pebc
PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

2019

EMPLOYEE HEALTH BENEFITS

ENROLLMENT GUIDE

A UNIQUE APPROACH TO CONTROLLING BENEFITS COST

This Employee Health Benefits Enrollment Guide is filled with information about your plan choices and key changes effective January 1, 2019.

PEBC OVERVIEW

The member governments of the PEBC are dedicated to offering choice, flexibility and value as we strive to manage costs in an era of rising health care costs. Through the PEBC, the member governments work diligently to keep benefits costs affordable. The PEBC provides many services, including the joint purchase of employee benefits and a 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.

ABOUT THE ENROLLMENT GUIDE

This guide highlights the main features of many of the benefit plans sponsored by PEBC. Full details of these plans are contained in the legal documents governing the plans. If there is a discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. PEBC reserves the right to modify, amend or terminate any benefit plan or practice described in this guide.

This Employee Health Benefits Enrollment Guide is used by multiple employers. Please be aware that the enrollment deadlines for your specific employer apply. If you have 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. In addition, benefits are subject to plan provisions and eligibility on the date the service is delivered.

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EMPLOYEE OVERVIEW

There are typically changes to some provisions of your benefit plans each year. The changes listed below are all effective January 1, 2019. Carefully read this Employee Health Benefits Enrollment Guide to identify those items that apply to you. For your convenience, a contact list is located at the back of this guide.

PLAN CHANGES JANUARY 1, 2019

New websites and updates

1. pebcinfo.com

You may notice your centralized website has a new look and feel to it. Please visit the website for information about your benefits. No password is required to login on the website.

2. Effective January 15, 2019, you can manage your FLEX accounts on the new updated website at **pebc.payflex.com**.

New dental provider

Cigna will be the new vendor selected to provide Dental HMO and Dental PPO services effective January 1, 2019. To view the dentists in Cigna's network, please visit their website at **myCigna.com**. Please watch your mail for the new dental cards you will receive to access your dental services in 2019.

If you are currently enrolled in the Dental PPO plan or Dental HMO plan, you will receive a dental card from Cigna for the 2019 plan year. If you enroll in the Dental PPO plan or Dental HMO during annual enrollment, you will also receive a dental card from Cigna for the 2019 plan year.

New vision provider

EyeMed will be the new vendor selected to provide vision services effective January 1, 2019. To view the vision providers in EyeMed's network, please visit their website at **eyemedvisioncare.com/PEBC**.

Please watch your mail for the vision card you will receive to access your vision services in 2019.

HSA contributions

The maximum contribution to a HSA for 2019 is $3,500 for individuals and $7,000 for families. Remember, 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.

FLEX elections

If you intend to participate in a FLEX account, you must elect it each year during annual enrollment. The maximum employee election for 2019 is $2,650. 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. If you have qualifying day care expenses, you may want to enroll in the dependent care FLEX spending account. This account is not for medical expenses.

Required time-sensitive enrollment action

During annual enrollment, an employee who covers a spouse must sign a Spouse Medical Plan Surcharge Affidavit attesting to the spouse's access to employer medical plan coverage through his/her employer, regardless if he/she enrolled in that coverage. A copy of the form will be in the Annual Enrollment Packet and at **pebcinfo.com**.

Spouse surcharge (medical plans only)

A Spouse Medical Plan Surcharge Affidavit is required every year.

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 turn in the required Spouse Medical Plan Surcharge Affidavit or if you were late turning it in.

The spouse surcharge *will not apply* if:

1. Your spouse is enrolled in both 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.
6. Your spouse is enrolled in dental and vision coverage.

For purposes of the spouse surcharge, the spouse's employer plan must be an affordable medical plan with minimum essential coverage (MEC) as defined by the Affordable Care Act (ACA).

Spouse Medical Plan Surcharge Affidavit due by December 31, 2018.

Turn in the Affidavit before **December 31, 2018**. 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 or stoppedthe surcharge.

EMPLOYEE CHOICES

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.

Medical plans

(1) PPO plan
(2) High deductible plan (HDP) with health savings account (HSA) if eligible for HSA
(3) Opt out (proof of comparable coverage and certification form required)

Dental plans

(1) PEBC — Cigna PPO Dental Plan
(2) ANT — Cigna HMO Dental Plan

Vision plan

EyeMed

Flexible spending (FLEX) accounts

Account choice depends on the medical plan you select. Beginning January 15, 2019, employer contributions (if applicable) can be found at **pebc.payflex.com**. You may continue to use **pebc.healthhub.com** until January 15, 2019.
(1) FXM — health care flexible spending account
(2) LPX — limited-purpose health care flexible spending account (LP-FLEX)
(3) FXD — dependent care FLEX account

Life insurance

(1) TLF — Employee optional term life
(2) SLF — Spouse optional term life
(3) DGL — Dependent term life

EMPLOYEE RESOURCES

pebcinfo.com

New year. New website. No password required. Just press the button for your employer group. You can access the **pebcinfo.com** website beginning November 1, 2018.

- To compare plans, check the easy-to-understand Summary of Benefits and Coverage. The Summary helps you compare certain health plan provisions regardless if coverage is purchased privately or through your employer.
- 2019 Employee Benefits Rate Sheet — lists employee contribution rates for each plan along with the various "account" options available to you (HSA, FLEX, LP-FLEX).

myuhc.com®

Use for locating a provider, estimating costs, and linking to the wellness site and Optum Bank® (HSA). Find other resourceful tools such as:

- **Cost estimator** is a great tool to help you estimate your out-of-pocket cost, compare treatment options and select a quality provider for a procedure.
- **myClaims Manager** helps you manage claims and understand your share of the plan cost. You can view your deductible, annual maximum out-of-pocket cost and your claims history.
- You can even pay your out-of-pocket costs from this site and find network providers (including Tier 1 and Premium Care physicians) by selecting the link "Find Physician, Laboratory or Facility."

express-scripts.com

Log into or download the Express Scripts® app to manage your prescription drug benefits. Information right at your fingertips!

cigna.com

Before you enroll, you can view the Dental PPO and HMO networks. You can also find in-network providers.

mycigna.com

After January 1, 2019, once you enroll in either the Cigna Dental PPO or the HMO, you can register online at **myCigna.com**. The site will give you information for your specific dental plan. You can view your benefits, use cost tools and search for a network dentist. You can also print ID cards.

eyemed.com

Go online to find doctors, and search the different frames that are available to you. Starting **January 1, 2019**, you can go online and register your account. You can also print ID cards.

ENROLLMENT OVERVIEW

Annual enrollment is the only time during the year that you can change your benefit elections 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 2019. 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.

New hire enrollment

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.
- The PPO is the default medical plan. 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**.

How to select a plan

- 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 offered through PEBC 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 are not eligible for HSA contributions, seed money goes to an LP-FLEX.
- If you enroll in the PPO plan or opt out of medical coverage, you can also save by electing a health care FLEX account.

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
- 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

Dependent verification

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

Who is NOT an eligible dependent?

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

Ineligible spouse

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

Ineligible child(ren)

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

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

2019 MEDICAL PLANS

Regardless of the medical plan you select, certain things work the same. 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

If care is provided by a network doctor, hospital or other health care provider, you do not need 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 you may incur higher costs. It is your responsibility to make sure your out-of-network care is pre-certified.

Network

To locate a doctor, hospital or other provider in UnitedHealthcare's Choice Plus network, 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)

If your medical care is delivered in-network, your annual 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 in-network 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-Express Advantage Network (EAN) retail pharmacy, the $10 upcharge does not count toward your OOP.

HDP: If you enroll in the HDP, all eligible in-network 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.

Coinsurance and in-network cost

Certain expenses are covered by the plans based on a percentage of allowed cost. 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 OOP.

Coinsurance and out-of-network cost

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.

When possible, use **myuhc.com** to confirm the 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.

Items excluded from OOP

Regardless of your plan, when you reach the maximum in-network OOP, you are done. The plan will then pay 100% of eligible in-network costs, and 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 if you choose a brand when a generic is available
- The $10 upcharge to fill a prescription at a non-EAN pharmacy
- Specialty drugs filled at a pharmacy other than Accredo, unless a "stat" retail pharmacy fill applies.

