Your spouse does not work outside the home and has no access to employer coverage; or Your spouse's employer does not offer medical coverage, or your spouse is not eligible for that coverage
- Your spouse's other coverage is Medicare, Medicaid, TRICARE® or care received at a Department of Veteran Affairs (VA) facility
- You turned in the required Spouse Medical Plan Surcharge Affidavit on time

PLEASE NOTE: The surcharge may apply for each month the Spouse Medical Plan Surcharge Affidavit was not submitted (even if the surcharge does not apply or if it was submitted late) or if you fail to notify your employer of a change, which would have triggered or stopped the surcharge.

Welcome to Blue Cross and Blue Shield of Texas

The choices you make each day affect your health now and in the future. That's why BCBSTX has been committed to the wellbeing of the communities we serve. We provide a range of online tools and resources to help you plan and manage your health care.

Annual enrollment is the only time of the year that you can change your benefit elections or dependents without a qualified change in status event. It's important to read your plan options closely to help you make the choices that are best for you. Here are a few helpful things to remember.

- Compare the differences between the plans.
- Check with doctors, hospitals and other providers to confirm they are in-network.
- Think about potential health needs in the coming year. Estimate your out-of-pocket cost for each available plan for services you might receive, as well as the premium cost.
- If you enroll in the HDP, consider the additional savings and benefits of a health savings account (HSA), especially if partnered with a limited-purpose flexible spending account (LP-FSA). Your employer contributes "seed money" to your HSA to help you save even more. If you are not eligible for HSA contributions, the seed money goes to an LP-FSA.
- If you enroll in the PPO plan or opt out of medical coverage, you can also save by electing a health care FSA.
- **Choose from a large provider network.** The BCBSTX network includes a range of independently contracted hospitals, doctors and other health care providers. Blue Cross and Blue Shield plans work together to help ensure you receive reliable, affordable health care when you need it while traveling in the U.S. outside of Texas. You have access to an established network of doctors, hospitals and other health care providers throughout the country.
- **Use our wellness resources.** We provide helpful articles, emails and text alerts about general and specific health issues to support you.
- **Get deals and discounts.** Save money on fitness gear, family activities, healthy eating choices and more from local and national retailers.

- **Find information about doctors.** Our online directory is the quick and easy way to find doctors, hospitals or other health care providers in your network. Follow these steps:
  - Go to **bcbstx.com**
  - Click **Find Care**
  - Click **Find a Doctor or Hospital** and then **Search for Doctors as a Guest**
  - Answer a few questions and follow the prompts

Check out our free app

Access all of our mobile websites and services in one spot. Text* **BCBSTXAPP** to **33633** to learn more.

Find more online

After you receive your member ID card, go to **bcbstx.com/member** to sign up for **Blue Access for Members**℠. You can use this secure website from your desktop or mobile device to:

- Check the status of a claim and your claims history
- See who is covered under your plan
- View and print an Explanation of Benefits statement
- Review articles on healthand wellness topics
- Print a temporary ID card
- Find a doctor, hospital or other health care provider in the network
- Estimate the cost of a provider's procedures, treatments and tests
- Get answers to frequently asked questions
- Use your benefits wisely
- Manage prescriptions
- Learn more about medications
- Find network pharmacies

If you have questions, BCBSTX Customer Service Advocates can help. Call the number on the back of your member ID card, Monday through Friday, 8 a.m. to 6 p.m. CT.

* Message and data rates may apply. Terms, conditions and privacy policy can be found at **bcbstx.com/mobile/text-messaging**.

1. After you receive your ID card, go to **bcbstx.com/member**
2. Click **Register Now**
3. Use the information on your BCBSTX ID card to complete the registration process

Text* **BCBSTXAPP** to **33633** to get the BCBSTX App that lets you use BAM℠ while you're on the go.

*Message and data rates may apply

NOTE: During annual enrollment, you must re-enroll if:

- Anything changed, including dependent eligibility, your address or your plan choice
- You want to contribute to an FSA or an limited purpose FSA (LP-FSA).

You have to re-enroll each year if you want to contribute to an FSA, even if you do not change your annual election amount.

pebcinfo.com

Go to **pebcinfo.com** and click the button for your employer group.

- To compare plans, check the Summary of Benefits and Coverage (SBC). The SBC helps you compare certain health plan provisions.
- To see employee contribution rates for each plan along with the various account options available to you (HSA, FSA, LP-FSA), view the 2025 Employee Benefits Rate Sheet

MyPrime.com, Prime's member website, helps you manage your pharmacy benefits when you're at home or on the go. You can visit the website to:

- Check medicine cost and coverage details
- See your prescription claims history
- Find in-network pharmacies
- Connect with the pharmacy delivery services
- Compare pricing for drugs and pharmacies
- Get any forms you may need
- Learn about drug interactions, possible side effects and more

You can also access many of the same features on BAM or connect to **myprime.com** from BAM.

Qualified events

Change in family status

Applies to employee, employee's spouse or employee's dependents:

- Marriage, divorce or annulment
- Death of your spouse or dependent
- Child's birth, adoption or placement for adoption (your newborn or adopted child is not automatically enrolled in your medical plan)
- An event causing a dependent to no longer meet eligibility requirements, such as reaching age 26

Examples of events that do not qualify:

- Your doctor or provider is not in the network
- You prefer a different medical plan
- You were late turning in your paperwork

Change in employment status

The following changes in the employment status of an employee, spouse or dependent may affect benefit eligibility under your benefit plan or the employer benefit plan of your spouse or your dependent:

- Switching from a salaried to an hourly paid job (or vice versa)
- Reduction or increase in hours of employment, such as going from part time to full time
- Any other employment-related change that results in becoming eligible for or losing eligibility for a particular plan
- Termination or commencement of employment
- Strike or lockout
- Start or return from an unpaid leave of absence
- USERRA (military) leave

Important deadlines apply

You must take action **within 31 days of the qualifying event** — coverage elections are not retroactive.

- **31-day notification rule.** You must notify your Human Resources department of the event AND turn in required paperwork (including proof of the change) within 31 days of the event date.
- **Effective date.** The change is effective the first day of the month following the date you notified your employer of the qualified change in status event and provide documentation. Effective date exception: Newborns are effective on the date of birth, and adoptions are effective the date placed for adoption or on the adoption date.

Retirement

Thinking about retirement?

Your employer offers retiree health benefits, but these cost more than your active employee coverage. Make an appointment to discuss your retiree benefit options with your Human Resources department at least 60 days before you retire.

If you are age 65 or older, or if you are turning 65 soon, contact the Social Security Administration at least 90 days before you retire. Carefully review the Retiree Health Benefits Guide, available at **pebcinfo.com** or from your employer.

Turning age 65 and still working

Most people become eligible for Medicare when they turn 65. If you are still working and covered under your employer's plan, you can delay your Medicare enrollment until you retire.

If you are already collecting Social Security payments, you are automatically enrolled in Part A. Otherwise, you may choose to delay your Medicare enrollment until you retire for several reasons, including:

- You are an active employee and you (and your spouse, regardless of spouse's age) are enrolled in the employer health plan
- You (and your spouse, regardless of spouse's age) want to delay payment of Part B premium
- You still want contributions to be made to your HSA (as long as you are not enrolled in Medicare and you are enrolled in the HDP)

CAUTION: If you are preparing to retire and you or your spouse are age 65 or older or turning 65 soon, you must contact the Social Security Administration to enroll in Medicare Part A and Part B. If you delay, your Medicare enrollment can be delayed, and you may be subject to a higher Part B premium.

After you retire, Medicare becomes primary for you and your Medicare-eligible spouse. You may be eligible for PEBC's Medicare Advantage HMO or PPO retiree plans but only if you are enrolled in both Medicare Part A and Part B.

Choosing the medical plan that is right for you

Understanding how much you can expect to pay

Your out-of-pocket costs and your deductible — the amount you must pay each year before the plan begins to pay — will be different, depending on the plan you choose.

PPO

With this plan, you pay a fixed copay for many services, which counts toward your out-of-pocket costs. Copays do not count toward the deductible.

Network deductibles	Out-of-network deductibles
For 2025, your deductible for services in the network is:	**The individual out-of-network deductible applies to each enrolled family member and does not have a family deductible limit:**
$500 for individual (single) coverage	$1,000 for each individual (single)
$1,000 for family coverage*	Unlimited for family coverage

* If you cover family members, the network family deductible is met when the combined eligible network expenses for you and/or your covered family members reach $1,000. If one family member reaches $500 but the combined family deductible of $1,000 has not been met, the member who met the $500 deductible can move to coinsurance until one more family member reaches the deductible. If no family member reaches the $500 deductible but the combined family deductible is met, all family members move to coinsurance.

Need more details?

Visit **pebcinfo.com**.

High deductible plan (HDP)

The HDP does not use copays. You pay 100% of the allowable cost for network services — including office visits, urgent care, prescription drugs, emergency room visits and other covered expenses — until your deductible is met. Once the deductible is met, you pay a portion of the costs as coinsurance.

The deductibles are another big difference between this plan and the PPO plan:

- $1,650 individual (single) deductible
- $3,300 family deductible*

* If you cover any family member, the entire network family deductible must be met before any family member can move to coinsurance. The HDP network family deductible is met when the combined eligible expenses for you and/or any covered family members reach $3,300. Even if one family member reaches the $1,650 deductible, that member cannot move to coinsurance until the full $3,300 family deductible is met.

Opting out of a medical plan

You may be able to opt out of your employer's medical plan if you submit the following to your Human Resources department before the enrollment deadline:

- Valid proof of other comparable medical plan coverage that meets minimum essential coverage rules under the Affordable Care Act (ACA), confirmed by your employer
- A completed "certification of other coverage" form

If you do not provide a certification of other coverage form, or if your proof of coverage is found to be invalid, your employer can enroll you in the PPO plan (employee-only coverage). If you opt out, you will not be eligible for continuation of medical coverage (COBRA). Examples of coverage that cannot be used to opt out of your employer's medical plan include:

- Medicaid
- TRICARE "supplemental" coverage
- Marketplace
- Student insurance
- Coverage that does not meet minimum ACA requirements

PLEASE NOTE: If your employer contributes to a health care FSA due to your medical plan opt-out status, that contribution is subject to valid proof of other comparable coverage and a current, signed certification of other coverage form. If your other coverage is found to be invalid or expired, the employer contribution is discontinued. You may be required to repay any employer contributions, and you could be subject to serious consequences.

Participation or continuation of any employer contribution program is at the discretion of the employer. **Coverage obtained through the Health Care Marketplace (Exchange) is not eligible for employer opt-out contributions.**

Transition benefits

In certain circumstances, the health plan may authorize the member to continue receiving medical care from an out-of-network provider at the in-network level of benefit for covered services. It may be necessary to request medical information from your current provider(s).

There are certain circumstances when on the date of enrollment, a new member is already getting care for a certain health issue. Transition of care (also called continuation of care) provides a brief period of in-network coverage if you are new to BCBSTX and your doctor is outside your new plan's network. Transition of care also applies if your doctor leaves the network or changes network status. Transition of care may allow you to see an out-of-network provider at in-network rates for a certain amount of time if you have certain health conditions or are participating in an active course of care.

Examples include pregnancy, hospitalization, terminal illness with life expectancy of less than six months, long term treatment of cancer, heart disease and transplants.

If you have transition of care concerns, please call BCBSTX at **888-306-5753**.

Understanding HSAs

What is an HSA?

An HSA is a savings account that you can use to help cover qualified health care expenses. You must be enrolled in a high-deductible health plan to participate. Unlike an FSA, there is no "use it or lose it" rule and it comes with triple-tax benefits:

- Deposits are income tax-free
- Savings grow tax-free
- Withdrawals made for qualified expenses are also income tax-free

For 2025, you can contribute $4,300 through payroll deduction if you have individual coverage or $8,550 if you have family coverage. The IRS also allows catch-up contributions of $1,000 if you are age 55 or older.

The new HSA provider for 2025 is HealthEquity. You can learn more about HSAs at **healthequity.com**.

To be eligible to contribute to an HSA, you must:

- Be enrolled in a high-deductible health plan
- Not have health coverage except for a high-deductible health plan
- Not be claimed as a dependent on someone's tax return
- Not be enrolled in Medicare
- Not have received Veteran's Affairs benefits in past 3 months

HSA tax benefits

HSAs are the only benefit to offer triple-tax savings:

Tax-free contributions - You don't pay taxes on the money you put into the account.

Tax-free account growth - Invest your HSA and any growth is tax-free—just like with retirement accounts.

