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, 2016. Your employer wants you to clearly understand your plan choices, and this 2016 Employee 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 pebcinfo.com. In all cases, you should refer to the plan documents for additional details.

What’s new in 2016?

**Medical plan changes**
Here is some quick info about changes effective in 2016. You can find more information later in this Guide and in the plan documents. Learn more at pebcinfo.com.

**Annual out-of-pocket maximum**
The in-network, annual out-of-pocket maximum has changed. Regardless of the medical plan you select (PPO or HDP), after you meet $3,000 (individual) or $6,000 (family) in eligible, annual out-of-pocket expenses, the plan will pay 100%. Eligible expenses include copays and covered medical and pharmacy expenses. Out-of-network services do not have an annual out-of-pocket maximum limit.

**Coinsurance**
Coinsurance is your portion of eligible cost after any deductibles that may apply. In 2016, just like the PPO, if you enroll in the HDP, your in-network services subject to coinsurance will require you pay 20% of the eligible cost until you reach the out-of-pocket maximum. For out-of-network services, you will pay 40% of the eligible cost plus the difference between provider-billed and eligible cost (balance-billing) without an out-of-pocket maximum.

**New HDP out-of-network services**
In 2016, the HDP has out-of-network benefits, although you will pay more of the cost if you use an out-of-network provider or facility. The Quick Reference Guide compares in-network and out-of-network services, including deductible and coinsurance differences.

**PPO plan emergency room (ER) cost**
PPO members will pay a $300 ER copay, plus 20% of the cost after your deductible is met. This means that, depending on when your ER claim is paid, you could pay even more if your deductible is not met when your ER claim processes.

**PPO 2016 prescription drug copays**
Brand-name prescription drug copays increased a bit in 2016. There is no change to generic copays.

- Retail — preferred $30; non-preferred $60
- Home delivery — preferred $60; non-preferred $120

In some cases, your medication must be pre-authorized. Your pharmacist or physician can do that for you. Always check the formulary for additions, changes and exclusions before the start of the new plan year.

**Other changes**

**Full-time employee definition**
The definition of a full-time employee has changed. To summarize, you are a regular, active full-time employee eligible for health and life benefits if you work, on average, at least 30 hours per week (130 hours per month) based on your employer’s calculations. This typically means you are regularly scheduled to work or are expected to work an average of 30 hours or more per week (130 hours per month). Part-time, variable-hour and seasonal employees not expected to work or average 30 hours per week are not eligible.
Wellness rewards
In 2016, you can earn a $300 wellness reward for yourself and a $300 wellness reward for your covered spouse. This means that together, you and your spouse can earn $600 in wellness rewards once each year. You cannot be paid for the spouse reward unless you earned your own wellness reward first. Check page 22 of this Guide for more information.

Optional life insurance cost
The cost for both employee optional life (TLF) and spouse optional life (SLF) is reduced beginning in 2016. Check the optional term life rate chart on p. 33 to determine the age-rated cost per $1,000 of coverage.

Employee FLEX elections
In 2016, the maximum election to the health care spending account is increased to $2,550. This amount includes general purpose and limited purpose employee elections. Employer contributions to your FLEX account(s) do not count toward the employee annual election limit.

New spouse surcharge (medical plans only)
Regardless of the medical plan you select, new rules may affect the amount you pay for coverage if you enroll your spouse in your medical plan. A spouse surcharge will not apply if your spouse enrolls in both your spouse’s employer plan and your employer plan. If your spouse does not enroll in his/her employer medical plan first, you will pay more to enroll your spouse in your PPO plan or HDP. Review your specific situation during annual enrollment.

The spouse surcharge will apply if:
1. Your spouse’s employer offers a medical plan and your spouse did not enroll in that plan; and
2. You cover your spouse in your employer PPO medical plan or HDP; then
3. A $200 per month spouse surcharge will apply to the cost of covering your spouse on your employer medical plan (deducted from payroll).
4. The surcharge will also apply if you fail to complete or were late turning in the required Spouse Medical Plan Surcharge Affidavit.

The spouse surcharge will not apply if:
1. Your spouse is enrolled in his/her employer medical plan (proof of enrollment required) and your PPO plan or HDP; or
2. Your spouse does not work outside the home and has no access to employer coverage; or
3. Your spouse’s employer does not offer medical coverage or your spouse is not eligible for that coverage; or
4. Your spouse’s other coverage is Medicare, Medicaid, TRICARE or care received at a VA facility; and
5. You turned in the required Spouse Medical Plan Surcharge Affidavit on time.

Required time-sensitive enrollment action
During annual enrollment, any employee who covers his/her spouse must sign a Spouse Medical Plan Surcharge Affidavit attesting to your spouse’s access to employer medical plan coverage through his/her employer, regardless if he/she enrolled in that coverage. Your employer may allow you to sign the Affidavit online when you enroll in coverage. Other employers require a paper form. More information and a copy of the form will be in the Annual Enrollment Packet and at pebinfo.com.

Spouse’s employer enrollment period
While many plans are calendar-year plans (like yours), some are not. If your spouse’s employer plan is not a calendar year plan, and your spouse did not enroll in his/her employer plan during your spouse’s annual enrollment, your spouse should check with his/her employer now to see if it is still possible to enroll. If the employer’s plan rules do not allow enrollment, then the spouse surcharge applies until your spouse’s employer coverage is effective.

Spouse Medical Plan Surcharge Affidavit due by December 31, 2015
If you enroll your spouse in your PPO plan or HDP, a spouse surcharge will be automatically deducted from your 2016 payroll check, unless your spouse enrolled in his/her employer medical plan first and you turned in the Affidavit on time.

Don’t delay. Turn in the Affidavit on or before December 31, 2015.

The surcharge will apply for each month an affidavit was not turned in (even if the surcharge does not apply or if it was turned in late) or if you fail to notify your employer of a change which would have triggered the surcharge.
Tools to help you choose

Visit pebcinfo.com
The PEBC website is the central benefits information website with tools to help you choose a health plan, estimate your out-of-pocket cost and forms and links to locate important information. Check it often!
To view 2016 plan information, enter the group password included in your enrollment packet.
The password is also available from your employer’s intranet, Human Resources Department or Benefits Office.