COPAYS AND OUT-OF-POCKET COST

PPO Plans

The PPO plan has a fixed copay for many services. While copays count toward in-network, out-of-pocket costs, copays do not count toward your deductible. Standard medical copays are listed on page 13. Check the prescription drug section for 2019 copays. Refer to the PPO plan Quick Reference Guide found later in this document, or visit **pebcinfo.com** for more information.

HDP out-of-pocket costs (in-network)

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. You can even use an in-network Virtual Visit at a cost of approximately $50 per visit. 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.

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.

Out-of-network deductibles
PPO plan — $1,000 each individual
HDP — $3,000 individual/$6,000 family

The individual out-of-network deductible applies to each enrolled family member and does not have a family deductible limit.

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 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 ACA. Your employer will confirm your other coverage. Check with your Human Resources department or Benefits Office if you have questions.

Participating employers only

If your employer contributes to a health care flexible spending account due to your medical plan opt-out status, that contribution is conditioned on valid proof of other comparable coverage and a current, signed Certification of Other Coverage form. If your other coverage is found to be invalid or expired, the employer contribution is discontinued. You may be required to repay any employer contributions, and you could be subject to serious consequences. Participation or continuation of any employer contribution program is at the discretion of the employer.

Coverage obtained through the Health Care Marketplace (Exchange) is not eligible for employer opt-out contributions.

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.

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.

Feature	PPO — medical plan **Your In-Network Cost**	PPO — medical plan **Your Out-of-Network Cost PLUS You Pay Charges Exceeding Plan Payment**
Annual Deductible	$500 individual/$1,000 family	$1,000 each person
Coinsurance (After the annual deductible is met)	20% after deductible	40% after deductible
Annual Coinsurance Maximum	$2,500 individual/$5,000 family	No limit
Annual Out-of-Pocket Maximum Limit (OOP)	$3,000 individual/$6,000 family Plan pays 100% after annual OOP	No limit
Physician Services		
Office Visits	$25 PCP/$25 Tier 1 Specialist $35 non-Tier 1 Specialist	40% after deductible
Virtual Visits	$0 copay	40% after deductible
Hospital Visits	20% after deductible	40% after deductible
Urgent Care Visit	$35 copay	40% after deductible
Preventive Care*		
Well-Child Care (Birth to age 17)	Covered at 100%	40% after deductible
Well-Woman Exam	Covered at 100%	40% after deductible
Routine Screening Mammography (Age 35+)	Covered at 100%	40% after deductible
Adult Health Assessments (Age 18+)	Covered at 100%	40% after deductible
Immunizations	Covered at 100%	40% after deductible
Screening Colonoscopy	Covered at 100%	40% after deductible
Maternity Services		
Routine Prenatal Care	Covered at 100%	40% after deductible
Delivery in Hospital	20% after deductible	40% after deductible
Newborn Care in Hospital (Routine)	20% after deductible	40% after deductible
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Lab & X-ray Outpatient (Minor)	Covered at 100% in physician office or in-network lab or radiological provider	40% after deductible
Hospital Emergency Care Services (Treated as in-network)	$300 copay + 20% after deductible copay waived if admitted	$300 copay + 20% after deductible copay waived if admitted
Skilled Nursing Facility	20% after deductible; up to 60 days annually	40% after deductible; up to 60 days annually
Home Health Care	20% after deductible; up to 120 visits annually	40% after deductible; up to 120 visits annually
Allergy Care Services	$25 PCP/$25 Tier 1 Specialist $35 non-Tier 1 Specialist	40% after deductible
Chiropractic	$35 copay per visit maximum 20 visits per year	40% after deductible maximum 20 visits per year
Infertility Services **Five (5) Artificial Insemination Visits (Lifetime)**	20% after deductible (excludes in vitro and drug coverage)	40% after deductible (excludes in vitro and drug coverage)
Medical Supply & Equipment (DME)	20% after deductible	40% after deductible
Mental Health Services		
Outpatient Visits	$25 visit: maximum 20 visits per year	50% after deductible; maximum 20 visits per year
Inpatient	20% after deductible; limits apply to number of days annually	40% after deductible; limits apply to number of days annually
Serious Mental Illness	Treated like any other illness	Treated like any other illness
Substance Abuse	Limited — 3 lifetime episodes of care	Limited — 3 lifetime episodes of care

* Subject to Affordable Care Act requirements

HDP QUICK-REFERENCE GUIDE

Refer to plan documents for limitations and additional information.

Feature	HDP — medical plan **Your In-Network Cost**	HDP — medical plan **Your Out-of-Network Cost PLUS You Pay Charges Exceeding Plan Payment**
Annual Deductible (The entire family deductible must be met before benefits pay — unless you selected employee only)	$1,500 individual/$3,000 family	$3,000 individual/$6,000 family
Coinsurance (After the annual deductible is met)	20% after deductible	40% after deductible
Annual Coinsurance Maximum	$1,500 individual/$3,000 family	No limit
Annual Out-of-Pocket Maximum Limit (OOP)	$3,000 individual/$6,000 family	No limit
Physician Services		
Office Visits	20% after deductible	40% after deductible
Virtual Visits	20% after deductible	40% after deductible
Hospital Visits	20% after deductible	40% after deductible
Urgent Care Visit	20% after deductible	40% after deductible
Preventive Care*		
Well-Child Care (Birth to age 17)	Covered at 100%	40% after deductible
Well-Woman Exam	Covered at 100%	40% after deductible
Routine Screening Mammography (Age 35+)	Covered at 100%	40% after deductible
Adult Health Assessments (Age 18+)	Covered at 100%	40% after deductible
Immunizations	Covered at 100%	40% after deductible
Screening Colonoscopy	Covered at 100%	40% after deductible
Maternity Services		
Routine Prenatal Care	Covered at 100%	40% after deductible
Delivery in Hospital	20% after deductible	40% after deductible
Newborn Care in Hospital (Routine)	20% after deductible	40% after deductible
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Lab & X-ray Outpatient (Minor)	20% after deductible	40% after deductible
Hospital Emergency Care Services (Treated as in-network)	20% after deductible	20% after deductible
Skilled Nursing Facility	20% after deductible; up to 60 days annually	40% after deductible; up to 60 days annually
Home Health Care	20% after deductible; up to 120 visits annually	40% after deductible; up to 120 visits annually
Allergy Care Services	20% after deductible	40% after deductible
Chiropractic	20% after deductible; maximum 20 visits per year	40% after deductible; maximum 20 visits per year
Infertility Services **Five (5) Artificial Insemination Visits (Lifetime)**	20% after deductible; (excludes in vitro and drug coverage)	40% after deductible; (excludes in vitro and drug coverage)
Medical Supply & Equipment (DME)	20% after deductible	40% after deductible
Mental Health Services		
Outpatient Visits	20% after deductible; maximum 20 visits per year	50% after deductible; maximum 20 visits per year
Inpatient	20% after deductible; limits apply to number of days annually	40% after deductible; limits apply to number of days annually
Serious Mental Illness	Treated like any other illness	Treated like any other illness
Substance Abuse	Limited — 3 lifetime episodes of care	Limited — 3 lifetime episodes of care

* Subject to Affordable Care Act requirements

HEALTH SAVINGS ACCOUNT (HSA)

You must enroll in a high deductible health plan to participate in an HSA. A HSA will be opened with Optum Bank for all newly enrolled HSA participants.

What is an HSA?