Tax-free spending - Use HSA funds for HSA-qualified expenses, and you never pay taxes on that money.

HSA-qualified expenses

There are thousands of qualified medical expenses and services you can pay for with an HSA. Here are a few:

- Doctor visits
- Prescription medications
- Dental care
- Vision care
- Over-the-counter medications

See a list of qualified medical expenses at **healthequity.com**.

HSA investing

You can invest the money in your HSA and any account growth is tax-free.

This helps you save for retirement, which makes the HSA an important part of your overall retirement savings strategy.

After age 65, you can use the money in your HSA for any expense, you'll simply need to pay ordinary income taxes on the withdrawals.

You can also sell your mutual funds to pay for qualified medical expenses at any time.

Contributions from your employer

If you enroll in the HDP during annual enrollment, your employer will make a one-time cash deposit to your HSA in January. For new employees, these "seed money" contributions are available as soon as possible once your HDP becomes effective.

If you are not eligible for HSA contributions — for example, if you are enrolled in Medicare — the seed money contribution will go to an LP-FSA. Seed money is not offered to those who add coverage in the high-deductible plan as a result of a mid-year qualifying event.

PLEASE NOTE: Some other restrictions apply, especially if you receive services at a VA facility or clinic. Contact your tax or financial advisor if you have questions. If you switch to a health plan that makes you ineligible to continue depositing money in an HSA, you can continue to use the money in your account for qualified medical expenses, but you can no longer make deposits.

If you enroll in the HDP with an HSA, be sure to save receipts.

You are responsible for verifying your HSA was used for eligible medical expenses under the IRS tax code. Contact HealthEquity for details.

HealthEquity Visa

The HealthEquity Visa card works with multiple accounts including HSA, FSA and LP-FSA as a convenient way to pay for eligible expenses.

This new card will automatically draw from the account appropriate for the eligible expense. For example, if you have an HSA and LP-FSA, then it will draw first from the LP-FSA for dental and vision expenses. Once those funds are depleted, it will access funds from your HSA.

Saving money using pretax dollars

Flexible spending accounts

A health care FSA is a way to set aside money from your earnings before taxes are withheld to pay eligible out-of-pocket health care expenses and qualifying dependent daycare expenses. Here's how it works:

- Use your HealthEquity Visa Card to pay for eligible health care expenses, or submit a claim for reimbursement of eligible expenses from your account
- Expenses must be incurred by Dec. 31
- Expenses must be submitted to HealthEquity by April 30 of the following year to avoid loss of funds
- Claims must be submitted within one year of the date of service
- Your active employee FSA ends the date your employment ends

Rollover funds

The IRS allows employees with a health care FLEX account to roll over up to $640 of their unused funds to the next plan year. Whether you enroll in the general purpose FLEX account or the LP-FLEX account, and regardless if the contribution is from you or your employer, a combined total up to $640 of unused funds will automatically roll over for use in the next plan year. Automatic rollover will occur after the end of the run-out period. The run-out period ends April 30, 2025, which means 2024 rollover funds will be available in May 2025.

You have until April 30, 2025, to submit claims for expenses incurred during 2024

Expenses are incurred when the medical care is provided or the service is delivered, not when you are billed, charged or pay for the care.

A note for highly compensated employees

The Internal Revenue Code (IRC) provides that health care FSAs and dependent care FSAs cannot discriminate in favor of highly compensated employees (as defined by the IRS). The plan reserves the right to reduce or adjust your contributions, elections and/or benefits to maintain the tax-qualified status of the health care and dependent care FSAs.

Manage your accounts online

Visit **healthequity.com** to manage your FSA. If you have more than one type of 2025 FSA, you will see more than one account listed. The combined total represents your available funds. You can file your claims electronically and either upload or fax your claims substantiation.

General-purpose FSA

If you enroll in the PPO plan or if you opt out of medical coverage and your comparable coverage is through a traditional plan (non-HDP), you can select the general-purpose FSA. The general-purpose FSA can be used to pay your eligible out-of-pocket health care expenses, including dental and vision costs. Expenses paid by insurance or another source are not eligible for reimbursement.

Limited-purpose FSA

If you enroll in the HDP with contributions to an HSA, you cannot elect a general-purpose FSA, but you can elect an LP-FSA. The LP-FSA reimburses you for eligible vision and dental expenses and eligible out-of-pocket medical expenses after your deductible is met.

HealthEquity Visa card

All participating members will receive a HealthEquity Visa card at no cost, which makes it easy to access your health care FSA funds. Your entire health care FSA election amount is available for claims incurred at either January 1, 2025, or your effective date, whichever is later.

IRS requirements apply when you use a HealthEquity Visa card, and every cardholder agrees to follow IRS rules. Read the cardholder agreement that accompanied your Health Care Spending Card.

Claims substantiation and receipts

The IRS requires claims substantiation for debit card transactions. We only request receipts for transactions where the merchant did not receive an authorization from Visa. If you are unable to use your HealthEquity Visa Card, you will need to submit a claim for reimbursement.

Employer contributions

In some cases, employers may contribute to an employee FSA or LP-FSA. If your employer contributes, you will find the maximum contribution amounts on the back of the 2025 Employee Benefit Plan Rates document included in your enrollment packet. Employer contributions are in addition to and do not count toward the employee $3,200 health care FSA annual election limit.

	General-purpose FSA	Limited-purpose FSA
Medical plan enrollment required	PEBC PPO plan or opt out with a traditional plan as comparable coverage.	HDP or opt out with an HDP as comparable coverage.
What can be reimbursed?	Eligible qualified expenses including out-of-pocket medical, dental and vision expenses.	Eligible qualified dental and vision expenses, and out-of-pocket eligible medical expenses after your deductible is met.
Can I use an account debit card?	Yes — HealthEquity Visa Card	Yes — HealthEquity Visa Card
What is the maximum amount an employee can elect annually?	$3,200 general purpose or LP-FSA	
Can I be enrolled in both accounts at the same time?	You cannot be actively enrolled in an LP-FSA if you're enrolled in a general-purpose FSA at the same time.	You cannot be actively enrolled in a general-purpose FSA if you are enrolled in the LP-FSA at the same time.
Does "use it or lose it" apply?	The IRS allows employees with a health care FLEX account to roll over up to $640 of their unused funds to the next plan year. This changed the "use it or lose it" rule which previously required you spend all of your funds before the end of the plan year or you lost the money you saved. Whether you enroll in the general purpose FLEX account or the LP-FLEX account, and regardless if the contribution is from you or your employer, a combined total up to $640 of unused funds will automatically roll over for use in the next plan year. Automatic rollover will occur after the run-out period, which ends April 30.	

Managing your account

Visit **healthequity.com** and use your HealthEquity credentials to sign in and manage your accounts online.

- Check debit card status
- File a claim
- Upload claim substantiation
- Review your account(s)
- Download forms
- Learn more about the plan

FSAs are ONLY for those eligible claims incurred by you or your dependents for federal income-tax purposes, without regard to income limitations. Claims must be submitted within 1 year of the date of service. Contact your tax or financial advisor for information about your specific situation.

To mail or fax in an FSA claim

Use the claim form available on **healthequity.com** and mail to the address indicated on the form.

Dependent care FSA

This account primarily benefits those with a qualifying child (under age 13) or qualifying dependent by reimbursing eligible daycare expenses to allow a parent to work or attend school. This account is NOT for reimbursement of dependent health care expenses. The annual dependent care FSA maximum annual election is $5,000 (married and filing a joint tax return) or $2,500 (single or married and filing a separate tax return).

Customer service

Call HealthEquity customer service 24/7 at **844-396-0226** for help with a variety of topics:

- Activating a new card
- Reporting a lost or stolen card and requesting card deactivation and/or a new card
- Checking account balance information and card transaction history
- Reporting fraud
- Disputing card transactions up to 90 days from date of charge

Find Better Care with Provider Finder®

Connecting you to high quality, cost-effective care

BCBSTX is making it simpler than ever to find the right provider at the best price. The latest update to Provider Finder uses leading-edge data evaluation techniques to measure the care delivered by physicians.

Primary care physicians and many specialists* are compared to their peers on three main measures of health care standards.

Quality of patient care: Holding physicians accountable for doing the right things for their patients, and doing them well.

Medical appropriateness: Comparing how well physicians follow clinical guidelines and making sure they are not giving patients low-value care.

Cost efficiency: Looking at the whole episode of care that physicians give their patients and comparing the cost of service versus national benchmarks.

Physician quality impacts cost of care

People diagnosed with colon cancer found by a colonoscopy had 70% lower total costs than those whose cancer was found when they had symptoms.

On average, women who received a screening mammogram that detected breast cancer had 27% lower outpatient costs than those who had cancer detected when they became symptomatic.

Find top performing physicians on Provider Finder

Top performing physicians are shown on the Provider Finder platform with an icon and a hover-over key explaining that "the top performing physician" designation highlights physicians who are highly rated for quality, cost-efficient care and appropriate treatment plans.

The Provider Profile pages will show a physician's performance scores on quality of patient care, medical appropriateness and cost efficiency. You can reach Provider Finder at **bcbstx.com** under the **Find Care** tab.

Provider Finder from BCBSTX helps you to quickly find in-network physicians, medical groups, hospitals, pharmacies and urgent care. You can search for physicians using ZIP code, gender, specialty, languages spoken and other factors. Through Provider Finder, you can read or share physician reviews and view clinical certifications and recognitions, as well as quality awards, for physicians.

*Not all specialties are part of this program

PEAQ℠-related information is not presently available in Provider Finder any HMO networks. PEAQ-related information may not yet be available with respect to Texas-based physicians

To view top performing physicians you can use Provider Finder or, for best results, log in to or make a Blue Access for Members account at **bcbstx.com**.

Mental health support

Sometimes a little extra help can go a long way. Your benefits include behavioral health support provided by BCBSTX, with some resources that can be accessed right at home. From everyday challenges to more serious issues, support is on your side.

To view information on your mental health benefits coverage, search for a provider or access online resources, log into Blue Access for Members at **bcbstx.com** and click on **Healthy Living** and **Digital Mental Health**

Learn to Live

Learn to Live is a behavioral health digital platform which offers condition-specific programs, each delivered in a user-paced multimedia experience. Services are also available on demand with the options for one-to-one clinician coaching services. Go to **learntolive.com/welcome/bcbstx** and enter access code **BETTERME** to get started.

Virtual Visits – powered by MDLIVE®

Get care when and where you need it through MDLIVE – available 24 hours a day, seven days a week, 365 days a year. Behavioral health services are included. Visit **mdlive.com/bcbstx** for more information and to activate your account.

These services and programs are for informational purposes only and should not be used for emergency or urgent care needs. In an emergency, call **911** or go to the nearest emergency room. This content is for informational and/or educational purposes only. It is not meant to be used in place of professional clinical consultations for individual health needs. Certain treatments may not be covered in some benefit plans.

If you are in crisis, call the national suicide prevention lifeline at **1-800-273-TALK (8255)** or call **911** if you feel you are in immediate danger.

Virtual Visits may be limited by plan. For providers licensed in New Mexico and the District of Columbia, Urgent Care service is limited to interactive online video; Behavioral Health service requires video for the initial visit but may use video or audio for follow-up visits, based on the provider's clinical judgment. Behavioral Health is not available on all plans.

MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Employee Assistance Program

Find professional support when you need it for challenging life events.

ComPsych GuidanceResources is an Employee Assistance Program (EAP) included with your BCBSTX plan. You and your family members have access to a suite of EAP services including up to five free therapy sessions per issue. Once you've used these free sessions, you can transition to your BCBSTX network benefits and keep seeing the same therapist in most cases. You will be responsible for copay and additional charges after the five sessions per issue.

Connect with the EAP!

Don't be afraid to reach out for help. Your personal records are kept private from your employer, as required by law.

- Call: **844-213-8968**
- Online: **guidanceresources.com**
- App: **GuidanceNow**
- Web ID: **BCBSTXEAP**

Make a positive change

Connect with a therapist for confidential emotional support. A trained mental health professional can counsel you through a variety of concerns, such as:

- Sadness, worry and stress
- Alcohol or drug use
- Grief, loss and personal struggles
- Personal relationship issues

Check off your to-dos

ComPsych GuidanceResources specialists can save you time by searching for local, professional services so you don't have to. They can help you find:

- Child, elder or pet care
- Movers or home repair services
- And much more

Have your legal questions answered

Talk to an attorney for help with legal questions, including:

- Divorce, adoption and family law
- Wills and trusts
- Landlord/tenant issues

Get help with your finances

Financial experts can help with a wide range of money matters, including:

- Retirement planning or taxes
- Budgeting, debt or bankruptcy

Access online tools 24/7

The ComPsych GuidanceResources website and mobile app provide information and support whenever you need it. Log on for:

- Articles, podcasts, videos and slideshows
- On-demand trainings
- "Ask the Expert" responses to your questions
- Other self-service tools

DISCLAIMER: ComPsych Corp. is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide employee assistance services for members with coverage through BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

PPO plan quick reference guide

Refer to plan documents for limitations and additional information.

