Miscellaneous

Q. What is an LEP or Late Enrollment Penalty?

A. A Late Enrollment Penalty is a monetary penalty incurred if the prospective member does not enroll within three months of turning 65.

Q. What is an RFI or Request for Information?

A. An RFI, or Request for Information, is a CMS-directed request regarding a prospective member's enrollment. It means either their application is missing information or more context is needed regarding their individual situation. A prospective member has 21 days to respond to the RFI.

Q. What happens if I do not have or cannot enroll in Medicare Parts A and/or B?

A. Medicare Advantage requires you have both Medicare Parts A and B before you can enroll in Part C. You will need both to enroll in either the Open Access PPO or HMO plan.

Q. What is the BCBSTX Customer Service number?

A. The pre-enrollment Education Helpline can be reached at **1-877-842-7564** TTY **711**.

Post-enrollment Customer Service can be reached at **1-877-299-1008** TTY **711**.

Q. What is the BCBSTX group retiree website?

A. Please visit **www.bcbstx.com/retiree-medicare-pebc.**

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 **1-855-756-4448**.

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 Open Access Plan and the HMO 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. 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 performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedema.

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 Jan. 1, 2025, and ending Dec. 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 benefit plans and about your options under Medicare's prescription drug 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 Oct. 15 through Dec. 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, 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 visit **www.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 **www.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: **myalhipp.com/**

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

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website: **myakhipp.com/**

Phone: **1-866-251-4861**

Email: **CustomerService@MyAKHIPP.com**

Medicaid Eligibility:
health.alaska.gov/dpa/Pages/ default.aspx

ARKANSAS – Medicaid

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

California – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program **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

Health First Colorado Website:
www.healthfirstcolorado.com/

Health First Colorado Member Contact Center:
1-800-221-3943 | State Relay **711**

CHP+: **hcpf.colorado.gov/child-health-plan-plus**

CHP+ Customer Service: **1-800-359-1991**

State Relay **711**

Health Insurance Buy-In Program (HIBI):
www.mycohibi.com/
HIBI Customer Service: **1-855-692-6442**

FLORIDA – Medicaid

Website:
www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html

Phone: **1-877-357-3268**

GEORGIA – Medicaid

Website:
medicaid.georgia.gov/health-insurance- premium-payment-program-hipp

Phone: **1-678-564-1162** Press **1**

GA CHIPRA website: **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: **www.in.gov/fssa/hip/**
Phone: **1-877-438-4479**

All other Medicaid

HIPP Website: **www.in.gov/medicaid/**

HIPP Phone **1-800-457-4584**

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: **dhs.iowa.gov/ime/members**

Medicaid Phone: **1-800-338-8366**

Hawki Website: **dhs.iowa.gov/Hawki**

Hawki Phone: **1-800-257-8563**

HIPP Website:
dhs.iowa.gov/ime/members/ medicaid-a-to-z/hipp

HIPP Phone: **1-888-346-9562**

KANSAS – Medicaid

Website: **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: **chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**

Phone: **1-855-459-6328**

Email: **KIHIPP.PROGRAM@ky.gov**

KCHIP Website: **kidshealth.ky.gov/Pages/index.aspx**

Phone: **1-877-524-4718**

Kentucky Medicaid Website: **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: **www.mymaineconnection.gov/benefits/s/?language=e n_US**

Phone: **1-800-442-6003** TTY: Maine relay **711**

Private Health Insurance Premium Website: **www.maine.gov/dhhs/ofi/applications-forms** Phone: **1-800-977-6740** TTY: Maine relay **711**

MASSACHUSETTS – Medicaid and CHIP

Website: **www.mass.gov/masshealth/pa**

Phone: **1-800-862-4840** TTY: **(617) 886-8102**

MINNESOTA – Medicaid

Website: **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: **www.dss.mo.gov/mhd/participants/ pages/hipp.htm**

Phone: **1-573-751-2005**

MONTANA – Medicaid

Website: **dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**

Phone: **1-800-694-3084**

Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – Medicaid

Website: **www.ACCESSNebraska.ne.gov**

Phone: **1-855-632-7633**

Lincoln: **1-402-473-7000**

Omaha: **1-402-595-1178**

NEVADA – Medicaid

Medicaid Website: **dhcfp.nv.gov**

Medicaid Phone: **1-800-992-0900**

NEW HAMPSHIRE – Medicaid

Website: **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: **www.state.nj.us/humanservices/ dmahs/clients/medicaid/**

