What is the PEBC?

Faced with increasing medical costs, in 1998 Dallas and Tarrant counties banded together to form a regional cooperative program, called the Public Employee Benefits Cooperative of North Texas (PEBC), to help generate savings in its employee health-benefits program.

One year later, the North Texas Tollway Authority joined the PEBC to leverage cost savings to its employee health plan. Denton County joined the cooperative effective January 1, 2003, and the PEBC welcomed its newest employer group, Parker County, on January 1, 2010.

The member governments of the PEBC are dedicated to offering choice, flexibility and value as we strive to manage costs in an era of double-digit health care increases. Through the PEBC, the member governments work diligently to keep benefits costs affordable.

The PEBC provides many services, including joint purchase of employee benefits and cost-effective, centralized administration. With current economic conditions and the rapidly rising cost of health care, benefits of PEBC membership are even more valuable today.

A note about this Benefits Enrollment Guide

This Benefits Enrollment Guide provides highlights of your employer’s benefits package. Full details are available in the legal documents governing the individual plans. If there is any discrepancy or conflict between the plan documents and the information presented here, the plan documents govern.

This Benefits Enrollment Guide is used by multiple employers. Please be aware that the enrollment deadlines for your specific employer apply. If you have any questions about the contents of this guide or how this information may apply to you, please contact your Human Resources Department.

Your employer reserves the right to change or discontinue the plans contained in this guide at any time. Issuance of an ID card is not a guarantee of benefits. Benefits are subject to plan provisions and eligibility on the date the service is delivered.
This Enrollment Guide is filled with information about your plan choices and key changes effective January 1, 2015. Your employer wants you to clearly understand your plan choices, and this 2015 Health Benefits Enrollment Guide will help you do just that.
The Employee Health Benefits Enrollment Guide provides quick summary information about your health benefits. More information can be found at www.pebcinfo.com. In all cases, you should refer to the plan documents for additional details.

What’s new in 2015?

UnitedHealth Premium® designation program Tier 1 doctors
Whether you are enrolled in the PPO or HDP medical plan, you may want to look for the Premium Tier 1 designation to help you identify quality and cost-efficiency. You can find a Premium Tier 1 doctor at myuhc.com®. Read more about the UnitedHealth Premium Tier 1 designation later in the Enrollment Guide.

PPO medical plan
Annual deductible increased to:
- $500 single; $1,000 family (in-network)
- $1,000 per member (out-of-network)

Out-of-pocket maximum increased (includes deductible) to:
- $3,500 single; $7,000 family (in-network)

Remember, the out-of-pocket maximum includes eligible medical and pharmacy copays.

Copay changes:
- $25 reduced in-network specialist copay if your in-network specialist is a UnitedHealth Premium Tier 1 specialist
- $35 in-network copay for non-Tier 1 specialists
- $35 in-network urgent care copay
- $35 in-network chiropractor copay

High deductible medical plan (HDP) with health savings account (HSA)
The high deductible medical plan is simply referred to as the HDP plan and the health savings account is referred to as the HSA. This is the same plan sometimes referred to as the HSA plan. The HDP deductible and out-of-pocket maximum did not increase for 2015. If you are not enrolled in this plan, this is an excellent time to consider making the change.

The IRS increased the maximum amount you can contribute to your 2015 HSA to:
- $3,350 single/$6,650 family
- If you are age 55 or older on January 1, 2015, you can contribute $1,000 more to the amounts shown above

About Health Care Reform
You have already heard about the health insurance marketplace, sometimes called 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 new health care law.

The health coverage offered by your employer is excellent and the benefits fully meet the law’s standards.

The health insurance marketplace is not intended for someone already covered by an employer plan and you may not qualify for the tax credit.

But if you have family members who are not eligible for your employer plan, such as children over age 26, you might want to learn about options available to them. Visit www.healthcare.gov for more information.
It’s UnitedHealthcare calling!
Many people screen their phone calls to avoid telemarketers and other unwanted calls. But if you see “UnitedHealthcare” on your caller ID, it may be a call that could change your life. The UnitedHealthcare nurses and health experts may call to invite you to participate in a program to manage your medical condition. Your information and participation are always confidential. Anything you discuss will not be shared with your employer. If you can’t talk when they call, ask the nurse to call back at a more convenient time. This is one call you don’t want to miss!

Prescription drug program
Express Scripts
The Express Advantage Network (EAN) program is effective January 1, 2015.
To save the most money, use an EAN retail pharmacy to fill your prescription (Kroger, Target, Walmart, Costco, Safeway, Albertsons, Tom Thumb, Brookshire and more). The 2015 retail copay remains at 2014 levels for prescriptions filled at an EAN retail pharmacy (subject to formulary changes).
If you fill your prescription at a non-EAN retail pharmacy, you will pay an additional $10 per prescription, and the $10 upcharge will not count toward your out-of-pocket (OOP) maximum. Non-EAN pharmacies include CVS, Walgreens and other retail pharmacies. Contact Express Scripts to check EAN status.
Enrolled in the HDP medical plan? You pay the full cost of your prescription drugs while you are in the deductible phase. If you use a non-EAN pharmacy, the $10 upcharge will not start until you move to the coinsurance phase.

Formulary changes
• Check the 2015 formulary for new generic drugs, drugs that moved from preferred to non-preferred status (and vice versa), newly excluded drugs and drugs requiring prior authorization. Express Scripts can help you identify any changes.
• Compound drugs in most topical cream/ointment forms are no longer covered. The plan will still cover many of the ingredients, but only in the FDA-approved form (such as a tablet). Contact Express Scripts for more information.
• Refer to the Prescription Drug section of this Enrollment Guide for more information about changes to the prescription drug program.

New hearing aid benefit
Beginning in 2015, both the PPO Plan and HDP Plan will provide limited coverage toward the purchase of hearing aids. The hearing aid must be medically necessary, proven and FDA approved. If you use a non-network provider, you must file the claim to be reimbursed for eligible expenses.
• Coverage is up to $1,000 for a single purchase (per ear) every four years.
• The deductible and coinsurance do not apply.
• Benefits are for the hearing aid, fitting and testing only (does not cover batteries, accessories, dispensing fees or hearing aid repair).
• Provided certain medical conditions are met, bone-anchored devices may be considered a covered health service under your medical plan surgical plan benefit, with the device itself subject to hearing aid device limits.

PEBC Dental Plan annual limit increase
(Delta Dental)
If you are enrolled in this dental plan, the amount the plan will pay (per person per year) increased to $2,000 beginning January 1, 2015 (was $1,500). Most preventive care is still covered at 100% and does not count toward the $2,000 maximum, making your benefit stretch even more. Orthodontic benefits did not change. The plan pays a maximum of $1,750 for orthodontic benefits per person per lifetime.

PEBC wellness program
Want to earn an extra $300? Read about the new PEBC Wellness Program starting January 1, 2015. Timing is important and you do not want to miss out! You will receive more information in the coming months, but check page 7 of the Enrollment Guide for preview information.

Access to flu shots and vaccines
You will have more convenient access to flu shots and vaccines beginning January 1, 2015. Read the Flu Shot and Vaccines section to choose the best resource for your flu shot during the 2014 flu season and new access available in 2015.
Tools to help you choose

When it comes to choosing your benefits, it’s important to take the time to find the plans that are right for you. Your employer offers health plan options that vary by plan design, premiums, deductibles, copays and coinsurance. But how do you know which plan is right for you? Use this Health Benefits Enrollment Guide, along with information in the enrollment packet, and visit [www.pebcinfo.com](http://www.pebcinfo.com) to help you evaluate your options, estimate your benefit needs and compare your benefit choices.

### Make an informed choice

In today’s economy, it’s more important than ever to make the most of your benefit dollars. It’s your responsibility to carefully evaluate your options and make informed choices. To do that, use all of the resources available to you to learn more about your plan options. Weigh the cost of each plan against your needs and determine the right benefits mix for you and your family. Making smart decisions about your health benefits helps you keep costs down while getting the coverage you and your family need.

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Here are some tools to help:

- **www.pebcinfo.com** — a one-stop site with plan information, forms and links to all PEBC vendor sites
- Check the 2015 Plan Cost Estimator, a tool to help you compare out-of-pocket costs as you consider the HDP or PPO Plan
- **myuhc.com** — a great place for electronic tools to help you evaluate the plans
- myHealthcare Cost Estimator can help you estimate the cost of your care based on your selected plan
- See past claims at myClaims Manager (how much the plan paid, plan discounts and your cost responsibility)
- Search for in-network providers by selecting the link “Find Physician, Laboratory or Facility”
- **www.express-scripts.com** for PEBC prescription drug services
- Summary of Benefits and Coverage (available at **www.pebcinfo.com**) — an easy-to-understand summary to help you compare health plans and coverage, regardless if coverage is purchased privately or through your employer
- Health Benefits Enrollment Guide — a quick summary guide which includes features of each plan available to you, contact information and other important information about your plan benefits
- 2015 Employee Benefits Rate Sheet — lists employee contribution rates for each plan with the various “account” options available to you (HSA, FLEX, LP-FLEX)
- Employee Assistance Program (EAP) brochure — summarizes this employer-paid benefit that helps you deal with the pressures of work and daily life
- Important Notices — 2015
Enrolling during annual enrollment?
If you are currently enrolled in a plan, annual enrollment is the only time during the year that you can change your benefit selections or dependents without first experiencing a qualified change in status event. It is very important that you follow your employer’s annual enrollment instructions and deadlines so that you can enroll in your chosen benefits plan in 2015.

You cannot change from one plan to another in 2015 (without a qualifying change of status event), so make sure you consider carefully.

Enrolling as a newly hired employee?
If you are a newly hired employee and selecting benefits for the first time (not during annual enrollment), review your enrollment information with careful attention to deadlines.

- You must return your enrollment documents to the Human Resources Department within 14 days of the date you begin working. If you miss that deadline, your employer will automatically enroll you in a default medical plan, employee-only coverage.

- If you are a Dallas County employee hired January 1, 2015, or later, your default medical plan is the HDP. For all other employer groups, the PPO is the default medical plan. You cannot change from default plan enrollment until the next annual enrollment period unless you first experience a qualified change in status event.

- Your health benefits 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 www.pebcinfo.com.