An HSA is a savings account for health care expenses. Unlike an FSA, your savings account can grow from year to year and there is no "use it or lose it" rule. 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

The PEBC HDP is an HSA-eligible plan. You are eligible to deposit funds in an HSA if:

- You are covered under an eligible high deductible plan (like the HDP)
- You are not covered by another medical plan (unless it is an HDP) 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 2019, you may contribute $3,500 if you have individual coverage or $7,000 if you have family coverage. The IRS also allows 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

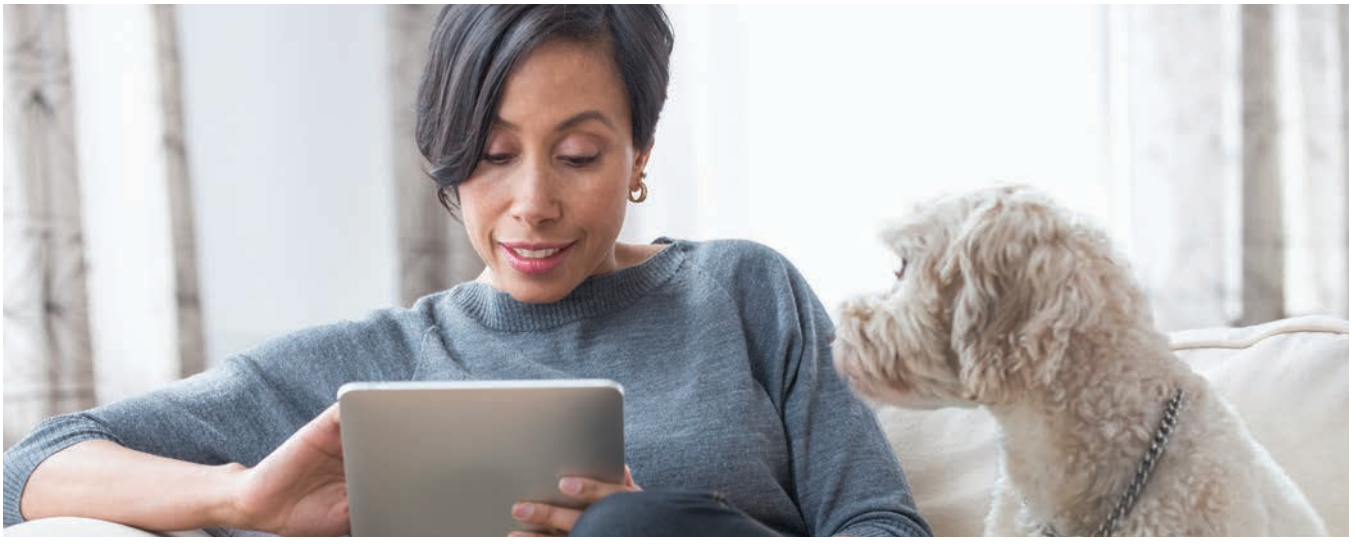
You must file IRS Form 8889 with your annual tax return to report contributions to and distributions from your HSA. HSA contributions, investment earnings (if any) and withdrawals (if made for qualified medical expenses) are generally not taxable for federal (and, in most cases, state and local) income 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 or your account will not be opened. As long as you maintain an account balance of $500 or more, you will not be charged the $1 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 during annual enrollment, your employer will make a one-time cash deposit to your HSA in January. If you are a newly hired employee, seed money contributions are available as soon as reasonably possible once your HDP becomes effective. Seed money contributions do not apply to qualifying events. Your HSA balance builds even faster if you contribute funds through payroll deduction. Set a goal, even a small one, and regularly contribute to your HSA. The 2019 Employee Rate Sheet provides more employer "seed-money" information. If you are not eligible for HSA contributions (example — you are enrolled in Medicare), the seed money contribution will go to a LP-FLEX.

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 identity theft recovery services. Self-help and interactive learning programs are also available to you when you want them.

Call the EAP anytime at 1-888-779-2225 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

TIER 1 AND PREMIUM CARE PROGRAM

Choosing a doctor is one of the most important health decisions you'll make.
UnitedHealthcare can help you find doctors who are right for you and your family.

Find quality, cost-efficient care.
Studies show that people who actively engage in their health care decisions have fewer hospitalizations, fewer emergency visits, higher utilization of preventive care and overall lower medical costs.

Take an active part in your health by seeking out and choosing providers, with the help of two indicators that appear when you search for a provider.

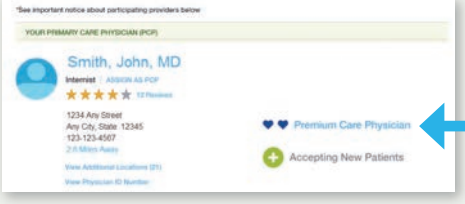
Look for blue hearts.
The UnitedHealth Premium® program makes it easy for you to find doctors who meet benchmarks based on national standards for quality and local market cost efficiency. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate quality and cost-efficient providers.

Pay less by using TIER 1 Tier 1 providers.
Your UnitedHealthcare plan is designed so you will pay less when you see doctors and specialists. We update our Tier 1 providers annually. If you are enrolling during October — December, please look for the two blue hearts to confirm that your doctor will have Tier 1 status when your benefits start for the new year. Beginning in January, look for the Tier 1 icon when searching for providers.

Premium Care Physician
The physician meets the criteria for providing quality and cost-efficient care.

If a doctor does not have a Premium designation, it does not mean he or she provides a lower standard of care. It could mean that the data available to us was not sufficient to include the doctor in the program or that the doctor practices in a specialty not evaluated as a part of the Premium designation program. All doctors who are part of the UnitedHealthcare network must meet our credentialing requirements (separate from the Premium program).

Premium Care Physician
The physician meets the criteria for providing quality and cost-efficient care.



Here's how it looks 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 for or recently underwent a bone marrow or organ transplant.

The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information. Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician. Please visit myuhc.com for detailed program information and methodologies.

PHARMACY PLAN

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." Unless you are eligible for an emergency fill, you pay 100% of the cost of specialty medications filled at a pharmacy other than Accredo Specialty Pharmacy. If you currently use a non-EAN pharmacy and you want to avoid the upcharge, call an EAN pharmacy to transfer your prescription. To find an EAN pharmacy, call Express Scripts or visit **pebcinfo.com**.

Register at express-scripts.com

Manage your prescriptions online with tools available at **express-scripts.com**. You can view the price of a Medication, Save with My Rx Choices, Prescription History, Balances and view the current Preferred Drug List.

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 2019 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 (1-877-613-1227) if you have any questions.

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 OOP.

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

Out-of-pocket cost

Eligible pharmacy costs count toward your OOP. There are certain prescription drug expenses that do not count toward the OOP, such as items 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.

Pharmacy Access Options **Refills allowed as Prescribed**	PPO Plan	HDP
EAN Retail Pharmacy (in-network) up to a 30-day supply.	$15 generic $30 preferred brand $60 non-preferred brand	For retail and home delivery pharmacy you will pay 100% of the Express Scripts/ Accredo cost until you meet your deductible. After deductible, you pay 20% of the cost until the in-network OOP is met. After in-network OOP, plan pays 100%
Home Delivery Pharmacy up to a 90-day supply and 90-day Maintenance Meds filled at certain EAN pharmacies.	$30 generic $60 preferred brand $120 non-preferred brand	
Accredo Specialty Pharmacy up to a 30-day supply.	$10 generic $20 preferred brand $40 non-preferred brand	
Non-EAN Pharmacy upcharge applies to all prescriptions filled at a non-EAN pharmacy.	$10 upcharge per prescription (does not count toward OOP)	$10 upcharge per prescription (does not count toward OOP)

Accredo specialty pharmacy

Accredo, an Express Scripts Specialty Pharmacy, is the plan's specialty pharmacy. Accredo has a specific team of pharmacists, nurses, patient care advocates, social workers and others to make sure you have the best possible outcomes from your specialty drug therapy. Specialty drugs are those that are typically expensive and used to treat complex, chronic conditions and require an enhanced level of care. With Accredo, you get world-class care by a specialized patient care team and have access to a broad range of services and free supplies. Accredo works with you to schedule delivery at your convenience and quickly ship all your specialty drugs and supplies, including those that may require special handling like refrigeration.