PPO Medical Plan		
Feature	Your network cost	Your out-of-network cost PLUS you pay charges exceeding plan payment
Annual deductible	$500 individual/$1,000 family	$1,000 each person
Coinsurance (after the annual deductible is met)	20% after deductible	40% after deductible
Annual coinsurance maximum	$2,500 individual/$5,000 family	No limit
Annual out-of-pocket maximum (OOP)	$3,000 individual/$6,000 family Plan pays 100% after annual OOP	No limit
Physician services		
Office visits	$25 primary care physician (PCP) $35 specialist ($25 for tier one PEAQ specialist)[1]	40% after deductible
24/7 Virtual Visits (MDLIVE)	$0 copay	40% after deductible
Telehealth	$25 PCP $35 specialist	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visit	$35 copay	40% after deductible
Preventive care[2]		
Well-child care	Covered at 100%	40% after deductible
Well-woman exam	Covered at 100%	40% after deductible
Routine screening mammography	Covered at 100%	40% after deductible
Adult health assessments	Covered at 100%	40% after deductible
Immunizations	Covered at 100%	40% after deductible
Screening colonoscopy	Covered at 100%	40% after deductible
Maternity services		
Routine prenatal care	Covered at 100%	40% after deductible
Delivery in hospital	20% after deductible	40% after deductible
Newborn care in hospital (routine)	20% after deductible	40% after deductible
Infertility services: 5 artificial insemination visits (lifetime)	20% after deductible (excludes in vitro and drug coverage)	40% after deductible (excludes in vitro and drug coverage)
Additional services		
Inpatient hospital	20% after deductible	40% after deductible
Outpatient surgery	20% after deductible	40% after deductible
Lab & X-ray outpatient (minor)	Covered at 100% in physician office or network lab or radiological provider	40% after deductible
Hospital emergency care services (treated as network)	$300 copay + 20% after deductible; copay waived if admitted	$300 copay + 20% after deductible; copay waived if admitted
Skilled nursing facility	20% after deductible; up to 60 days annually[2]	40% after deductible; up to 60 days annually[2]
Home health care	20% after deductible; up to 120 visits annually[2]	40% after deductible; up to 120 visits annually[2]
Allergy care services	$25 PCP $35 specialist	40% after deductible
Chiropractic	$35 copay per visit; maximum 20 visits per year[2]	40% after deductible; maximum 20 visits per year[2]
Medical supply & equipment (DME)	20% after deductible	40% after deductible
Mental health services		
Outpatient visits	$25 visit	40% after deductible
Inpatient	20% after deductible	40% after deductible
Serious mental illness	Treated like any other illness	Treated like any other illness
Substance abuse	Treated like any other illness	Treated like any other illness

1. PEAQ refers to Physician Efficiency Appropriateness Quality score.
2. Subject to Affordable Care Act requirements.

HDP quick-reference guide

Refer to plan documents for limitations and additional information.

HDP Medical Plan		
Feature	Your network cost	Your out-of-network cost PLUS you pay charges exceeding plan payment
Annual deductible	$1,650 individual/$3,300 family	$3,000 individual/$6,000 family
Coinsurance (after the annual deductible is met)	20% after deductible	40% after deductible
Annual coinsurance maximum	$1,350 individual/$2,700 family	No limit
Annual out-of-pocket maximum	$3,000 individual/$6,000 family Plan pays 100% after annual OOP	No limit
Physician services		
Office visits	20% after deductible	40% after deductible
24/7 Virtual Visits (MDLIVE)	20% after deductible	40% after deductible
Telehealth	20% after deductible	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visit	20% after deductible	40% after deductible
Preventive care*		
Well-child care	Covered at 100%	40% after deductible
Well-woman exam	Covered at 100%	40% after deductible
Routine screening mammography	Covered at 100%	40% after deductible
Adult health assessments	Covered at 100%	40% after deductible
Immunizations	Covered at 100%	40% after deductible
Screening colonoscopy	Covered at 100%	40% after deductible
Maternity services		
Routine prenatal care	Covered at 100%	40% after deductible
Delivery in hospital	20% after deductible	40% after deductible
Newborn care in hospital (routine)	20% after deductible	40% after deductible
Infertility services: 5 artificial insemination visits (lifetime)	20% after deductible (excludes in vitro and drug coverage)	40% after deductible (excludes in vitro and drug coverage)
Additional services		
Inpatient hospital	20% after deductible	40% after deductible
Outpatient surgery	20% after deductible	40% after deductible
Lab & X-ray outpatient (minor)	20% after deductible	40% after deductible
Hospital emergency care services (treated as network)	20% after deductible	20% after deductible
Skilled nursing facility	20% after deductible; up to 60 days annually*	40% after deductible; up to 60 days annually*
Home health care	20% after deductible; up to 120 visits annually*	40% after deductible; up to 120 visits annually*
Allergy care services	20% after deductible	40% after deductible
Chiropractic	20% after deductible; maximum 20 visits per year*	40% after deductible; maximum 20 visits per year*
Medical supply & equipment (DME)	20% after deductible	40% after deductible
Mental health services		
Outpatient visits	20% after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible
Serious mental illness	Treated like any other illness	Treated like any other illness
Substance abuse	Treated like any other illness	Treated like any other illness

*Subject to Affordable Care Act requirements.

A home delivery (mail order) pharmacy service you can trust

Express Scripts® Pharmacy delivers your long-term (or maintenance) medicines right where you want them. No driving to the pharmacy. No waiting in line for your prescriptions to be filled.

Savings and convenience

- Express Scripts® Pharmacy delivers up to a 90-day supply of long-term medicines.[1]
- Prescriptions are delivered to the address of your choice, within the U.S., with free standard shipping.
- You can order from the comfort of your home — through your mobile device, online or over the phone. Your doctor can fax, call or send your prescription electronically to Express Scripts® Pharmacy.
- Tamper-evident, unmarked packaging protects your privacy.

Support and service

- You can receive notices by phone, email or text — your choice — when your orders are placed and shipped. You will be contacted, if needed, to complete your order. To select your notice preference, register online at **express-scripts.com/rx** or call **833-715-0942**.
- 24/7 access to a team of knowledgeable pharmacists and support staff.
- You can choose to receive refill reminder notices by phone or email.
- Multiple pharmacy locations across the U.S., for fast processing and dispensing.

5

Medicines may take up to five business days to deliver after Express Scripts Pharmacy receives and verifies your order.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Getting Started with Express Scripts® Pharmacy Mail Order

Online and mobile

You have more than one option to fill or refill a prescription online or from a mobile device:

- Visit **express-scripts.com/rx.** Follow the instructions to register and create a profile. See your active prescriptions and/or send your refill order.
- Log in to **myprime.com** and follow the links to Express Scripts® Pharmacy.

Over the phone

Call **833-715-0942**, 24/7, to get started with mail order, transfer a current prescription or to refill. Please have your member ID card, prescription information and your doctor's contact information ready.

Through the mail

To send a prescription order through the mail, visit **bcbstx.com** and log in to Blue Access for Members. Complete the mail order form. Mail your prescription, completed order form and payment to Express Scripts® Pharmacy.

Talk to your doctor

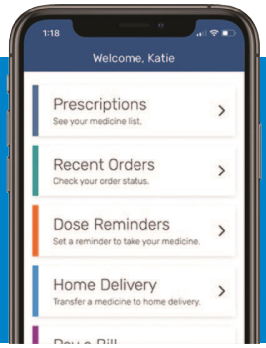
Ask your doctor for a prescription for up to a 90-day supply of each of your long-term medicines.[1] You can ask your doctor to send your prescription electronically to Express Scripts® Pharmacy, call **888-327-9791** for faxing instructions or call the pharmacy at **833-715-0942**. If you need to start your medicine right away, request a prescription for up to a one-month supply you can fill at a local retail pharmacy.

Refills are easy

Refill dates are shown on each prescription label. You can choose to have Express Scripts® Pharmacy remind you by phone or email when a refill is due. Choose the reminder option that best suits you.

Questions?

Visit **bcbstx.com**. Or call the phone number listed on your member ID card.



Use the mobile app to manage your prescriptions

- Refill prescriptions
- Track your order
- Make payments
- Set reminders to take medicines and more

1. Prescriptions of up to a 90-day supply, or the most amount allowed by the benefit plan.

Express Scripts® Pharmacy is a pharmacy that is contracted to provide mail pharmacy services to members of Texas. The relationship between Express Scripts® Pharmacy and Blue Cross and Blue Shield of Texas is that of independent contractors. Express Scripts® Pharmacy is a trademark of Express Scripts Strategic Development, Inc.

Prime Therapeutics LLC is a pharmacy benefit management company, contracted by BCBSTX to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics LLC. MyPrime.com is an online resource offered by Prime Therapeutics, LLC.

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Saving money on specialty medications

Blue Cross and Blue Shield of Texas supports members who need self-administered specialty medication and helps them manage their therapy. Accredo® is the specialty pharmacy chosen to do just that.[1]

Specialty drugs are often prescribed to treat complex and/or chronic conditions, such as multiple sclerosis, hepatitis C and rheumatoid arthritis.

Specialty drugs often call for carefully following a treatment plan (or taking them on a strict schedule). These medications have special handling or storage needs and may only be stocked by select pharmacies.

Some specialty drugs must be given by a health care professional, while others are approved by the FDA for self-administration (given by yourself or a care giver). Medications that call for administration by a professional are often covered under your medical benefit plan. Your doctor will order these medications. Coverage for self-administered specialty drugs is usually provided through your pharmacy benefit plan. Your doctor should write or call in a prescription for self-administered specialty drugs to be filled by a specialty pharmacy.

Your plan may require you to get your self-administered specialty drugs through Accredo or another in-network pharmacy. If you do not use these pharmacies, you may pay higher out-of-pocket costs.[2] Your doctor may also order select specialty drugs that must be given to you by a health professional through Accredo.

Do You Need Specialty Medications?

Examples of self-administered specialty medications

This chart shows some conditions self-administered specialty drugs may be used to treat, along with sample medications. This is not a complete list and may change from time to time. Visit **bcbstx.com** to see the up-to-date list of specialty drugs.

Condition	Sample Medications[3]
Autoimmune disorders	Cosentyx, Enbrel, Humira, Xeljanz
Osteoporosis	Forteo, Tymlos
Cancer (oral)	Gleevec, Nexavar, Sprycel, Sutent, Tarceva
Growth hormones	Norditropin Flexpro, Nutropin AQ, Omnitrope
Hepatitis C	Daklinza, Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi
Multiple sclerosis	Betaseron, Copaxone, Rebif

Support in managing your condition: Accredo

Accredo carries roughly 99% of specialty drugs, which means you're more likely to get all of your specialty drugs from one pharmacy. Through Accredo, you can have your covered, self-administered specialty drugs delivered straight to you. When you get your specialty drugs through Accredo, you get:

- One-on-one counseling from 500+ condition-specific pharmacists and 600+ nurses
- Simple communication, including refill reminders, by your choice of phone, email, text or web[4]
- An online member website to order refills, check order status and track shipments, view order and medication history, set profile preferences and learn more about your condition
- A mobile app that lets you refill and track prescriptions, make payments and set reminders to take your medicine[4]
- Free standard shipping
- 24/7 support

Ordering through Accredo

You can order a new prescription or transfer your existing prescription for a self-administered specialty drug to Accredo. **To start using Accredo, call 833-721-1619.** An Accredo representative will work with your doctor on the rest.

Once registered, you can manage your prescriptions on **accredo.com** or through the mobile app.

Receiving specialty medications

Since many specialty drugs have unique shipping or handling needs, shipments will be arranged with you through Accredo. Medications are shipped in plain, secure, tamper-evident packaging.