Dallas County employees only
If your hire date is January 1, 2015, or later, you can enroll in the HDP medical plan (with health savings account) or you can opt out of medical coverage as long as you are enrolled in other comparable coverage and provide the required documents. **You are not eligible to enroll in the PPO plan if your hire date is January 1, 2015, or later.** References in this Guide to the PPO plan as an available medical plan choice do not apply to you.

How to select a plan
Whether you are a newly hired employee or an active employee, before you enroll in a plan, consider your choices carefully. Even if you’ve been through annual enrollment dozens of times, don’t make the mistake of simply enrolling in the same coverage as last year.

- Compare the differences between the plans. Before you enroll, check the key features of each plan. If you have other coverage available (such as TRICARE, your spouse’s employer plan, etc.), check the features of that plan as well.

- Check which doctors, hospitals and providers are in the network. The PPO Plan uses the large UnitedHealthcare Choice Plus network. The HDP Plan uses the large Choice Network and does not cover out-of-network services.

- Think about potential health needs in the coming year. Estimate your out-of-pocket cost in each available plan for those services you might receive and the monthly premium cost. You may find that selecting the least costly medical plan, even with additional out-of-pocket expense, may result in the least out-of-pocket cost to you.

- If you enroll in the HDP Plan, consider the additional savings and benefits of the health savings account (HSA), especially if partnered with a limited-purpose health care spending account (LP-FLEX). If you enroll in the PPO Plan or opt out of medical coverage, you can also save by electing a health care FLEX account. If you enroll in the HDP plan, your employer contributes “seed money” to your health savings account to help you save more.

During annual enrollment, you must re-enroll if:

- Your employer requires you re-enroll (important deadlines apply);
- Anything changed, including dependent eligibility, your address or your plan choice; and/or,
- You want to contribute to a FLEX spending account or a limited purpose FLEX spending account. Remember — you have to re-enroll each year if you want to contribute to a FLEX spending account, even if you do not change your annual election amount. It’s an IRS rule.
Creating a culture of better health
New! PEBC Wellness Program

The new PEBC Wellness Program begins January 1, 2015. You will learn more about the program in the coming weeks, but this basic information will help you prepare. Almost everyone can take at least one step to help improve their health, and now you can earn points and dollars for doing just that.

Points and rewards
Make a difference in your life and earn a reward! To earn wellness points and rewards, you must be an active employee enrolled in either the PPO or HDP medical plans, and you must be registered at myuhc.com. To earn your $300 reward, you must earn 300 points. Partial points do not count and you will not receive more than one $300 reward in any year. There are many ways to earn points, but points must be earned during the period January 1, 2015, to October 31, 2015.

If you opt out of medical coverage, you can also access the wellness portal, but you cannot earn points or rewards. Take the health assessment, participate in online activities and learn more about how you can improve your health!

Confidentiality
Your employer does not have access to your confidential health information. The information you enter is secure, safe and protected.

Getting started (Enrolled in PPO or HDP)
Getting started is the key to earning points. Preventive screenings and biometrics performed at your doctor’s office will automatically reflect points earned once the claim is paid.

1. Health Assessment — Earn 100 points (once each year) by taking the 15-minute assessment at myuhc.com. You cannot earn additional points unless you take the health assessment.
2. Annual Physical — Earn 25 points (once each year) for your annual physical.
3. Biometric Screening — Earn 150 points (once each year) by having your doctor identify your biometrics (cholesterol, blood sugar, etc.) during a health provider office visit. As an alternative, some employers may sponsor a biometric screening event at work — and you can earn points there. You will receive information about scheduled events.
4. Preventive Screenings — Earn 25 points (once each year) for a mammogram, colonoscopy or a cervical screening.
5. Healthy Pregnancy — Earn 50 points when you enroll!
6. Online Learning Modules — Earn 50 points (once each year) for program completion. Choose the program that fits your wellness goal. Each program takes a minimum of five weeks to complete. Based on your health assessment, your interactive health coach may suggest health improvement programs to help you achieve your personal health goals.
Creating a culture of better health Continued

7. **Telephonic Learning Modules** — Earn 50 points (once each year). Connect one-on-one with a phone-based wellness coach who will help you with your personal health improvement plan. The program is adjusted to fit your needs, so the number of sessions will be determined by you and your coach. Each phone call lasts 20-30 minutes and can be spaced out over three to six months. You must complete the module to earn points. Log in to review the available programs. Two of the most popular modules are the QuitPower® and Healthy Weight programs.
   - QuitPower (tobacco cessation) — This is an enhanced phone-based tobacco cessation program that lets you work with your own personal coach who can help you quit tobacco and live a healthier life. You and your coach will work together to help you reach your goal. You may also qualify to receive up to eight weeks of nicotine replacement therapy (patches, gum, etc.) at no extra cost.
   - Healthy Weight — Your coach specializes in healthy weight loss. Get the answers, support and motivation you need to achieve your goals.
   - You can also earn points by participating in the Healthy Pregnancy Program.

8. **Disease Management** — If you are qualified for disease management as a result of a chronic condition and you are contacted by a UnitedHealthcare nurse, you can earn up to 100 points for participating.

9. **Employer Track** — If your employer participates in the Employer Track, you can earn up to 25 points (two times each year; 50 total points) for completing the health/life learning activities (such as Weight Watchers at Work, etc.) and/or fitness/activity. Not all employers participate, but if your employer does, you will receive more information about the employer track in the coming months.

**Register**

For those enrolled in the PPO or HDP medical plans, log in at myuhc.com and select the Health and Wellness tab to register. Most of your information is pre-populated. If you opt out of your employer’s medical plan, you can still access the wellness portal, take the health assessment and participate in activities, but you will not earn points or rewards. If you are an Opt-out, register at https://client.myoptumhealth.com/PEBC.

**Timing and earning points**

It is important that you remember key timing requirements to earn points.

- Reward earning period — During any calendar year, you cannot earn points before January 1 or after October 31.
- Time required to earn points — Start early! If you participate in a telephonic or online activity, it will take at least five to six weeks to complete in order to earn points. Because rewards must be earned by October 31, you should plan to start as soon as you can after January 1, 2015. You will not earn points for partially completed programs.

**How is the reward paid?**

The default payment method is cash, which means the funds will be included in a payroll check on a post-tax basis. For PEBC County participants only, you can choose to have your reward deposited to your health care flexible spending account or your health savings account (HSA). You will receive more information about your payment options when you qualify for the reward.

**When is your reward paid?**

Rewards are paid three times during the year based on when you earn 300 points. You cannot receive more than one reward each year.

- Points earned January 1 – March 31: paid by May 31
- Points earned April 1 – June 30: paid by August 31
- Points earned July 1 – October 31: paid by December 31

**The future holds...**

In 2016, both active employees and their covered spouses enrolled in the PPO or HDP medical plans can earn points and rewards. This means that the employee can earn up to $600 if both employee and spouse each earn 300 points.

In 2017, additional outcomes will be required to earn points. For example, you will be rewarded for reaching goals, such as reducing cholesterol levels. Your doctor will be able to assist with reasonable alternatives if the goal is not reachable for you.

**Start now!** Employees who participate in 2015 will be at an advantage in future years when goals must be met to earn your reward. You have time to take steps to improve your health now — and you will be happier and healthier for it!
Flu shots and vaccines

Whether you visit your doctor, get immunized at work or at your local health department, the flu shot and many other vaccines are available to you at no cost. You can also get age-appropriate immunizations at several retail pharmacy locations. Beginning January 1, 2015, retail pharmacy access to age-appropriate immunizations for you and your covered family members (enrolled in the PPO plan or HDP plan) will increase through the Express Scripts drug benefit.

Always check with the pharmacist to check your plan coverage before the immunization is administered to make sure the immunization is covered. Check with your doctor for specific age and flu shot requirements. Due to drug storage requirements, the vaccine may not always be readily available. Call ahead to check availability.

Vaccines at 100% coverage
Your benefit plan will cover the vaccines listed under the 100% preventive benefit when administered at a participating retail pharmacy.

Before January 1, 2015
Select retail pharmacy locations (UnitedHealthcare medical ID card required)
- CVS
- Kmart
- Meijer
- Rite Aid
- Safeway Co
- ShopKo
- Target
- Walgreens
- Network convenience care clinics

Vaccines
- Flu
- Zostavax (shingles)
- Tdap (whooping cough)
- Meningitis
- Pneumonia
- Hepatitis B
- Tetanus booster

Effective January 1, 2015, and later
In addition to the retail locations available through UnitedHealthcare, beginning January 1, 2015, you and your covered family members can get a flu shot and other age-appropriate immunizations using your Express Scripts pharmacy benefit. Save even more by using an EAN retail pharmacy. For non-EAN locations, you will pay an additional $10 per immunization, unless you are enrolled in the HDP medical plan and still in the deductible phase.

Effective January 1, 2015, select Express Scripts EAN retail pharmacies (Express Scripts ID card required)
- Albertsons
- Brookshire
- Costco
- HEB
- Kroger
- Minyard
- Rite Care
- Sam’s Club
- Target
- Tom Thumb
- Walmart

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

Convenience care clinics
Convenience care clinics are typically located in retail stores and don’t require appointments. They provide a limited range of simple care services for the cost of a primary care physician (PCP) copay. Services and treatments are offered to patients 18 months of age and older.

Visit a convenience care clinic for minor illness and injuries such as sore throats, earaches, coughs/congestion, minor cuts/rashes and urinary tract infections. You can also receive your flu shot or pneumonia vaccine at a convenience care clinic, but if you receive additional services, a copay or out-of-pocket expense may apply. DFW-area locations include MinuteClinic® located at certain CVS Pharmacy locations and Target Clinic® found at select Target locations.
Preventive care services

Understanding preventive care
Maintaining or improving your health with regular preventive care, along with following the advice of your doctor, can help you stay healthy. Routine checkups and screenings can help you avoid serious health problems, allowing you and your doctor to work as a team to manage your overall health and help you reach your personal health and wellness goals.

Your medical plan covers preventive care services at 100% whether you are enrolled in the PPO or HDP plan, as long as services are performed by an in-network provider. For more information about preventive care services that might be right for you, visit www.uhcpreventivecare.com. Always refer to your plan documents for details about the plan.

