

Employee Health Benefits

2022 ENROLLMENT GUIDE



Benefits
that deliver
choice,
flexibility
and value



Choice. Flexibility. Value.

The Public Employee Benefits Cooperative (PEBC) offers a variety of benefits and programs to help you manage your health while keeping benefit costs affordable. In this guide, you'll find information on your 2022 health plan benefits to help you choose the coverage that works best for you.

Questions? Please contact your Human Resources department.

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What's changing for 2022

Here's an overview of what you can expect

Health savings account (HSA) contributions

The maximum contribution to an HSA for 2022 is \$3,650 for individuals and \$7,300 for families, with deposits made through payroll deduction. If you are age 55 or older, you can make an extra catch-up deposit of \$1,000 in 2022.

Flexible spending account (FSA) contributions

You must elect an FSA every year you intend to participate. The maximum amount you can set aside for 2022 is \$2,750 – including general-purpose FSAs and limited-purpose FSAs (LP-FSAs). Employer contributions do not count toward the annual limit. To help pay for qualifying day care expenses, you can set aside up to \$5,000 in the dependent care FSA in 2022, which cannot be used for medical expenses.

New vision plan administrator

Starting Jan. 1, 2022, VSP will be administering the PEBC vision plan. Although VSP matched the previous plan, there could be slight changes to coverage, and Denton County is now offering a high/low option. In addition, the contact information for your vision plan will change. For more information, turn to page 22 of this guide.

New dental plan administrator

Starting Jan. 1, 2022, Delta Dental will be administering PEBC dental plan benefits. While there are no changes to coverage, the contact information for your dental plan will change. For more information, turn to page 24 of this guide.

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. Verify submission requirements and deadlines with your employer. Visit pebcinfo.com to get a copy of the form.

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 your employer PPO medical plan or HDP, a **\$200 per month spouse surcharge** will apply to the cost of covering your spouse on your employer medical plan (deducted from your paycheck).

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

The medical plan spouse surcharge will not apply if:

- Your spouse is enrolled in dental and vision coverage.
- Your spouse is enrolled in both their employer medical plan (proof of enrollment required) and your PPO plan or HDP; or
- 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; or
- Your spouse's other coverage is Medicare, Medicaid, TRICARE or care received at a Department of Veteran Affairs (VA) facility; and
- You turned in the required Spouse Medical Plan Surcharge Affidavit on time.

PLEASE NOTE: The surcharge will 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.

Enrolling in your 2022 medical plan

How to select a plan

Annual enrollment is the only time of the year that you can change your benefit elections or dependents without a qualified change in status event. It's important to read your plan options closely to help you make the choices that are best for you. Here are a few helpful things to remember.

- Compare the differences between the plans.
- Check which doctors, hospitals and providers are in the network. Both plans offered through PEBC use the large UnitedHealthcare Choice Plus network.
- Think about potential health needs in the coming year. Estimate your out-of-pocket cost for each available plan for services you might receive, as well as the premium cost.
- If you enroll in the HDP, consider the additional savings and benefits of the health savings account (HSA), especially if partnered with a limited-purpose flexible spending account (LP-FSA). Your employer contributes "seed money" to your HSA to help you save even more. If you are not eligible for HSA contributions, the seed money goes to an LP-FSA.
- If you enroll in the PPO plan or opt out of medical coverage, you can also save by electing a health care FSA.

NOTE: During annual enrollment, you must re-enroll if:

- Your employer requires you to re-enroll (important deadlines apply)
 - Anything changed, including dependent eligibility, your address or your plan choice
 - You want to contribute to an FSA or an LP-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.
-

Helpful tools

The following resources can help you choose the right plan, get the most out of your health plan benefits and maybe even save you time and money.

pebcinfo.com

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.
- To see employee contribution rates for each plan along with the various account options available to you (HSA, FSA, LP-FSA), view the 2022 Employee Benefits Rate Sheet.

myuhc.com[®]

Register for an account on myuhc.com and you'll be able to locate a network provider nearby, estimate costs for care, verify FSA balances or transactions, link to Live and Work Well for mental health and Employee Assistance Program (EAP) services, schedule a 24/7 Virtual Visit, access your HSA and much more.

- **Use the cost estimator** to help estimate your out-of-pocket costs, compare treatment options and select a quality provider for a procedure.
- **Access myClaims Manager** to help manage your claims and understand your share of the plan cost. You can view your deductible, annual out-of-pocket maximum and claims history.
- **Select "Find Physician, Laboratory or Facility"** to find network providers (including Tier 1 and Premium Care Physicians) and even pay your out-of-pocket costs securely online.
- **Download the UnitedHealthcare[®] app** to access your health plan ID card, find nearby care and more right on your phone or mobile device, anywhere, anytime.

caremark.com

Log in to or download the CVS Caremark[®] app to manage your prescription drug benefits.