Medications filled through Accredo are shipped to you in a 30-day supply (not 90-day). The PPO copay is one-third the cost of a 90-day mail-order copay until the PPO out-of-pocket limit is met. If you are enrolled in the HDP, you pay the actual cost until your deductible is met. After your deductible is met, you pay 20% of the actual cost until you meet the plan's out-of-pocket limit. Once you reach the out-of-pocket limit, your plan pays 100% of the cost of specialty drugs filled at Accredo.

Specialty medication

Unless your drug is needed on an "emergency" basis, all specialty drugs must be filled through Accredo, the plan's specialty pharmacy, or you pay 100% of the cost without credit to your annual out-of-pocket limit. Many specialty drugs have a copay assistance program that reduces your copay or out-of-pocket cost. Many programs are not income based. Accredo will make you aware if a copay assistance program applies, and your actual lower cost will apply to your deductible and/or out-of-pocket limit. The lower cost is also the only cost that should be claimed for FSA or HSA reimbursement.

How to get started with Accredo

Start using Accredo as soon as you can. Just call Accredo at 1-877-895-9697 to register and explain your prescription needs. Accredo will contact your doctor and start the arrangements to move your specialty prescriptions to Accredo. They will call you back to make arrangements to fill and deliver your prescription on a day that is convenient for you. Most supplies, likesyringes, needles and sharps containers, will be provided with your medication at no additional cost.

Preventive statin drugs

Certain low/moderate-dose generic statin drugs will be available at no cost to PPO and HDP members who meet certain criteria. The current list of no-cost preventive statin drugs is on page 21 and is available at **pebcinfo.com**. High-intensity statin doses are not included and not available at zero cost to the member.

Formulary and exclusions

Each year, there are changes to the prescription drug formulary and some drugs are excluded from the plan. Check the list of changes and review the information at **pebcinfo.com**. It is important that you make plans before the year is out in case there are alternatives to your drug. Talk with your doctor in advance or call Express Scripts.

For prior authorization or coverage review, you or your doctor can contact Express Scripts at 1-800-753-2851.

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 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)

90-day prescriptions

Get up to a 90-day supply of your medicine for the prescriptions you take regularly. Remember, you can fill maintenance medications at select EAN retail pharmacies. If you are enrolled in the PPO plan, the copay will mirror the home delivery copay. Home delivery allows you to get a three-month supply for the price of two copays. Specialty drugs are shipped in a 30-day supply. You will pay one-third the three-month supply copay for specialty drugs through Accredo. Home delivery includes free standard shipping. To get started with home delivery, 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 "Print & Request Forms & Cards" under "Health & Benefits Information"). 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 1-877-613-1227.

Preventive statin drugs

Certain low/moderate-dose generic statin drugs are considered preventive and will be available at no cost to PPO plan and HDP members who meet certain criteria and do not have a history of cardiovascular disease. This list is subject to change.

The list includes:
Atorvastatin: 10–20 mg
Fluvastatin IR 20-40mg
Fluvastatin XL–80mg
Lovastatin: 10–40 mg
Pravastatin: 10–80 mg
Simvastatin: 5–40 mg
Rosuvastatin: 5–10 mg

High-intensity statin doses are not included and are not available at zero cost share.

Atorvastatin: 40–80 mg
Lovastatin: 60–mg
Rosuvastatin: 20–40 mg
Simvastatin: 80 mg

Excluded drugs

Check the list of drugs excluded from the Express Scripts formulary. In many cases, the generic equivalent for the brand-name excluded drug is covered and will cost you less. In other cases, there is an alternative to the excluded medication. You pay 100% of the cost for any excluded drug, and that cost is not applied to the deductible or OOP. View the 2019 Excluded Drug list at **pebcinfo.com**

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.

VISION AND DENTAL PLANS

VISION BENEFITS

Lucky you! PEBC employees get vision benefits through EyeMed Vision Care®. Employees can go to any Target Optical or Sears Optical and select any frame, any brand, at any any price point with no out of pocket cost. You can also choose from thousands of independent providers, top optical retailers and online options. So you're free to see your best, be your best and look your best — when and where it's right for you. EyeMed makes it easy, too, with tools that help you find an eye doctor, schedule an appointment and manage your benefits. Plus, members enjoy extra perks, like everyday savings on additional complete pairs or glasses from participating in-network providers.

In-network benefits

Eye exam with dilation as necessary — $10 copay
(Once every 12 months)
A simple eye exam can help keep your vision sharp. It can also detect signs of some health problems, like diabetic retinopathy, high blood pressure or high cholesterol, since a clear view of your eyes' blood vessels gives your eye doctor a front row seat to your health. Vision is a gift. So there's no time like the present. Schedule an eye exam today.

Prescription lenses

- Single vision, bifocal, trifocal or lenticular lenses — $20 copay
- Polycarbonate lenses for dependent children under age 19 — $0
- Standard progressive lenses — $75 copay
- Savings on lens options, including UV treatment, scratch coating and polycarbonate from in-network providers

Frames — $0 copay
- $150 allowance
- 20% off balance over $150

Contact lenses — $0 copay
(Contact lens allowance includes material only)
- Conventional — $0 copay, $200 allowance, 15% balance over $200
- Disposable — $0 copay, $200 allowance, plus balance over $200
- Medically necessary — $0 copay, paid-in-full

Laser vision correction
- Discounts on LASIK from or PRK from U.S. Laser Network
- 15% off the retail price or 5% off the promotional price

Out-of-network benefits

While EyeMed's network gives you plenty of options, there may still be times when you choose to go out-of-network. Before you go, you'll want to check your out-of-network reimbursement. After your service, log in to **eyemedvisioncare.com/PEBC** (if you haven't already created an account) to check your claim status.

Out-of-network reimbursement
Eye exam: Up to $43
Single vision lenses: Up to $30
Bifocal lenses: Up to $45
Trifocal lenses: Up to $62
Lenticular lenses: Up to $100
Standard progressive lenses: Up to $45
Frames: Up to $40
Conventional or disposable contacts: Up to $185
Medically necessary contact lenses: Up to $210

Create an account on **eyemedvisioncare.com/PEBC** to learn more about your vision benefits, find special offers 24/7 and find an eye doctor near you. While you're there, check out the Know Before You Go out-of-pocket cost estimator to understand what you might pay before you even visit your eye doctor.

Plan exclusions

Benefits are not provided from services or materials arising from: Orthopic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered — fund as a Bifocal lens. Standard Progressive lens covered — fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

DENTAL BENEFITS

2019 Dental HMO and Dental PPO Benefits Provided by Cigna

Which network is right for me? Go to Cigna.com and follow the directions below:

- Go to **Cigna.com** and click on "Find a Doctor" at the top of the screen.
- Then choose a network directory by selecting "Plans through your employer or school" option.
- For DHMO — select "Cigna Dental Care Access"
- For DPPO — select "Cigna DPPO Advantage/Cigna DPPO"
- Next, click on "Find a Dentist"

Dental HMO Plan (Cigna)

The DHMO Plan offers a wide range of dental benefits through a network of participating dentists. Your Cigna Dental Care plan is a **copayment** plan. With your Cigna DHMO plan, some preventive services are covered at 100%. Your plan also covers many other dental services at a set copayment. There are no **annual maximums** and **no deductibles**!
Here are some of the services in this plan, all of which will help you lower your dental care costs.

Remember — When you enroll in Cigna DHMO

1. After January 1, 2019, you will want to select your DHMO dentist
2. Log in to **mycigna.com**
3. Select Cigna Dental Care Access Network
4. Choose your DHMO dentist
5. A new ID card with your dentist selection will be mailed to you

Procedure	Copayment
Office Visit	$0 per visit — Office visit fee — (per patient, per office visit in addition to any other applicable patient charges)
Preventive Services	$0 exams $7 sealants (per tooth) $0 x-rays
Crowns	$220 — Titanium
Orthodontics	$1,464 — Children $2,160 — Adults
Root Canals	$90 — $310
Extractions	$55 — $175
General Anesthesia & Nitrous Oxide	$15 — $80

Dental PPO Plan (Cigna)

The Dental PPO Plan offers access to both in-network and out-of-network benefits. Cigna's DPPO Network provides access to a large network of participating dentists, which translates into more cost savings for you. Under the DPPO dental plan you have the freedom to visit any licensed dentist or specialist without a referral.