What is preventive care?
Preventive care focuses on evaluating your current health status when you are symptom free. Preventive care allows you to obtain early diagnosis and treatment to avoid more serious health problems. Your preventive care services may include physical examinations, immunizations, laboratory tests and other types of screening tests. During your preventive visit, your doctor will determine what tests or health screenings are right for you based on many factors such as your age, gender, overall health status, personal health history and your current health condition.

What health services are NOT considered preventive care?
Medical treatment for specific health issues or conditions, on-going care, laboratory tests or other health screenings necessary to manage or treat an already-identified medical issue or health condition are considered diagnostic care, not preventive care. You may be charged a copay or out-of-pocket cost if these services are provided, even if the service is provided at the same time a preventive care service is performed.

Preventive services at no cost to you
Preventive services covered at no cost are those services described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC and HRSA Guidelines for women, as well as children, including the American Academy of Pediatrics Bright Futures periodicity guidelines. Effective January 1, 2013, the list of women’s preventive services expanded. Certain prenatal and breastfeeding supplies and services are covered at no cost to you. Visit www.pebcinfo.com to view a summary of no-cost preventive services.
The Healthy Pregnancy Program was created to help ensure you have a smooth pregnancy, delivery and a healthy baby. By seeing your doctor regularly, and by enrolling in our Healthy Pregnancy Program, which is provided at no additional cost, you’ll have built-in support through every stage of your pregnancy.

**Personal attention**
When you enroll in the Healthy Pregnancy Program, a care coordinator will consult with you by telephone, to help you determine what, if any, risks or complications could arise during your pregnancy. The care coordinator can help you learn and practice healthy pregnancy habits and protect the well-being of your baby. If you have individual needs, a Healthy Pregnancy Program nurse will provide one-on-one support throughout your pregnancy.

**When to enroll**
To get the most from the program, it’s best to enroll during your first trimester, but you can enroll whenever you like, up through your 34th week of pregnancy. After you enroll in the program, you can call the maternity nurses 24 hours a day to ask questions or talk over your concerns. Experienced nurses are available to talk by phone, even after your baby is born.

**Educational materials and resources**
At [www.healthy-pregnancy.com](http://www.healthy-pregnancy.com), you can access a full range of articles covering nutrition, exercise, childbirth preparation, tips for dads and more. You will also receive complimentary gifts for you and your baby and money-saving coupons. The website offers you a *Healthy Pregnancy Owners’ Manual* that will walk you through what to expect before, during and after your pregnancy.

To enroll in the Healthy Pregnancy Program, call **800-411-7984** (Monday – Saturday).

For more information, visit [www.healthy-pregnancy.com](http://www.healthy-pregnancy.com).

**Important! Don’t forget to add your newborn to your medical plan**
Your newborn is **not** automatically enrolled in your medical plan. You are responsible for contacting the Human Resources Department to complete the required 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. Don’t risk forgetting this important step.

**Talk to your doctor**
Consult your doctor for your specific preventive health recommendations as he or she is your most important source of information about your health.
When you have a health concern, it can be difficult and time-consuming to find the information you need. myNurseLine can help you make smart health care decisions with immediate telephone and online access to experienced registered nurses.

**Your health advocate**

One toll-free number connects you with a registered nurse who will take the time to understand what is going on with your health and provide personalized information that is right for you. And this is all available 24 hours a day, seven days a week, at no additional cost to you. It is included in your benefits. myNurseLine also gives you access to an audio health information library. Choose from more than 1,100 health and well-being topics, with 600 messages available in Spanish. Services are available to translate 140 languages and for callers with hearing impairments.

**Experience you can rely on**

myNurseLine nurses have an average of 15 years clinical nursing experience. They are an excellent resource when you need help choosing care, managing a chronic condition, understanding treatment options and more.

**Your one-stop source**

Feel free to call myNurseLine to check if a provider is in the network, a United Health Premium Tier 1 specialist or accepting new patients. Whether you have a baby with a 102-degree temperature at midnight or need help managing your diabetes, myNurseLine is the one source to give you the answers you need.

Not sure if you need a doctor, urgent care clinic or just some good health advice? Think of myNurseLine as your one-stop resource to help you make smart health care decisions every day.

To talk with a myNurseLine nurse, call the Customer Care number on the back of your health plan ID card, or visit myuhc.com.

**myNurseLine can help you:**

- Chat with a nurse live on myuhc.com.
- Understand treatment options.
- Ask medication questions.
- Choose appropriate medical care.
- Locate available local resources.
- Find a doctor, hospital or specialist and check if a doctor is in your network and is accepting new patients. They may even be able to make the appointment for you.
UnitedHealth Premium Tier 1 designation

The UnitedHealth Premium program recognizes doctors who meet quality and cost-efficiency guidelines. The UnitedHealth Premium program uses criteria from national organizations that identify evidence-based standards for treating medical conditions across 25 specialties.

The fact that a doctor does not have a quality designation does not mean that the doctor does not provide quality health services. All doctors who are part of the UnitedHealthcare network must meet standard credentialing requirements (separate from the Premium program).

UnitedHealth Premium Tier 1 physicians have received one of the following Premium designations:

- Quality & Cost Efficiency
- Cost Efficiency & Not Enough Data to Assess
- Quality

The assessment result “Not Enough Data to Assess” is not an indicator of the total number of patients treated by the doctor or the number of procedures performed by the doctor. Rather, it reflects the statistical requirements of the program. For more information on the UnitedHealth Premium program, visit www.UnitedHealthPremium.com.

Whether you are enrolled in the PPO or HDP plan, a UnitedHealth Premium Tier 1 indicator may help you when choosing a doctor. You can find a doctor’s Premium designation on myuhc.com.

Should you go to the emergency room (ER)?

Many times the emergency room is the right choice. But did you know your doctor can treat many of the same problems you might go to the ER for? If your doctor is unavailable, there are other lower-cost alternatives to the ER.

Doctor’s Office — typically the lowest-cost option. Your primary doctor knows you and your health history and can provide routine and preventive care and treatment for a current health issue or refer you to a specialist.

Convenience Care Clinic — such as MinuteClinic or Target Clinic. If you can’t get to the doctor’s office and the condition is not urgent or an emergency, you may find this a great alternative for minor health conditions. PPO members pay a $25 PCP copay.

Urgent Care Center — such as PrimaCare. Urgent Care Centers offer treatment for non-life threatening injuries or illnesses, including sprains, minor infections and minor burns. PPO members pay a $35 copay.

Emergency Room — typically the highest cost option. If you need immediate treatment of a very serious or critical condition, go to the nearest emergency room. Do not ignore an emergency and call 911 if the situation is life threatening.
Medical plans

PPO PLAN

- **Pre-certification**: As long as your care is provided by an in-network doctor, hospital or other health care provider, you do not need a pre-certification for services. UnitedHealthcare uses a Notification Process with its participating doctors, hospitals and other health care service providers, and they will handle that for you. If you receive care from an out-of-network provider, your care must be pre-certified or penalties apply. It is your responsibility to make sure your out-of-network care is pre-certified.

- **Network**: The broad, national UnitedHealthcare Choice Plus network is available to everyone enrolled in the PPO Plan. To locate a doctor, hospital or other provider, visit [myuhc.com](http://myuhc.com). The PPO Plan includes out-of-network benefits, but you will often pay more for care received from an out-of-network provider, plus the difference between billed cost and the plan’s allowed cost (balance-billing).

**Copays (in-network)**

- Office visit: $25 PCP/$25 Tier 1 specialist/
  $35 non-Tier 1 specialist
- Urgent care: $35
- Mental health: $25 office visits (example: therapists)
- Emergency room: $150 (in-network or out-of-network, waived if admitted)

**Deductible**

The 2015 in-network deductible is $500/single and $1,000/family. (If you use out-of-network services, a $1,000 deductible applies to each person, and there is no annual maximum out-of-pocket limit.) If you elect family coverage, the in-network family deductible is met when the combined eligible expenses for you and/or any covered family members reach the family deductible amount of $1,000. If one person reaches the $500 deductible but the others did not, then the deductible is met for that family member only. When the family’s combined expenses reach the deductible, the family deductible is met.

**Coinsurance and in-network cost**

Certain expenses are covered by the plan based on a percentage of allowed cost. For example, after the in-network deductible is met, the plan pays 80% of in-network outpatient and inpatient hospital costs. Your 20% portion (coinsurance) applies to your annual maximum out-of-pocket limit (OOP).

**Out-of-pocket maximum limit**

As long as your medical care is delivered in-network, after you reach $3,500 ($500 deductible plus $3,000 OOP) the plan then pays 100% of eligible expenses. If you are enrolled in family coverage, after you reach $7,000 ($1,000 deductible plus $6,000 OOP) the plan then pays 100% of your eligible expenses.

**Coinsurance and out-of-network cost**

If you choose to receive care from an out-of-network doctor, hospital or other provider, you will pay more of the cost. Not only is the deductible higher, but the OOP is unlimited. This means that the plan will never pay 100% of your costs, even after the OOP is met. If you receive care from out-of-network providers, you will pay the out-of-network deductible, 40% coinsurance and any billed charges exceeding the maximum allowed for that service, referred to as “balance-billing.” With the number of in-network providers available, it is rare that you would have to seek services outside the network.
HIGH DEDUCTIBLE PLAN (HDP) WITH HEALTH SAVINGS ACCOUNT (HSA)

- **Pre-certification:** As long as your care is provided by an in-network doctor, hospital or other health care provider, you do not need a pre-certification for services. UnitedHealthcare uses a Notification Process with its participating doctors, hospitals and other health care service providers, and they will handle that for you.

- **Copays:** The HDP Plan does not use copays. You pay 100% of the allowable cost until the deductible is met. Eligible medical, pharmacy and mental health expenses count toward the deductible. The allowable cost is the discounted cost from UnitedHealthcare, Express Scripts and/or MHN. It is not “retail” cost.

- **Deductible:** There is an important distinction in how the “family” deductible works in the HDP Plan when compared to the PPO Plan. With the HDP Plan, if you choose employee plus spouse, children or family coverage, the IRS requires that the entire family deductible ($3,000) be met before coinsurance applies. Even if one family member meets the individual deductible of $1,500, coinsurance does not apply until the entire family deductible of $3,000 is met. Likewise, if none of the family members meet the $1,500 individual deductible, but combined, the $3,000 family deductible is met, then the entire family deductible is met.

