NORTH TEXAS TOLLWAY AUTHORITY

pebc
PUBLIC EMPLOYEE BENEFITS COOPERATIVE

Employee Benefits Guide 2026

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Use this Benefits Guide to see what's new and to learn about your benefit plan options.

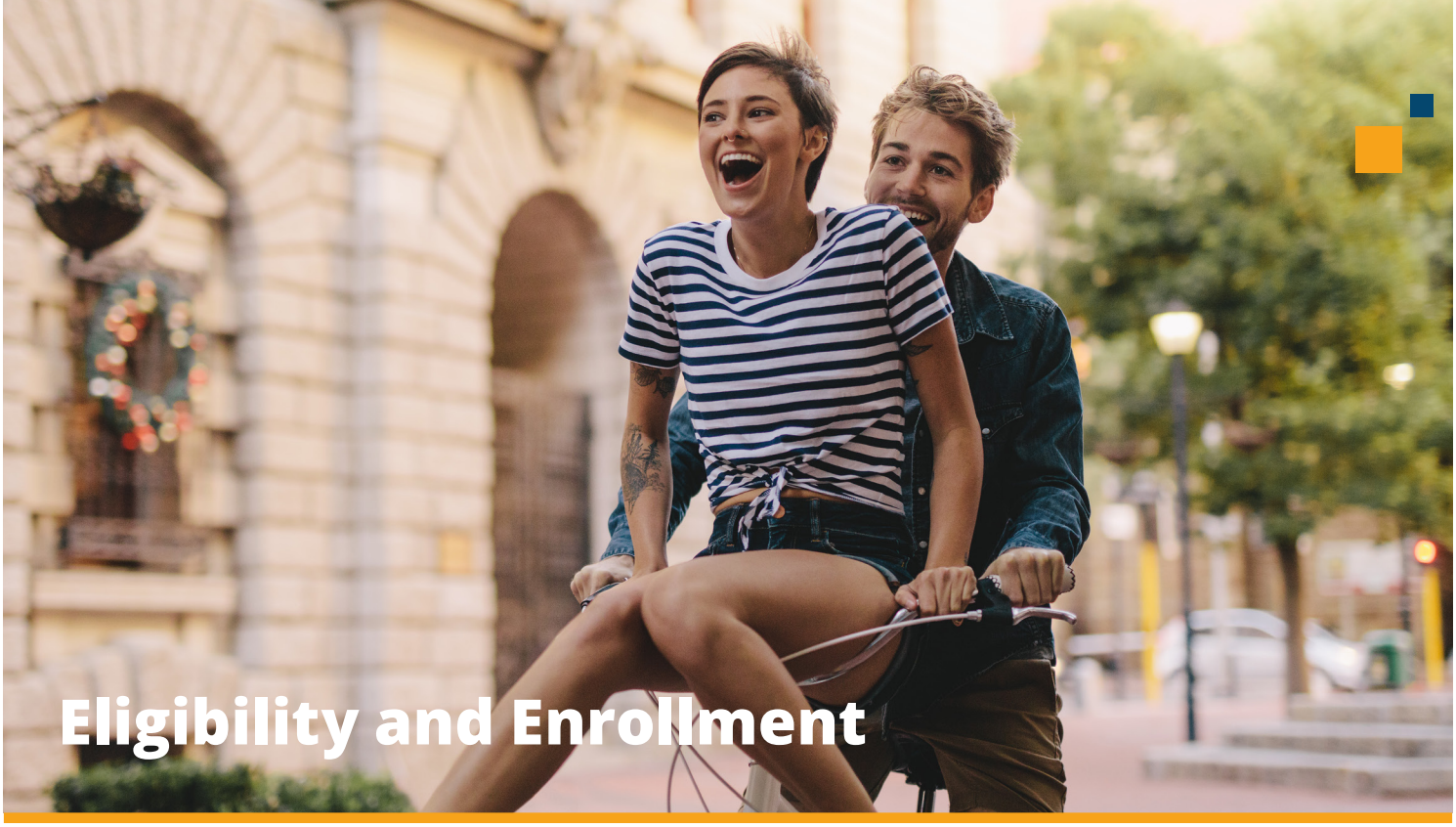
What's Inside

If you have benefits questions, please contact your Human Resources/Benefits Department.

Disclaimer: This guide provides a summary of plan highlights. This is not a binding contract. In the event of any difference between the information contained herein and the plan documents, the plan documents will supersede and control over this guide. Please consult the Summary Plan Description for information on covered charges, limitations, and exclusions.

Vendor Contacts

Benefit	Vendor	Phone	Email/Web Address
Medical	BCBSTX	888-306-5753	bcbstx.com/member
Virtual Visits	MDLIVE	888-680-8646	mdlive.com/bcbstx
24/7 NurseLine	BCBSTX	800-581-0368	bcbstx.com
Pharmacy Rx	Prime	888-306-5753	myprime.com
Mail-Order Pharmacy	Express Scripts	833-715-0942	expressscripts.com/rx
Specialty Pharmacy	Accredo	833-721-1619	accredo.com
Navigate Well-being Progam	Navigate	888-282-0822	PEBCNavigatewellbeing.com
Employee Assistance Program (EAP)	ComPsych	844-213-8968	guidanceresources.com
Dental DPPO	Delta Dental	800-521-2651	deltadentalins.com
Dental DHMO	Delta Dental	800-422-4234	deltadentalins.com
Vision	VSP	800-877-7195	vsp.com
Life Insurance	The Standard	800-628-8600	standard.com
Long-Term Disability	The Standard	800-368-2859	standard.com
Health Savings Account (HSA)	HealthEquity	844-396-0226	my.healthequity.com
Flexible Spending Accounts (FSAs)	HealthEquity	844-396-0226	my.healthequity.com
Health Insurance Marketplace	Department of Health & Human Services	800-318-2596	healthcare.gov



Eligibility and Enrollment

DEPENDENT ELIGIBILITY

Who is an eligible dependent? Your dependent can be enrolled in a plan only if they are an eligible dependent residing in the United States. If both of you and your spouse work for the same employer, both of you need to enroll in your own insurance and one of you needs to cover your dependents.