The DPPO dental plan will cover eligible dental expenses after you meet any applicable waiting periods and meet any deductibles. The plan is based on coinsurance levels that determine the percentage of costs covered by the plan for different types of services. A new ID card will be mailed to you for the 2019 plan year.

Procedure	In-Network	Out-of-Network
Deductible (per person) **Annual Maximum Benefit (per person)**	$50 (maximum of $150) $2,000	$50 (maximum of $150) $2,000
Preventive • Two Cleanings in 12 months • Two Exams per calendar year • Two Fluoride Treatments per calendar year for dependent children up to 16th birthday • Full Mouth X-rays: One per 36 months • Bitewing X-rays: One set per calendar year for adults; one per calendar year for children	100% no deductible	100% no deductible
Basic Restorative • Fillings: No Limit • Extractions • Oral Surgery • Periodontal Treatment • Root Canal • Crown Repair • General Anesthesia: When dentally necessary in connection with oral surgery, extractions or other covered dental services	80% after deductible	80% after deductible
Major Restorative • Benefits begin after 6 months of coverage • Crown Installation • Denture and Bridges • Endodontics	50% after deductible	50% after deductible
Orthodontia • Benefits begin after 12 months of coverage Orthodontia Lifetime Maximum (per person)	50% after deductible $1,750	50% after deductible $1,750

ACCESS TO CARE

ACCESS TO CARE ANYTIME

A Virtual Visit lets you see and talk to a doctor from your smartphone, tablet or computer. You can make an appointment or you can choose to chat with the next available doctor. Most visits take about 10 – 15 minutes. You can find a network provider at **myuhc.com** or the Health4Me® app.

Virtual Visits in-network

Doctor on Demand and **Amwell** are the in-network Virtual Visit providers. You can set up an account or download the app. You do not have to be enrolled in a medical plan to use Doctor on Demand or Amwell, but if you are enrolled in the PPO plan or HDP, your visit will coordinate with your insurance.

Conditions commonly treated include:

- Cold/flu/sore throat
- Sinus/allergies
- Fever
- Bladder infection/urinary tract infection
- Bronchitis
- Diarrhea
- Migraine/headaches
- Pink eye
- Stomachache
- Rash

Cost

After registering and requesting a visit, your credit/debit card is authorized and charged the service cost (if applicable) at the end of the visit. PPO plan members do not pay a copay for in-network Virtual Visits. If you are not enrolled in the PPO plan, a $50 service cost applies.

Prescriptions

If a prescription is written, it is electronically transmitted to your selected retail pharmacy where you can pick it up and pay your out-of-pocket prescription cost. Remember, you save more if you use an EAN pharmacy. The Virtual Visit cannot be used for certain prescription drugs including controlled substances, narcotics, opioids, certain sedatives and muscles relaxants, or medications that require close monitoring or administration by a health care professional.

Use Virtual Visits when:

- Your doctor is not available
- You become ill while traveling
- You are considering a hospital emergency room visit for a non-emergency health condition

Not good for:

- Anything requiring an exam or test
- Complex or chronic conditions
- Injuries requiring bandaging or sprains/broken bones

NurseLine

NurseLine connects you with registered nurses 24/7 and at no additional cost. To connect with NurseLine, call 1-877-370-2849. You can also chat with a registered nurse live at **myuhc.com**. The nurses can assist you with choosing appropriate medical care, whether that is an ER, doctor visit or self-care. They can help you understand your treatment options and answer questions about your medications or help you decide whether a Virtual Visit might be a good option for you.

Virtual Visits are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. Payment for Virtual Visit services does not cover pharmacy charges; members must pay for prescriptions (if any) separately.

For informational purposes only. Nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care.

URGENT CARE VS. EMERGENCY ROOM USE

About emergency room care

The hospital emergency room is for life-threatening or very serious conditions that require immediate care. There are other lower-cost alternatives if you do not have a life-threatening or critical condition.

Virtual Visits — let you see a doctor via your smartphone, tablet or computer for non-emergency medical conditions. PPO members pay a $0 copay. Others pay a $50 service cost.

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.

Convenience care clinic — such as MinuteClinic® or Baylor Scott & White Convenient Care Clinics located inside certain Tom Thumb stores. 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 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. PPO members pay a $300 ER copay (copay waived if admitted) plus 20% coinsurance (after deductible). HDP members pay 20% coinsurance (after deductible) for ER services.

Freestanding emergency room

A freestanding ER can easily be confused with an urgent care center or convenience clinic. Visiting a freestanding ER can result in higher out-of-pocket costs for you including balance-billing charges especially if you are out of network.

There are other lower-cost alternatives available. For a non-life-threatening or critical situation, consider one of the other options listed here. You can contact NurseLine at 877-370-2849 to help you determine which one is best or use the Health4Me app to locate the nearest urgent care or convenience care location.

Emergency outside the U.S.

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 health 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 U.S. 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.

THE PEBC WELLNESS PROGRAM

Active employees and a spouse enrolled in either the PPO or HDP medical plan are eligible to participate in the wellness plan and earn an incentive.

Let's get started — what is Rally®, how do I find it?

Download the Rally app on your phone or get to Rally via **myuhc.com**. For those enrolled in the PPO plan or HDP, log in at **myuhc.com** and select the icon "Visit Rally Health and Wellness" to register and take your health assessment.

If you opt out of your employer's medical plan, you can still access the wellness portal at **https://werally.com/client/pebc/register/**. Although you cannot earn points or a reward, you can take the health assessment, participate in online activities and learn more about how you can improve your health!

Timing and earning points

- Rewards earning period — January 1 through October 31.
- Time required to earn points — Personal Wellness Coaching, Missions, Disease Management take time to complete — plan accordingly to complete by October 31.
- Points are not awarded for partially completed programs and do not roll over to another year.
- An employee can earn a $300 reward for achieving 300 points.
- A spouse can earn a $300 reward for achieving 300 points — **as long as the employee has earned 300 points.**
- The spouse must be enrolled in the plan to participate and remain enrolled at the time of payout for additional reward payout.

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, if you have not exceeded the annual HSA contribution limit, to your HSA. You may select your preferred payment options when you qualify for a reward.

When is your reward paid?

Rewards are paid three times during the year based on when you earn 300 points individually or 600 points when participating with a spouse. You must be an employee (or a covered spouse) at the time of payout to receive your reward.

Date Points are Earned	Date Reward is Paid
January 1 — March 31	May 31
January 1 — June 30	August 31
January 1 — October 31	December 31

EARNING POINTS

REQUIRED — First complete the Health Risk Assessment (Health Survey) and earn 75 points. Then earn additional points as shown below.

Earn 300 points

Between January 1, 2019, and October 31, 2019, using any combination of the options below.

Earn 150 points

Once per year either at a:

- Biometric screening onsite — your employer may sponsor screening events at work.
- Or, have your doctor identify your biometrics during an office visit (cholesterol, blood sugar, etc.). Points are triggered via UHC claims; they generally appear within 21 business days from the date of service, dependent on when the provider submits the claim.

Earn 100 points

If you are qualified for **Disease Management** for the treatment of a chronic condition and you are contacted by a UnitedHealthCare nurse, you can earn 100 points for participating.

Earn 75 points

If you complete 3 Rally Missions (once each year):

- Each Mission takes 4 weeks.
- You must complete 3 Missions to earn 75 points.
- If you want, you can do all 3 at the same time.

Earn 50 points

For each of the following activities (once per year):

- Complete **Personal Wellness Coaching** — this can be either telephonic, email or chat. It can be done once per week. Minimum of 3 sessions over 6 weeks.
- Complete **Quit for Life**.
- Complete **Healthy Weight**.
- Enroll in **Healthy Pregnancy**.
- Complete a **Challenge** on Rally.