Before your scheduled fill date, you will be contacted to:

- Confirm your drugs, dose and the delivery location
- Check any prescription changes your doctor may have ordered[5]
- Discuss any changes in your condition or answer any questions about your health[5]

One-on-one support

Accredo has 15 Therapeutic Resource Centers® (TRCs), each focused on a specific specialty condition. Through your one-on-one counseling sessions, they'll discuss how to reduce your disease progression and achieve your treatment goals, manage any side effects from your drugs, help you stick to your regimen and monitor your progress. They can also offer support with any financial or insurance concerns you may have.

Certain coverage exclusions and limits may apply, based on your health plan. For some medicines, members must meet certain criteria before prescription drug benefit coverage may be approved. Check your benefit materials for details, or call the customer service number listed on your ID card with questions.

1. Blue Cross and Blue Shield of Texas (BCBSTX) contracts with Prime Therapeutics to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.
2. The BCBSTX specialty pharmacy network includes Accredo as well as other in-network specialty pharmacies for select specialty drugs. Based on the benefit plan, members may be responsible for the full cost of the specialty drug for not using an in-network specialty pharmacy. You can log in to your Blue Access for Members℠ (BAM℠) account to find an in-network specialty pharmacy near you.
3. Third-party brand names are the property of their respective owners.
4. Not all medicines can be refilled on the app, by text or email.
5. Treatment decisions are between you and your doctor.

Accredo is contracted to provide services for BCBSTX. Accredo is a trademark of Express Scripts Strategic Development, Inc.

Pharmacy access options Refills allowed as prescribed	PPO plan	HDP
Retail up to a 30-day supply	$15 generic $30 preferred brand $60 non-preferred brand	• For retail and home delivery pharmacy, you will pay 100% of the cost until you meet your deductible. • After deductible, you pay 20% of the cost until the network OOP is met. • After network OOP, plan pays 100%.
Retail up to a 90-day supply	$30 generic $60 preferred brand $120 non-preferred brand	
Mail order pharmacy up to a 90-day supply	$30 generic $60 preferred brand $120 non-preferred brand	
Specialty pharmacy up to a 30-day supply	$10 generic $20 preferred brand $40 non-preferred brand	

No-additional-cost contraceptive services (prescription required)

The medical or pharmacy benefit plan covers certain contraceptives at no additional cost to you, when you use a network doctor or pharmacy. Pharmacies can be retail or home delivery. This includes generic contraceptives and some brand-name drugs in certain cases. Not all drugs or services are covered. If you have questions, call the number on your ID card.

Your plan covers the following methods:

- Hormonal methods, like birth control pills, patches, vaginal rings and injections
- Barrier methods, like diaphragms and cervical caps (covered under medical)
- Over-the-counter barrier methods (male and female condoms, spermicides and sponges, when prescribed by a doctor)
- Intrauterine contraceptives (Kyleena, Mirena®) (covered under medical)
- Implantable medications (Nexplanon) (covered under medical)
- Emergency contraceptives (Plan B, ella®)

Preventive drugs

Your health plan includes other drugs often used for preventive care at no additional cost to you when you use a pharmacy or doctor in your plan's network. Age limits, restrictions and other requirements may apply.

Examples of some drugs that may be covered are:

- aspirin
- bowel prep for a colonoscopy
- breast cancer primary prevention
- fluoride, folic acid and iron supplements
- HIV prevention
- single agent statins
- smoking cessation
- vaccines

Enhancing well-being with vision and dental benefits

Vision benefits

Vision benefits are available through VSP®. It's easy to find a nearby network doctor. Get the most from your coverage with bonus offers and savings that are exclusive to Premier Program locations — including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

Create an account on **vsp.com** to learn more about your vision benefits and find an eye doctor near you.

To learn more about your vision benefits and find an eye doctor near you, create an account at vsp.com.

Exclusions and limitations

Some brands of spectacle frames may be unavailable for purchase as plan benefits, or may be subject to additional limitations. Covered persons may obtain details regarding frame brand availability from their VSP member doctor or by calling VSP's Customer Care Division at **800-877-7195**.

NOT COVERED

- Services and/or materials not specifically included in this schedule as covered plan benefits
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Suncare enhancement, if purchased by client
- Two pairs of glasses instead of bifocals
- Replacement of lenses, frames and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when plan benefits are otherwise available
- Orthoptics or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Replacement of lost or damaged contact lenses, except at normal intervals when services are otherwise available
- Contact lens modification, polishing or cleaning
- Local, state and/or federal taxes, except where VSP is required by law to pay
- Services associated with corneal refractive therapy (CRT) or orthokeratology

VSP Advantage Plan

	High option		Low option for Denton County only	
	Network	Non-network reimbursement	Network	Non-network reimbursement
Vision exam	$10	Up to $43	$10	Up to $43
Eyeglass lenses				
Single vision	$20	Up to $30	$25	Up to $30
Bifocal	$20	Up to $45	$25	Up to $45
Trifocal	$20	Up to $62	$25	Up to $62
Lenticular	$20	Up to $100	$25	Up to $100
Standard progressive lenses	$20	Up to $45	$25	Up to $45
Frames*	$200 allowance; 20% off balance over $200 $250 at Visionworks	Up to $40	$150 allowance; 20% off balance over $150 $200 at Visionworks	Up to $40
Contact lenses**	Frames and contacts BOTH available in same plan year in lieu of eyeglass lenses (12/12/12 frequency)		Contacts in lieu of glasses (12/12/24 frequency)	
Non-elective	Covered at 100%	Up to $210	Covered at 100%	Up to $210
Elective	$200 allowance; not to exceed $40 copay for contact lens exam	Up to $185	$150 allowance; not to exceed $40 copay for contact lens exam	Up to $135
Service frequency				
Exams	12 months	12 months	12 months	12 months
Prescription lenses	12 months	12 months	12 months	12 months
Frames	12 months	12 months	24 months	24 months
Contact lenses	12 months	12 months	12 months	12 months
Laser care	Average 15% off the regular price or 5% off the promotional price		Average 15% off the regular price or 5% off the promotional price	

*NOT in lieu of contacts on 12/12/12 High option; ARE in lieu of contacts on 12/12/24 Low option.

**In lieu of only eyeglass lenses on 12/12/12 High option; frames and contacts available; Low option alternative 12/12/24 — contacts are in lieu of glasses.

Dental benefits

For 2025, you can choose between the DeltaCare USA (DHMO) and the Delta Dental PPO plans.

Delta Dental HMO Plan (DeltaCare USA DHMO)

The DHMO plan offers a wide range of dental benefits through a network of participating dentists. Your DeltaCare USA plan is a copayment plan available in AL, MO, OK, OR, TN, TX and WI.

With your DeltaCare USA DHMO plan, some preventive services are covered at 100%. Your plan also covers many other dental services at a set copay. **There are no annual maximums and no deductibles.**

Procedure	Copayment
Office visit	$0 per visit — office visit fee (per patient, per office visit in addition to any other applicable patient charges)
Preventive services	$0 exams $10 sealant permanent molars (per tooth) $0 X-rays
Crowns	$160–$380 — titanium
Orthodontics	$1,150–$1,900 — child $2,100 — adult
Root canals	$110–$350
Extractions	$50–$130
General anesthesia	$80

When you enroll in DeltaCare USA DHMO:

- Delta Dental will assign a primary care dentist based on your ZIP code
- You will receive welcome materials that include a welcome letter with your assigned dentist, plan booklet and ID card
- You can request a change to your primary care dentist at anytime. Simply visit our website and log on to your online account or contact customer service. Change requests received by the 21st of the month will be effective the first day of the following month.
- Each family member can select his or her own primary care network dentist
- Refer to your evidence of coverage/plan booklet for the full copayment schedule
- You must visit your primary dentist to receive benefits

See which network is right for you:

1. Go to **deltadentalins.com** and click **Find a dentist** at the top of the screen.
2. Enter your ZIP code and select the network based on the dental plan you chose.
3. For DeltaCare USA DHMO — select "DeltaCare USA."
4. For DPPO — select "Delta Dental PPO."
5. Click on "Find a Dentist."

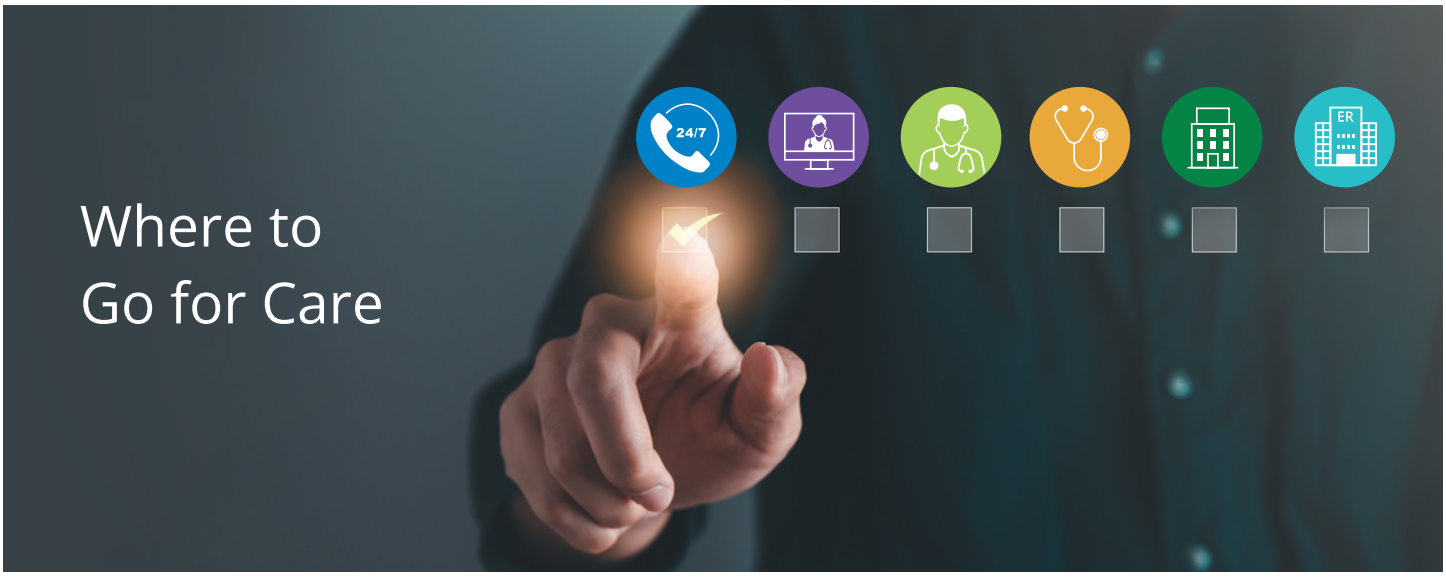
Delta Dental PPO Plan (Delta Dental DPPO)

Visit a dentist in the PPO network to maximize your savings. Network dentists have agreed to reduced fees and you won't get charged more than your expected share of the bill. If you cannot find a PPO network dentist, then Delta Dental Premier is your next-best option. Under this plan, you have freedom to visit any licensed dentist or specialist without a referral, however, Delta Dental dentists offer cost protections and convenient services. The Dental PPO plan offers access to Delta Dental dentists and out-of-network benefits.

Procedure	Network	Out-of-network
Deductible (per person) Annual maximum benefit (per person)*	$50 (maximum of $150) $2,000	$50 (maximum of $150) $2,000
Preventive • 2 cleanings per calendar year • 2 exams per calendar year • 2 fluoride treatments per calendar year for dependent children under age 19 • Full mouth X-rays: 1 per 60 months • Bitewing X-rays: 1 set per calendar year for adults; 2 per calendar year per child to age 18	100%, no deductible	100%, no deductible
Basic restorative • Fillings • Extractions • Oral surgery • Periodontal treatment • Endodontics: Root canal • General anesthesia: In conjunction with covered oral surgery, and select endodontic and periodontic procedures	80% after deductible	80% after deductible
Major restorative • Benefits begin after 6 months of coverage • Crowns • Denture and bridges • Implants	50% after deductible	50% after deductible
Orthodontia Benefits begin after 12 months of coverage; orthodontic lifetime deductible and maximum (per person)	50% after lifetime deductible $1,750	50% after lifetime deductible $1,750

* Diagnostic and preventive services do not count toward the annual maximum

Getting the right care at the right time



What do you do if your clutch player breaks an arm in the big game? Or you slice your finger chopping veggies? Or have stomach cramps after last night's sushi date? Often the choice is clear. If you have signs of a heart attack, it's best to go to the emergency room. But what if you have a sore throat? Or lower back pain?

Knowing where to go can make a big difference in the cost of your care – especially when you use in-network providers.