Dependent eligibility

Who is an eligible dependent?

Your dependent can be enrolled in a plan only if they are an eligible dependent. If both you and your spouse work for the same employer, your dependents can be covered by only one of you.

Eligible spouse

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

Eligible child(ren)

- Your natural child under age 26
- Your natural, mentally or physically disabled child, if the child has reached age 26 and is dependent upon you for more than one-half of their support as defined by the Internal Revenue Code. To be eligible, the disability must occur before or within 31 days of the child's 26th birthday.
- Your legally adopted child, including a child who is living with you who has been placed for adoption or for whom legal adoption proceedings have been started, or a child for whom you are named Permanent Managing Conservator
- **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.



Managing conservator

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

Dependent verification

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

Who is *not* an eligible dependent?

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

Ineligible spouse

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

Ineligible child(ren)

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

When a child's coverage ends

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

New hire enrollment

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

- You must return 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.
- If you select optional Term Life insurance (TLF) when you are newly hired and enrolling for the first time, you do not have to provide Evidence of Insurability (EOI). If you select spouse optional Term Life (SLF) in an amount greater than \$25,000, EOI is required. Instructions are found on the back of the enrollment form, available at pebcinfo.com. TLF coverage requirements vary by employer. Check with your employer to confirm your EOI requirements.



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.

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

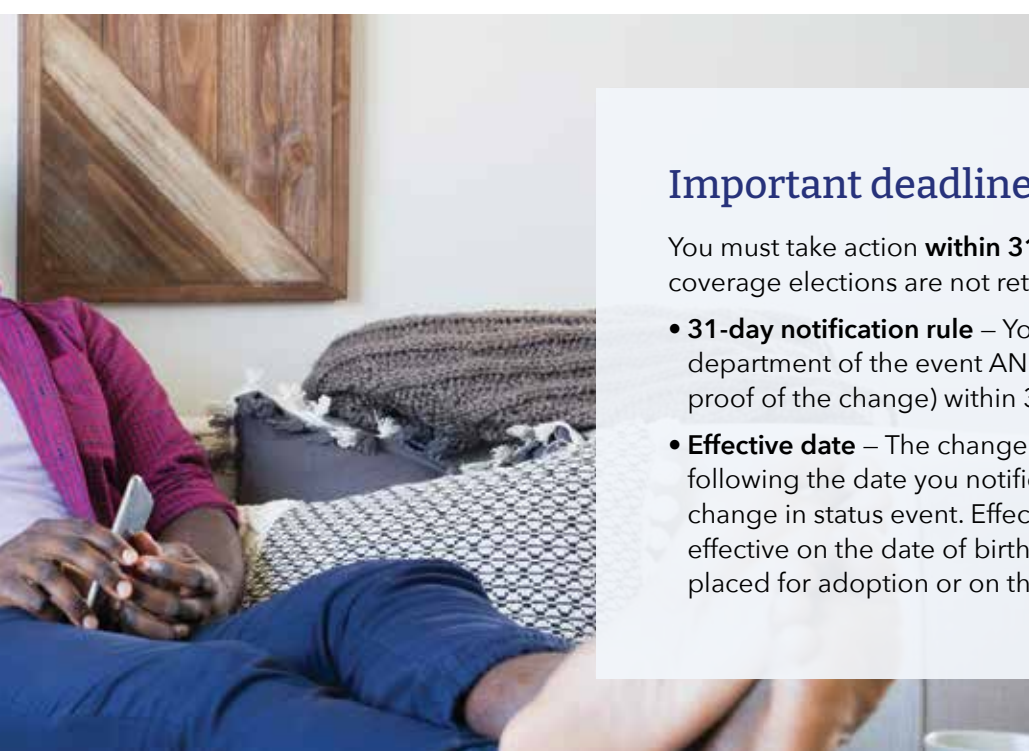
Examples of events that do not qualify:

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

Change in employment status

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



Important deadlines apply

You must take action **within 31 days of the qualifying event** – coverage elections are not retroactive.

- **31-day notification rule** – You must notify your Human Resources department of the event AND turn in required paperwork (including proof of the change) within 31 days of the event date.
- **Effective date** – The change is effective the first day of the month following the date you notified your employer of the qualified change in status event. Effective date exception: Newborns are effective on the date of birth, and adoptions are effective the date placed for adoption or on the adoption date.

Retirement

Thinking about retirement?

Your employer offers retiree health benefits, but retiree health benefits 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.

If you are age 65 or older, or if you are turning 65 soon, contact the Social Security Administration at least 90 days before you retire. Carefully review the Retiree Health Benefits Guide, available at pebcinfo.com or from your employer.

Turning age 65 and still working

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

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

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

CAUTION: If you are preparing to retire and you or your spouse are age 65 or older or turning 65 soon, 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 your employer's Medicare Advantage HMO or PPO retiree plans but only if you are enrolled in both Medicare Part A and Part B.