- **Network:** The broad, national UnitedHealthcare Choice network is available to everyone enrolled in the HDP Plan. To locate a doctor, hospital or other provider, visit myuhc.com. The HDP Plan does not offer out-of-network benefits and out-of-network charges do not count toward the OOP.

In-network costs
You will pay 100% of the allowed cost until your deductible is met. The “allowed” in-network cost is the network discounted cost. This means you pay all of the cost for office visits, urgent care, prescription drugs, emergency room and other covered expenses.

Coinsurance and in-network cost
After the deductible is met, the plan pays 90% of the allowable for in-network services. Once you reach the maximum OOP, you are done. The plan will then pay 100% of eligible costs. If you choose a brand-name drug when a generic is available, the cost difference between the brand-name and generic drugs will not count toward your deductible or OOP. Once you reach the coinsurance phase, if you fill a prescription at a non-EAN pharmacy, the $10 upcharge does not count toward OOP. Other costs may not apply to the OOP as shown below.

Coinsurance and out-of-network costs
This plan does not cover services received from out-of-network providers, although you can use HSA funds to pay for out-of-network care if you wish.

Out-of-pocket maximum
As long as your medical care is delivered in-network, if you are enrolled in single coverage, once you reach $2,500 ($1,500 deductible plus $1,000 OOP) the plan then pays 100% of eligible expenses. If you are enrolled in family coverage, if you reach $5,000 ($3,000 plus $2,000 OOP) the plan then pays 100% of your eligible expenses.

Health Savings Account
If you are newly enrolled in the HDP plan, a health savings account (HSA) will be opened in your behalf with Optum BankSM.

Regardless of plan choice
Regardless of the plan in which you enroll, certain items do not count toward the OOP:

- Expenses not covered by the plan
- Charges for services or supplies not pre-certified or pre-authorized (if required)
- Services that are not medically necessary
- Out-of-network costs
- Expenses exceeding the maximum allowable (if you use out-of-network providers)
- The cost difference between the generic and brand-name drug does not count toward the OOP if you choose a brand when generic is available
- The $10 upcharge to fill a prescription at a non-EAN pharmacy

A special note about mental health and substance abuse services
When you enroll in either the PPO or HDP Plan, mental health and substance abuse services are provided by MHN, not UnitedHealthcare. The UnitedHealthcare networks do not extend to your mental health and substance abuse benefits. To receive mental health plan benefits, you must pre-certify care before you receive it. To pre-certify care, call MHN at 888-779-2225.
Medical plans Continued

What is an HSA?
Think of an HSA as a savings account for health care you’ll need today, tomorrow and into the future. Unlike a flexible spending account (FSA), your savings grow from year to year. The HSA account works differently than a flexible spending account. A big difference is that the HSA account has triple-tax benefits.

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

What else you need to know about an HSA
To deposit money into an HSA, you must be enrolled in an HSA-eligible health plan. You are eligible if:

- You are covered under an eligible high-deductible health plan (like the HDP Plan).
- You are not covered by another medical plan or a general purpose FSA account.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else’s tax return.

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.

For 2015, the IRS allows total deposits up to $3,350 if you have individual coverage or $6,650 if you have family coverage. The IRS also allows you to make an extra catch-up deposit of $1,000 if you are age 55 or older. Your deposits are made through payroll deduction.

Important information if you enroll in the High Deductible Plan (HDP) with Health Savings Account (HSA)
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 Optum 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
- Identifying tax implications and reporting distributions to the IRS.

Contact Optum 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 a specific advice about your situation. Your employer cannot provide you tax advice.
**About the HSA bank account**

If you are newly enrolled in the HDP Plan, your employer will automatically notify Optum Bank (affiliated with UnitedHealthcare) to open your bank account. After your account is opened, you will receive a Welcome Kit from Optum Bank. The Welcome Kit has detailed account information. If the bank needs additional information in order to open your account, they will contact you by mail — you do not need to contact the bank. Your HSA expenses are not eligible expenses until your account is opened. If you receive a letter from Optum Bank requesting more information, please respond as soon as possible.

As long as you maintain an account balance of $500 or more, you will not be charged the $1.00 monthly account maintenance fee. If your account balance is $2,000 or more, you can choose to invest funds if you wish. More information is included in your Welcome Kit.

**Employer “seed money”**

If you enroll in the HDP Plan, your employer will make a one-time cash deposit to your HSA in early January. The funds are intended to serve as a “buffer” until your HSA fund balance builds. Your HSA balance builds if you contribute to funds through payroll deduction. The 2015 Employee Rate Sheet shows employer “seed-money” information.

**Visit www.pebcinfo.com**

The PEBC website is the central benefits information website with links to each plan provider search option. To view 2015 plan information, enter the group password included in your enrollment packet. It is also available from your employer intranet or Human Resources Department or Benefits Office.
# PPO Plan quick-reference guide

Refer to plan documents for limitations and additional information.

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</thead>
<tbody>
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<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$500 individual/$1,000 family</td>
<td>$1,000 individual</td>
</tr>
<tr>
<td>Coinsurance (after deductible)</td>
<td>You 20%; Plan 80%; Plan 100% after OOP</td>
<td>You 40%; Plan 60%</td>
</tr>
<tr>
<td>Coinsurance Maximum</td>
<td>$3,000 individual/$6,000 family</td>
<td>No Limit</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum Limit (OOP)</td>
<td>$3,500 individual/$7,000 family</td>
<td>No Limit</td>
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<td>Physician Services</td>
<td></td>
<td></td>
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<tr>
<td>Office Visits</td>
<td>$25 PCP/$25 Tier 1 Specialist/ $35 non-Tier 1 Specialist</td>
<td>You 40%; Plan 60%</td>
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<td>Hospital Visits</td>
<td>You 20%; Plan 80%; Plan 100% after OOP</td>
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</tr>
<tr>
<td>Urgent Care Visit</td>
<td>$35 copay</td>
<td>You 40%; Plan 60%</td>
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<td>Preventive Care*</td>
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<tr>
<td>Well-Child Care (birth to age 17)</td>
<td>Covered at 100%</td>
<td>You 40%; Plan 60%</td>
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<td>Well-Woman Exam</td>
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<tr>
<td>Routine Screening Mammography (age 35+)</td>
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<td>Adult Health Assessments (age 18+)</td>
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<td>$150 copay — waived if admitted</td>
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<td>Chiropractic</td>
<td>$35 copay per visit maximum 20 visits per year</td>
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<td>$25 visit — maximum 20 visits per year You 20%; Plan 80%; limits apply to number of days annually</td>
<td>You 50%; Plan 50%; maximum 20 visits per year You 40%; Plan 60%; limits apply to number of days annually</td>
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## HDP Plan quick-reference guide

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### HDP Plan: In-network benefits only

The HDP Plan does not provide out-of-network benefits, except in an emergency. In an emergency, you should go to the nearest emergency room.

### Transition benefits

Are you new to the HDP or PPO Plan? Transition of care is a service that enables new enrollees to receive time-limited care for specific medical conditions from an out-of-network doctor but at the in-network benefit level. Transition of care benefits must be approved by UnitedHealthcare. Complete Sections 1 and 2 of the Application for Transition of Care form (available at [www.pebcinfo.com](http://www.pebcinfo.com) or from your Human Resources Department). Ask your doctor to complete Section 3 and forward to UnitedHealthcare no later than 30 days after your benefits become effective.

Applications may be reviewed even before your benefits become effective. Transition benefits may apply if you are in your second or third trimester of pregnancy, a high-risk pregnancy, in nonsurgical treatment (radiation, chemotherapy) for cancer, treatment for symptomatic AIDS, treatment for severe or end-stage kidney disease, or if you are on the waiting list or recently underwent a bone marrow or organ transplant.
Your prescription drug benefits are administered by Express Scripts. Express Scripts ensures that you have access to high-quality, cost-effective medications through a network of retail pharmacies and by offering convenient home delivery of your maintenance medications from the Express Scripts Pharmacy.

**New! Express Advantage Network (EAN)**
If you fill your prescription at a retail pharmacy, starting in 2015, you will save by filling the prescription at an EAN pharmacy. EAN pharmacies include many national grocery and big-box chains such as Kroger, Albertsons, Target, Costco, Sam’s Club, Tom Thumb and Walmart. You can still fill a prescription at a non-EAN pharmacy, but you will pay an additional $10 per prescription, referred to as an “upcharge.” For those enrolled in the HDP plan, since you pay 100% of the cost during the deductible phase, the upcharge does not start until you reach the coinsurance phase. If you currently use a non-EAN pharmacy and you want to avoid the upcharge, call an EAN pharmacy to transfer your prescription. Don’t wait until the last minute to make the change. To find an EAN pharmacy, call Express Scripts or visit [www.pebcinfo.com](http://www.pebcinfo.com).

**Out-of-pocket cost**
Whether you are enrolled in the PPO or HDP Plan, your eligible pharmacy cost counts toward your OOP. This means copays and out-of-pocket costs will help limit the amount of total cost you pay each plan year. There are certain expenses that do not count toward the OOP, such as items not covered or excluded by the plans, the cost difference if you choose a brand-name drug instead of a generic, or the $10 upcharge if you fill your prescription at a non-EAN pharmacy.

**Please note:** You pay 100% of the cost for drugs excluded from the formulary.

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<tr>
<th>Access Options</th>
<th>PPO Plan</th>
<th>HDP Plan</th>
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<tbody>
<tr>
<td>EAN Retail Pharmacy (in-network)</td>
<td>$15 Generic $25 Preferred Brand $50 Non-Preferred Brand</td>
<td>Regardless if retail or home delivery pharmacy, you pay 100% of Express Scripts cost until you meet deductible. After deductible, you pay 10% of Express Scripts cost until the maximum OOP is met. After OOP, plan pays 100%.</td>
</tr>
<tr>
<td>up to a 30-day supply. Refills allowed as prescribed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Delivery Pharmacy</td>
<td>$30 Generic $50 Preferred Brand $100 Non-Preferred Brand</td>
<td>After deductible is met, $10 upcharge per prescription (does not count toward OOP).</td>
</tr>
<tr>
<td>up to a 90-day supply. Refills allowed as prescribed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-EAN Pharmacy additional upcharge applies.</td>
<td>$10 upcharge per prescription (does not count toward OOP).</td>
<td></td>
</tr>
</tbody>
</table>
Generics first
If you choose a brand-name drug when a generic is available, your cost will dramatically increase. The pharmacist may alert you if a generic is available. Your doctor can help you determine if the generic is best for you.