ELIGIBLE SPOUSE

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

ELIGIBLE CHILDREN

- Your natural child under age 26
- Your natural, mentally, or physically disabled child, if the child has reached age 26 and is dependent upon you for more than one-half of their support as defined by the Internal Revenue Code. To be eligible, the disability must occur before or within 31 days of the child's 26th birthday.
- Your legally adopted child, including a child who is living with you who has been placed for adoption or for whom legal adoption proceedings have been started, or a child for whom you are named permanent managing conservator
- Your grandchildren can be covered once you have completed a Grandchild Affidavit and it has been approved. Please contact your Human Resources/Benefits department for more information.

Your newborn is not automatically enrolled in your medical plan. You are responsible for contacting your Human Resources department and completing the required enrollment paperwork to add your newborn.

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

Eligibility and Enrollment (cont.)

MANAGING CONSERVATOR

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

DEPENDENT VERIFICATION

Valid proof of dependent eligibility is required before you can add a new dependent or spouse to the plan. Check with your Human Resources/Benefits department for more information or help determining which dependents you can cover on your benefits.

WHEN A CHILD'S COVERAGE ENDS

You may cover your child (natural child, stepchild, adopted child) in a medical, dental, vision, and/or life insurance 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.

Eligibility and Enrollment (cont.)

NEW HIRE ENROLLMENT

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

- You must submit your enrollment documents to your Human Resources department within 14 days of the date you begin working. If you miss that deadline, you'll automatically be enrolled in a default medical plan, employee-only coverage.
- The PPO is the default medical plan. You cannot change from PPO default plan enrollment until the next annual enrollment period unless you experience a qualified change in status event.
- Your coverage becomes effective on the first day of the month after 30 consecutive calendar days of active, regular employment.

OPTIONAL TERM LIFE

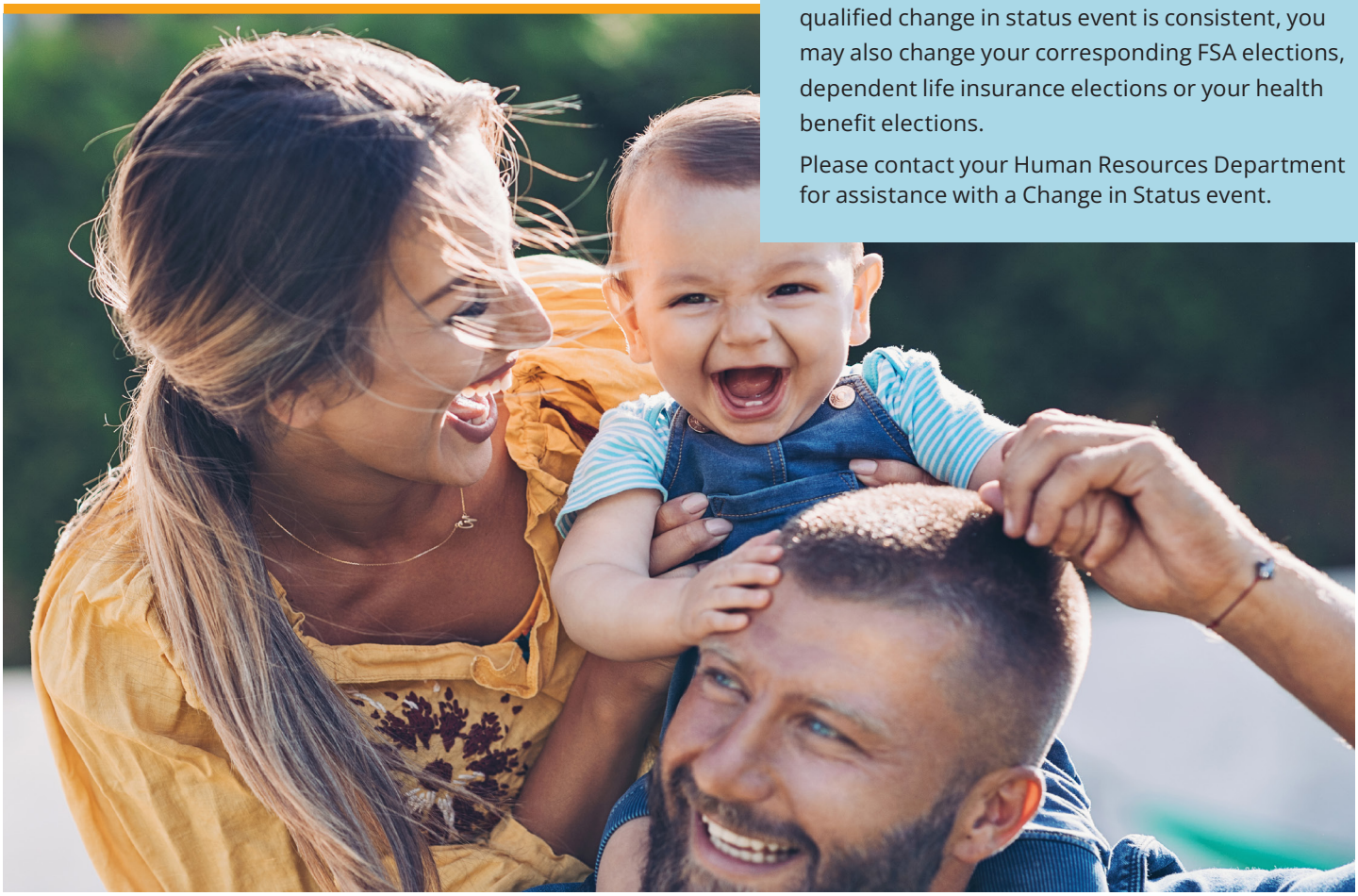
- If you select Optional Term Life insurance when you are newly hired and enrolling for the first time, you do not have to provide Evidence of Insurability (EOI).
- If you select Spouse Optional Term Life in an amount greater than $25,000, EOI is required.