Make an informed choice
As you know, the world of health benefits has changed. 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.

Employee choices
Medical plan
- PPO plan
- High deductible plan (HDP) with health savings account (HSA)
- OPT-out (proof of comparable coverage required)

Dental plans
- PEB — Delta Dental PPO Dental Plan
- ANT — Assurant Dental HMO Plan

Vision plan
- VIS — VSP Choice Plan

Flexible spending (FLEX) accounts (employee elections)
Account choice depends on the medical plan you select. In 2016, employer contribution account values (if applicable) can be found at pebc.healthhub.com.
- FXM — health care flexible spending account
- LPX — limited purpose health care flexible spending account (LP-FLEX)

Life insurance (multiple options available)
- TLF — Employee optional term life
- SLF — Spouse optional term life
- DGL — Dependent term life

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- DGL — Dependent term life
Enrollment resources and tools

- **pebcinfo.com** — the centralized benefits site with plan information, forms and links to PEBC vendor sites.

- **myuhc.com** — a great place for locating a provider, estimating costs and linking to the wellness site and Optum Bank® (HSA).

- **myHealthcare Cost Estimator** ([myuhc.com](http://myuhc.com)) is a great tool to help you estimate your out-of-pocket cost, compare treatment options and select a quality provider for a procedure.

- Visit [myClaims Manager](http://myclaimsmanager.com) to manage your claims and understand your share of the plan cost. See where you are in meeting your deductible, your annual maximum out-of-pocket cost and view your claims history.

- Find in-network providers (including Premium physicians) by selecting the link “Find Physician, Laboratory or Facility”.

- Log-in to [express-scripts.com](http://express-scripts.com) or download the Express Scripts app to manage your prescription drug benefits. Information right at your fingertips!

- To compare plans, check the easy-to-understand Summary of Benefits and Coverage available at [pebcinfo.com](http://pebcinfo.com). The Summary helps you compare certain health plan provisions regardless if coverage is purchased privately or through your employer.

- **2016 Employee 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 benefits.

- **2016 Employee Benefits Rate Sheet** — lists employee contribution rates for each plan along 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** — 2016.

- Check the various online flyers for more information about special topics.
Enrollment

Enrolling during annual enrollment?
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 for 2016. You cannot change from one plan to another during the plan year (without a qualifying change of status event), so make sure you consider your annual enrollment choices 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 PEBC employer groups (except Dallas County), the PPO is the default medical plan, and you cannot change from PPO 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 pebcinfo.com.

Dallas County employees only
If your hire date is January 1, 2015, or later, you can enroll in the HDP (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 a continuing 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. Both plans use the large UnitedHealthcare Choice Plus network.

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

• If you enroll in the HDP, consider the additional savings and benefits of the HSA, especially if partnered with a limited-purpose health care spending account (LP-FLEX). Your employer contributes “seed money” to your HSA to help you save even more.

• If you enroll in the PPO plan or opt out of medical coverage, you can also save by electing a health care FLEX account.

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 an LP-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.
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

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.

When a child’s coverage ends
You may cover your child (natural child, stepchild, adopted child) in a medical, dental and/or vision plan until the last day of the month in which the child turns age 26, whether or not the child is a student, working, living with you and regardless of the child’s marital status. This coverage does not extend to your child’s spouse or their children. Your grandchild is eligible only if the grandchild is unmarried and your dependent for federal income tax purposes. You must provide your Form 1040 to prove grandchild dependent status.
Medical plans 2016

Regardless of the medical plan you select, certain things work the same. Beginning in 2016, both plans have the same coinsurance levels, annual out-of-pocket maximums, and offer limited out-of-network benefits. In other ways, the plans work differently, including deductibles and how they work, and copays.

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 plans. To locate a doctor, hospital or other provider, visit myuhc.com. While each plan includes out-of-network benefits, you will often pay more for care received from an out-of-network provider.

Out-of-pocket maximum limit (OOP)
Regardless of the medical plan you select, as long as your medical care is delivered in-network, your annual out-of-pocket maximum (OOP), including in-network deductible, coinsurance and copays, will not exceed $3,000/single and $6,000/family. After you meet the OOP, the plan then pays 100% of your eligible expenses.

PPO plan: If you are enrolled in the PPO plan, in-network medical and prescription drug copays count toward your OOP but not to your deductible. 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. If you fill your prescription at a non-EAN retail pharmacy, the $10 upcharge does not count toward OOP.

HDP: If you enroll in the HDP, all eligible out-of-pocket expenses count toward your OOP. After you meet your deductible, you pay 20% of eligible in-network expenses until you reach your OOP. The IRS requires that the family deductible be met if you enroll in anything other than single coverage.

Regardless of your plan, when you reach the maximum in-network OOP, you are done. The plan will then pay 100% of eligible costs.

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

- 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

Coinsurance and in-network cost
Certain expenses are covered by the plans based on a percentage of allowed cost. In 2016, for those services subject to coinsurance, after the in-network deductible is met, each plan pays 80% of in-network costs. Your 20% portion (coinsurance) applies to your annual maximum out-of-pocket limit (OOP).

Coinsurance and out-of-network cost
In 2016, both the PPO plan and HDP allow limited out-of-network services. If you choose to receive covered services 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 deductible is met.

If you receive care from out-of-network providers, you will pay more of the cost, including 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. Always check to make sure your doctors, facilities and other service providers are in-network. Visit myuhc.com or contact myNurseLine (877-370-2849) if you need help finding a network provider.
About copays and out-of-pocket cost

PPO plan
If you are enrolled in the PPO plan, you pay a fixed-copay for many services. In some cases, you pay coinsurance (after deductible) instead of a copay. For emergency room services, you will pay both a copay and coinsurance. While copays count toward in-network out-of-pocket cost, copays do not count toward your deductible. Standard medical copays are listed below. Check the prescription drug section for 2016 copays. Refer to the PPO plan Quick Reference Guide found later in this Guide, or visit pebcinfo.com for more information.