**PPO Plan members:** If you choose the brand-name drug and you are enrolled in the PPO Plan, you’ll pay the applicable copay plus the cost difference between the generic and brand-name drug. The generic copay only will count toward your maximum OOP.

**HDP Plan members:** If you choose the brand-name drug when a generic is available, only the generic cost will apply to your maximum OOP.

Other changes effective January 1, 2015
- Most compound medications in the form of a cream, gel or ointment are excluded by the formulary. If you are currently using this type of product, you will receive a letter from Express Scripts about your options. FDA-approved hormone replacement products and diaper rash creams with prescription ingredients are not affected.
- Hepatitis C medications now require prior authorization.
- Certain over-the-counter bowel preparations (in preparation for an outpatient colonoscopy) are now covered at no cost to you, as long as you have a doctor’s prescription.Covered products include generic preparations and single-source brands such as Visicol®, Osmoprep®, Suprep® and Prepopik®. Fill limit is two prescriptions at $0 cost per 365 days.
- Certain medications for primary prevention of breast cancer are now covered at zero cost to you. Both Tamoxifen andRaloxifene (Evista®) are covered at zero cost to you based on your age, previous breast cancer diagnosis or if you are determined to be at high risk for breast cancer. Check with your doctor to determine if these medications are appropriate for you.
- Read elsewhere in this guide about more access to flu shots and vaccinations at the retail pharmacy starting January 1, 2015.

Specialty pharmacy
Through its relationship with Express Scripts, Accredo provides specialty pharmacy services for patients with certain complex and chronic conditions. Specialty drugs treat complex conditions such as cancer, hepatitis C, growth hormone deficiency, multiple sclerosis, immune deficiency and rheumatoid arthritis. Specialty drugs typically cost at least $500 or more for a 30-day supply and can require frequent dosing adjustments. Whether specialty drugs are taken orally, self-injected or administered by a health care professional, specialty drugs require intensive clinical monitoring.

You can use either the retail pharmacy or home delivery benefit when filling your specialty drug prescription. Specialty drugs usually require special storage and handling and may not be readily available at your retail pharmacy. In some cases, a 90-day supply may not be shipped due to the dosing, packaging or medication requirements.

Register at Express-scripts.com
Take advantage of the convenient way to manage your prescriptions through the many online tools available at www.express-scripts.com. To help you plan, budget and save, check Price a Drug, Express Preview, and Save on My Prescriptions. Did you know you can download your Rx history for a specific date range? The Rx history is acceptable as FLEX claim substantiation.
Prescription drug benefits Continued

Express Scripts national preferred formulary
The formulary is the list of safe and effective medications available for you. Not all medications on the formulary are covered by your plan and some medications are excluded entirely. A national panel of doctors and pharmacists reviews and compares prescription drugs to ensure the formulary includes proven medications to treat every condition. Some drugs may no longer be included when other safe and effective alternatives are available, and the formulary changes every year.

Your enrollment packet includes the 2015 Express Scripts Preferred Drug List (most commonly prescribed) with a list of the excluded medications and covered preferred alternatives. Talk to your doctor about an alternative that can work for you. Call Express Scripts Customer Service (877-613-1227) if you have any questions.

No-cost contraceptives
Your plan covers certain contraceptives at no cost to you and all can be filled through Home Delivery or at the retail pharmacy.

- Oral contraceptives (generic only)
- Barrier method (diaphragm)
- Implanted device (Mirena)
- Emergency contraceptives (generic only)

Other ways to save
Many retailers offer $4-generic programs (30-day supply) and some offer $10-generic programs (90-day supply). With your plan coverage, you will always pay the lesser of the retail cost or the generic copay you are charged.

Home delivery is easy, safe and convenient
Get up to a 90-day supply of your medicine for the prescriptions you take regularly. If you are enrolled in the PPO Plan, home delivery allows you to get a three-month supply for the price of two copays. Home delivery includes free standard shipping.

To get started, get a 90-day prescription from your doctor, plus refills for up to one year (if applicable). Complete a home delivery order form (available at express-scripts.com; click on “Forms”) and mail the form and prescription to Express Scripts at the address on the form. You can also ask your doctor to ePrescribe or fax your prescription.

Join the thousands of PEBC members who already enjoy the safety and convenience of home delivery pharmacy services from Express Scripts to your door. If you have questions about home delivery, call the number on your Express Scripts ID card.
Opt out of a medical plan

If you can show valid proof of other comparable medical plan coverage, such as another employer plan or TRICARE, you may choose to opt out of your employer’s medical plan. In addition to providing valid proof of comparable medical plan coverage, you must complete a “Certification of Other Coverage” form. Both documents must be received by your employer’s Human Resources Department before the enrollment deadline. 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 are a Dallas County employee hired January 1, 2015, or later, your employer can enroll you in the HDP Plan.

If you select opt-out, you are considered absent from the medical plans. This means that you are not eligible for continuation of medical coverage (COBRA) if you elect to opt out of medical coverage. Examples of other coverage that cannot be used to opt out of your employer’s medical plan include Medicaid, TRICARE “supplemental” coverage or student insurance. Your employer will confirm your other coverage. Check with your Human Resources Department or Benefits Office if you have questions.

Participating employers only

If your employer contributes to a health care flexible spending account due to your medical plan opt-out status and your proof of other coverage is found to be invalid or expired, the employer contribution is discontinued. You will be required to repay any employer contributions, and you could be subject to serious consequences. Coverage obtained through the Health Care Marketplace (Exchange) is not eligible for employer opt-out contributions. Participation or continuation of any employer contribution program is at the discretion of the employer.

Employee assistance program (EAP)

The EAP is completely confidential and is provided to you at no cost, regardless of the medical plan you selected. When you call, a customer service representative will ask a few questions and connect you with the right EAP solution for you. If you like, you can meet, face-to-face, with an MHN network counselor, therapist or psychologist, up to three times per incident, per calendar year. You can even schedule a private telephone or Web-video meeting if it is more convenient.

The EAP also has experts available via telephone to help you with work and life services, such as child or elder care assistance, certain financial and legal services, and identity theft recovery services. Self-help and interactive learning programs are also available to you when you want them.

Call the EAP anytime 888-779-2225 for help with:

- Marriage, family and relationship issues
- Problems in the workplace
- Stress, anxiety, changes in mood and sadness
- Grief, loss or responses to traumatic events
- Concerns about use of alcohol or drugs
More to consider

Thinking about retirement?
If your employer offers retiree health benefits, this information may apply to you. Be sure you review your employer’s retiree health policies before you retire. They may have changed. Make an appointment to discuss your options with the Human Resources department. If you are planning to retire sometime during 2015, pay particular attention to the November 2014 enrollment period. Elections during your last active employee annual enrollment period will affect the retiree benefits for which you may be eligible. Contact the Social Security Administration at least 90 days before you retire. If you are considering retirement, check out the Retiree Health Benefits Guide, available at www.pebcinfo.com or from your employer.

Celebrating your 65th birthday?
Most people become eligible for Medicare Part A when they turn 65, regardless of when they retire. If you are actively employed and age 65 or older, you will likely delay Part B until you retire. Medicare coverage is effective the first day of the month in which you turn 65. If your birthday is on the first day of the month, Medicare is effective the first day of the month before your 65th birthday. As long as you are an active employee, your employer plan is primary for you and your spouse, even if you or your spouse are age 65 or older. (Exceptions may apply for those with ESRD or Lou Gehrig’s Disease.) Once you retire, Medicare is primary. Make sure you contact Medicare 90 days before you retire to avoid higher Part B premiums.

What is a self-funded health plan?
PEBC employer groups self-fund (or self-insure) the HDP Plan, the PPO Plan and the PEBC Dental Plan. This means there is not an insurance company and your employer funds the cost of health claims. With self-funding, each PEBC employer group’s experience stands on its own and is not combined with any other group. Your plan cost is based on your workforce alone — not on the claims of other member groups — and your employee cost is based on the experience of your employer group. Even with the administrative costs associated with self-funded plans, when compared to fully insured plans (e.g., an HMO plan), the savings can be significant. The PEBC consistently administers all PEBC employer health plans which drives savings even farther. Subject to benefit differences, to an employee and health care provider, a self-funded insurance plan may feel no different than many insurance plans, even without an insurance company.

Subrogation requirements
Both the HDP and PPO plans 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. For example, if you are in a car accident that results in medical claims paid by the HDP or PPO plans, then the plans have a right to recover amounts paid by the plan on your behalf if you receive a payment from the other driver’s insurance company. If you are enrolled in Medicare, you cannot contribute to an HSA. You can delay your Medicare enrollment if you wish, but important deadlines apply once you retire. Contact the Social Security Administration or your tax advisor if you have any questions.

Retired public safety officers only:
The HELP Act
If you are a retired public safety officer and you enroll in the retiree group health plan, you may benefit from a new tax savings provision, known as the HELP Act. Federal law now permits eligible retired public safety officers to exclude up to $3,000 of their qualified health insurance premiums from their gross taxable income each year, as long as the premiums are deducted from their retirement benefit. This means your health premium must be deducted from your TCDRS monthly retirement benefit to qualify for the tax savings.

Contact the Human Resources Department (not TCDRS) for additional information and the required enrollment form. Information is also available at www.pebcinfo.com (select “Retiree” from the top menu). If you are currently enrolled, you do not need to enroll again.

If you are considering retirement, check the Retiree Health Benefits Guide for more information. Visit www.pebcinfo.com and select “Retiree” from the top menu.

Subrogation requirements
Both the HDP and PPO plans 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. For example, if you are in a car accident that results in medical claims paid by the HDP or PPO plans, then the plans have a right to recover amounts paid by the plan on your behalf if you receive a payment from the other driver’s insurance company. If you are involved in an accident, you will receive an Accident Investigation Form from Optum®, a UnitedHealthcare company. To avoid claim payment delays, it is very important you act quickly. Complete the form and return it as requested, following the instructions provided to you.
Dental benefits

The PEBC offers a choice of two dental plans.