Change in Status

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

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

Please contact your Human Resources Department for assistance with a Change in Status event.



Eligibility and Enrollment (cont.)

REQUIRED ENROLLMENT ACTION

Spouse Medical Plan Surcharge Affidavit

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

Contact your Human Resources/Benefits Department to verify submission requirements and deadlines for the Spouse Affidavit.

Medical Plan Spouse Surcharge

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

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

The medical plan spouse surcharge will not apply if:

- Your spouse is enrolled in only dental and vision coverage
- Your spouse is enrolled in both their employer medical plan (proof of enrollment required) and your medical plan
- Your spouse does not work outside the home and has no access to employer coverage; or Your spouse's employer does not offer medical coverage, or your spouse is not eligible for that coverage
- Your spouse's other coverage is Medicare, Medicaid,TRICARE® or care received at a Department of VeteranAffairs (VA) facility

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

Eligibility and Enrollment (cont.)

QUALIFIED EVENTS

Change in family status. Applies to employee, employee's spouse or employee's dependents:

- Marriage, divorce, or annulment
- Death of your spouse or dependent
- Child's birth, adoption, or placement for adoption (your newborn or adopted child is not automatically enrolled in your medical plan)
- An event causing a dependent to no longer meet eligibility requirements, such as reaching age 26
- **If you experience a qualifying life event, you must notify your Human Resources department to request a benefits change and submit required documentation within 31 days of the event.**

CHANGE IN EMPLOYMENT STATUS

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

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

Eligibility and Enrollment (cont.)

RETIREMENT

Thinking about retirement?

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

Turning age 65 and still working

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

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

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

CAUTION:

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

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

Medical Benefits

CHOOSING THE MEDICAL PLAN THAT IS RIGHT FOR YOU

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

PPO

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

NETWORK DEDUCTIBLES

For 2026, your deductible for services in the network is:

$500 for individual (single) coverage

$1,000 for family coverage*

OUT-OF-NETWORK-DEDUCTIBLES

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

$1,000 for each individual (single)

Unlimited for family coverage

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

Need more details? Visit **pebcinfo.com**.

PPO Plan Quick Reference Guide

Refer to plan documents for limitations and additional information.

PPO Medical Plan		
Feature	**Your Network Cost**	**Your Out-Of-Network Cost** PLUS You Pay Charges Exceeding Plan Payment
Annual deductible	$500 individual/$1,000 family	$1,000 each person
Coinsurance (after the annual deductible is met)	20% after deductible	40% after deductible
Annual coinsurance maximum	$2,500 individual/$5,000 family	No limit
Annual out-of-pocket maximum (OOP)	$3,000 individual/$6,000 family Plan pays 100% after annual OOP	No limit
Physician Services		
Preventive Care	$0—Plan pays 100%	40% after deductible
Office visits	$15 Primary Care Physician (PCP)/$25 specialist	40% after deductible
24/7 Virtual Visits (MDLIVE)	$0—Plan pays 100%	$0 deductible does not apply
Telehealth	$15 PCP/$25 specialist	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visit	$35 copay	40% after deductible
Maternity Services		
Routine Prenatal Care	$0—Plan pays 100%	40% after deductible
Delivery and Newborn Care in hospital (routine)	20% after deductible	40% after deductible
Infertility services: 5 artificial insemination visits	20% after deductible (excludes in vitro and drug coverage)	40% after deductible (excludes in vitro and drug coverage)
Additional Services		
Inpatient hospital	20% after deductible	40% after deductible
Outpatient surgery	20% after deductible	40% after deductible
Hospital emergency care services (treated as network)	$300 copay + 20% after deductible; copay waived if admitted	$300 copay + 20% after deductible; copay waived if admitted
Mental Health Services		
Outpatient visits	$15 visit	40% after deductible
Inpatient	20% after deductible	40% after deductible

Medical Benefits (cont.)

HIGH DEDUCTIBLE PLAN (HDP)

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

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

- $1,700 individual (single) deductible
- $3,400 family deductible*

* If you cover any family member, the entire network family deductible must be met before any family member can move to coinsurance. The HDP network family deductible is met when the combined eligible expenses for you and/or any covered family members reach $3,400. Even if one family member reaches the $1,700 deductible, that member cannot move to coinsurance until the full $3,400 family deductible is met.

OPTING OUT OF A MEDICAL PLAN

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

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

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.

HDP Quick Reference Guide

Refer to plan documents for limitations and additional information.

HDP Medical Plan		
Feature	**Your Network Cost**	**Your Out-Of-Network Cost** PLUS You Pay Charges Exceeding Plan Payment
Annual deductible	$1,700 individual/$3,400 family	$3,000 individual/$6,000 family
Coinsurance (after the annual deductible is met)	20% after deductible	40% after deductible
Annual coinsurance maximum	$1,350 individual/$2,700 family	No limit
Annual out-of-pocket maximum (OOP)	$3,050 individual/$6,100 family Plan pays 100% after annual OOP	No limit
Physician Services		
Preventive Care	$0—Plan pays 100%	40% after deductible
Office visits	20% after deductible	40% after deductible
24/7 Virtual Visits (MDLIVE)	$0—Plan pays 100%	40% after deductible
Telehealth	20% after deductible	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visit	20% after deductible	40% after deductible
Maternity Services		
Routine Prenatal Care	$0—Plan pays 100%	40% after deductible
Delivery and Newborn Care in hospital (routine)	20% after deductible	40% after deductible
Infertility services: 5 artificial insemination visits (lifetime)	20% after deductible (excludes in vitro and drug coverage)	40% after deductible (excludes in vitro and drug coverage)
Additional Services		
Inpatient hospital	20% after deductible	40% after deductible
Outpatient surgery	20% after deductible	40% after deductible
Hospital emergency care services (treated as network)	20% after deductible	20% after deductible
Mental Health Services		
Outpatient visits	20% after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible

BCBS Texas Free App

FIND INFORMATION ABOUT DOCTORS

Our online directory is the quick and easy way to find doctors, hospitals, or other health care providers in your network. Follow these steps:-

1. Go to **bcbstx.com**
2. **Click** *Find Care*
3. **Click** *Find a Doctor* or *Hospital* and then Search for "*Doctors*" as a Guest
4. **Answer** a few questions and follow the prompts

MORE INFORMATION

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

- **Find** in-network doctors, facilities, and pharmacies
- **Access** your digital ID card
- **View** your coverage and plan documents
- **Estimate** service costs, and much more

Download our Free App

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

Texas

GET IT ON Google Play

Download on the App Store

NOTE: DURING ANNUAL ENROLLMENT, YOU MUST RE-ENROLL IF:

- Anything changed, including dependent eligibility or your plan choice
- You want to contribute to a Health Care FSA, a limited purpose FSA (LP-FSA), or Dependent Care FSA. You have to re-enroll each year if you want to contribute to an FSA, even if you do not change your annual election amount.