PPO copays (in-network)
- Office visit: $25 PCP/$25 Premium specialist/ $35 non-Premium specialist
- Urgent care: $35
- Mental health (MHN): $25 office visit (example: therapists)
- Emergency room: $300 plus 20% coinsurance on the remaining amount (after deductible); waived if admitted

HDP out-of-pocket costs
The HDP does not use copays. You pay 100% of the allowable cost until the applicable in-network deductible is met. This means you pay all of the cost for office visits, urgent care, prescription drugs, emergency room and other covered expenses. Eligible medical, pharmacy and mental health expenses all count toward the deductible. Once the deductible is met, coinsurance applies. The allowed in-network cost is the network “discounted” cost, not “retail” cost.

About deductibles
The deductible is the amount you must pay each year before the plan begins paying benefits for expenses. The deductibles for the PPO plan and the HDP work differently.

In-network deductibles
PPO plan (copays do not count toward deductible)
- $500 individual (single) deductible
- $1,000 family deductible
*If you cover family members, the in-network family deductible is met when the combined eligible in-network expenses for you and/or your covered family members reach $1,000. If one of the family members reaches $500 but the combined family deductible of $1,000 has not been met, the member who met the $500 deductible can move to coinsurance until one more family member reaches the deductible. If no family member reaches the $500 deductible, but the combined family deductible is met, all family members move to coinsurance.

HDP (an important difference)
- $1,500 individual (single) deductible
- $3,000 family deductible**
The HDP in-network deductible works similar to the PPO plan, but there is an important distinction.

**If you cover any family member, the entire in-network family deductible must be met before any family member can move to coinsurance. This is different than the PPO plan.

The HDP in-network family deductible is met when the combined eligible expenses for you and/or any covered family members reach $3,000. Even if one family member reaches the $1,500 deductible, that member cannot move to coinsurance until the full $3,000 family deductible is met. It doesn’t matter if one or more family members incur the expenses that meet the total family deductible. The IRS requires that the full family deductible be met before any family member moves to coinsurance.

Out-of-network deductibles
PPO plan — $1,000 individual
HDP plan — $3,000 individual/$6,000 family
In the PPO Plan, the individual out-of-network deductible:
- Applies to each enrolled family member
- Does not have a family deductible limit

A special note about mental health and substance abuse services
When you enroll in either the PPO plan or HDP, 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.
# PPO plan quick-reference guide

Refer to plan documents for limitations and additional information.

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<tr>
<td>Newborn Care in Hospital (Routine)</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Lab &amp; X-ray Outpatient (Minor)</strong></td>
<td>Covered at 100% in physician office or in-network lab or radiological provider</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Hospital Emergency Care Services</strong></td>
<td>$300 copay + 20% after deductible waived if admitted</td>
<td>$300 copay + 20% after deductible waived if admitted</td>
</tr>
<tr>
<td>(treated as in-network)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>20% after deductible up to 60 days annually</td>
<td>40% after deductible up to 60 days annually</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>20% after deductible up to 120 visits annually</td>
<td>40% after deductible up to 120 visits annually</td>
</tr>
<tr>
<td><strong>Allergy Care Services</strong></td>
<td>$25 PCP/$25 Tier 1 Specialist $35 non-Tier 1 Specialist</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Chiropractic</strong></td>
<td>$35 copay per visit maximum 20 visits per year</td>
<td>40% after deductible maximum 20 visits per year</td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td>20% after deductible (excludes in vitro and drug coverage)</td>
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</tr>
<tr>
<td>Five (5) Artificial Insemination Visits (Lifetime)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Supply &amp; Equipment (DME)</strong></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$25 visit: maximum 20 visits per year 20% after deductible; limits apply to number of days annually Treated like any other illness Limited — 3 lifetime episodes of care</td>
<td>50% after deductible; maximum 20 visits per year 40% after deductible; limits apply to number of days annually Treated like any other illness Limited — 3 lifetime episodes of care</td>
</tr>
<tr>
<td>Serious Mental Illness Substance Abuse</td>
<td></td>
<td></td>
</tr>
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</table>

* Subject to Affordable Care Act requirements.
# HDP quick-reference guide

Refer to plan documents for limitations and additional information.

<table>
<thead>
<tr>
<th>Feature</th>
<th>HDP Your In-Network Cost</th>
<th>HDP Your Out-of-Network Cost PLUS You Pay Charges Exceeding Plan Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (The entire family deductible must be met before benefits pay — unless you selected employee only)</td>
<td>$1,500 individual/$3,000 family</td>
<td>$3,000 individual/$6,000 family</td>
</tr>
<tr>
<td>Coinsurance (After the annual deductible is met)</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Annual Coinsurance Maximum</td>
<td>$1,500 individual/$3,000 family</td>
<td>No limit</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum Limit (OOP)</td>
<td>$3,000 individual/$6,000 family</td>
<td>No limit</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Hospital Visits</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>20% after deductible</td>
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<tr>
<td>Preventive Care*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Care (Birth to age 17)</td>
<td>Covered at 100%</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Well-Woman Exam</td>
<td>Covered at 100%</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Routine Screening Mammography (Age 35+)</td>
<td>Covered at 100%</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Adult Health Assessments (Age 18+)</td>
<td>Covered at 100%</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered at 100%</td>
<td>40% after deductible</td>
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<tr>
<td>Routine Eye Exam</td>
<td>Refer to VSP Choice Plan</td>
<td>Refer to VSP Choice Plan</td>
</tr>
<tr>
<td>Screening Colonoscopy</td>
<td>Covered at 100%</td>
<td>40% after deductible</td>
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<tr>
<td>Eyewear, Frames, Contacts</td>
<td>Refer to VSP Choice Plan</td>
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<td>Maternity Services</td>
<td></td>
<td></td>
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<td>Routine Prenatal Care</td>
<td>Covered at 100%</td>
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About the Health Savings Account (HSA)

If you enrolled in the HDP, you are eligible for an HSA. If you are new to the HDP, an HSA will be opened on your behalf with Optum Bank. Read more about this valuable savings tool, designed to help you save for out-of-pocket expenses, now or in the future.