Medicaid Phone: **1-609-631-2392**

CHIP Website: **www.njfamilycare.org/index.html**

CHIP Phone: **1-800-701-0710**

NEW YORK – Medicaid

Website: **www.health.ny.gov/health_care/medicaid/**

Phone: **1-800-541-2831**

NORTH CAROLINA – Medicaid

Website: **medicaid.ncdhhs.gov/**

Phone: **1-919-855-4100**

NORTH DAKOTA – Medicaid

Website: **www.nd.gov/dhs/services/medicalserv/medicaid/**

Phone: **1-844-854-4825**

OKLAHOMA – Medicaid and CHIP

Website: **www.insureoklahoma.org**

Phone: **1-888-365-3742**

OREGON – Medicaid

Website:
healthcare.oregon.gov/Pages/index.aspx
www.oregonhealthcare.gov/index-es.html

Phone: **1-800-699-9075**

PENNSYLVANIA – Medicaid and CHIP

Website:
www.dhs.pa.gov/Services/Assistance/ Pages/HIPP-Program.aspx

Phone: **1-800-692-7462**

CHIP Website: **www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP**

Phone: **1-800-986-KIDS** (**5437**)

SOUTH CAROLINA – Medicaid

Website: **www.scdhhs.gov**

Phone: **1-888-549-0820**

SOUTH DAKOTA – Medicaid

Website: **dss.sd.gov**

Phone: **1-888-828-0059**

TEXAS – Medicaid

Website: **www.hhs.texas.gov/services/health/medicaid-chip**

Phone: **1-800-440-0493**

UTAH – Medicaid and CHIP

Medicaid Website: **medicaid.utah.gov/**

CHIP Website: **health.utah.gov/chip**

Phone: **1-877-543-7669**

VERMONT– Medicaid

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

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

VIRGINIA – Medicaid and CHIP

Website:
www.coverva.org/en/famis-select
www.coverva.org/en/hipp

Medicaid Phone: **1-800-432-5924**

CHIP Phone: **1-800-432-5924**

WASHINGTON – Medicaid

Website: **www.hca.wa.gov/**

Phone: **1-800-562-3022**

WEST VIRGINIA – Medicaid and CHIP

Website: **dhhr.wv.gov/bms/ mywvhipp.com/**

Medicaid Phone: **1-304-558-1700**

CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: **www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**

Phone: **1-800-362-3002**

WYOMING – Medicaid

Website:
health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

Phone: **1-800-251-1269**

To see if any other states have added a premium assistance program since Jan. 31, 2024, 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

PEBC Privacy Notice

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 one or more of your providers, such as when your primary care providers consults with a specialist about 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 one 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 any time, 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 willprovide 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.

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 seven 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.

Group Medicare Advantage PPO and HMO Required Information

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

Benefits, features and/or devices vary by plan/

area. Limitations and exclusions may apply. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Texas members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The Telephonic Nurse Services should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only.

The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.

This is not a complete description of benefits. Please refer to your plan documents for details. The relationship between these vendors and Blue Cross and Blue Shield of Texas is that of independent contractors. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by the above-mentioned vendors.

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 and dollar amounts in this guide differ from what is in the official benefit coverage documents, the official 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.

Disclaimers

Prime Therapeutics LLC is a pharmacy benefit management company, contracted by Blue Cross and Blue Shield of Texas (BCBSTX) to provide pharmacy benefit management services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Accredo is a specialty pharmacy that is contracted to provide services to members of Blue Cross and Blue Shield of Texas. Accredo is a trademark of Express Scripts Strategic Development, Inc.

Amazon Pharmacy is contracted to provide pharmacy home delivery services to Blue Cross and Blue Shield of Texas.

Walgreens Mail Service is contracted to provide mail pharmacy services to members of Blue Cross and Blue Shield of Texas.

Walgreens Specialty Pharmacy is contracted to provide specialty pharmacy services to members of Blue Cross and Blue Shield of Texas.

Prime Therapeutics LLC provides pharmacy benefit management services for Blue Cross and Blue Shield of Texas and is owned by 19 Blue Cross and Blue Shield Plans, subsidiaries or affiliates of those plans.

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. 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.

Modivcare, formerly LogistiCare, is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide transportation services for members with coverage through BCBSTX.

Blue365 is a discount program only for BCBSTX members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Employees should check their benefit booklet or call the Customer Service number on the back of their ID card for specific benefit facts. Use of Blue365 does not change monthly payments, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors that take part in this program. BCBSTX does not guarantee or make any claims or recommendations about the program's services or products. Members should consult their doctor before using these services and products. BCBSTX reserves the right to stop or change this program at any time without notice.

The Healthy Activity Portal is a website owned and operated by HealthMine, Inc., an independent company, that has contracted with Blue Cross and Blue Shield of Texas to provide digital health and personal clinical engagement tools and services for members with coverage through BCBSTX.

SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company. Tivity Health and SilverSneakers® are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries.

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

HMO and PPO plans provided by Blue Cross and Blue Shield of Texas, which refers to HCSC Insurance Services Company (HISC) and GHS Insurance Company (GHSIC). HMO and PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC, HISC and GHSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC, HISC and GHSIC are Medicare Advantage organizations with a Medicare contract. Enrollment in these plans depends on contract renewal.