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

- To compare plans, check the Summary of Benefits and Coverage (SBC). The SBC helps you compare certain health plan provisions.

Where to Go for Care

What do you do if your clutch player breaks an arm in the big game? Or you slice your finger chopping veggies? Or have stomach cramps after last night's sushi date? Often the choice is clear. If you have signs of a heart attack, it's best to go to the emergency room. But what if you have a sore throat? Or lower back pain? Knowing where to go can make a big difference in the cost of your care—especially when you use in-network providers.

WE MAKE IT EASY TO FIND INDEPENDENTLY CONTRACTED, IN-NETWORK PROVIDERS NEAR YOU:

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

24/7 NURSELINE

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

Good for: Health questions and health advice
Average Wait: None
Cost: None

VIRTUAL VISITS

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

Good for: Health exams, colds, flu, minor injuries
Average Wait: Less than 20 minutes
Cost: In network $

DOCTOR

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

Good for: Health exams, shots, cough, sore throat
Average Wait: None
Cost: None

RETAIL HEALTH CLINIC

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

Good for: Headache, stomach ache, sinus pain
Average Wait: Variable
Cost: In network $, out of network $$

URGENT CARE CENTER

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

Good for: Back pain, vomiting, animal bite, asthma
Average Wait: 30 minutes or less
Cost: In network $$, out of network $$$

HOSPITAL ER

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

Good for: Chest pain, bleeding, broken bones
Average Wait: 1 hour or more
Cost: In network $$$, out of network $$$$

Mental Health Support

Connect with the EAP!

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

- Call: **844-213-8968**
- Online: **GuidanceResources.com**
- App: **GuidanceNow**
- Web ID: **TXEAP**

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

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

LEARN TO LIVE

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

VIRTUAL VISITS—POWERED BY MDLIVE®

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

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

Additional Programs

OVIA HEALTH: A DIGITAL SUPPORT PROGRAM

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

Download the app that's right for you:
Ovia – Reproductive Health, Fertility and Menopause
Ovia Pregnancy – Pregnancy & Postpartum
Ovia Parenting – Family & Working Parents

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

DIABETES MANAGEMENT BY TELADOC® HEALTH

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

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

HYPERTENSION MANAGEMENT BY TELADOC HEALTH

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

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

WONDR™

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

HINGE HEALTH

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

VIRTUAL VISITS BY MDLIVE

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

FITNESS PROGRAM

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

Other program perks include:
No long-term contract: Membership is month to month. Flexible plans from $19 to $129 per month and studio classes are available.

Healthy choices build lasting positive change.

You can visit **PEBCNavigatewellbeing.com** or use this QR code to get started.

You can also **download** the Navigate app!

GET IT ON Google Play

Download on the App Store

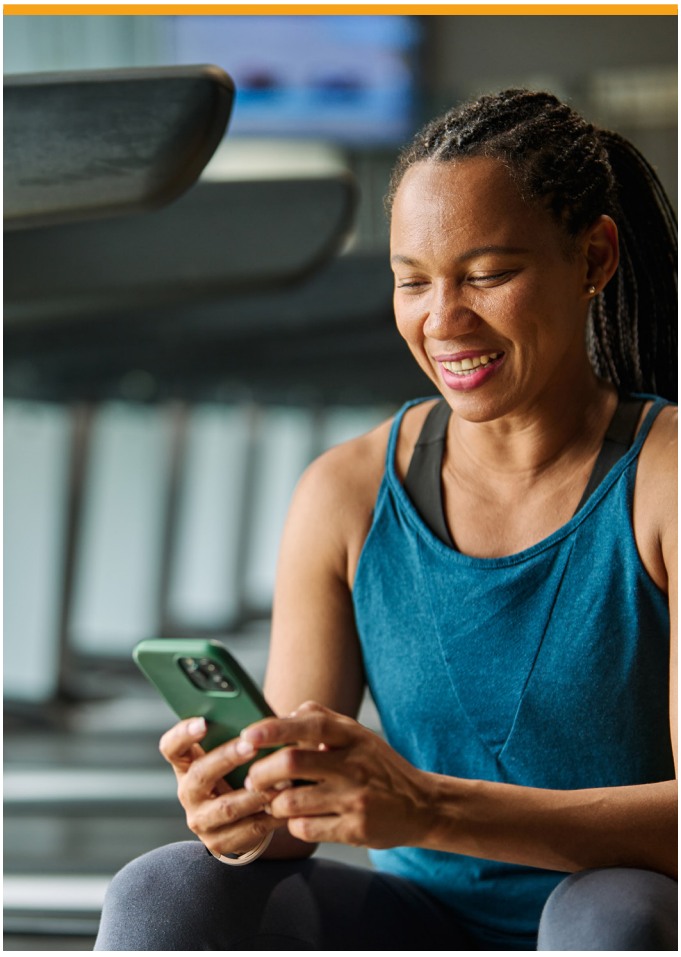
COMING FOR 2026!

Your well-being goes beyond physical health—it includes your mental, emotional, and financial wellness, too. The **Navigate Wellness Platform** brings it all together in one easy-to-use app and website, giving you the tools, resources, and motivation to take charge of your health.