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 an FSA, your savings grow from year to year. The HSA works differently than a flexible spending account. A big difference is that the HSA has triple-tax benefits.

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

Things you need to know about an HSA
To deposit money into an HSA, you must be enrolled in an HSA-eligible health plan. The PEBC HDP is an HSA-eligible plan. You are eligible for this plan if:

- You are covered under an eligible high-deductible health plan (like the HDP).
- You are not covered by another medical plan (unless it is a HDHP) or a general purpose FSA.
- 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 2016, the IRS allows total deposits up to $3,350 if you have individual coverage or $6,750 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 HDP with 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.

To make sure your HSA contributions and any investment earnings remain free of income taxes, penalties and/or excise taxes, make sure you understand the eligibility and contribution rules for HSAs. Since this is your personal account and you are responsible for compliance with the tax rules, it is recommended you consult with your personal tax advisor about your personal situation. Your employer cannot provide you tax advice.
Your bank account
If you are newly enrolled in the HDP, 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, 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 even faster if you contribute to funds through payroll deduction. The 2016 Employee Rate Sheet provides more employer “seed-money” information.

Employee assistance program (EAP)
The EAP is completely confidential and is provided to you at no cost, regardless of the medical plan you selected. Even if you opt-out of medical coverage, the EAP is available to you. 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 identify theft recovery services. Self-help and interactive learning programs are also available to you when you want them.

Call the EAP anytime at 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

Visit pebcinfo.com
The PEBC website is the central benefits information website with links to each plan provider search option. To view 2016 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.
Prescription drug benefits — PPO plan or HDP

Your outpatient 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.

**Express Advantage Network (EAN)**

If you fill your prescription at a retail pharmacy, 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, 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, since you pay 100% of the cost during the deductible phase, the upcharge does not start until you meet your deductible and you are in 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 [pebcinfo.com](http://pebcinfo.com).

**Out-of-pocket cost**

Whether you are enrolled in the PPO plan or HDP, your eligible pharmacy cost counts toward your in-network 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 prescription drug 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.

<table>
<thead>
<tr>
<th>Access Options</th>
<th>PPO Plan</th>
<th>HDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAN Retail Pharmacy (in-network)</td>
<td>$15 Generic</td>
<td>Regardless if retail or home delivery pharmacy, you pay 100% of Express Scripts cost until you meet your deductible.</td>
</tr>
<tr>
<td>up to a 30-day supply. Refills allowed as prescribed.</td>
<td>$30 Preferred Brand</td>
<td>After deductible, you pay 20% of Express Scripts cost until the maximum OOP is met.</td>
</tr>
<tr>
<td></td>
<td>$60 Non-Preferred Brand</td>
<td>After OOP, plan pays 100%.</td>
</tr>
<tr>
<td>Home Delivery Pharmacy</td>
<td>$30 Generic</td>
<td></td>
</tr>
<tr>
<td>up to a 90-day supply. Refills allowed as prescribed.</td>
<td>$60 Preferred Brand</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$120 Non-Preferred Brand</td>
<td></td>
</tr>
<tr>
<td>Non-EAN Pharmacy upcharge applies to all prescriptions filled at a non-EAN pharmacy.</td>
<td>$10 upcharge per prescription (does not count toward OOP).</td>
<td>After deductible is met, $10 upcharge per prescription (does not count toward OOP).</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 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, 2016
- Brand-name prescription drug copays increased. Preferred brand copays are $30 if filled at the retail pharmacy and $60 if filled via home delivery. Non-preferred brand copays are $60 if filled at the retail pharmacy and $120 if filled via home delivery.
- Based on recommendations by the U.S. Preventive Services Task Force, based on your age and gender, generic low-dose aspirin and Vitamin D may be covered without cost to you. A prescription is required.

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. 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 all at once 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 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 2016 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**
(prescription required)
The outpatient pharmacy benefit plan covers certain contraceptives at no cost to you, which can be filled through home delivery or at the retail pharmacy.

Generic contraceptives are available with zero cost to the member. In certain situations, if your prescriber indicates a brand product must be dispensed, after a prior authorization review, the brand product may also be available at zero copay. Not all drugs are covered. Check the Formulary for more information. If you have questions, contact Express Scripts.

The outpatient pharmacy benefit covers the following methods:

- **Hormonal methods**, like birth control pills, patches, vaginal rings and injections
- **Barrier methods**, like diaphragms and cervical caps
- **Over-the-counter barrier methods** (female condoms, spermicides and sponges)
- **Intrauterine contraceptives** (Mirena)
- **Implantable medications** (Implanon)
- **Emergency contraceptives** (Plan B, Ella)

**Shop smart!**
Many retailers offer $4-generic programs (30-day supply) and some offer $10-generic programs (90-day supply). If you are enrolled in the PPO plan, you will always pay the lesser of the retail cost or the generic copay. HDP members can also save with these programs.

**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, you save even more. 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 Express Scripts at 877-613-1227.
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 (must meet minimum essential coverage rules under the ACA), 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 select opt-out, you are considered absent from the medical plans. This means that you are not eligible for continuation of medical coverage (COBRA). Examples of other coverage that cannot be used to opt out of your employer’s medical plan include Medicaid, TRICARE “supplemental” coverage, student insurance or coverage that does not meet minimum essential coverage requirements under the Affordable Care Act. 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 or your health savings 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 may 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.

Opt-out requirements

- Valid proof of other comparable medical plan coverage (must meet ACA requirements for minimum essential coverage)
- A “Certification of Other Coverage” form
- If you and your spouse work for the same employer, neither can opt out of the medical plan
- Check your employer’s policies for other coverage requirements

Retiring soon?