We make it easy to find independently contracted, in-network providers near you:

- Go to **bcbstx.com** and click **Find Care**
- For personalized search results, go to **bcbstx.com**, click **Log In or Sign Up**, choose **Member Log In or Sign Up** and search in Blue Access for Members
- Call BCBSTX Customer Service at the number on your ID card

24/7 Nurseline[1]

Wonder if your heartburn needs an antacid or trip to the ER? Is your child's fever 102 degrees? Confused about a health test? Talk confidentially with a registered nurse in English or Spanish — anytime. Call **800-581-0393**.

Good for: health questions and health advice
Average Wait: none
Cost: none

Virtual Visits[2]

Do you have an itchy rash or sinus problems? Fighting a fever? Talk with a doctor — 24/7. Online appointments via MDLIVE® put care at your fingertips. Call **888-680-8646** or go to **MDLIVE.com/bcbstx**.

Good for: health exams, colds, flu, minor injuries
Average Wait: less than 20 minutes
Cost: in network **$**

Doctor

Is your blood pressure high? Are allergies making you miserable? Can't sleep? Your go-to provider is a good place to start. Some even offer telemedicine. If you need a specialist, your doctor will tell you.

Good for: health exams, shots, cough, sore throat
Average Wait: less than 20 minutes[3]
Cost: in network **$** out of network **$$**

Retail Health Clinic

Need a flu shot? Feel queasy? Have an earache or rash? Many grocery stores and pharmacies have on-site medical clinics. Some may even see patients evenings, weekends and holidays.

Good for: headache, stomach ache, sinus pain
Average Wait: variable
Cost: in network **$** out of network **$$**

Urgent Care Center[4]

Sprain your ankle? Have a monster migraine? Can't stop coughing? Need non-emergency care right away, but your doctor's office isn't open? These centers offer care evenings, weekends and holidays.

Good for: back pain, vomiting, animal bite, asthma
Average Wait: 30 minutes or less[5]
Cost: in network **$$** out of network **$$$**

Hospital ER

Worried you may be having a heart attack? Did you black out after a nasty fall? ER doctors and staff treat serious and life-threatening health issues 24/7. If you receive ER care from an out-of-network provider, you may have to pay more.

Good for: chest pain, bleeding, broken bones
Average Wait: 1 hour or more[6]
Cost: in network **$$$** out of network **$$$$**

Know the Difference: Freestanding ER vs. Urgent Care Center

Freestanding ERs look a lot like urgent care centers, but may not be affiliated with an in-network hospital. That means you could end up with a hefty bill (or several bills). You might even be sent to a hospital ER for care! Here are ways to spot a freestanding ER:

1. Look for "Emergency" on the building exterior.
2. Check the hours. If it's open 24/7, it's a freestanding ER. Urgent care centers close at night.
3. Confirm it's not connected to a hospital.
4. Ask if it follows the copay, coinsurance and deductible payment model.

If you need emergency care, call 911 or seek help from any doctor or hospital immediately.

Note: Many sites of care now offer telehealth options for your visit. Check with your preferred provider to see if they offer telehealth visits.

1. 24/7 Nurseline is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.
2. Virtual Visits may be limited by plan. For providers licensed in New Mexico and the District of Columbia, Urgent Care service is limited to interactive online video; Behavioral Health service requires video for the initial visit but may use video or audio for follow-up visits, based on the provider's clinical judgment. Behavioral Health is not available on all plans.
   MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.
3. Vitals Annual Wait Time Report, 2017.
4. The closest urgent care center may not be in your network. Be sure to check Provider Finder® to make sure the center you go to is in-network.
5. Wait Time Trends in Urgent Care and Their Impact on Patient Satisfaction, 2017.
6. National Center for Health Statistics, Centers for Disease Control and Prevention, 2019.

Information provided in this flier is not intended as medical advice, nor meant to be a substitute for the individual medical judgment of a doctor or other health care professional. Please check with your doctor for individualized advice on the information provided. Coverage may vary depending on your specific benefit plan and use of network providers. For questions, please call the number on your member ID card.

Emergencies outside the U.S.

Through the Blue Cross Blue Shield Global Core® program, you have access to hospitals on almost every continent and to a broad range of assistance services when you travel or live outside the United States. Blue Cross Blue Shield Global Core provides the following services:

- Provider location
- Referral information
- Medical monitoring
- Wire transfers/overseas mailing
- Translation
- Coverage verification
- Currency conversion

If you need to locate a doctor, other provider or hospital, or need medical assistance, call the service center at **800-810-BLUE (2583)** or call collect at **804-673-1177**, 24 hours a day, seven days a week. A medical assistance coordinator, in conjunction with a medical professional, will arrange hospitalization, if necessary. Network benefits will apply for inpatient care at Blue Cross Blue Shield Global Core hospitals.

In an emergency, go directly to the nearest hospital.

Preventive care

Both the PPO plan and HDP cover preventive care at 100% as long as services are performed by a network provider. Preventive care services may include physical examinations, immunizations, laboratory tests and other types of screening tests. To see which preventive care services may be right for you, visit **pebcinfo.com**.

Preventive care vs. diagnostic care

During a preventive care visit, if you discuss symptoms or treatment of a health concern, your visit will become diagnostic. For diagnostic care, you may be charged a copay, coinsurance or deductible. Discuss all of your health concerns with your provider but be aware that you will be billed based on the type of visit — preventive or diagnostic. Examples of diagnostic care may include:

- Medical treatment for specific health issues or conditions
- Ongoing care for a health condition
- Lab tests or other screenings necessary to diagnose, manage or treat an identified health issue

Preventive services covered at no extra cost

Covered preventive services are based on the recommendations of the United States Preventive Services Task Force (USPSTF), the U.S. Department of Health and Human Services, the Advisory Committee on Immunization Practices (ACIP) of the CDC and the HRSA Guidelines for women and children, including the American Academy of Pediatrics Bright Futures periodicity guidelines.

Contraception, prenatal and breastfeeding

The plan covers, at no additional cost to you, at least one form of contraception in each of the 18 methods identified and approved by the FDA, including necessary clinical services, patient education and counseling. Certain prenatal and breastfeeding supplies and services are also covered. To view a summary of covered preventive services, visit **pebcinfo.com**.

Flu shots and vaccines

Flu shots and many other vaccines are available to you at no extra cost. Age-appropriate immunizations are available at many retail pharmacy locations. Always ask the pharmacist to check your plan coverage before the immunization is administered to make sure the immunization is covered.

Retail pharmacy vaccines

Your pharmacy benefits will cover many vaccines under the 100% preventive benefit when administered at a participating retail pharmacy. Example participating pharmacies include CVS, Walgreens, Tom Thumb, Kroger, Albertson's and Wal-Mart. While flu shots do not require a prescription, other vaccines may require a prescription.

Covered vaccines include:

- Flu
- Childhood diseases (MMR, etc.)
- COVID-19
- Hepatitis B
- Meningitis
- Pneumonia
- Rabies*
- Tdap (whooping cough)
- Tetanus booster
- Travel vaccines*
- Zoster (shingles)

* Additional cost may apply.

IMPORTANT: Always check before you receive an immunization at the retail pharmacy to make sure you know how much your immunization will cost. The list of available pharmacies is subject to change.

Additional programs available to you

Ovia Health: A digital support program

Ovia Health provides maternity and family apps to support you through the entire parenthood journey. These apps are included in your health plan, offered through BCBSTX.

With Ovia, you'll have access to enhanced, personalized health and wellness features:

- Health assessment and symptom tracking; receive alerts and predictive, personal coaching when Ovia detects a potential medical issue
- More than fifty physician-developed clinical programs to help you be as healthy as possible; engage with personalized health and wellness programs to help you navigate infertility, sexual health, birth planning, preterm delivery, mental health, breastfeeding and more
- Unlimited one-on-one coaching; message a health coaches to ask all your questions
- Career and return-to-work programs; find coaching and career advice about preparing for maternity leave, returning to work and being a working parent

Download the app that's right for you:

- **Ovia** – Reproductive Health, Fertility and Menopause
- **Ovia Pregnancy** – Pregnancy & Postpartum
- **Ovia Parenting** – Family & Working Parents

To create an account, choose "I have Ovia Health as a benefit" before tapping "Sign up." Select BCBSTX as your health plan and enter your employer name.

Adding newborns to benefits

Your newborn is not automatically enrolled in your medical plan. Contact your Human Resources department and complete the required enrollment paperwork to add your newborn. If you enroll your newborn within 31 days from the date of birth, coverage is effective on the date of birth. If you do not add your newborn within 31 days from the date of birth, you cannot add your newborn until the next annual enrollment period.

Diabetes Management by Teladoc® Health

Teladoc Health's Diabetes Management program is designed to help you manage your diabetes better by providing a coach who can help support your efforts. You'll get a blood glucose meter that you can use to upload your blood sugar readings.

Get access to readings, along with graphs and insights, from a mobile app and website. You'll also get unlimited, no-cost strips and lancets shipped to your door.

Hypertension Management by Teladoc Health

The Hypertension Management program from Teladoc Health offers a blood pressure monitor combined with the power of personalized coaching. Your coach can help you stabilize your blood pressure, make sense of your readings and give feedback to easily track your progress.

You'll also learn to eat healthier and discover new ways to lose weight as well as better manage your medications.

Wondr™

Wondr is a weekly, self-paced, online program that teaches you how to manage your weight and improve your health without giving up your favorite foods. Wondr is based on Eatology™, the study of when, why and how we eat. It teaches common-sense skills to help you lose weight and keep it off in the real world, which leads to feeling your best. It can also reduce your risk for serious conditions like diabetes and heart disease. For more information, visit **wondrhealth.com/pebc**.

Hinge Health

With the Hinge Health program, you'll have access to a new innovative digital program for chronic back, shoulder, neck, hip or knee pain. Use the app and wearable sensors for a personalized exercise therapy (done in your own home) that is shown to reduce pain from chronic conditions.

You'll also get unlimited one-on-one coaching to help support you.

Virtual Visits by MDLIVE

Whether you're at home or traveling, you and your covered dependents have access to 24/7 non-emergency care from a board-certified doctor or therapist through MDLIVE. The average wait time is less than 20 minutes.

Experience wellness your way

Well onTarget® gives you the tools and resources to create your personal journey — no matter where you may be on your path to wellness.

Well onTarget can give you the support you need to make healthy choices — while rewarding you for your hard work.

Take Wellness on the Go. Check out the AlwaysOn Wellness mobile app, available for iPhone® and Android™ smartphones. It can help you work on your health and wellness goals — anytime and anywhere.

Member wellness portal

The heart of Well onTarget is the member portal, available at **wellontarget.com**.* It links you to a suite of inviting programs and tools.

Health assessment[1]**:** The HA presents a series of questions to learn more about you. After you take the HA, you will get a personal and confidential wellness report. The report offers you tips for living your healthiest life. Your answers will help tailor the Well onTarget portal with the programs that may help you reach your goals. If you choose, you can share this report with your health care provider.

Self-management programs: These programs let you work at your own pace to reach your health goals. Learn more about nutrition, fitness, losing weight, quitting smoking, managing stress and more. Track your progress as you make your way through each lesson. Reach your milestones and earn Blue Points℠.[2]

Wellness coaching: Certified health coaches offer you guidance with these programs — Decrease Weight, Maintain Weight, Manage Stress, Quit Tobacco, Maintain Tobacco-Free Status, Improve Blood Pressure, Improve Cholesterol, Improve Dietary Habits and Improve Fitness Level.

- **Online wellness challenges:** Challenge yourself to meet your wellness goals. Plus, corporate challenges let you track your progress against other Well onTarget members.
- **Tools and trackers:** These resources can help keep you on course while making wellness fun. Use symptom checkers and health trackers.
- **Fitness tracking:** Track your fitness activity using popular fitness devices and mobile apps.
- **Blue Points Program:** Blue Points can help motivate you to maintain a healthy lifestyle. Earn points for participating in wellness activities. You can redeem points in the online shopping mall.[3]
- **Health and wellness content:** Reader-friendly articles about conditions and medicines.

Fitness program

Fitness can be easy, fun and affordable. The Fitness Program gives you unlimited access to a nationwide network of more than 10,000 fitness locations. You can visit locations while you're on vacation or traveling for work.

Other program perks include:

- No long-term contract: Membership is month to month. Flexible plans from $19 to $129 per month and studio classes are available.[4]
- Blue Points: Get 2,500 points for joining the Fitness Program. Earn additional points for weekly visits.
- Convenient payment: Monthly fees are paid via automatic credit card or bank account withdrawals.
- Web resources: You can go online to search for locations and track your visits.
- Complementary and Alternative Medicine: Discounts are through the Whole Health Living Choices Program, a nationwide network of 40,000 health and wellbeing providers, such as acupuncturists, massage therapists and personal trainers. When you join the Fitness Program through the Well onTarget portal, you can gain access to this program.