WHAT YOU GET

- **Personalized Challenges & Rewards:** Stay motivated with wellness challenges, track your progress, and earn rewards along the way.
- **Health Tracking Tools:** Monitor activity, nutrition, sleep, and more with easy integrations to your favorite devices and apps.
- **Educational Resources:** Access articles, videos, and tips on fitness, nutrition, stress management, and financial wellness.
- **Team Engagement:** Join group challenges, connect with colleagues, and build a culture of well-being together.
- **24/7 Access:** Available anytime on desktop or through the Navigate mobile app.

The Navigate Wellness Platform is designed to help you **live well, feel supported, and stay engaged.** Whether you're setting new health goals, managing stress, or just looking for a boost of motivation, Navigate makes it simple and rewarding to stay on track.



Prescription Benefits

Your prescription drug benefit helps you and your family access the medications you need, from everyday prescriptions to specialty drugs, at an affordable cost.

Below is a summary of your 2026 prescription drug benefits.

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

Home Delivery by Express Scripts® Pharmacy

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

SAVINGS AND CONVENIENCE

- Express Scripts® Pharmacy delivers up to a 90-day supply of long-term medicines.
- Prescriptions are delivered to the address of your choice, within the U.S., with free standard shipping.

SUPPORT AND SERVICE

You can receive notices by phone, email or text—your choice—when your orders are placed and shipped. You will be contacted, if needed, to complete your order. To select your notice preference, register online at **express-scripts.com/rx** or call **833-715-0942**.

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

Prescription Benefits (cont.)

UNDERSTANDING SPECIALTY DRUGS

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

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

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

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

DO YOU NEED SPECIALTY MEDICATIONS?

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

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

SUPPORT IN MANAGING YOUR CONDITION: ACCREDO

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

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

ORDERING THROUGH ACCREDO

You can order a new prescription or transfer your existing prescription for a self-administered specialty drug to Accredo. **To start using Accredo, call 833-721-1619**.

An Accredo representative will work with your doctor on the rest. Once registered, you can manage your prescriptions on **accredo.com** or through the mobile app.

Tools to Help You Manage the Details

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

MANAGING YOUR MEDICAL CLAIMS

Medical claims

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

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

Account balances

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

MANAGING YOUR PRESCRIPTIONS

MYPRIME.COM helps you manage your pharmacy benefits when you're at home or on the go. You can visit the website to:

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

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

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

Health Saving Account

WHAT IS A HEALTH SPENDING ACCOUNT (HSA)?

An HSA is a savings account that you can use to help cover qualified health care expenses. To be eligible to contribute to an HSA, you must:

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

Unlike an FSA, there is no "use it or lose it" rule and it comes with triple-tax benefits:

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

For 2026, the IRS maximum HSA contribution limit is $4,400 if you have individual coverage or $8,750 if you have family coverage. The IRS also allows catch-up contributions of $1,000 if you are age 55 or older.

Your employer contributes to your HSA:

- $1,000 Employee-Only medical coverage
- $1,500 Employee + Spouse medical coverage
- $2,000 Employee + Child(ren) or Family medical coverage

Please keep in mind the amount you plan to contribute for the year, as your contribution and your employer's contribution together cannot exceed the IRS maximum limit. The HSA provider for 2026 is HealthEquity.

HSA TAX BENEFITS

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

- Tax-free contributions – You don't pay taxes on the money you put into the account.
- Tax-free account growth – Invest your HSA and any growth is tax-free.
- Tax-free spending – Use HSA funds for HSA-qualified expenses, and you never pay taxes on that money.

CONTRIBUTIONS FROM YOUR EMPLOYER

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

Flexible Spending Accounts

WHAT IS A FLEXIBLE SPENDING ACCOUNT (FSA)?

A Health Care FSA is a way to set aside money from your earnings before taxes are withheld to pay eligible out-of-pocket health care expenses and qualifying dependent daycare expenses.

Here's how it works:

- Use your HealthEquity Visa Card to pay for eligible healthcare expenses, or submit a claim for reimbursement of eligible expenses from your account
- Expenses must be incurred by Dec. 31
- Expenses must be submitted to HealthEquity by April 30 of the following year to avoid loss of funds
- Your active employee FSA ends the date your employment ends, unless you elect COBRA benefits. If you enroll in COBRA coverage, your FSA will continue.

There are three types of FSA:

- **General-purpose FSA.** If you enroll in the PPO plan or if you opt out of medical coverage and your comparable coverage is through a traditional plan (non-HDP), you can select the general-purpose FSA.
- **Limited-purpose FSA (LP-FSA).** If you enroll in the HDP with contributions to an HSA, you cannot elect a general-purpose FSA, but you can elect an LP-FSA.
- **Dependent Care FSA.** To help pay for qualifying daycare expenses, you can set aside up to $7,500 annually (or $3,750 if filing your taxes separately) in the dependent care FSA in 2026. Remember, Dependent Care FSA funds cannot be used for medical expenses.

Note: You must elect an FSA every year you intend to participate. The maximum amount you can set aside for 2026 is $3,300—including general-purpose FSAs and limited-purpose FSAs (LP-FSAs).

ROLLOVER FUNDS

The IRS allows employees with a health care FLEX account to roll over up to $660 of their unused funds to the next plan year.

MANAGE YOUR ACCOUNTS ONLINE

Visit **healthequity.com** to manage your FSA.

Dental Benefits

For 2026, you can choose between the DeltaCare USA (DHMO) and the Delta Dental PPO plans.