To enroll in the retiree medical plan, you must be enrolled in a medical plan when you retire. If you opt-out, carefully consider your options. You may want to reconsider your opt-out status during your last active employee annual enrollment period before you retire. Check with your employer for more details.

Hearing aid coverage

If you are enrolled in the HDP, hearing aids are subject to deductible and coinsurance. For PPO plan members, you have limited hearing aid benefits as long as the hearing aid is medically necessary, proven and FDA approved. Check the PPO hearing aid information below. If you use an out-of-network provider, you must file the claim for reimbursement.

- You can be reimbursed up to $1,000 for a single purchase (per ear) every four years.
- Deductible and coinsurance do not apply.
- Benefits are for the hearing aid, fitting and testing only (no batteries, accessories, dispensing fees or repairs).
- Provided certain medical conditions are met, bone-anchored devices may be considered a covered health service under your medical plan’s surgical benefit, with the device itself subject to hearing aid device limits.
Vision benefits

**VSP Choice Plan**
Eye exams are an important part of your overall health care. For that reason, the VSP Choice Plan is available to you. The VSP network is made up of private practice doctors (including 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)
A WellVision Exam performed by a VSP doctor is more than a quick eye check. It’s an in-depth exam designed to help detect health conditions like high blood pressure, diabetes and high cholesterol — along with other eye and health issues. Your vision is checked during the exam, and if you need corrective lenses, that is covered, too!

**Prescription lenses** (copay is 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 is 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. Check the out-of-network reimbursement schedule if you choose a non-VSP provider. Claim forms are available online at pebcinfo.com or vsp.com.

**Out-of-network reimbursement**
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
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 pebinfo.com) lists each service and the applicable copay.

PEBC Dental plan (Delta Dental)
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.

<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</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></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>$1,750 per person per lifetime</td>
</tr>
</tbody>
</table>

Assurant DHMO
- Service area — Texas only
- No claims to file
- Includes adult/child orthodontics
You must select a general dentist. Call Assurant DHMO at 800-227-3055 and they will help you.

PEBC Dental plan by Delta Dental
- Nationwide service area
- Freedom to see any dentist, but you pay more for out-of-network care

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 PayFlex 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 PayFlex Card.
myNurseLine℠

Sometimes you want immediate answers to your health concerns and you can’t wait until morning. With so many choices, it can be hard to know where to look for trusted information and support. 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.

Trusted support for your health concerns
Feel free to call myNurseLine to check if a provider is in the network, a UnitedHealth Premium specialist or accepting new patients.

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 learn more or to talk with a myNurseLine registered nurse, call 877-370-2849 or visit myuhc.com.

myNurseLine can help you:
• Chat with a registered nurse live on myuhc.com.
• Understand your diagnosis and explore treatment options and outcomes.
• Answer questions about your medications.
• Choose appropriate medical care for your needs, whether that is an ER, doctor visit or self-care.
• Locate available local resources.
• Find a doctor, hospital or specialist and check network participation.
Care when you need it

About emergency care
Many times the hospital emergency room (ER) is the right choice. But did you know your doctor can treat many of the same problems? If your doctor is unavailable, there are other lower-cost alternatives to the ER. Emergency room care is considered in-network, even if services are provided at an out-of-network ER.

Doctor’s Office — 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. PPO members pay a $25 copay for these services.

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 life-threatening or critical condition, go to the nearest emergency room (in-network benefits apply). Do not ignore an emergency and call 911 if the situation is life threatening. In 2016, PPO members pay a $300 ER copay (waived if admitted) plus 20% coinsurance (after deductible). HDP members pay 20% coinsurance (after deductible) for ER services.

The new freestanding ERs
Freestanding ERs are showing up everywhere. A freestanding ER can easily be confused with an urgent care center or convenience clinic, but it is still considered part of a hospital ER. Visiting a freestanding ER can result in higher out-of-pocket costs for you.

Many hospitals and other organizations are opening new freestanding ER locations in your community. If you receive care at a freestanding ER, you may be charged hospital ER rates for any or all of your services. There are other lower cost alternatives available. If it is not a life-threatening or critical situation, call myNurseLine at 877-370-2849 or use the UnitedHealthcare Health4Me® app to locate the nearest urgent care or convenience care location.

Foreign travel
PEBC plans do not cover foreign claims, or claims for any health services provided outside the United States, unless services are provided in connection with a life-threatening emergency.

If a covered member traveling outside the United States experiences a life-threatening emergency, the member should go to the nearest emergency room and contact UnitedHealthcare’s “Personal Health Support” within 24 hours. To reach Personal Health Support, the member should call the Customer Service telephone number on the back of the medical plan ID card, selecting the prompt for Personal Health Support. The nurses will be in touch with the facility and provide limited assistance to the member in identifying those emergency services covered by the plan.

When traveling outside the country, you are strongly encouraged to obtain medical travel insurance while outside the US. There are many reputable firms and coverage is typically inexpensive. If someone is traveling as a result of a sponsoring organization (such as an educational institution, church group, etc.), they generally also have coverage information available. Visit the U.S. State Department website (travel.state.gov), which provides information about emergency medical coverage for U.S. citizens traveling outside the U.S. and includes a list of U.S. owned insurance companies that offer coverage.
Creating a culture of better health
The PEBC Wellness Program

Almost everyone can take at least one step to help improve their health, and now you (and your covered spouse!) can earn points and dollars for doing just that.

How it works
To earn wellness points and rewards, you must be an active employee enrolled in either the PPO plan or HDP and you must be registered at myuhc.com. To earn an employee $300 reward, an employee must earn 300 points. Partial points do not count. There are many ways to earn points, but points must be earned during the period January 1, 2016, to October 31, 2016. Points do not roll over from a previous year.

New! Earn points and rewards for you and your covered spouse
Beginning in 2016, employees can also earn rewards for spouses, which means together, you can earn more money for taking steps to improve your health! An employee can earn a $300 reward for achieving 300 points, or a $600 reward if both the employee and the covered spouse each achieve 300 points (600 points total). Spouse points will not be paid unless the employee earns 300 points. The spouse must be enrolled in the plan to participate and remain enrolled at the time of payout for additional reward payout.