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. Preventive care services may include physical examinations, immunizations, laboratory tests and other types of screening tests. During a 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. Your medical plan covers certain preventive care services at 100% whether you are enrolled in the PPO plan or HDP and as long as services are performed by a network provider. For more information about preventive care services that might be right for you, visit **uhcpreventivecare.com**.

What health services are NOT considered preventive care?

Medical treatment for specific health issues or conditions, ongoing 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, coinsurance or deductible, even if the service is provided at the same time a preventive care service is performed.

Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the Health Survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

PREVENTIVE SERVICES AT NO COST TO YOU

Covered, no-cost preventive services are based on the recommendations of the United States Preventive Services Task Force (USPSTF), the U.S. Department of Health and Human Services, the Advisory Committee on Immunization Practices (ACIP) of the CDC and the HRSA Guidelines for women and children, including the American Academy of Pediatrics Bright Futures periodicity guidelines. 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

There are many convenient options to get your flu shot or other 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. Age-appropriate immunizations are available at many retail pharmacy locations. Always ask the pharmacist to check your plan coverage before the immunization is administered to make sure the immunization is covered. Talk with your doctor about specific age and gender 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. While flu shots do not require a prescription, other vaccines may require a prescription. Save even more by using an EAN retail pharmacy. For non-EAN locations, you will pay an additional $10 per immunization.

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).

North Texas EAN retail pharmacies:

- Albertsons
- Minyard
- Brookshire
- RiteCare
- Costco
- Tom Thumb
- HEB
- Walmart/Sam's Club
- Kroger

Covered vaccines include:

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

*Additional cost may apply

UnitedHealthcare retail pharmacy vaccines

Select vaccines can be administered at certain retail pharmacies using your UnitedHealthcare ID card. North Texas retail pharmacies include those listed below. Visit **myuhc.com** if you need more information.

- Albertsons
- CVS
- HEB
- Kroger
- Safeway/Tom Thumb
- Walgreens
- Walmart/Sam's Club

Convenience care clinics

You can receive your flu shot or pneumonia vaccine at a convenience care clinic. Convenience care clinics are typically located in retail stores and do not require an appointment. They provide a limited range of care services at the cost of a primary care physician (PCP) copay. Services and treatments are offered to patients 18 months of age and older. DFW-area locations include MinuteClinic located at certain CVS Pharmacy locations and Baylor Scott & White Convenient Care Clinics located at certain Tom Thumb stores. If you receive additional services, a copay or out-of-pocket expense may apply.

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

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 well-being 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. It is so easy to enroll. Simply visit **cx.uhc.com/uhcpregnancy** to sign up online. 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 **cx.uhc.com/uhcpregnancy**, you can access a full range of articles covering nutrition, exercise, childbirth preparation, tips for dads and more. You will also receive complimentary gifts for you and your baby and money-saving coupons. The website 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 through Friday, 8 a.m. to 8 p.m. CT). For more information about a healthy pregnancy, visit **cx.uhc.com/uhcpregnancy.**

Adding newborn to benefits

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. This is the only way you can add your newborn to your medical plan. 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.

CHANGE IN STATUS

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.

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

Examples of events that do not qualify:

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

CHANGE IN EMPLOYMENT STATUS

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:

- 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
- Termination or commencement of employment
- Strike or lockout
- Start or return from an unpaid leave of absence
- USERRA (military) leave

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.

- **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.
- **Effective date** — Provided you met the 31-day rule noted above, the change is effective the first day of the month following the date you notified your employer of the qualified change in status event. Effective date exception: Newborns are effective on the date of birth, and adoptions are effective the date placed for adoption or on the adoption date.

To illustrate

- 31-day notification: You married on November 9, and on December 3 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 1. Your spouse's coverage could have been effective on December 1 if you had notified your Human Resources department by November 30.

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. Your active employee FLEX account ends the date your employment ends.

Rollover 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 previously required you spend all of your funds before the end of the plan year or you lost the money you saved. Whether you enroll in the general purpose FLEX account or the LP-FLEX account, and regardless if the contribution is from you or your employer, a combined total up to $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, 2019, which means 2018 rollover funds will be available in May 2019.

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 (non-HDP), you can select the general purpose health care FLEX account. The general purpose health care FLEX account can be used to pay your eligible out-of-pocket health care expenses, including dental and vision costs. Expenses paid by insurance or another source are not eligible for reimbursement.

Limited-purpose 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.

If you are enrolled in the HDP and are filing an LP-FLEX claim, you must provide documentation that shows your deductible is met and the date it was met. To show the date the deductible was met, submit an EOB with (1) an EOB date which is after the date of service; and (2) the deductible shown as met. (See the last page of UnitedHealthcare's EOB.) The EOB date is not the date of service. The EOB date is typically on page 1 of the EOB and is the date the EOB was processed.

Manage your account

Beginning January 15, 2019, visit **pebc.payflex.com**. You may continue to use **pebc.healthhub.com** until January 15, 2019. Download the PayFlex app — use the same credentials as your online login.

- 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. Beginning January 15, 2019, visit **pebc.payflex.com**. You may continue to use **pebc.healthhub.com** until January 15, 2019. Use your PayFlex credentials to log in and manage your accounts online.

To mail a claim

Use the claim form available at **pebc.payflex.com** beginning January 15, 2019. You may access the claim form at **pebc.healthhub.com** until January 15, 2019. Mail to the address shown on the form. PayFlex Systems USA, Inc. P.O. Box 981158, El Paso, TX 79998-1158. VOICE: 1-877-644-5124

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 2019 Employee Benefit Plan Rates document included in your enrollment packet. Employer contributions are in addition to and do not count toward the employee $2,650 health care FLEX account annual election limit.

	GENERAL PURPOSE FLEX ACCOUNT	LP-FLEX ACCOUNT
Medical plan enrollment required	PEBC PPO plan or opt out with a traditional plan as comparable coverage	HDP or opt out with an HDP as comparable coverage
What can be reimbursed?	Eligible qualified expenses including out-of-pocket medical, dental and vision expenses	Eligible qualified dental and vision expenses, and out-of-pocket eligible medical expenses after your deductible is met
Can I use an account debit card?	Yes — PayFlex Card	Yes — PayFlex Card
What is the maximum amount an employee can elect annually?	$2,650 general purpose or limited purpose	
Can I be enrolled in both accounts at the same time?	You cannot be actively enrolled in an LP-FLEX account if you're enrolled in a general purpose FLEX account at the same time.	You cannot be actively enrolled in a general purpose FLEX account if you are enrolled in the LP-FLEX account at the same time.
Does "use it or lose it" apply?	$500 of unused funds will automatically roll over to the next plan year and is in addition to the annual plan maximum of $2,650. You will forfeit unused funds exceeding $500.	

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.

You have until April 30, 2019, to submit claims for expenses incurred during 2018.

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

A note for highly compensated employees

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

Manage your accounts online

Starting January 15, 2019, visit **pebc.payflex.com** to manage your FLEX accounts. You may also continue to use **pebc.healthhub.com** to manage your FLEX accounts until January 15, 2019. If you have more than one 2019 FLEX account type, you will see more than one 2019 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, 2019, or your effective date.

A $9 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 receive 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.

Need an extra PayFlex Card?

If you need another card for an eligible family member, order one at **pebc.payflex.com** starting January 15, 2019. You may continue to use **pebc.healthhub.com** until January 15, 2019, or call PayFlex at 1-877-644-5124. Remember, you are still responsible for appropriate use of the PayFlex Card, even if used by another family member.

PayFlex Card FAQs

Will the PayFlex Card work if you select 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 1-877-644-5124.

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 Cigna PPO, 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 Cigna DMHO, 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 2019 PayFlex Card will not work if you did not provide requested 2018 information.

Is the debit card expired?

Check the card's expiration date. The PayFlex Card has a five-year term. The card will work in 2019 as long as it is not expired. If the PayFlex Card is nearing expiration, you will receive a new card before it expires.

RETIREMENT

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 2019, pay particular attention to the November 2018 annual enrollment period. Elections during your last active employee annual enrollment will affect the retiree benefits for which you may be eligible. If you are age 65 or older, or if you are turning 65 soon, contact the Social Security Administration at least 90 days before you retire. Carefully review the Retiree Health Benefits Guide, available at **pebcinfo.com** or from your employer.