DELTA DENTAL HMO PLAN (DELTACARE USA DHMO)

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

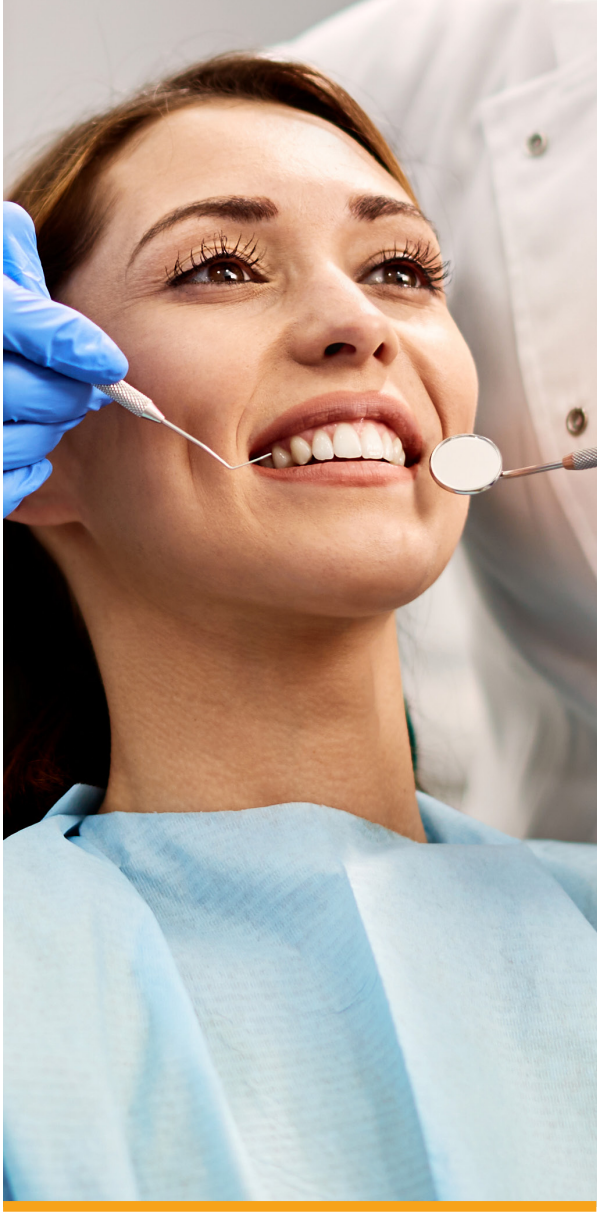
With your DeltaCare USA DHMO plan, some preventive services are covered at 100%. Your plan also covers many other dental services at a set copay. **There are no annual maximums and no deductibles.**

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

DELTA DENTAL HMO PLAN (DELTACARE USA DHMO)

When you enroll in DeltaCare USA DHMO:

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



SEE WHICH NETWORK IS RIGHT FOR YOU:

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

Dental Benefits (cont.)

DELTA DENTAL PPO PLAN (DELTA DENTAL DPPO)

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

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

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

Vision Benefits

VISION BENEFITS

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

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

EXCLUSIONS AND LIMITATIONS

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

VSP Advantage Plan	NETWORK	NON-NETWORK REIMBURSEMENT
Vision exam	$10	Up to $43
Eyeglass lenses		
Single vision	$20	Up to $30
Bifocal	$20	Up to $45
Trifocal	$20	Up to $62
Lenticular	$20	Up to $100
Standard progressive lenses	$20	Up to $45
Frames	$200 allowance; 20% off balance over $200 $250 at Visionworks	Up to $40
Contact lenses	Frames and contacts both available in same plan year in lieu of eyeglass lenses (12/12/12 frequency)	
Non-elective	Covered at 100%	Up to $210
Elective	$200 Allowance; not to exceed $40 copay for contact lens exam	Up to $185
Service frequency		
Exams	12 months	12 months
Prescription lenses	12 months	12 months
Frames	12 months	12 months
Contact lenses	12 months	12 months
Laser care	Average 15% off the regular price or 5% off the promotional price	

SERVICES NOT COVERED

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

Life & AD&D Insurance

SUPPORTING FINANCIAL SECURITY

Basic Life Benefits

Basic Life and Accidental Death & Dismemberment (AD&D) insurance provides a benefit in the event of your death. This benefit is paid for by your employer. Your Basic Life Benefit is one times your annual salary, rounded to the next $1,000 up to $300,000. Your AD&D benefit automatically matches your Basic Life benefit.

Basic Term Life

- Coverage Amount: Annual Earnings rounded to the next $1,000 up to a maximum of $300,000
- Minimum coverage is $20,000 regardless of salary
- AD&D coverage matches Basic Term Life coverage

Optional Term Life Benefits

Employee Optional Term Life is voluntary and based on your annual salary times your selected coverage level, rounded to the next higher $1,000. Use the Optional Rate Chart on page **28** to calculate your monthly cost. AD&D automatically matches your optional term life benefit.

Employee Optional Term Life

- 1x annual salary
- 2x annual salary
- 3x annual salary
- 4x annual salary
- Up to a maximum of $500,000

Optional Spouse Term Life Benefits

Optional Spouse Term Life Benefits cannot exceed 50% of an employee's Optional Term Life coverage amount. Any amounts elected over $25,000 will require Evidence of Insurability (EOI).

Optional Spouse Term Life

Levels:

- $10,000
- $25,000
- $50,000
- $75,000
- $100,000
- Spouse Term Life cannot exceed 50% of Employee Optional Term Life.

Dependent Group Life Benefits

You can select Dependent Group Life coverage for your spouse and dependent child(ren), even if you already elected optional spouse life coverage. Dependent Group Life provides a fixed amount of coverage for all eligible dependents.

Dependent Group Life

Option 1	Option 2
• $5,000 spouse • $2,500 each dependent	• $10,000 spouse • $5,000 each dependent

Reduction and termination

Your Basic Life & AD&D benefits and the additional as part of your optional life and AD&D coverage. Optional Term Life and Optional Spouse Life coverage you select reduce beginning at age 70, and end at employment termination or retirement, unless you elect to port or convert all or part of your optional life coverage. Reduced % of coverage amount by age:

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

All Optional Term Life and Dependent Group Life benefits are voluntary and employee-paid.