To illustrate:
• If the employee did not earn 300 points but the covered spouse did, a reward will not be paid.
• When the employee earns 300 points, a $300 reward will be paid to the employee.
• If a spouse earned 300 points, as long as the employee earned 300 points, a total of $600 in rewards will be paid to the employee for the year.

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.

Earning points
You (and your covered spouse) must be enrolled in the PPO plan or HDP to earn points. Preventive screenings and biometrics performed at your doctor’s office will automatically reflect points earned once the claim is paid. Tell your doctor if the visit is for preventive services only. If other services are provided, the visit may no longer qualify as a preventive visit.

1. **Health Assessment** — In 2016, earn 75 points (once each year) by taking the 15-minute assessment at myuhc.com. You cannot earn additional points unless you first 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 Cancer Screenings** — Earn 25 points (once each year) for a mammogram, colonoscopy or a cervical screening.

5. **Healthy Pregnancy** — Earn 50 points when you enroll — and dads can earn points, too!

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.
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, an employee 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 plan or HDP, 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 member, 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, 2016. Points are not earned for partially completed programs and do not roll over to another year.

**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 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 (600) points. You must be an employee (and covered spouse if applicable) at time of payout to receive your reward.

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

**Coming soon...**

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!** Those who participate in 2016 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!
Preventive care services

Understanding preventive care
Maintaining or improving your health with regular, age-appropriate preventive care and 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 plan or HDP and 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 uhcpreventivecare.com.

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 diagnose, manage or treat an already-identified medical issue or health condition are considered diagnostic care, not preventive care. During a preventive care visit, if you discuss any other health concerns such as abnormal symptoms or treatment of a health concern, your visit will no longer be considered a preventive visit, and the visit may no longer be covered at 100%. The visit may also not be eligible for wellness rewards. You may be charged a copay or out-of-pocket cost, 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. The plan also covers, at no cost to the member, at least one form of contraception in each of the 18 methods identified and approved by the FDA, including necessary clinical services, patient education and counseling. Certain prenatal and breastfeeding supplies and services are also covered at no cost to you. Visit pebcinfo.com to view a summary of no-cost preventive services.
Flu shots and vaccines

Whether you visit your doctor, stop at the retail pharmacy, 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 many retail pharmacy locations.

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

Express Scripts retail pharmacy vaccines

Your outpatient pharmacy benefits (Express Scripts) will cover many vaccines under the 100% preventive benefit when administered at a participating retail pharmacy.

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 and still in the deductible phase.

Here are a few of the many North Texas EAN retail pharmacies. Contact Express Scripts or visit pebcinfo.com for more EAN options (Express Scripts ID card required).

- Albertsons
- Brookshire
- Costco
- HEB
- Kroger
- Minyard
- Rite Care
- Sam’s Club
- Target*
- Tom Thumb
- Walmart

(*Check Target EAN status before you fill a prescription or get a vaccine)

Covered vaccines

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

Plus

- Childhood diseases (MMR, etc.)
- Rabies (additional cost may apply)
- Travel vaccines (additional cost may apply)

UnitedHealthcare retail pharmacy vaccines

Select vaccines can be administered at the retail pharmacies listed below using your UnitedHealthcare ID card. The retail pharmacies listed below are available in the North Texas area. Visit myuhc.com if you need more information.

- Albertsons
- CVS
- Safeway/Tom Thumb
- Target
- Walgreens

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.
Healthy Pregnancy Program

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 the UnitedHealthcare 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 registered nurse will consult with you by telephone to help you determine what, if any, risks or complications could arise during your pregnancy. The nurse can help you learn and practice healthy pregnancy habits and protect the wellbeing of your baby. If you have individual needs, a Healthy Pregnancy Program nurse will provide one-on-one support throughout your pregnancy.

Enroll at your convenience
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 the end of your 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 healthy-pregnancy.com, you can access a full range of articles covering nutrition, exercise, childbirth preparation, tips for dads and more. Enroll in the Healthy Pregnancy Program and receive a complimentary book, Mayo Clinic Guide to a Healthy Pregnancy. You will also receive complimentary gifts for you and your baby and money-saving coupons. The website also 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 888-246-7389 (Monday – Friday, 8 a.m. to 8 p.m. CST). For more information, visit 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 and completing the required enrollment paperwork to add your newborn. If you enroll your newborn within 31 days from the date of birth, coverage is effective on the date of birth. If you do not add your newborn within 31 days from the date of birth, you cannot add your newborn until the next annual enrollment period. Don’t risk forgetting this important step.

Becoming a dad?
The Healthy Pregnancy program isn’t just for moms! Start preparing now to find out what you need to know as you prepare to become a dad. You can enroll in the Health Pregnancy program, too!
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 payroll contribution amount to your HSA, 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 following month. 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) and the change affects benefits eligibility
• Reduction or increase in hours of employment, such as going from part-time to full-time, and the change affects benefits eligibility
• 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 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.
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 PayFlex Card to pay for eligible health care expenses, or submit a claim for reimbursement of eligible expenses from your PayFlex account.

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

About roll over funds

The IRS allows employees with a health care 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 all of 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 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 in the next plan year.

Automatic rollover will occur after the end of the run-out period. The run-out period ends April 30, 2016, which means 2015 roll over funds will be available in May 2016.

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 (not HDHP), 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 (LP-FLEX)

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

Why would you want to enroll in the LP-FLEX when you already have an HSA? Because both accounts have annual contribution limits. Enrolling in both may help you stretch your dollars 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 funds. If you are submitting medical claims for reimbursement after you met the HDP deductible, you must also submit the EOB which shows the date you met the deductible.

It’s easy to manage your account!

Visit pebc.healthhub.com or follow the link from pebcinfo.com.

Download the PayFlex app — use the same credentials as your online log-in.

• 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.

New website

pebc.healthhub.com

Use your PayFlex credentials to log in and manage your accounts online!