**Assurant Dental HMO plan (DHMO)**
Provided by United Dental Care of Texas, Inc., the Assurant DHMO is a fully insured dental HMO plan. The plan offers many preventive services at $0 copay. Other dental services have pre-established copays which are less than you would pay without the plan.

There are no deductibles, coinsurance or annual maximum limits, and this plan does not require waiting periods. You will find a smaller network than the PEBC Dental Plan, but the employee premium is less. The Assurant DHMO booklet (available at [www.pebcinfo.com](http://www.pebcinfo.com)) lists each service and the applicable copay.

**PEBC Dental plan**
The PEBC Dental plan is a self-funded PPO plan with access to both in-network and out-of-network benefits. The best-in-class Delta Dental Network provides access to a large network of participating dentists, which translates into more cost savings to you.

Both Delta Dental PPO Dentists and Delta Dental Premier Dentists are considered in-network, although you will save more when you select a PPO dentist. This plan is a non-duplicating plan, which means if this plan is secondary to another dental plan, this plan will not pay if the primary plan allowable cost is greater than the PEBC Dental Plan allowable cost. This plan requires a six-month waiting period for major services and a 12-month waiting period for orthodontic benefits (see below). Enrollment in a dental plan other than the PEBC Dental Plan does not count toward meeting the required waiting period.

**Submitting FLEX claims for dental reimbursement**
Assurant DHMO — Because this is a DHMO plan, you will not receive an insurance EOB form. To avoid confusion, clearly write “DHMO Plan” on your itemized receipts before you send them to PayFlex.

PEBC Dental Plan — Wait for the EOB from Delta Dental which shows your financial responsibility.

Submitting a claim or using the FLEX Debit Card to pay for your dental expenses before you receive the EOB could result in an overpayment from your FLEX account. In that case, you must repay the overpayment amount or submit an eligible, unrelated claim (in the same plan year) to offset the overpayment. In some cases, your dentist may have to credit the overpayment to your FLEX debit card.

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**PEBC Dental plan**

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Annual deductible</th>
<th>After deductible plan pays</th>
<th>Maximum benefit by plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care includes checkups, cleaning, X-rays</td>
<td>$0</td>
<td>100%</td>
<td>Most preventive services do not count toward the $2,000 annual maximum plan benefit</td>
</tr>
<tr>
<td>Basic care includes fillings, oral surgery, periodontal treatment, root canals, crown repair</td>
<td>$50 per person per year for basic and major services combined — up to 3 deductibles per family</td>
<td>80%</td>
<td>$2,000 per person per year effective January 1, 2015</td>
</tr>
<tr>
<td>Major care includes crown installation, fixed bridgework, dentures and dental implants. Benefits begin after 6 months of coverage</td>
<td>$50 per person per year for basic and major services combined — up to 3 deductibles per family</td>
<td>50%</td>
<td>$1,750 per person per lifetime</td>
</tr>
<tr>
<td>Orthodontia benefits begin after 12 months of coverage</td>
<td>$50 per person per year for basic and major services combined — up to 3 deductibles per family</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

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Vision benefits

VSP Choice plan
Consider enrolling in the VSP Choice vision plan. The VSP network is made up of private practice doctors (ophthalmologists and therapeutic optometrists) and many offer affordable, high-quality eyewear choices on-site.

In-network benefits
VSP WellVision Exam® — $30 copay
(Every calendar year)

The VSP WellVision Exam is more than a quick eye check. It’s an in-depth exam that focuses on the health and overall wellness of your eyes. VSP doctors look for more than just vision problems — detecting signs of serious health conditions like glaucoma, diabetic eye disease, high blood pressure and high cholesterol.

Prescription lenses (copay combined with exam)
• Single vision, lined bifocal and lined trifocal lenses
• Polycarbonate lenses for dependent children
• Average 20–25% off lens options including progressives, anti-reflective, photochromics, scratch-resistant coating, polycarbonate, plastic dyes and UV protection

Frames (Copay combined with exam)
• Covered in full up to $150 retail allowance for frame of your choice
• 20% off amount over the allowance for frames
• $200 allowance for contacts and contact lens exam (fitting and evaluation)

Laser vision correction
• VSP-contracted laser centers provide discounts for laser surgery including PRK, LASIK and Custom-LASIK
• Discounts average 15% off the regular price or 5% off if the laser center is offering a promotional price

Out-of-network benefits
Although most VSP members choose to see a VSP doctor, your choice is important. At right is a reimbursement schedule for those members who choose a non-VSP provider. Claim forms are available online at www.pebcinfo.com or www.vsp.com.

Out-of-network reimbursements replace in-network services and are available once each plan year.

Eye Exam: up to $43
Single Vision Lenses: up to $30
Lined Bifocal Lenses: up to $45
Lined Trifocal Lenses: up to $62
Lenticular Lenses: up to $100
Progressive Lenses: up to $45
Frames: up to $40
Contacts: up to $185

Find an eyecare provider who’s right for you. Visit vsp.com or call 800-877-7195.

Plan exclusions
The following items are excluded under this plan:
• Two pairs of glasses instead of bifocals
• Replacement of lenses, frames or contacts
• Medical or surgical treatment
• Orthoptics, vision training or supplemental testing

The following items are not covered under the contact lens coverage:
• Insurance policies or service agreements
• Artistically painted or nonprescription lenses
• Additional office visits for contact lens pathology
• Contact lens modification, polishing or cleaning
Flexible spending accounts

A health care flexible spending account (FLEX account) is a way to set aside money from your earnings before taxes are withheld in order to pay eligible out-of-pocket health care expenses and qualifying dependent day care expenses. Use your FLEX Debit Card from PayFlex to pay for eligible health care expenses, or you can submit a claim for reimbursement of eligible health care and dependent care expenses using tax-free dollars from your PayFlex account. This reduces the amount you pay in taxes and increases your spendable income.

Expenses must be incurred by December 31 and submitted to PayFlex by April 30 of the following year to avoid loss of funds.

About rollover funds

The IRS allows employees with a health care flexible spending (FLEX) account to roll over up to $500 of their unused funds to the next plan year. This changed the “use-it-or-lose-it” rule which required you spend your funds before the end of the plan year or risk losing the money you saved.

Whether you enroll in the general purpose FLEX account or the limited purpose LP-FLEX account, and regardless if the contribution is from you or your employer, a combined total up to $500 of unused funds will automatically roll over for use during the next plan year.

Automatic rollover will occur after the end of the run-out period. The run-out period ends April 30, 2015, which means 2014 rollover funds will be available in May 2015.

Health care FLEX accounts

General purpose health care FLEX account

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

Limited purpose health care FLEX account

If you enroll in the HDP Plan with HSA, you cannot elect a general purpose health care FLEX account. But you can elect a limited purpose health care FLEX account (LP-FLEX). The LP-FLEX only reimburses you for eligible vision and dental expenses and out-of-pocket medical expenses after your HSA Plan deductible is met.

Why would you want to enroll in the LP-FLEX when you already have an HSA account? Because both plans have annual contribution limits. Enrolling in both may help you stretch your dollars even further. For example, if you know you will need significant dental work in the upcoming year, you can use the LP-FLEX account to pay for those expenses, preserving your HSA account balance. If you are submitting claims for reimbursement after you met the HDP deductible, you must also submit the EOB which shows the date you met the deductible.

Manage your account online!


- Check debit card status
- Use Express Claims to file a claim
- Upload claim substantiation
- Review your account(s)
- Download forms
- Learn more about the plan

FLEX claims must be incurred by you or your federal tax dependents only. FLEX accounts are ONLY for those eligible claims incurred by you or your dependents for federal income-tax purposes, without regard to income limitations. Do not risk IRS difficulties. Contact your tax or financial advisor for information about your specific situation.

To mail a claim

PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039

Toll-free: 877-644-5124

Use direct deposit

Safe and fast! Need a form?
www.mypayflex.com/pebc
Flexible spending accounts  Continued

<table>
<thead>
<tr>
<th>Health Care FLEX</th>
<th>General Purpose FLEX Account</th>
<th>Limited Purpose FLEX Account</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What can be reimbursed?</strong></td>
<td>Eligible qualified expenses such as out-of-pocket medical, dental and vision expenses</td>
<td>Eligible qualified dental and vision expenses, and only out-of-pocket medical expenses greater than the HSA Plan deductible</td>
</tr>
<tr>
<td><strong>Which account can I enroll in if I choose the PPO Plan? What about the HDP Plan or Opt-Out?</strong></td>
<td>PEBC PPO Plan or Opt-Out with a traditional plan as comparable coverage</td>
<td>HDP Plan or Opt-Out with a high-deductible plan/HSA as comparable coverage</td>
</tr>
<tr>
<td><strong>Can I use a FLEX Debit Card?</strong></td>
<td>Yes — PayFlex Debit Card</td>
<td>Yes — PayFlex Debit Card</td>
</tr>
<tr>
<td><strong>What is the maximum amount an employee can elect annually?</strong></td>
<td>$2,500 per plan year combined</td>
<td></td>
</tr>
<tr>
<td><strong>Can I have both accounts at the same time?</strong></td>
<td>No — you cannot have the LP-FLEX if you are enrolled in the general purpose FLEX account.</td>
<td>No — you cannot have the general purpose FLEX account if you are enrolled in the limited purpose LP-FLEX.</td>
</tr>
<tr>
<td><strong>Does “use it or lose it” apply?</strong></td>
<td>$500 of unused funds will automatically roll over to the next plan year. You will forfeit unused funds exceeding $500.</td>
<td></td>
</tr>
</tbody>
</table>

**Employer contributions**
In some cases, employers may contribute to an employee FLEX or LP-FLEX account. If your employer contributes, you will find the contribution amount on the back of the 2015 Employee Benefit Plan Rates document included in your enrollment packet. Employer contributions do not count toward the employee $2,500 health care FLEX account annual election limit.

**Dependent care FLEX account**
This account primarily benefits those with a qualifying child (under age 13) or qualifying dependent by reimbursing eligible day care 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 FLEX account 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). If you have questions about this account or whether you should take a credit on your federal income tax return, consult your tax professional or contact the IRS Help Line.