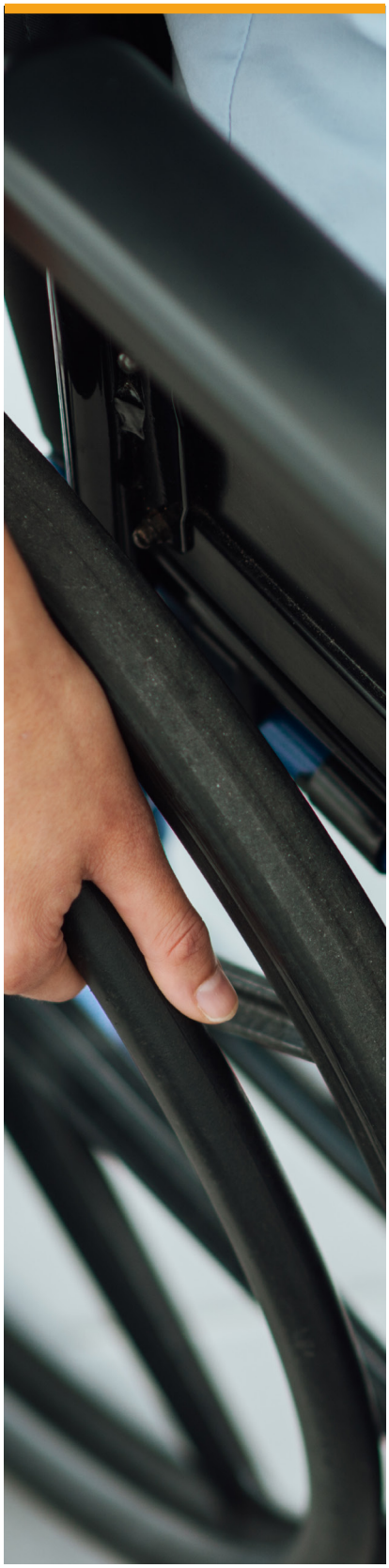
Voluntary Accidental Death & Dismemberment (AD&D)

AD&D insurance provides extra financial protection for you and your family in the event of a serious accident. This coverage pays a benefit if you suffer certain injuries or loss of life due to an accident—helping ease financial stress during a difficult time.

	Voluntary AD&D Insurance		
	Employee	Spouse	Child
Benefit Schedule	Increments of $5,000	Option 1: 100% of Employee Amount Option 2: 50% of Employee Amount	10% of Employee Amount
Maximum Benefit	$300,000 or 10x annual earnings	$300,000 or 10x annual earnings	$30,000
Minimum Benefit	$25,000	$12,500	$2,500

Disability Insurance

In the event you become disabled from a non-work related injury or sickness, disability income benefits will provide a partial replacement of lost income. Through your employer, you have access to both Short-Term and Long-Term Disability Benefits.



SHORT-TERM DISABILITY (STD)

Your employer provides a base STD coverage that offers income protection if you're unable to work due to a covered illness, off-the-job injury, or recovery from surgery. This benefit replaces a portion of your weekly pay—helping you keep up with everyday expenses like rent, groceries, and bills while you focus on getting well.

If your annual salary is over $43,300, you also have the option of enrolling in additional, "buy up" coverage.

Base STD *(Employer-Paid)*	**Optional STD Buy-up** *(Employee-Paid)*
60% of weekly earnings to a maximum $500 weekly benefit	60% of weekly earnings to a maximum $3,000 weekly benefit
14-day waiting period	14-day waiting period
22-week maximum benefit period	22-week maximum benefit period

LONG-TERM DISABILITY (LTD)

Long-Term Disability (LTD) benefits are available at no cost to you. LTD benefits are a type of insurance policy that provides financial assistance to individuals who become unable to work for an extended period due to a medical condition.

Long-Term Disability Benefits *(Employer-Paid)*	
Monthly Benefit Amount	60% of the first $9,167 of your pre-disability earnings, reduced by deductible income.
Monthly Benefit Min/Max	Minimum: $100 Maximum: $5,500
Benefit Waiting Period	180 days
Maximum Benefit Period	Determined by your age when your disability begins.

2026 Benefits Costs

MEDICAL - Per Pay Period (24 pay periods)

	PPO	HDP
Employee	$59.85	$34.30
Employee + Spouse	$253.75	$207.20
Employee + Child(ren)	$197.95	$161.15
Family	$326.85	$268.05

DENTAL

	DPPO	DHMO
Employee	$20.27	$4.67
Employee + Spouse	$38.27	$7.96
Employee + Child(ren)	$47.29	$10.50
Family	$65.28	$13.42

VISION

	VISION
Employee	$3.12
Employee + Spouse	$5.85
Employee + Child(ren)	$6.22
Family	$9.70

Calculating Your Optional Term Life Premium Cost

Using your annual salary on December 31, 2025, and your age on January 1, 2026, calculate your monthly Optional Term Life premium cost. To calculate your per-paycheck cost, simply multiply the monthly cost by 12 and divide by the number of 2026 payroll checks from which benefits are deducted (24).

Age	Monthly Rate - Employee Coverage	Monthly Rate - Spouse Coverage
< 25	$0.059	$0.034
25-29	$0.059	$0.034
30-34	$0.075	$0.050
35-39	$0.093	$0.068
40-44	$0.125	$0.100
45-49	$0.175	$0.150
50-54	$0.255	$0.230
55-59	$0.425	$0.400
60-64	$0.685	$0.660
65-69	$0.995	$0.970
70+	$1.775	$1.750

How to Calculate	Example
Step 1. Annual salary at December 31, 2025 rounded up to next $1,000	You are 35 years old and have an annual salary of $70,800. $70,800 – Round to the nearest $1,000 — $71,000
Step 2. Select coverage level (100%, 200%, 300%, 400%)	You elect 1x your salary in Optional Term Life coverage
Step 3. Multiply Step 1 amount by Step 2 coverage amount	$71,000 x 1 = $71,000
Step 4. Divide Step 3 amount by $1,000	$71,000 / $1,000 = 71
Step 5. Multiply Step 4 amount by appropriate rate for your age on January 1, 2026 (Optional Term Life Rate Chart, Column A)	71 x $.093 = $6.60
This is your monthly TLF premium amount	**You will pay $6.60 each month** for your Optional Term Life coverage.