To mail a claim

Use the claim form available at pebc.healthhub.com and mail to the address shown on the form.

For more information, call the PEBF/PayFlex Information Line.

Voice: 877-644-5124
Fax: 877-645-7637
Web: pebc.healthhub.com
Employer contributions
In some cases, employers may contribute to an employee FLEX or LP-FLEX account. If your employer contributes, you will find the maximum contribution amounts on the back of the 2016 Employee Benefit Plan Rates document included in your enrollment packet. Employer contributions are in addition to and do not count toward the employee $2,550 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 instead, 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 pebc.healthhub.com to manage your FLEX accounts. If you have more than one 2016 FLEX account type, you will see more than one 2016 account listed. 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.
PayFlex Card

A PayFlex Card, your account 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 claims incurred at the later of either January 1, 2016, 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 PayFlex Card, and every cardholder agrees to follow IRS rules. Each time you use your PayFlex 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 PayFlex 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 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.

Don't ignore letters from PayFlex
If you received a letter from PayFlex requesting claims substantiation or receipts for your debit card expenses, take action immediately. If claims substantiation is not submitted as requested, then your card will be suspended until it is received. You may be required to repay the amount charged. If you receive a notice from PayFlex asking you to reimburse the account or provide an offsetting receipt for the same plan year, act quickly before additional action is taken.

FAQs about the PayFlex Card

Will the PayFlex 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 for either the FLEX or LP-FLEX account.

Why doesn't your PayFlex Card work?
If you experience difficulty and none of the situations below apply to you, contact PayFlex for assistance at 877-644-5124.

Did you select a PayFlex Card during annual enrollment?
You must select a PayFlex 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 PayFlex Card purchase will be denied.

Did your dentist require that 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 your dental services is to review the EOB form. Sometimes, dentists require payment before the EOB is available. If you use your PayFlex 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 PayFlex 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 PayFlex Card to pay for over-the-counter (OTC) drugs without a prescription?
Due to the rules connected to OTC drugs, your PayFlex Card will not work unless you have a prescription.

Are you in overpayment status? 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 PayFlex Card is temporarily deactivated. You must also repay the plan unless you have an offsetting expense incurred in the same plan year. You can reactivate your card by providing the claims substantiation requested. Remember, your 2016 PayFlex Card will not work if you did not provide requested 2015 information.

Is the debit card expired?
Check the card’s expiration date. Your PayFlex Card will work in 2016 as long as it is not expired. If the PayFlex Card expires soon, you will receive a new card before it expires.

Need an extra PayFlex Card?
If you need another card for an eligible family member, order one at pbec.healthhub.com, or call PayFlex at 877-644-5124. Remember, you are still responsible for appropriate use of the PayFlex Card, even if used by another family member.

You have until April 30, 2016, to submit claims for expenses incurred during 2015. Expenses are incurred when the medical care is provided or the service is delivered, not when you are billed, charged or pay for care.
More to consider

Thinking about retirement?
Your employer offers retiree health benefits, but retiree health benefits cost more than your active employee coverage. Avoid problems. Review your employer’s retiree health policies before you retire. They may have changed. Make an appointment to discuss your retiree benefit options with the Human Resources department at least 60 days before you retire. If you are planning to retire during 2016, pay particular attention to the November 2015 annual enrollment period. Elections during your last active employee annual enrollment will affect the retiree benefits for which you may be eligible. Contact the Social Security Administration at least 90 days before you retire. Carefully review the Retiree Health Benefits Guide, available at pebcinfo.com or from your employer.

Turning age 65 and still working
If you are actively employed and your 65th birthday is coming up, this information is for you. Most people become eligible for Medicare when they turn 65. If you are still working and covered under your employer’s plan, you can delay your Medicare enrollment until you retire.

If you are actively employed, you may choose to delay your Medicare enrollment until you retire for several reasons, including:
- You (and your spouse — regardless of spouse age) can continue on the employer health plan;
- You (and your spouse — regardless of spouse age) can delay payment of Part B premium;
- Contributions can still be made to your HSA as long as you are not enrolled in Medicare (and you are enrolled in the HDP); and
- Your employer health plan is the primary plan for you and your covered spouse as long as you are actively employed (subject to spouse surcharge).

Caution: If you are preparing to retire, it is critically important that you contact the Social Security Administration to enroll in Medicare Part A and Part B. If you delay, your Medicare enrollment can be delayed and you may be subject to higher Part B premium. When you retire, Medicare becomes primary for you and your covered spouse. You may be eligible for your employer’s retiree plan, but only if you are enrolled in both Medicare Part A and Part B.

What is a self-funded health plan?
PEBC employer groups self-fund (or self-insure) the HDP, 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 plan have important subrogation requirements. Subrogation is the right of a party that has paid medical claims on your behalf to recover amounts paid if the beneficiary of those payments recovers funds from another source. For example, if you are in a car accident that results in medical claims paid by the HDP or PPO plan, 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.

Retired public safety officers only: The HELPS 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 HELPS Act. Federal law 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 pebcinfo.com (select “Retiree” from the top menu). If you are currently enrolled, you do not need to enroll again.
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, 2016, basic life insurance amount is based on the later of either your annual salary at December 31, 2015, or your 2016 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 both an optional life application form and an EOI form, mailing both to Dearborn National by November 30, 2015. Use the Optional 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 an employee’s TLF coverage amount. During a newly hired employee’s initial enrollment period, both the $10,000 and $25,000 coverage levels are available without EOI. At all other times, whether you are selecting SLF for the first time or you are increasing 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, 2015. 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>
<th>Employee-paid optional term life capped at $400,000 (TLF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 x your annual salary</td>
<td>1/2 x annual salary</td>
</tr>
<tr>
<td>Minimum coverage $20,000 regardless of salary</td>
<td>1 x annual salary</td>
</tr>
<tr>
<td>Maximum coverage $50,000</td>
<td>2 x annual salary</td>
</tr>
<tr>
<td>AD&amp;D coverage at 1 x basic term life coverage</td>
<td>3 x annual salary</td>
</tr>
<tr>
<td></td>
<td>Select no optional coverage (prior year grandfathered amounts may apply)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NTTA employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 x annual salary</td>
</tr>
<tr>
<td>2 x annual salary</td>
</tr>
<tr>
<td>3 x annual salary</td>
</tr>
<tr>
<td>4 x annual salary</td>
</tr>
<tr>
<td>Select no optional coverage</td>
</tr>
</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>*Dependents up to age 26</td>
</tr>
<tr>
<td>OPTION 2</td>
</tr>
<tr>
<td>$10,000 Spouse</td>
</tr>
<tr>
<td>$5,000 Each Dependent*</td>
</tr>
</tbody>
</table>