**A note for highly compensated employees**
The Internal Revenue Code (IRC) provides that health care FLEX spending accounts and dependent care FLEX spending accounts cannot discriminate in favor of highly compensated employees (as defined by the IRC). 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 FLEX spending accounts.

**Manage your accounts online**
Visit [www.mypayflex.com/pebc](http://www.mypayflex.com/pebc) to manage your FLEX accounts. If you have more than one account type, you will see more than one 2015 account. The combined total represents your available funds. If you did not select a FLEX debit card, you can file your claims electronically and either upload or fax your claims substantiation.
FAQs about debit cards

Will the FLEX debit card work if you elect the LP-FLEX account?
Yes. Do not throw your card away. As long as it is not expired, it will work.

Why doesn’t your FLEX debit card work?
There could be a situation when your FLEX debit card does not work. If you experience difficulty and none of these situations described below apply to you, contact PayFlex for assistance.

Did you select a FLEX debit card during annual enrollment?
You must select a FLEX debit card during annual enrollment or your card will NOT work — even if you already have a card and it is not expired.

Do you have available funds in your health care FLEX spending account?
If there are insufficient funds to cover your entire purchase, your FLEX debit card purchase will be denied.

What if your dentist requires you pay in advance?
If you are enrolled in the Delta Dental Plan, the only way to know for sure how much you owe for services you received is to refer to the Explanation of Benefits (EOB) form. Sometimes, dentists require payment before the EOB is available. If you use your FLEX Debit Card to pay in advance and you discover you overpaid when you receive the EOB, you should contact your dentist so that the overpayment can be credited to your FLEX Debit Card.

If you are enrolled in the Assurant Plan, you will not receive an EOB. The dentist will likely confirm the out-of-pocket cost (per service) in advance.

Are you using the FLEX debit card to pay for over-the-counter (OTC) drugs without a prescription?
Due to the rules connected to OTC drugs, your FLEX debit card will not work unless you have a prescription.

Did you provide claims substantiation as requested by PayFlex?
The IRS requires claims substantiation. If you do not respond to a letter from PayFlex requesting that information, your FLEX debit card is temporarily deactivated. You can reactivate your card by providing the claims substantiation requested. Remember, your 2015 FLEX debit card will not work if you did not provide requested 2014 information.

Is the debit card expired?
Check the card’s expiration date. Your debit card will work in 2015 as long as it is not expired. If the debit card expires soon, you will receive a new card before it expires.

Need an extra FLEX debit card?
If you need another card for an eligible family member, just call PayFlex. Remember, you are still responsible for appropriate use of the FLEX debit card, even if used by another family member.

PayFlex debit card

A FLEX debit card makes it easy to access your health care FLEX spending account funds. Your entire health care FLEX spending account election amount is available for use at the later of either January 1, 2015, or your effective date. A $9.00 annual fee is deducted from your account at the beginning of the year. IRS requirements apply when you use a FLEX debit card, and every cardholder agrees to follow IRS rules. Each time you use your FLEX debit card, you agree that 1) the expense is an eligible expense incurred by you or a dependent claimed on your Federal Income Tax Return, 2) you have not received reimbursement from any other source, and 3) you will not request reimbursement elsewhere. Read the cardholder agreement that accompanied your FLEX debit card.

Claims substantiation and receipts
The IRS requires claims substantiation for debit card transactions. Unless you are using the card to pay an eligible expense with a fixed copay, you must provide claims substantiation when requested by PayFlex. You will also be asked to provide an Explanation of Benefits (EOB) form to show your out-of-pocket cost for that particular service. If your out-of-pocket cost is less than the amount charged to your debit card, you are required to either repay the plan or substitute another eligible expense incurred during the same plan year. In accordance with IRS requirements, failure to provide claims substantiation will cause your debit card to be temporarily deactivated.

FLEX accounts and dental expenses
You can use your health care FLEX spending account to pay for eligible dental expenses. Refer to the Dental Benefits page for helpful information about using your FLEX account to pay for dental expenses.

You have until April 30, 2015, to submit claims for expenses incurred during 2014. Expenses are incurred when the medical care is provided or the service is delivered, not when you are billed, charged or pay for care.
Life insurance and 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, 2015, basic life insurance amount is based on the later of either your annual salary at December 31, 2014, or your 2015 hire date. *Your AD&D coverage is equal to your basic term life insurance amount. Basic life and AD&D coverage is not less than $20,000 or more than $50,000. Coverage reduces beginning at age 70.

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

Optional term life (TLF)
Employee TLF is voluntary and is based on your annual salary times your selected coverage level. During annual enrollment, if you change your coverage level (for example, from one times salary to two times salary), you must complete an optional life application form and an EOI form, mailing both to Dearborn National by November 30, 2014. Use the Optional Term Life Rate Chart (Column A) on the following page to calculate your monthly cost.

Spouse optional term life (SLF)
SLF coverage amount cannot exceed 50% of the employee TLF coverage amount. During a newly hired employee’s initial enrollment period, both the $10,000 and $25,000 coverage levels are available without evidence of insurability (EOI). At all other times, whether you are selecting SLF for the first time or you are increasing 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 (Column B) on the following page to determine SLF monthly cost.

Evidence of insurability (EOI)
During annual enrollment, you must complete both an Optional Life Application form and an EOI form only if you are increasing your TLF or SLF coverage level or adding TLF or SLF coverage for the first time. All forms must be mailed to Dearborn National on or before November 30, 2014. Forms postmarked after that date or envelopes with missing forms are invalid and will not be accepted.

<table>
<thead>
<tr>
<th>Employer-paid term life and AD&amp;D (GLF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1 x your annual salary</td>
</tr>
<tr>
<td>• Minimum coverage $20,000 regardless of salary</td>
</tr>
<tr>
<td>• Maximum coverage $50,000</td>
</tr>
<tr>
<td>• AD&amp;D coverage at 1 x basic term life coverage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee-paid optional term life capped at $400,000 (TLF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>County employees</td>
</tr>
<tr>
<td>• 1/2 x annual salary</td>
</tr>
<tr>
<td>• 1 x annual salary</td>
</tr>
<tr>
<td>• 2 x annual salary</td>
</tr>
<tr>
<td>• Select no optional coverage (prior year grandfathered amounts may apply)</td>
</tr>
<tr>
<td>NTTA employees</td>
</tr>
<tr>
<td>• 1 x annual salary</td>
</tr>
<tr>
<td>• 2 x annual salary</td>
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<tr>
<td>• 3 x annual salary</td>
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<tr>
<td>• 4 x annual salary</td>
</tr>
<tr>
<td>• Select no optional coverage</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependent optional term life (DGL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPTION 1</td>
</tr>
<tr>
<td>$5,000 Spouse</td>
</tr>
<tr>
<td>$2,500 Each Dependent*</td>
</tr>
<tr>
<td>OPTION 2</td>
</tr>
<tr>
<td>$10,000 Spouse</td>
</tr>
<tr>
<td>$5,000 Each Dependent*</td>
</tr>
<tr>
<td>*Dependents up to age 26</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SLF</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Can be selected in addition to DGL</td>
</tr>
<tr>
<td>• SLF cannot exceed 50% of employee TLF</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SLF coverage levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000 $25,000 $50,000 $75,000 $100,000</td>
</tr>
</tbody>
</table>
To calculate monthly premium cost (TLF/SLF)

Using your annual salary at December 31, 2014, and your age on January 1, 2015, calculate your monthly TLF premium cost. To calculate your per-payroll check cost, simply multiply the monthly cost by 12 and divide by the number of 2015 payroll checks from which benefits are deducted (24 or 26).

**County employees**

**Step 1** Select coverage level (50%, 100%, 200%)  ________ %

**Step 2** Multiply annual salary at 12/31/14 by coverage level  $__________

**Step 3** Round Step 2 amount to the next highest $1,000  $__________

**Step 4** Divide Step 3 amount by $1,000  $__________

**Step 5** Multiply Step 4 amount by appropriate rate for your age at 1/1/15 (Optional Term Life Rate Chart, Column A). This is your monthly TLF premium amount.  $__________

**NTTA employees**

**Step 1** Annual salary at 12/31/14 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 at 1/1/2015 (Optional Term Life Rate Chart, Column A). This is your monthly TLF premium amount.  $__________

**Optional term life rate chart**

*Rates listed are per $1,000 of coverage*

Visit [www.pebc.com](http://www.pebc.com) for forms and more information.

<table>
<thead>
<tr>
<th>Age</th>
<th>Column A* Includes AD&amp;D</th>
<th>Column B** Without AD&amp;D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30</td>
<td>$.09</td>
<td>$.05</td>
</tr>
<tr>
<td>30-34</td>
<td>$.11</td>
<td>$.07</td>
</tr>
<tr>
<td>35-39</td>
<td>$.13</td>
<td>$.09</td>
</tr>
<tr>
<td>40-44</td>
<td>$.17</td>
<td>$.13</td>
</tr>
<tr>
<td>45-49</td>
<td>$.24</td>
<td>$.20</td>
</tr>
<tr>
<td>50-54</td>
<td>$.35</td>
<td>$.31</td>
</tr>
<tr>
<td>55-59</td>
<td>$.53</td>
<td>$.49</td>
</tr>
<tr>
<td>60-64</td>
<td>$.87</td>
<td>$.83</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.41</td>
<td>$1.37</td>
</tr>
<tr>
<td>70 and over</td>
<td>$2.38</td>
<td>$2.34</td>
</tr>
</tbody>
</table>

* Includes AD&D of $0.04/$1,000 ** Without AD&D

**Portability**

If your coverage terminates, you can continue an amount up to the full amount of your Optional Term Life (TLF and SLF) and DGL benefit without evidence of insurability and at the same low cost provided to active employees (without AD&D). Use the Optional Term Life Rate Chart (Column B) to determine your initial cost. Rates increase as you age in five-year increments. You must be enrolled in life insurance for at least 12 months to carry over coverage. If your spouse is enrolled in SLF, the SLF coverage must be in place for at least 12 months to port SLF coverage.

**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 Dearborn National for cost information. You do not have to be covered for at least one year to convert coverage and conversion locks you into a specific rate based on your age at the time of conversion.