2026 IMPORTANT NOTICES

The following notices are intended for benefits-eligible members enrolled in a PEBC health plan for the 2026 plan year. If you are not eligible for or enrolled in a PEBC plan, the notices will not apply to you.

Contents:

Uniform Summary of Benefits and Coverage (SBC)

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

Genetic Information Nondiscrimination Act of 2008

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

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

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

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

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

3. Required coverage for reconstructive surgery following mastectomies. Certain requirements to provide benefits for breast reconstruction after a mastectomy. (Women's Health & Cancer Rights Act [WHCRA]). If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician

and the patient, for:

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

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

Medicare Part D Notice of Creditable Coverage

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

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

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

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

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

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

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

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

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

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

2026 IMPORTANT NOTICES

For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.
You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if PEBC Plan prescription drug coverage changes. You also may request a copy from your Employer.

More information about your options under Medicare prescription drug coverage

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

For more information about Medicare prescription drug coverage:

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

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

KEEP THIS CREDITABLE COVERAGE NOTICE

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

PEBC Health Plans Notice

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

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

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

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

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

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

ALABAMA – Medicaid
Website: **http://myalhipp.com**
Phone: **1-855-692-5447**

2026 IMPORTANT NOTICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEBRASKA – Medicaid
Website: **https://iserve.nebraska.gov/**
Phone: **1-855-632-7633**
Lincoln: **1-402-473-7000**
Omaha: **1-402-595-1178**

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

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

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

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

NORTH CAROLINA – Medicaid
Website: **https://medicaid.ncdhhs.gov**
Phone: **1-919-855-4100**

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

OKLAHOMA – Medicaid and CHIP
Website: **https://oklahoma.gov/ohca/insureoklahoma/about.html**
Phone: **1-888-365-3742**

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

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

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

SOUTH CAROLINA – Medicaid
Website: **https://www.scdhhs.gov**
Phone: **1-888-549-0820**

SOUTH DAKOTA – Medicaid
Website: **http://dss.sd.gov**
Phone: **1-800-452-7691**

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

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

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VERMONT– Medicaid
Website: **https://dvha.vermont.gov/members/medicaid/hipp-program**
Phone: **1-800-250-8427**

VIRGINIA – Medicaid and CHIP
Website: **https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp**
Phone: **1-855-242-8282**

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

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

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

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

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

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

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

Continuation of Group Coverage (COBRA)
Initial Notice

Continuation coverage rights under COBRA
Introduction

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

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

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

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

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

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

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

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

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

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

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

When is COBRA coverage available?

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

You must give notice of some qualifying events

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

How is COBRA coverage provided?

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

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

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are 2 ways in which this 18-month period of COBRA continuation coverage can be extended.

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Disability extension of 18-month period of continuation coverage

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

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

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

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

Are there other coverage options besides COBRA continuation coverage?

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

If you have questions

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

Keep your plan informed of address changes

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

Plan contact information

You should contact your Employer's Human Resources department first with any questions regarding COBRA continuation coverage.
The COBRA Benefit Administrator is HealthEquity.
The COBRA Benefit Administrator is responsible for administering COBRA continuation coverage. HealthEquity COBRA Member Services can be reached at 877-722-2667.

Employer Notice of Exchange

Health Insurance Marketplace coverage options and your health coverage

General information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

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

How can I get more information?

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

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

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

PEBC Privacy Notice

PEBC Group Health Plans

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

Effective date of notice: Sept. 23, 2013

The "Plan" as described below refers to all PEBC group health plans, including the High Deductible Medical Plan (HDP), EPO Medical Plan, PPO Medical Plan, PEBC Dental Plan, PEBC Vision Plan and Health Care Spending Accounts (both general and limited purpose) if offered by your Employer. "You" or "yours" refers to individual participants in the Plan. If you are covered by a PEBC dental HMO plan, you will receive a separate notice from that HMO. Throughout this document are references to the "Plan" and its administration. With regard to health plans offered on a fully insured basis (e.g., dental HMO and vision), information received from the "Plan" will generally be coming from the insurer on behalf of the Plan. For self-funded plans, "Plan" administration includes your Employer's own internal administration of the Plan, as well as PEBC and other administration activities.

Use and disclosure of protected health information

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

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

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

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

For health care operations purposes, use and disclosure may take place in a number of ways involving plan administration, including for quality assessment and improvement, vendor review, and underwriting activities. Your information could be used, for example, to assist in the evaluation of 1 or more vendors who support the Plan, or our vendors may contact you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the Plan. Health care operations may also include, but are not limited to, disease management, case management, legal reviews, handling appeals and grievances, plan or claims audits, fraud and abuse compliance programs, and other general administrative activities.
The Plans covered by this Notice may share Protected Health Information with each other as necessary to carry out treatment, payment or health care operations. For example, your requests for claim payment may automatically be sent from a PEBC Medical Plan to the Health Care Spending Account Plan in order to simplify and accelerate claims payment.

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

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

The Plan is prohibited from using or disclosing genetic information for underwriting purposes, and will not use or disclose any of your Protected Health Information which contains genetic information for underwriting purposes. In addition, the Plan may use or disclose your Protected Health Information without your authorization under conditions specified in federal regulations, including:

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

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

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

Uses and disclosures for which an authorization is required

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

Your rights regarding Protected Health Information
You have the right to:

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

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

About this Notice

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

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

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Contacting the plan administrator

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

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

Patriot Act Notice

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

Important information about procedures for opening a new account

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

What this means for you:

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

Important Health Savings Account Information

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

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

- Determining your eligibility to contribute to an HSA;
- Keeping receipts to show you used your HSA for qualified medical expenses;
- Tracking contribution limits and withdrawing any excess contributions;
- Making sure funds are transferred to a qualified HSA; and
- 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 $300 or more per calendar year for completing wellness activities as well as an additional $300 or more if an enrolled spouse participates. Refer to the PEBC Wellness Program Summary Plan Description for details. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive reward.

Incentives may be available for employees who participate

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

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

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

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

Protections from disclosure of medical information

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

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

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your Employer's Human Resources department or Benefits Office.

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately 7 minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210, or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

NOTES

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