SLF
- Can be selected in addition to DGL
- SLF cannot exceed 50% of employee TLF

SLF coverage levels
- $10,000
- $25,000
- $50,000
- $75,000
- $100,000
To calculate monthly premium cost (TLF/SLF)

Using your annual salary at December 31, 2015, and your age on January 1, 2016, calculate your monthly TLF premium cost. To calculate your per-paycheck cost, simply multiply the monthly cost by 12 and divide by the number of 2016 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 12/31/15 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 1/1/16
(Optional Term Life Rate Chart, Column A).
This is your monthly TLF premium amount. $________

NTTA employees

**Step 1** Annual salary at 12/31/15 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 1/1/16
(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 pebc.com for forms and more information.

<table>
<thead>
<tr>
<th>Age</th>
<th>Column A* Active Employee (TLF) Includes AD&amp;D</th>
<th>Column B** Spouse (SLF) and Ported (TLF or SLF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30</td>
<td>$.08</td>
<td>$.04</td>
</tr>
<tr>
<td>30-34</td>
<td>$.10</td>
<td>$.06</td>
</tr>
<tr>
<td>35-39</td>
<td>$.12</td>
<td>$.08</td>
</tr>
<tr>
<td>40-44</td>
<td>$.16</td>
<td>$.12</td>
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<td>45-49</td>
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<td>60-64</td>
<td>$.83</td>
<td>$.79</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.34</td>
<td>$1.30</td>
</tr>
<tr>
<td>70 and over</td>
<td>$2.26</td>
<td>$2.22</td>
</tr>
</tbody>
</table>

* Includes AD&D of $0.04/$1,000
** AD&D not available

Portability

If your coverage terminates, you can continue an amount up to the full amount of your TLF, SLF and DGL benefit without EOI and at the same low cost available 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 (port) coverage. If you enrolled your spouse 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. Life insurance coverage begins to reduce at age 70.
UnitedHealth Premium designation program

You can take an active part in your health by seeking out and choosing quality, cost-efficient care. The UnitedHealth Premium program can help you choose a doctor with confidence. The program recognizes doctors who meet quality and cost-efficiency guidelines. The program evaluates doctors in 27 different medical specialties, using national standards for quality and local benchmarks for cost efficiency. You can use this information to help you choose the care that’s right for you.

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).

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. Learn more at UnitedHealthPremium.com.

Make the most of your benefits. PPO members have a lower copay when using Premium program doctors, and HDP members typically pay less for services. Whether you are enrolled in the PPO plan or HDP, a UnitedHealth Premium indicator may help you when choosing a doctor. You can find a doctor’s Premium designation on myuhc.com.

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 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.
Understanding claim payments

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 balance. The balances are shown at the top of the page.

Prescription drug claims
To view your prescription drug claims information, register at 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 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, PPO plan or PEBC Dental plan) is primary for you if you are an active employee, regardless of your age or your Medicare eligibility. (See Medicare rules for certain exceptions such as end stage renal disease.) You can update your Coordination of Benefits information at any time 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.
ID card and debit 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 plans during annual enrollment and if the plan issues ID cards, you should receive your new ID card in early January 2016. If you do not receive your card by January 20, print a temporary ID card and notify your Human Resources or Benefits Office. If you failed to notify your employer that you moved, 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 has information about accessing MHN mental health services.

- **UnitedHealthcare Plans** — New 2016 ID cards will be issued to all enrolled in the PPO plan and the HDP.
- **Express Scripts** — You will not receive a new 2016 Express Scripts ID card unless you are new to the plan or you changed dependents. Your current ID card 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 Card** — Don’t throw your existing card away! The card will work for both the general purpose and limited purpose FLEX accounts as long as the card 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 expiration date. The PayFlex Card has a $9.00 annual fee which is deducted from your 2016 health care FLEX account in early January. (The PayFlex Card is not available with dependent care accounts.)
- **Optum Bank** — If you are newly enrolled in the HSA, in about 7-10 days after your account is opened, you will receive a UnitedHealthcare Health Savings Account MasterCard® (debit card from Optum Bank) in the mail. The card does not have an annual card fee. If you are currently enrolled, as long as the card is not expired, your current Optum Bank debit card will work in 2016.

Let us know if you moved
If you move, be sure to provide your Human Resources Department/Benefits Office 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.

If you do not receive your ID card by late January, print a temporary ID card or call the plan’s Customer Service Department. Your eligibility is not interrupted as a result of an ID card delay.

Providers can confirm eligibility by contacting the appropriate plan. As long as you are enrolled in a plan, a provider can electronically confirm your eligibility and that of your covered dependents with the information from your ID card. You should present the correct ID card whenever you access service at the doctor’s office, hospital, pharmacy or other health care provider.
Contacts

It's easy to stay connected! Visit 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® App Store™ and at Google Play™.

Medical Plans (PPO Plan/HDP)
UnitedHealthcare Customer Care
877-370-2849
myuhc.com
advocate4me@myuhc.com
App: Health4Me

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

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

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

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

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

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

Other Contacts

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

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

myNurseLine
877-370-2849
myuhc.com

FLEX Accounts
PayFlex
877-644-5124
pebc.healthhub.com
App: PayFlex Mobile

HSAs
Optum Bank
800-791-9361
myuhc.com or
optumbank.com

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
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 15-774b)