Turning age 65 and still working

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

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

Caution: If you are preparing to retire and you or your spouse are age 65 or older or turning 65 soon, 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 a higher Part B premium. After 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 careprovider, a self-funded insurance plan may feel no different than many insurance plans, even without an insurance company.

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 "employer member group," then select "retiree" from the top menu for retiree information specific to your employer). If you are currently enrolled, you do not need to enroll again.

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.

LIFE INSURANCE AND AD&D

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, 2019, Basic Life insurance amount is based on the later of either your annual salary at December 31, 2018, or your 2019 hire date. Additional AD&D coverage is included and equal to your GLF coverage 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. Additional AD&D coverage is included at one times your TLF coverage amount. 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, 2018. 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. SLF coverage does not include AD&D.

Evidence of insurabilty (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. Forms are not needed if you are not requesting a change. **All forms must be mailed to Dearborn National on or before November 30, 2018**. Forms postmarked after that date or envelopes with missing forms are invalid and will not be accepted

Employer-paid Term Life and AD&D (GLF)

- 1x your annual salary
- Minimum coverage $20,000 regardless of salary
- Maximum coverage $50,000
- AD&D coverage at 1x basic term life coverage

Employee-paid optional Term Life capped at $400,000 (TLF)

County employees

- 1/2x annual salary
- 1x annual salary
- 2x annual salary
- Select no optional coverage (prior-year grandfathered amounts may apply)

NTTA employees

- 1x annual salary
- 2x annual salary
- 3x annual salary
- 4x annual salary
- Select no optional coverage

Dependent optional Term Life (DGL)

County employees

Option 1	Option 2
$5,000 Spouse	$10,000 Spouse
$2,500 Each Dependent*	$5,000 Each Dependent*

* Dependents up to age 26.

Spouse optional Term Life (SLF)

SLF cannot exceed 50% of employee TLF.

SLF coverage levels

$10,000	$25,000	$50,000
$75,000	$100,000	

CALCULATE MONTHLY PREMIUM COST (TLF/SLF)

Using your annual salary on December 31, 2018, and your age on January 1, 2019, 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 2019 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 12/31/18 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 1/1/19 (Optional Term Life Rate Chart, Column A)

This is your monthly TLF premium amount. $ _____

NTTA employees

Step 1 Annual salary at 12/31/18 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 1/1/19 (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

Age	Column A* Active Employee (TLF) Includes AD&D	Column B** Spouse (SLF) and Parted (TLF or SLF)
Less than 30	$.08	$.04
30–34	$.10	$.06
35–39	$.12	$.08
40–44	$.16	$.12
45–49	$.23	$.19
50–54	$.33	$.29
55–59	$.51	$.47
60–64	$.83	$.79
65–69	$1.34	$1.30
70 and over	$2.26	$2.22

* Includes AD&D of $.04/$1,000.
** AD&D not available.

Continuing your life insurance

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

Portability

If your coverage terminates, you can continue an amount up to 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.

MANAGING YOUR CLAIMS

Medical claims

Get started by logging in to **myuhc.com**. You can understand your benefits and claims, find a doctor, estimate future treatment costs and much more — all with practical, personalized information. If you are a mobile device user, the Health4Me app provides access to the claims management features as well.

Claims section

Navigate to the claims section to view your most recent claims highlighted by family member, health care provider, date, amount billed, amount you may owe and other key details. There are features to help you track and manage your claims. You can also view more details for a specific claim, including plan discounts, what was paid by your plan and how much you owe. You can view a breakdown showing how much was applied to the deductible and out-of-pocket maximums.

Payment resources

If you do owe your provider, you may be able to send payment from the site. Payment processing is managed by InstaMed®. You can save your desired card or bank account information securely, making it easy to make payments in the future. After a payment is made, your claim on **myuhc.com** will be updated. With My Claim Payments, you can review a history of payments you've made on the InstaMed site, sort by payment date and family member, or export data to Microsoft Excel.

Account balances

The account balances page shows current values and visuals of your progress toward meeting deductible and out-of-pocket maximums. If you are enrolled in the HDP and have a health savings account, your balance is also shown here.

Prescription drug claims

Manage your prescription drug claims at **express-scripts.com**. You can 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. Search medication information, locate a pharmacy and review your cost options. Visit **express-scripts.com/pebc** to check specific costs for those drugs covered by your plan. You can see Accredo specialty drug information here as well.

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**.

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 2019. If you do not receive your card by January 25, 2019, 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. The medical ID card has information about accessing MHN mental health services.

- **UnitedHealthcare plans** — You will not receive a new 2019 PPO or HDP ID card unless you are new to the plan or changed dependents.
- **Express Scripts** — You will not receive a 2019 Express Scripts ID card unless you are new to the plan or changed dependents. Your current ID card will work.

Dental plans

- **Cigna DHMO** — You will receive a new ID card following annual enrollment because Cigna is the new dental provider for the DHMO plan.
- **Cigna PPO** — You will receive a new ID card because Cigna is the new dental provider for the PPO plan.

Vision plan

- **EyeMed** — When you visit a network provider, the provider's office will confirm your eligibility electronically. You will also receive an ID card from EyeMed for the 2019 plan year.

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 annual fee which is deducted from your 2019 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 2019.

Did you move?

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.

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.

IMPORTANT PROVIDER CONTACTS

Benefit	Vendor	Phone Number	Email /Web Address
Medical	UnitedHealthcare	1-877-370-2849	**myuhc.com**
Pharmacy RX	Express Scripts	1-877-613-1227	**Express-scripts.com**
Specialty Pharmacy	Accredo	1-800-501-7210	**Express-scripts.com, click Accredo**
Mental Health and EAP	MHN	1-888-779-2225	**mhn.com**
Dental PPO	Cigna	1-800-244-6224	**mycigna.com***
Dental HMO	Cigna	1-800-244-6224	**mycigna.com***
Vision	EyeMed	1-866-804-0982	**eyemedvisioncare.com/PEBC***
Life Insurance	Dearborn National	1-800-778-2281	**Pebcinfo.com**
FLEX Account	PayFlex	1-877-644-5124	**pebc.payflex.com****
HSA Account	Optum Bank	1-800-791-9361	**Optumbank.com**
PEBC Wellness Plan	Optum	1-877-818-5826	**myuhc.com**
NurseLine	UnitedHealthcare	1-877-370-2849	**myuhc.com**
Health Insurance Marketplace		1-855-889-4325	**healthcare.gov**

*After January 1, 2019.
**Effective January 15, 2019.

2019 IMPORTANT NOTICES

The following Notices are intended for benefits-eligible members enrolled in a PEBC health plan for the 2019 Plan year. If you are not eligible for or enrolled in a PEBC Plan, the Notices will not apply to you.

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UNIFORM SUMMARY OF BENEFITS AND COVERAGE (SBC)

The uniform Summary of Benefits and Coverage (SBC) provision of the Affordable Care Act requires all insurers and group health plans to provide consumers with an SBC to describe key plan features, including limitations and exclusions, in a mandated format. The provision also requires that consumers have access to a uniform glossary of terms commonly used in health care coverage. The PEBC SBCs are available online at **pebcinfo.com**. You can view the glossary at **healthcare.gov/SBC-glossary**. To request a copy of these documents free of charge, call the SBC Hotline at 1-855-756-4448.