It's easy to join the Fitness Program! Just call the toll-free number **888-762-BLUE (2583)** Monday through Friday, between 7 a.m. and 7 p.m. CT.

Wellness Program Questions?

Call Customer Service at **877-806-9380**.

1. Well onTarget is a voluntary wellness program. Completion of the Health Assessment is not required for participation in the program.
2. Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal at wellontarget.com for further information.
3. Member agrees to comply with all applicable federal, state and local laws, including making all disclosures and paying all taxes with respect to their receipt of any reward.
4. Taxes apply. Individuals must be at least 18 years old to purchase a membership. Dependents, 16-17 years old, can join but must be accompanied to the location by a parent/guardian who is also a Fitness Program member. Check your preferred location to see their membership age policy. Underage dependents can log in and join through the primary member's account as an "additional member."

The Fitness Program is provided by Tivity Health™ Services, LLC, an independent contractor which administers the Prime® Network of fitness centers. The Prime Network is made up of independently-owned and managed fitness centers. Prime is a registered trademark of Tivity Health, Inc. Tivity Health is a trademark of Tivity Health, Inc.

AlwaysOn is owned and operated by Onlife Health Inc. an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide digital health management for members with coverage through BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

PEBC Incentive Program

Well OnTarget is a voluntary wellness program. Well OnTarget is an informational resource provided to members and is not a substitute for the independent medical judgement of a health care provider. Members are instructed to consult their health care provider before beginning their journey toward wellness. Participation in the Health Assessment is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Earning points

It's time to be rewarded for taking care of you! Complete tasks between January 1, 2025, and October 31, 2025, to earn rewards.

Category	Incentivized Activities	Maximum Completions per Year	Reward
Health Assessment	Health assessment completion – must complete to earn any incentive reward	1	75
Foundational	Biometric screening – Through Catapult, at home kit or your PCP	1	100
	Women's and family health enrollment – This is provided through Ovia	1	50
	Women's and family health postpartum assessment – This is provided through Ovia	1	50
	Virtual visits registration - Through MDLIVE	1	50
	24/7 Nurseline engagement – Call number on ID card	1	50
	Preventive screenings including: • Cervical cancer • Mammogram • Colon cancer • Bone density testing	2	50
	Annual physical	1	50
Coaching	Engagement with our clinician post-outreach (up to one interaction)	1	100
	Wellness coaching (up to 4 coaching sessions) • Manage stress • Improve fitness level • Improve dietary habits • Quit tobacco • Improve blood pressure • Improve cholesterol	4	50
	Corporate challenges – 2025 Challenges will be provided in Dec. 2024	3	25

- Active employees and their spouses enrolled in either the PPO or the HDP plan are eligible to participate in the wellness program and earn an incentive.
- Participants must first complete the health assessment through Well OnTarget in order to earn points.
- Enrolled employees can earn at least a $300 reward ($500 for NTTA) for achieving 300 points. Reward amount may vary by employer. Employee must be enrolled in the plan at the time of the reward payout.
- Enrolled spouses can earn at least $300 reward ($500 for NTTA) for achieving 300 points, so as long as the employee earned 300 points. Spouse must be enrolled in the plan at the time of the reward payout.
- Rewards are paid three times during the year based on when an employee completes 300 points individually or 600 points when participating with a spouse.
- Points are not rewarded for partially completed programs and points do not rollover to into the new plan year.

  For points earned:

  - Points earned through March 31 will be paid by May 31
  - Points earned through June 30 will be paid by August 31
  - Points earned through October 31 will be paid by December 31

Well OnTarget is a voluntary wellness program. It does not provide medical advice or other health services and is not a substitute for a doctor's care. If an employee have specific health care needs, they should consult an appropriate health care professional. For the Health Assessment, responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Supporting financial security

Life insurance and accidental death & dismemberment (AD&D)

Basic employee Term Life and AD&D (GLF); employer paid

If you are a benefits-eligible employee, your employer provides this coverage at no cost to you. Under the Basic Term Life plan, your beneficiary receives a single payment from the plan when you die. If the cause of death is due to an accident, your beneficiary is eligible for an additional AD&D insurance benefit. You could qualify to receive partial AD&D benefits if you suffer serious injuries from an accident.

Basic Life (GLF) insurance amount

Your January 1, 2025, Basic Life insurance amount is based on your annual salary on the later of either December 31, 2024, or your 2025 hire date. Basic Life and AD&D coverage varies by employer. Check with your employer to confirm the coverage amount available to you.

Optional Term Life (TLF)

Employee TLF is voluntary and is based on your annual salary times your selected coverage level. Use the Optional Rate Chart on page 35 (Column A) to calculate your monthly cost. AD&D automatically matches the elected TLF.

Optional Spouse Term Life (SLF)

The SLF coverage amount cannot exceed 50% of an employee's TLF coverage amount. During a newly hired employee's initial enrollment period, both the $10,000 and $25,000 coverage levels are available without EOI. At all other times, whether you are selecting SLF for the first time or you are increasing the SLF coverage amount, EOI is required and acceptance is not guaranteed. The employee is the beneficiary when SLF coverage is selected. Use the Optional Term Life Rate Chart on page 35 (Column B) to determine your SLF monthly cost. SLF coverage does not include AD&D.

Dependent Group Life (DGL)

Even if you selected SLF coverage, you can also select DGL coverage for your spouse and dependent child(ren). DGL provides a fixed amount of coverage for all of your dependents and does not require Evidence of Insurability (EOI). The employee is the beneficiary when DGL coverage is selected.

Evidence of Insurability (EOI)

During annual enrollment, you must complete the EOI process if you are adding or increasing SLF to $50,000 or more. The EOI process is not required if you are not requesting a change. Contact your Human Resources department for more information.

Designate a beneficiary

The Hartford's Beneficiary Designation website makes it easy to designate beneficiaries for your life insurance benefits. It's important to keep your beneficiaries updated, and you can add or change your beneficiaries at any time. A good practice is to review your beneficiary designations each year, and also when a life event occurs, such as a marriage, divorce or birth of a child.

Call **855-396-7655** or contact your Human Resources department/Benefits Office for log-in instructions.

Reduction and termination

The Life and AD&D coverage amounts you select for GLF, TLF and SLF reduce beginning at age 70 and end at employment termination or retirement, unless you elect to port or convert all or part of your optional life coverage.

Reduced % of coverage amount by age:

- To 65% at age 70
- To 40% at age 75
- To 25% at age 80
- To 15% at age 85
- To 10% at age 90

Continuing your life insurance

You can choose to either carry over or convert selected life insurance when employment ends, paying your premium directly to The Hartford. You must apply and pay your premium to The Hartford no later than 31 days after your coverage ends. Visit **pebcinfo.com** for more information about portability and conversion.

Portability

If your coverage terminates, you can continue an amount up to $250,000 of your TLF and the full amount of your SLF and DGL benefit without EOI at The Hartford's portability rates (without AD&D). Portability rates are higher than the cost available to active employees. Contact The Hartford for cost information.

Conversion

Conversion allows employees and covered dependents to convert all or part of GLF, TLF/SLF or DGL to an individual whole-life policy. Whole life costs more than group Term Life coverage. Contact The Hartford for cost information. Conversion locks you into a specific rate based on your age at the time of conversion.

Calculate your monthly premium cost worksheet

Employer-paid Term Life and AD&D (GLF)
• Coverage amount varies by employer • Minimum coverage is $20,000 regardless of salary • AD&D coverage matches Basic Term Life coverage

Employee-paid optional Term Life capped at $400,000 (TLF)	
County employees	NTTA employees
• 1/2x annual salary • 1x annual salary • 2x annual salary • Select no optional coverage (prior-year grandfathered amounts may apply)	• 1x annual salary • 2x annual salary • 3x annual salary • 4x annual salary • Select no optional coverage

Dependent optional Term Life (DGL)	
Option 1	Option 2
• $5,000 spouse • $2,500 each dependent*	• $10,000 spouse • $5,000 each dependent*

Dependents up to age 26.

Spouse optional Term Life (SLF)
SLF coverage levels:
• $10,000 • $25,000 • $50,000 • $75,000 • $100,000
SLF cannot exceed 50% of employee TLF.

Calculate monthly premium cost (TLF/SLF)

Using your annual salary on December 31, 2024, and your age on January 1, 2025, calculate your monthly TLF premium cost. To calculate your per-paycheck cost, simply multiply the monthly cost by 12 and divide by the number of 2025 payroll checks from which benefits are deducted (24 or 26).

Age	Column A* Active Employee (TLF) Includes AD&D	Column B** Spouse (SLF)
Less than 30	$.06	$.03
30–34	$.08	$.05
35–39	$.09	$.07
40–44	$.13	$.10
45–49	$.18	$.15
50–54	$.26	$.23
55–59	$.43	$.40
60–64	$.69	$.66
65–69	$1.13	$1.11
70 and over	$1.91	$1.89

* Includes AD&D of $.025/$1,000.
** AD&D not available.

County employees	
Step 1. Select coverage level (50%, 100%, 200%)	%
Step 2. Multiply annual salary at December 31, 2024, by coverage level	
Step 3. Round Step 2 amount to next $1,000	
Step 4. Divide Step 3 amount by $1,000	
Step 5. Multiply Step 4 amount by appropriate rate for your age on Jan. 1, 2025 (Optional Term Life Rate Chart, Column A)	
This is your monthly TLF premium amount	

NTTA employees	
Step 1. Annual salary at December 31, 2024, rounded up to next $1,000	
Step 2. Select coverage level (100%, 200%, 300%, 400%)	%
Step 3. Multiply Step 1 amount by Step 2 coverage amount	
Step 4. Divide Step 3 amount by $1,000	
Step 5. Multiply Step 4 amount by appropriate rate for your age on January 1, 2025 (Optional Term Life Rate Chart, Column A)	
This is your monthly TLF premium amount	

NTTA employees — Your Basic Life insurance is salary times 3, up to a maximum of $300,000. Premiums for coverage over $50,000 may result in additional taxable income to you.

Employee premiums (basic + optional) greater than $50,000 cannot be offered on a pretax basis and may result in additional taxable income to you. Life insurance coverage begins to reduce at age 70.

Tools to help you manage the details

Get the most from your health plan. Below are some other helpful resources you should know about. Take advantage of these services to get the most from your benefits.

Managing your medical claims

Medical claims

Get started by signing into BAM at **bcbstx.com/member**. You can understand your benefits and claims, find a doctor, estimate future treatment costs and much more.

Prefer mobile? The BCBSTX App provides access to these features as well.

Account balances

The account balances page shows current info on your progress toward meeting your deductible and out-of-pocket maximums. If you are enrolled in the HDP and have an HSA, your balance is also shown here.

Prescription drug claims

Manage your prescription drug claims at **myprime.com**. If you select Rx History Claims and Balances, you can view and print a prescription drug claims history by date range. The information and cost (by date range) is excellent documentation to submit for an FSA reimbursement or to document your HSA spending.

Visit **myprime.com** to check specific costs for drugs covered by your plan. You can see specialty drug information here as well.

You can also access many of the same features on BAM or connect to **myprime.com** from BAM.

Manage your specialty drug prescriptions with **accredo.com** or the mobile app.

Coordination of benefits non-duplicating plan

If you or your enrolled dependents are covered by more than one plan (such as your spouse's group plan), the plans coordinate benefits to avoid duplication of payment. This ensures your total benefit amount is no larger than the amount you would have received from the PEBC plan.

To coordinate benefits, one plan must be "primary" and pay benefits first. If you and your family are covered by only one plan, that plan is primary. Your employer plan (the HDP, PPO plan or PEBC Dental plan) is primary for you if you are an active employee, regardless of your age or your Medicare eligibility. (See Medicare rules for certain exceptions such as end-stage renal disease.) You can update your coordination of benefits information at any time by calling BCBSTX at **888-306-5753**.

If your spouse has coverage through your plan AND his or her employer's plan, your plan is primary for you and secondary for your spouse. For a child covered under both parents' plans (each parent covered under his or her own employer plan), the plan that covers the parent whose birthday comes first in the calendar year is primary. In a divorce situation, the plan of the parent with custody usually pays benefits first, unless a court order places financial responsibility on the noncustodial parent.