**Employee premiums (basic + optional) greater than $50,000 cannot be offered on a pre-tax basis and may result in additional taxable income to you. TLF includes additional AD&D coverage equal to one times the optional term life coverage amount.**
Change in status events

As a condition for offering tax-free benefits to you, eligible benefit premiums are deducted from your payroll check on a pre-tax basis. Your employee benefits are offered to you through your employer’s cafeteria plan. You should choose your benefits wisely. IRS regulations provide that, unless you experience a qualified “change in status” event (described below), you cannot change your benefit choices until the next annual enrollment period. If you experience a qualified change in status event, you may make a new election for coverage as long as the election is consistent with the qualified change in status event and the change is prospective (not retroactive).

To be considered consistent, 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 FLEX spending account elections, dependent life insurance elections or your health benefit elections. If you want to change the amount of your payroll contribution to your HSA account, you can do that without first experiencing a change in status event. To change the amount, contact the Human Resources or Benefits Office. Changes can be made once each month with the change effective the month following the change. Your payroll contribution will be adjusted as soon as administratively possible. Refer to the plan documents for additional information.

Two types of 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
• An event causing a dependent to no longer meet eligibility requirements, such as reaching age 26

Change in employment status
Applies to any change in the employment status of an employee, spouse or dependent that affects benefit eligibility under your benefit plan or the employer benefit plan of your spouse or your dependent:
• Termination or commencement of employment
• Strike or lockout
• Start or return from an unpaid leave of absence
• USERRA (military) leave
• 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 makes the individual become eligible for or lose eligibility for a particular plan

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.

Important deadlines apply
Timing is very important. According to IRS rules, coverage elections cannot be retroactive. Except for newborns and adoptions, a qualified change in status event is effective the first day of the month following the date you notify your employer, provided you meet the 31-day notification rule.

1. 31-day notification rule — You must notify your Human Resources department of the event AND you must complete and turn in required paperwork (including proof of the change) within 31 days of the event date. If you do not, you cannot make the change.

2. Effective date — Provided you met the 31-day rule noted in #1 above, the change is effective the first day of the month following the date you notified your employer of the qualified change in status event. 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.

To illustrate:
31-day notification: You married on November 9th and on December 3rd you told your Human Resources department that you want to add your spouse to your medical plan. You met the 31-day notification deadline. Refer to the information below to determine effective date.

Effective date: In this case, your spouse’s coverage is effective January 1st. Your spouse’s coverage could have been effective on December 1st if you had notified your Human Resources department by November 30th.
Understanding claim payment

Managing your claims and benefits
The enhanced “myClaims Manager” claims display on myuhc.com provides a clear explanation of your medical claims and benefits, which helps you better understand and manage your health care expenses all in one place. If you have an out-of-pocket responsibility amount for any claim, you can even pay your health care providers online.

To view “myClaims Manager,” log in to myuhc.com and select the “Manage My Claims” button.

Here you’ll see your Claims Summary, which displays a list of your most recent claims. If you’re looking for a specific claim, you can search by time frame, family member or claim type. You can even click the “Export” link to download your claims information at tax time, or for other record-keeping purposes.

Claim summary
The Claim Summary table provides a list of your claims highlighted by family member, health care provider, date, amount billed, amount you owe and other key details.

The “Manage Claim” column has features to help you track and manage your claims. You can flag claims you’d like to watch, mark claims that you’ve already paid and add personalized notes to each claim so that you can remember important details.

View claim
Click on “View Claim” to see an at-a-glance graphic view of the claim displayed. This shows how a claim was processed, plan discounts, what was paid by your plan and how much you owe. There’s also a breakdown of your responsibility, indicating how much of the claim was applied to your deductible and out-of-pocket maximum to help you better understand what you owe your health care provider. If you do owe your health care provider, you can easily send an electronic payment by clicking the “Make Payment” button.

The “Detailed Costs” table provides information about the claim, including user-friendly descriptions of the specific health care services received.

If you have an HSA
In addition to claim information, myClaims Manager provides a detailed display of your HSA account balance. The balances are shown at the top of the page.

Prescription drug claims
To view your prescription drug claims information, register at www.express-scripts.com. The Prescription Benefits section allows you to order prescriptions and check the status of your order. 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 a FLEX reimbursement or to document your HSA spending. Visit www.express-scripts.com/pebc to check specific costs for those drugs covered by your plan.

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 with the benefits you receive from other group health plans. This ensures that benefits are coordinated to avoid duplication of payment. This also ensures that 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 Plan, 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 end-stage renal disease exceptions.) You can update your Coordination of Benefits information at any time at myuhc.com. After you click on the “Claims and Accounts tab,” scroll down to “Member Actions” and select “Coordination of Benefits.”

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. Whenever the plan is secondary, the plan pays the difference between what the primary plan paid and what your plan would have paid if the other plan didn’t exist, except that you will never be reimbursed more for the same expenses under both this plan and the primary plan than this plan would have paid alone. This means if the primary plan allowable amount for each service is greater than this plan, this plan will pay nothing. 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 non-custodial parent.
Dependent eligibility summary

Who is an eligible dependent?
Your dependent can be enrolled in a plan only if he/she is an eligible dependent. If both you and your spouse work for the same employer, your dependents can be covered by only one of you. It is important that you enroll eligible dependents only.

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 child(ren)
- 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

Managing conservator
- Your stepchild (natural or adopted child of employee’s 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
Before you add a new dependent or spouse, valid proof of eligibility is required before coverage is effective. Check with the Human Resources Department for more information.

Who is NOT an eligible dependent?
Enrollment of an ineligible dependent can be considered fraud and can subject you to severe 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 boyfriend or girlfriend
- A surviving spouse who was not covered by the deceased retiree at the time of the retiree’s death

Ineligible child(ren)
- 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 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 brother, sister, other family member or an individual not specifically listed by the plan as an eligible dependent

IMPORTANT: Check both columns. Full details regarding eligibility are found in the legal documents governing the plans.

Health Care Reform
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.
ID card information

Will I get a new ID card?
ID card information is listed below. In most cases, you can log in to the applicable plan website and print a temporary ID card until your ID card arrives. Check the Contacts section of this guide for website information.

When will my ID card arrive?
If you changed medical plans during annual enrollment or you are enrolled in the PPO Plan, you should receive your new ID card in early January, 2015. If you do not receive your card by January 20, print a temporary ID card and notify your Human Resources or Benefits Office. Remember to notify your employer if you moved. If you failed to notify your employer, your ID card will be delayed. As long as you are correctly enrolled in a plan, providers can electronically confirm your eligibility and that of your covered dependents.

Medical plans
Each medical plan uses two ID cards — one for UnitedHealthcare and one for Express Scripts (ESI). The medical ID card is used to access MHN mental health services.

- **PPO Plan** — You will receive a new UnitedHealthcare ID card but your current Express Scripts ID card will work.
- **HDP Plan** — You will not receive a new 2015 UnitedHealthcare or Express Scripts ID card unless you are new to the plan. Your current ID cards will work.

Dental plans
- **Assurant DHMO** — You will not receive a new ID card unless you are new to the plan.
- **Delta Dental** — You will not receive a new ID card unless you are new to the plan.

Vision plan
- **VSP** — You will not receive an ID card. When you visit an in-network provider, the provider’s office will confirm your eligibility electronically.

What about my debit cards?

- **PayFlex** — Don’t throw your existing card away! The card will work for both the general purpose and limited purpose FLEX accounts as long as it is not expired and you indicated you wanted to continue your card during annual enrollment. If your card is about to expire, you will receive a new card before the card expires. The FLEX debit card has a $9.00 annual fee which is deducted from your 2015 health care FLEX account in early January. (Debit cards are not applicable to Dependent Care accounts.)
- **Optum Bank** — If you are newly enrolled in the HSA, after your account is opened, you will receive a UnitedHealthcare Health Savings Account MasterCard® (debit card) from Optum Bank. The card does not have an annual card fee. Even if you have not yet received your HSA account debit card, as long as your account is active, you can still use the online bill pay to pay your provider or reimburse yourself if needed. If you are currently enrolled, your current debit card will work in 2015.

Let us know if you have a change of address
If you move, be sure to provide your Human Resources Department with your new address as soon as possible. This is the best way to ensure that you avoid delays in receiving your ID cards, EOB forms and other valuable information.

Resources at your fingertips
We encourage you to register at myuhc.com and express-scripts.com. Once you register, you will have access to personalized tools, information and answers for managing your health care.
Contacts

It’s easy to stay connected! Visit www.pebcinfo.com or the vendor websites shown below, or if you are on the go, stay connected with the apps shown below. Most are available at the Apple iTunes Store and at Google Play.

Medical Plans (PPO Plan/HDP Plan)
UnitedHealthcare Customer Care
877-370-2849
www.myuhc.com
App: UnitedHealthcare Health4Me™

Express Scripts/Accredo Specialty Pharmacy
877-613-1227
www.express-scripts.com
App: Express Scripts Mobile App
For Specialty Pharmacy, contact Accredo
800-501-7210

MHN (mental health care)
888-779-2225 (all care must be pre-certified)
www.mhn.com

Dental Plans
Assurant DHMO Series 189 Plan
(United Dental Care of Texas, Inc.)
800-227-3055
www.pebcinfo.com

PEBC Dental Plan
Delta Dental PPO/Premier
800-521-2651
www.deltadental.com
App: Delta Dental Mobile

Vision Plan
VSP Choice Plan
800-877-7195
www.vsp.com

Life Insurance
Dearborn National
800-778-2281
www.pebcinfo.com

Other Contacts

EAP Program
MHN
888-779-2225
www.members.mhn.com (code – pebc)

Wellness Plan
Optum
877-818-5826
www.myuhc.com (PPO/HDP)
https://client.myoptumhealth.com/PEBC (Opt-Outs)

myNurseLine
855-690-0360
www.myuhc.com

FLEX Accounts
PayFlex
877-644-5124
www.payflex.com/pebc

HSA Accounts
Optum Bank
800-791-9361
www.myuhc.com or
www.optumbank.com

www.pebcinfo.com
The easy-to-navigate benefits information website with plan details, forms, links to network sites and much more. Your group password is included in your enrollment packet materials.

Health Insurance Marketplace
Helps uninsured people find insurance
www.healthcare.gov
For informational purposes only. Nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor’s care.

(CCS 14-757)