GENETIC INFORMATION NON-DISCRIMINATION ACT OF 2008

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

MEDICAL PLAN OPT OUT OF CERTAIN PROVISIONS OF THE PUBLIC HEALTH SERVICE (PHS) ACT

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

1. Standards related to benefits for mothers and newborns

Protection against limiting stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section. (Newborn and Mother's Health Protection Act)

2. Parity in the application of certain limits to mental health benefits
Protection against having benefits for mental health and substance abuse disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

3. Required coverage for reconstructive surgery following mastectomies
Certain requirements to provide benefits for breast reconstruction after a mastectomy. (Women's Health & Cancer Rights Act [WHCRA])

4. Coverage of dependent students on medically necessary leave of absence
Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution. (Michelle's Law)

The exemption from these federal requirements will be in effect for the 2019 plan year, beginning January 1, 2019, and ending December 31, 2019. The exemption may be renewed for subsequent plan years. Please note that PEBC employer groups currently voluntarily provide coverage that substantially complies with the requirements of the Newborn and Mother's Protection Act and the WHCRA.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Important Notice from Your Employer About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The prescription drug coverage provided by the PEBC Plans has been examined by consulting actuaries and is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage.

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

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

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

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

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

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

More information about your options under Medicare prescription drug coverage

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

For more information about Medicare prescription drug coverage:

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

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

KEEP THIS CREDITABLE COVERAGE NOTICE

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

PEBC HEALTH PLANS NOTICE

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Health First Colorado Website: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: **Colorado.gov/HCPF/Child-Health-Plan-Plus** CHP+ Customer Service: 1-800-359-1991 | State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	Website: **http://flmedicaidtplrecovery.com/hipp/** Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (1-855-692-7447)	Website: **http://dch.georgia.gov/medicaid** Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

INDIANA – Medicaid	MISSOURI – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: **http://www.in.gov/fssa/hip/** Phone: 1-877-438-4479 All other Medicaid Website: **http://www.indianamedicaid.com** Phone 1-800-403-0864	Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005
IOWA – Medicaid	**MONTANA – Medicaid**
Website: **http://dhs.iowa.gov/hawk-i** Phone: 1-800-257-8563	Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: **http://www.kdheks.gov/hcf/** Phone: 785-296-3512	Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Website: **https://chfs.ky.gov** Phone: 1-800-635-2570	Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: **http://dhh.louisiana.gov/index.cfm/subhome/1/n/331** Phone: 1-888-695-2447	Website: **https://www.dhhs.nh.gov/ombp/nhhpp/** Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html** Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** Medicaid Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: **http://www.mass.gov/eohhs/gov/departments/masshealth/** Phone: 1-800-862-4840	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Phone: 1-800-657-3739	Website: **https://dma.ncdhhs.gov/** Phone: 919-855-4100

NORTH DAKOTA – Medicaid	UTAH – Medicaid and CHIP
Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825	Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669
OKLAHOMA – Medicaid and CHIP	**VERMONT– Medicaid**
Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742	Website: **http://www.greenmountaincare.org/** Phone: 1-800-250-8427
OREGON – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: **http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html** Phone: 1-800-699-9075	Medicaid Website: **http://www.coverva.org/programs_premium_assistance.cfm** Medicaid Phone: 1-800-432-5924 CHIP Website: **http://www.coverva.org/programs_premium_assistance.cfm** CHIP Phone: 1-855-242-8282
PENNSYLVANIA – Medicaid	**WASHINGTON – Medicaid**
Website: **http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm** Phone: 1-800-692-7462	Website: **http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program** Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	**WEST VIRGINIA – Medicaid**
Website: **http://www.eohhs.ri.gov/** Phone: 1-855-697-4347	Website: **http://mywvhipp.com/** Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH CAROLINA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf** Phone: 1-800-362-3002
SOUTH DAKOTA - Medicaid	**WYOMING – Medicaid**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: **https://wyequalitycare.acs-inc.com/** Phone: 307-777-7531
TEXAS – Medicaid	
Website: **http://gethipptexas.com/** Phone: 1-800-440-0493	

To see if any more states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, you can contact either:

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

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

CONTINUATION OF GROUP COVERAGE (COBRA) INITIAL NOTICE

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

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

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

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

The COBRA Benefit Administrator is:

PayFlex Systems USA, Inc.
P.O. Box 953374
St. Louis, MO 63195-3374
1-877-644-5124

The COBRA Benefit Administrator is responsible for administering COBRA continuation coverage.

EMPLOYER NOTICE OF EXCHANGE

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace runs from November 1, 2018, through December 15, 2018, for 2019 coverage. This is not your employer's annual enrollment period.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards, you may be eligible for a tax credit that lowers your monthly premium. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% of your household income for the year 2019, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Your employer offers excellent health coverage and the benefits fully meet the law's standards. The coverage meets the minimum value standard, and the cost of the coverage is intended to be affordable based on employee wages.

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

How Can I Get More Information?

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

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

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

PEBC PRIVACY NOTICE

Privacy of Your Information
NOTICE OF PRIVACY PRACTICES
PEBC Group Health Plans

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

Effective Date of Notice: September 23, 2013.

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

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

Use and Disclosure of Protected Health Information

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

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

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

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

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

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

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

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

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

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

- As required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
- For public health activities;
- To an appropriate government authority regarding victims of abuse, neglect or domestic violence;
- To a health oversight agency for oversight activities authorized by law;
- In connection with judicial and administrative proceedings;
- To a law enforcement official for law enforcement purposes;
- To a coroner or medical examiner;
- To cadaveric organ, eye or tissue donation programs;
- For research purposes, as long as certain privacy-related standards are satisfied;
- To avert a serious threat to health or safety;
- For specialized government functions (e.g., military and veterans activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations); and
- For workers compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

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

Uses and Disclosures for which an Authorization is Required

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

Your Rights Regarding Protected Health Information

You have the right to:

- ***Inspect and Copy your Protected Health Information:*** Upon written request, you have the right to inspect and get copies of your Protected Health Information (and that of an individual for whom you are a legal guardian). There are some limited exceptions.
- ***Request an Amendment:*** You have the right to amend or correct inaccurate or incomplete Protected Health Information. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
- ***Receive An Accounting of Non-Routine Disclosures:*** You have the right to receive a list of non-routine disclosures we have made of your Protected Health Information. However, you are not entitled to an accounting of several types of disclosures including, but not limited to:

  - Disclosures made for payment, treatment or health care operations;
  - Disclosures you authorized in writing; or
  - Disclosures made before April 14, 2003.

- ***Request Restrictions:*** You have the right to request that we place additional restrictions on our use or disclosure of your Protected Health Information as we carry out payment, treatment, or health care operations. You may also ask us to restrict how we use and disclose your Protected Health Information to your family members, relatives, friends or other persons you identify who are involved in your care or payment for your care. We do not have to agree to these additional restrictions, but if we do, we must abide by our agreement (except in emergencies).
- ***Request Confidential Communications:*** You may request to receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may want to have Protected Health Information sent only by mail or to an address other than your home.
- ***Receive Notice of a Breach:*** You have the right to be notified upon a breach of your unsecured Protected Health Information, if a disclosure occurs that meets the definition and thresholds of a breach under the law.
- ***Receive a Paper Copy of This Notice:*** You have the right to a paper copy of this Notice, even if you have agreed to receive this notice electronically.

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

About This Notice

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

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

Contacting the Plan Administrator

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

PEBC
PO Box 5888
Arlington, TX 76005-5888
817-608-2317

PATRIOT ACT NOTICE

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

Important Information about Procedures for Opening a New Account

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

What this means for you:

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

IMPORTANT HEALTH SAVINGS ACCOUNT INFORMATION

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

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

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

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

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

NOTICE REGARDING THE PEBC WELLNESS PROGRAM

For the Americans with Disabilities Act (ADA)

The PEBC Wellness Program is a voluntary wellness program available to all active employees participating in a PEBC medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness

program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include a blood test to check for cholesterol levels, blood sugar levels, or other measures to help identify medical risk factors. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

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

Incentives may be available for employees who participate in certain health-related activities, such as having recommended preventive care screenings based on your age and gender, completing wellness learning modules, or participating in fitness activities. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Optum (part of UnitedHealthcare) at 1-877-818-5826.

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

Protections from Disclosure of Medical Information

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

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

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

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

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

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pebc
PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

Summaries of Benefits and Coverage

The government-required Summaries of Benefits and Coverage (SBC), which summarize important information about your PEBC medical plan options, are available online at **Pebcinfo.com**.

UnitedHealthcare®