Subrogation requirements

Both the HDP and PPO plan have important subrogation requirements. Subrogation is the right of a party that has paid medical claims on your behalf to recover amounts paid if the beneficiary of those payments recovers funds from another source.

Well onTarget is a voluntary wellness program. Completion of the Health Assessment is not required for participation in the program.

Teladoc Health, Wondr Health, Ovia, Learn to Live and Hinge Health are independent companies that have contracted with Blue Cross and Blue Shield of Texas to provide health management solutions for members with coverage through BCBSTX.

Virtual Visits may be limited by plan. For providers licensed in New Mexico and the District of Columbia, Urgent Care service is limited to interactive online video; Behavioral Health service requires video for the initial visit but may use video or audio for follow-up visits, based on the provider's clinical judgment. Behavioral Health is not available on all plans.

MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

Message and data rates may apply. Terms, conditions and privacy policy are available at **bcbstx.com/mobile/text-messaging.**

2025 Important Notices

The following notices are intended for benefits-eligible members enrolled in a PEBC health plan for the 2025 plan year. If you are not eligible for or enrolled in a PEBC plan, the notices will not apply to you.

Contents:

Uniform Summary of Benefits and Coverage (SBC)

The Uniform Summary of Benefits and Coverage (SBC) provision of the Affordable Care Act requires all insurers and group health plans to provide consumers with an SBC to describe key plan features, including limitations and exclusions, in a mandated format. The provision also requires that consumers have access to a uniform glossary of terms commonly used in health care coverage. The PEBC SBCs are available online at **pebcinfo.com**. You can view the glossary at **healthcare.gov/SBC-glossary**. To request a copy of these documents free of charge, call the SBC Hotline at **855-756-4448**.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits group health plans and health insurance issuers from discriminating based on genetic information. In compliance with GINA, the PEBC Health Plans do not discriminate in individual eligibility, benefits or premiums based on any health factor (including genetic information). The PEBC Health Plans are prohibited from using or disclosing genetic information for underwriting purposes, and will not use or disclose any of your Protected Health Information which contains genetic information for underwriting purposes.

Medical Plan Opt Out of Certain Provisions of the Public Health Service (PHS) Act

Group health plans sponsored by state and local government employers must generally comply with federal law requirements in Title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Each of the employer groups participating in the Public Employee Benefits Cooperative of North Texas (PEBC) has elected to exempt the PPO Plan and the High Deductible Plan (HDP) from such requirements.

1. **Standards related to benefits for mothers and newborns.** Protection against limiting stays in connection with the birth of a child to less than 48 hours for a vaginal delivery and 96 hours for a cesarean section. (Newborn and Mother's Health Protection Act)
2. **Parity in the application of certain limits to mental health benefits.** Protection against having benefits for mental health and substance abuse disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
3. **Required coverage for reconstructive surgery following mastectomies.** Certain requirements to provide benefits for breast reconstruction after a mastectomy. (Women's Health & Cancer Rights Act [WHCRA]). If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician

and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was appearance;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses
- Treatment of physical complications of the mastectomy, including lyphodema.

4. **Coverage of dependent students on medically necessary leave of absence.** Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution. (Michelle's Law). The exemption from these federal requirements will be in effect for the 2025 plan year, beginning January 1, 2025, and ending December 31, 2025. The exemption may be renewed for subsequent plan years. Please note that PEBC employer groups currently voluntarily provide coverage that substantially complies with the requirements of the Newborn and Mother's Protection Act and the WHCRA.

Medicare Part D Notice of Creditable Coverage

Important notice from your employer about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage offered through your Employer's group benefit plans and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to keep only your Employer's group coverage, join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

You are receiving this notice because you may be enrolled in a health insurance plan offered by your Employer through your Employer's participation in the Public Employee Benefits Cooperative (PEBC). This notice applies to the self-funded PPO Plan and the self-funded High Deductible Plan (HDP), collectively referred to as "the PEBC Plan(s)."

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The prescription drug coverage provided by the PEBC Plans has been examined by consulting actuaries and is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage.

Because your existing PEBC Plan coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep your PEBC Plan coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) to join a Part D plan because you lost creditable coverage. In addition, if you lose or decide to leave your employer's sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your PEBC Plan coverage will not be affected. However, if you drop your PEBC Plan coverage, you and your dependents may not be able to get your PEBC Plan coverage back. If you are retired and join a Medicare drug plan, that coverage is primary and your PEBC Plan coverage is secondary.

You should also know that if you drop or lose your PEBC Plan coverage, and you don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at

least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if PEBC Plan prescription drug coverage changes. You also may request a copy from your Employer.

More information about your options under Medicare prescription drug coverage

More information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**
- Call your State Health Insurance Assistance Program for personalized help. In Texas, that number is **1-800-252-9240**
- Refer to your copy of the "Medicare & You" handbook for additional State Health Insurance Program telephone numbers
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **socialsecurity.gov**, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

KEEP THIS CREDITABLE COVERAGE NOTICE

If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

PEBC Health Plans Notice

Medicaid and the Children's Health Insurance Program (CHIP) offer free or low-cost health coverage to children and families.

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of Jan. 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: **http://myalhipp.com**

Phone: **1-855-692-5447**

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com**
Phone: **1-866-251-4861**
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – Medicaid

Website: **http://myarhipp.com**
Phone: **1-855-MyARHIPP (855-692-7447-7)**

California – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program **http://dhcs.ca.gov/hipp**
Phone: **916-445-8322**
Fax: **916-440-5676**
Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943 | State Relay 711
CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service:
1-800-359-1991 | State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com
HIBI Customer Service: **1-855-692-6442**

FLORIDA – Medicaid

Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: **1-877-357-3268**

GEORGIA – Medicaid

Website: **https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp**
Phone: **1-678-564-1162** Press **1**
GA CHIPRA website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance- program-reauthorization-act-2009-chipra**
Phone: **1-678-564-1162** Press **2**

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19–64
Website: **http://www.in.gov/fssa/hip**
Phone: **1-877-438-4479**
All other Medicaid
HIPP Website: **https://www.in.gov/medicaid/**
HIPP Phone **1-800-457-4584**

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: **https://dhs.iowa.gov/ime/members**
Medicaid Phone: **1-800-338-8366**
Hawki Website: **http://dhs.iowa.gov/Hawki**
Hawki Phone: **1-800-257-8563**
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: **1-888-346-9562**

KANSAS – Medicaid

Website: **https://www.kancare.ks.gov**
Phone: **1-800-792-4884**
HIPP Phone: **1-800-766-9012**

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: **1-855-459-6328**
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx**
Phone: **1-877-524-4718**
Kentucky Medicaid Website: **https://chfs.ky.gov**

LOUISIANA – Medicaid

Website: **www.medicaid.la.gov or www.ldh.la.gov/lahipp**
Phone: **1-888-342-6207 (Medicaid hotline)** or **1-855-618-5488 (LaHIPP)**

MAINE – Medicaid

Enrollment Website: **https://www.mymaineconnection.gov/benefits/s/?language=en_US**
Phone: **1-800-442-6003**
TTY: Maine relay **711**
Private Health Insurance Premium Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: **1-800-977-6740**
TTY: Maine relay **711**

MASSACHUSETTS – Medicaid and CHIP

Website: **https://www.mass.gov/masshealth/pa**
Phone: **1-800-862-4840**
TTY: **(617) 886-8102**

MINNESOTA – Medicaid

Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs- and-services/other-insurance.jsp**
Phone: **1-800-657-3739**

MISSOURI – Medicaid

Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: **1-573-751-2005**

MONTANA – Medicaid

Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: **1-800-694-3084**
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: **http://www.ACCESSNebraska.ne.gov**
Phone: **1-855-632-7633**

Lincoln: **1-402-473-7000**
Omaha: **1-402-595-1178**

NEVADA – Medicaid

Medicaid Website: **http://dhcfp.nv.gov**
Medicaid Phone: **1-800-992-0900**

NEW HAMPSHIRE – Medicaid

Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: **1-603-271-5218**
Toll-free number for the HIPP program: **1-800-852-3345, ext 5218**

NEW JERSEY – Medicaid and CHIP

Medicaid Website: **http://www.state.nj.us/humanservices/ dmahs/clients/medicaid**
Medicaid Phone: **1-800-701-0710**
CHIP Website: **http://www.njfamilycare.org/index.html**
CHIP Phone: **1-800-701-0710**

NEW YORK – Medicaid

Website: **https://www.health.ny.gov/health_care/medicaid/**
Phone: **1-800-541-2831**

NORTH CAROLINA – Medicaid

Website: **https://medicaid.ncdhhs.gov**
Phone: **1-919-855-4100**

NORTH DAKOTA – Medicaid

Website: **https://www.hhs.nd.gov/healthcare/medicaid**
Phone: **1-844-854-4825**

OKLAHOMA – Medicaid and CHIP

Website: **https://oklahoma.gov/ohca/insureoklahoma/about.html**
Phone: **1-888-365-3742**

OREGON – Medicaid

Website: **http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html**
Phone: **1-800-699-9075**

PENNSYLVANIA – Medicaid and CHIP

Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx**
Phone: **1-800-692-7462**
CHIP Website: **https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx**
Phone: **1-800-986-KIDS (5437)**

RHODE ISLAND – Medicaid and CHIP

Website: **http://www.eohhs.ri.gov**
Phone: **1-855-697-4347, or 1-401-462-0311** (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: **https://www.scdhhs.gov**
Phone: **1-888-549-0820**

SOUTH DAKOTA – Medicaid

Website: **http://dss.sd.gov**
Phone: **1-800-452-7691**

TEXAS – Medicaid

Website: **https://www.hhs.texas.gov/services/health/medicaid-chip**
Phone: **1-800-440-0493**

UTAH – Medicaid and CHIP

Medicaid Website: **https://medicaid.utah.gov/**
Website: **https://chip.utah.gov/**
Phone: **1-888-222-2542 or 1-877-KIDSNOW**

VERMONT– Medicaid

Website: **https://dvha.vermont.gov/members/medicaid/hipp-program**

Phone: **1-800-250-8427**

VIRGINIA – Medicaid and CHIP

Website: **https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp**
Phone: **1-855-242-8282**

WASHINGTON – Medicaid

Website: **https://www.hca.wa.gov**
Phone: **1-800-562-3022**

WEST VIRGINIA – Medicaid and CHIP

Website: **https://dhhr.wv.gov/bms http://mywvhipp.com**
Medicaid Phone: **1-304-558-1700**
CHIP Toll-free phone: **1-877-WVA-CHIP (877-982-2447)**

WISCONSIN – Medicaid and CHIP

Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: **1-800-362-3002**

WYOMING – Medicaid

Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**
Phone: **855-294-2127**

To see if any other states have added a premium assistance program since Jan. 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa | **1-866-444-EBSA (3272)**

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov | **1-877-267-2323, Menu Option 4, Ext. 61565**

Continuation of Group Coverage (COBRA) Initial Notice

Continuation coverage rights under COBRA Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of- pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either 1 of the following qualifying events happens:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his or her gross misconduct
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee's employment ends for any reason other than his or her gross misconduct
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child"

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify your Employer. The Plan requires that you notify your Employer in writing within 60 days after (1) the qualifying event occurs, or (2) the date the beneficiary would lose coverage under the Plan, whichever is later. You should provide this written notice to your Employer's Human Resources department. Your Employer will then notify the Plan Administrator. If written notice is not provided within the 60-day period, the beneficiary will not be entitled to COBRA continuation coverage.

How is COBRA coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's 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 Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children 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 (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are 2 ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify your Employer by sending written notice to your Employer's Human Resources department within 60 days of the latest of the qualifying event date, loss of coverage date or date of the SSA disability determination, and before the original COBRA continuation period ends. Your Employer will notify the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan.

This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed first to your Employer's Human Resources department. For more information about your rights under health plan regulations, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **dol.gov/ebsa**. For more information about the Marketplace, visit **healthcare.gov**.

Keep your plan informed of address changes

In order to protect your family's rights, you should keep your Employer informed of any changes in the addresses of family members or relevant changes in your marital status. You should also keep a copy, for your records, of any notices you send to your Employer regarding COBRA continuation.

Plan contact information

You should contact your Employer's Human Resources department first with any questions regarding COBRA continuation coverage.

The COBRA Benefit Administrator is HealthEquity. The COBRA Benefit Administrator is responsible for administering COBRA continuation coverage. HealthEquity COBRA Member Services can be reached at **877-722-2667**.

Employer Notice of Exchange

Health Insurance Marketplace coverage options and your health coverage

General information

Beginning in 2014, there was a new way to buy health insurance: The Health Insurance Marketplace (sometimes referred to as the "Exchange"). For Americans who do not have adequate health insurance, this is a way to buy coverage as part of the federal government's health care law. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The

Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace runs from November 1, 2024, through December 15, 2024, for 2025 coverage. This is not your employer's annual enrollment period.

Can I save money on my health insurance premiums in the marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan.

However, if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards, you may be eligible for a tax credit that lowers your monthly premium.

- If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% of your household income for the year 2025, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.*
- Your employer offers excellent health coverage and the benefits fully meet the law's standards. The coverage meets the minimum value standard and the cost of the coverage is intended to be affordable based on employee wages.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

For more information about coverage offered by your employer, please check your plan documents, enrollment guides, employer information and other plan materials available at pebcinfo.com and during November's annual enrollment period.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **healthcare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

PEBC Privacy Notice

PEBC Group Health Plans

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date of notice: Sept. 23, 2013

The "Plan" as described below refers to all PEBC group health plans, including the High Deductible Medical Plan (HDP), EPO Medical Plan, PPO Medical Plan, PEBC Dental Plan, PEBC Vision Plan and Health Care Spending Accounts (both general and limited purpose) if offered by your Employer. "You" or "yours" refers to individual participants in the Plan. If you are covered by a PEBC dental HMO plan, you will receive a separate notice from that HMO.

Throughout this document are references to the "Plan" and its administration. With regard to health plans offered on a fully insured basis (e.g., dental HMO and vision), information received from the "Plan" will generally be coming from the insurer on behalf of the Plan. For self-funded plans, "Plan" administration includes your Employer's own internal administration of the Plan, as well as PEBC and other administration activities.

Use and disclosure of protected health information

The Plan is required by federal law to protect the privacy of your individual health information (referred to in this Notice as "Protected Health Information"). The Plan is also required to provide you with this Notice regarding policies and procedures regarding your Protected Health Information, and to abide by the terms of this Notice, as it may be updated from time to time.

Under applicable law, the Plan is permitted to make certain types of uses and disclosures of your Protected Health Information, without your authorization, for treatment, payment and health care operations purposes.

For treatment purposes, routine use and disclosure may include providing, coordinating or managing health care and related services by 1 or more of your providers, such as when your primary care physician consults with a specialist regarding your condition.

For payment purposes, use and disclosure of your information may take place to determine responsibility for coverage and benefits, such as when the Plan checks with other health plans to resolve a coordination of benefits issue. The Plan also may use your Protected Health Information for other payment-related purposes, such as to assist in making plan eligibility and coverage determinations, or for utilization review activities. Payment purposes may also include, but are not limited to, billing, claims management, subrogation, reviews for medical necessity, utilization review and pre-authorizations.

For health care operations purposes, use and disclosure may take place in a number of ways involving plan administration, including for quality assessment and improvement, vendor review, and underwriting activities. Your information could be used, for example, to assist in the evaluation of 1 or more vendors who support the Plan, or our vendors may contact you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the Plan. Health care operations may also include, but are not limited to, disease management, case management, legal reviews, handling appeals and grievances, plan or claims audits, fraud and abuse compliance programs, and other general administrative activities.

The Plans covered by this Notice may share Protected Health Information with each other as necessary to carry out treatment, payment or health care operations. For example, your requests for claim payment may automatically be sent from a PEBC Medical Plan to the Health Care Spending Account Plan in order to simplify and accelerate claims payment.

The Plans may contract with individuals or entities known as Business Associates to perform various functions on the Plans' behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your Protected Health Information. For example, we may disclose your Protected Health Information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us. The Business Associate Agreement obligates each Business Associate to protect the privacy of your information, and Business Associates are not allowed to use or disclose any information other than as specified in our contract for services.

The Plan may disclose your Protected Health Information to the Employer that sponsors this Plan and to the PEBC in connection with these activities. The Plan does not use or disclose your Protected Health Information for employment-related actions, such as hiring or termination, or for any other purposes not authorized by the HIPAA privacy regulations. If you are covered under an insured health plan, such as a dental HMO, the insurer also may disclose Protected Health Information to the Employer that sponsors the Plan and to the PEBC in connection with payment, treatment or health care operations.

The Plan is prohibited from using or disclosing genetic information for underwriting purposes, and will not use or disclose any of your Protected Health Information which contains genetic information for underwriting purposes.

In addition, the Plan may use or disclose your Protected Health Information without your authorization under conditions specified in federal regulations, including:

- As required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law
- For public health activities
- To an appropriate government authority regarding victims of abuse, neglect or domestic violence
- To a health oversight agency for oversight activities authorized by law
- In connection with judicial and administrative proceedings
- To a law enforcement official for law enforcement purposes
- To a coroner or medical examiner
- To cadaveric organ, eye or tissue donation programs
- For research purposes, as long as certain privacy-related standards are satisfied
- To avert a serious threat to health or safety
- For specialized government functions (e.g., military and veterans activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
- For Workers' Compensation or other similar programs

established by law that provide benefits for work- related injuries or illness without regard to fault

In special situations, the Plan may disclose to one of your family members, to a relative, to a close personal friend or to any other person identified by you, Protected Health Information that is directly relevant to the person's involvement with your care or payment related to your care. In addition, the Plan may use or disclose the Protected Health Information to notify a member of your family, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, those involved in Plan administration will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your health care.

Uses and disclosures for which an authorization is required

Your authorization is required for most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures which constitute a sale of Protected Health Information. We will make any other uses and disclosures not described in this Notice only after you authorize them in writing. You may revoke your authorization in writing at anytime, except to the extent that we have already taken action in reliance on the authorization.

Your rights regarding Protected Health Information

You have the right to:

- **Inspect and copy your Protected Health Information:** Upon written request, you have the right to inspect and get copies of your Protected Health Information (and that of an individual for whom you are a legal guardian). There are some limited exceptions.
- **Request an amendment:** You have the right to amend or correct inaccurate or incomplete Protected Health Information. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
- **Receive an accounting of non-routine disclosures:** You have the right to receive a list of non-routine disclosures we have made of your Protected Health Information. However, you are not entitled to an accounting of several types of disclosures including, but not limited to:
  - Disclosures made for payment, treatment or health care operations;
  - Disclosures you authorized in writing; or
  - Disclosures made before April 14, 2003.
- **Request restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your Protected Health Information as we carry out payment, treatment or health care operations. You may also ask us to restrict how we use and disclose your Protected Health Information to your family members, relatives, friends or other persons you identify who are involved in your care or payment for your care. We do not have to agree to these additional restrictions, but if we do, we must abide by our agreement (except in emergencies).
- **Request confidential communications:** You may request to receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may want to have Protected Health Information sent only by mail or to an address other than your home.
- **Receive notice of a breach:** You have the right to be notified upon a breach of your unsecured Protected Health Information, if a disclosure occurs that meets the definition and thresholds of a breach under the law
- **Receive a paper copy of this notice:** You have the right to a paper copy of this Notice, even if you have agreed to receive this notice electronically

For more information about exercising these rights, contact the office at the end of this Notice.

About this Notice

The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all Protected Health Information maintained. If this Notice is changed, you will receive a new Notice by mail or by a Notice posted on the PEBC website, at **pebcinfo.com**.

If you believe that your privacy rights have been violated, or that the privacy or security of your unsecured Protected Health Information has been compromised, you may file a complaint. You may complain in writing at the location described below under "Contacting the Plan Administrator" or to the U.S. Department of Health and Human Services, Office for Civil Rights, Region VI, at 1301 Young Street, Suite 1169, Dallas, TX 75202. You will not be retaliated against for filing a complaint.

Contacting the plan administrator

You may exercise the rights described in this Notice by contacting the office identified below. They will provide you with additional information. The contact is:

PEBC
P.O. Box 5888
Arlington, TX 76005-5888
1-817-608-2317

Patriot Act Notice

If you are considering enrollment in the High Deductible Medical Plan (HDP) with Health Savings Account, this Notice applies to you.

Important information about procedures for opening a new account

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account.

What this means for you:

The Bank will ask for your name, address, date of birth and other information that will allow the Bank to identify you. The Bank may also ask to see your driver's license or other identifying documents.

Important Health Savings Account Information

You must file IRS Form 8889 with your annual tax return to report contributions to and distributions from your HSA. HSA contributions, investment earnings (if any) and withdrawals (if made for qualified medical expenses) are generally not taxable for federal (and, in most cases, state and local) income tax purposes. However, under certain circumstances, your HSA may be subject to taxes and/or penalties. And, if your HSA contributions for any year exceed the annual limit, you are responsible for contacting your bank to request a refund of the excess.

Be sure to save receipts for all withdrawals from your HSA. You are responsible for verifying eligible medical expenses under the IRS tax code. Some of your responsibilities include:

- Determining your eligibility to contribute to an HSA;
- Keeping receipts to show you used your HSA for qualified medical expenses;
- Tracking contribution limits and withdrawing any excess contributions;
- Making sure funds are transferred to a qualified HSA; and
- dentifying tax implications and reporting distributions to the IRS.

Once your account is open, contact your bank for detailed information about eligible expenses and your responsibilities regarding contributions and record keeping. Also, contact the IRS or consult with a qualified tax advisor for specific advice about your situation. Your employer cannot provide you tax advice.

If you enroll in Medicare or another plan that does not allow you to make HSA contributions, you are no longer eligible to contribute to your HSA; however, you can use the funds already in your HSA for qualified medical expenses (see IRS Publication 969). Consult your tax or financial advisor for specific information that may apply to you.

Notice Regarding the PEBC Wellness Program

For the Americans with Disabilities Act (ADA)

The PEBC Wellness Program is a voluntary wellness program available to all active employees participating in a PEBC medical plan. The program is administered according to federal rules permitting employer- sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes or heart disease). You may also be asked to complete a biometric screening, which may include a blood test to check for cholesterol levels, blood sugar levels or other measures to help identify medical risk factors. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees enrolled in the PPO plan or HDP who choose to participate in the wellness program may receive an incentive $300 or more per calendar year for completing wellness activities as well as an additional $300 or more if an enrolled spouse participates. Refer to the PEBC Wellness Program Summary Plan Description for details. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive reward.

Incentives may be available for employees who participate

in certain health-related activities, such as having recommended preventive care screenings based on your age and gender, completing wellness learning modules or participating in fitness activities. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard.

You may request a reasonable accommodation or an alternative standard by contacting BCBSTX at **888-306-5753**. Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means.

Contact us at **888-306-5753** and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from disclosure of medical information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the PEBC may use aggregate information it collects to design a program based on identified health risks in the workplace, the PEBC Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are providers (doctors and nurses) directly providing you care and HealthEquity, which administers this program, in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your Employer's Human Resources department or Benefits Office.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately 7 minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee

Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210, or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

Important Vendor Contacts

Benefit	Vendor	Phone number	Email/web address
Medical	BCBSTX	888-306-5753	bcbstx.com/member
Virtual Visits	MDLIVE	888-680-8646	mdlive.com/bcbstx
Pharmacy Rx	Prime	800-306-5753	myprime.com
Mail order pharmacy	Express Scripts	833-715-0942	expressscripts.com/rx
Specialty pharmacy	Accredo	833-721-1619	accredo.com
Mental health	BCBSTX	888-306-5753	bcbstx.com
EAP	ComPsych	844-213-8968	guidanceresources.com
Dental DPPO	Delta Dental	800-521-2651	deltadentalins.com
Dental DHMO	Delta Dental	800-422-4234	deltadentalins.com
Vision	VSP	800-877-7195	vsp.com
Life insurance	The Hartford	855-396-7655	mybenefits.thehartford.com
Life insurance claims	The Hartford	888-563-1124	mybenefits.thehartford.com
FSA	HealthEquity	844-396-0226	my.healthequity.com
HSA	HealthEquity	844-396-0226	my.healthequity.com
PEBC Wellness Program	BCBSTX	877-806-9380	wellontarget.com
24/7 NurseLine	BCBSTX	800-581-0368	bcbstx.com
Health Insurance Marketplace		800-318-2596	healthcare.gov

Summaries of Benefits and Coverage (SBC)

The government-required SBCs, which summarize important information about your PEBC medical plan options, are available online at **pebcinfo.com**.

This information is a general description of your coverage. It is not a contract and does not replace the official benefit coverage documents which may include a Summary Plan Description. If descriptions, percentages an benefits coverage documents prevail. This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. This outline is intended as a summary only. For a detailed description of the benefits available please refer to the official plan documents.

Administrative services provided by Blue Cross and Blue Shield of Texas.

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