Retired public safety officers: The HELPS ACT

If you are a retired public safety officer and you enroll in the retiree group health plan, you may benefit from a tax savings provision known as the HELPS Act.

Federal law permits eligible retired public safety officers to exclude up to \$3,000 of their qualified health insurance premiums from their gross taxable income each year as long as the premiums are deducted from their retirement benefit. This means your health premium must be deducted from your TCDRS monthly retirement benefit to qualify for the tax savings.

Contact your Human Resources department (not TCDRS) for additional information and the required enrollment form. Information is also available at pebcinfo.com (select "employer member group," then select "retiree" from the top menu for retiree information specific to your employer).

If you are currently enrolled, you do not need to enroll again.





Choosing the medical plan that's 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 count toward your out-of-pocket costs. **Copays do not count toward the deductible.**

Network deductibles	Out-of-network deductibles
For 2022, your deductible for services in the network is:	The individual out-of-network deductible applies to each enrolled family member and does not have a family deductible limit:
\$500 for individual (single) coverage	\$1,000 for each individual (single)
\$1,000 for family coverage*	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.

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:

- **\$1,500 individual (single) deductible**
- **\$3,000 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 \$3,000. Even if one family member reaches the \$1,500 deductible, that member cannot move to coinsurance until the full \$3,000 family deductible is met.

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

If you do not provide a Certification of Other Coverage form, or if your proof of coverage is found to be invalid, your employer can enroll you in the PPO plan (employee-only coverage). If you opt out, you will not be eligible for continuation of medical coverage (COBRA). Examples of coverage that cannot be used to opt out of your employer’s medical plan include:

- Medicaid
- TRICARE “supplemental” coverage
- Marketplace
- Student insurance
- Coverage that does not meet minimum ACA requirements

Transition benefits

Are you new to the HDP or PPO plan? Transition of Care is a service that enables new enrollees to receive time-limited care for specific medical conditions from an out-of-network doctor but at the network benefit level. Complete Sections 1 and 2 of the Application for Transition of Care form (available at pebcinfo.com or from your Human Resources department). Ask your doctor to complete Section 3 and forward to UnitedHealthcare no later than 30 days after your benefits become effective. Transition benefits may apply if you are in your second or third trimester of pregnancy, a high-risk pregnancy, in nonsurgical treatment (radiation, chemotherapy) for cancer, treatment for symptomatic AIDS, treatment for severe or end-stage kidney disease, or if you are on the waiting list for or recently underwent a bone marrow or organ transplant.

PLEASE NOTE: If your employer contributes to a health care FSA due to your medical plan opt-out status, that contribution is subject to valid proof of other comparable coverage and a current, signed Certification of Other Coverage form. If your other coverage is found to be invalid or expired, the employer contribution is discontinued. You may be required to repay any employer contributions, and you could be subject to serious consequences. Participation or continuation of any employer contribution program is at the discretion of the employer. **Coverage obtained through the Health Care Marketplace (Exchange) is not eligible for employer opt-out contributions.**

Questions?
Talk to your
Human Resources
representative.

Understanding HSAs

What is an HSA?

An HSA is a savings account that you can use to help cover qualified health care expenses. You must be enrolled in a high-deductible health plan to participate. 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 2022, you can contribute \$3,650 through payroll deduction if you have individual coverage or \$7,300 if you have family coverage. The IRS also allows catch-up contributions of \$1,000 if you are age 55 or older.

Your HSA

An HSA will be opened with Optum Bank® for all newly enrolled HSA participants. Once your account is opened, you will receive a Welcome Kit in the mail. As long as you maintain an account balance of \$500 or more, you will not be charged the \$1 monthly account maintenance fee. If your account balance is \$2,000 or more, you can choose to invest funds – look for details in your Welcome Kit.

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.

If you are not eligible for HSA contributions – for example, if you are enrolled in Medicare – the seed money contribution will go to an LP-FSA. Seed money is not offered to those who add coverage in the high-deductible plan as a result of a mid-year qualifying event.

If you enroll in the HDP with an HSA, be sure to save receipts.

You are responsible for verifying your HSA was used for eligible medical expenses under the IRS tax code. Contact Optum Bank for details.

4 things you need to know about HSAs

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

1. You are covered under an eligible high-deductible plan (like the HDP).
2. You are not covered by another medical plan (unless it is an HDP) or a general-purpose FSA.
3. You are not enrolled in Medicare.
4. You cannot be claimed as a dependent on someone else's tax return.

PLEASE NOTE: Some other restrictions apply, especially if you receive services at a VA facility or clinic. Contact your tax or financial advisor if you have questions. If you switch to a health plan that makes you ineligible to continue depositing money in an HSA, you can continue to use the money in your account for qualified medical expenses, but you can no longer make deposits.

Build your balance

You can also make pretax contributions to your HSA, up to IRS limits, to help your account grow.

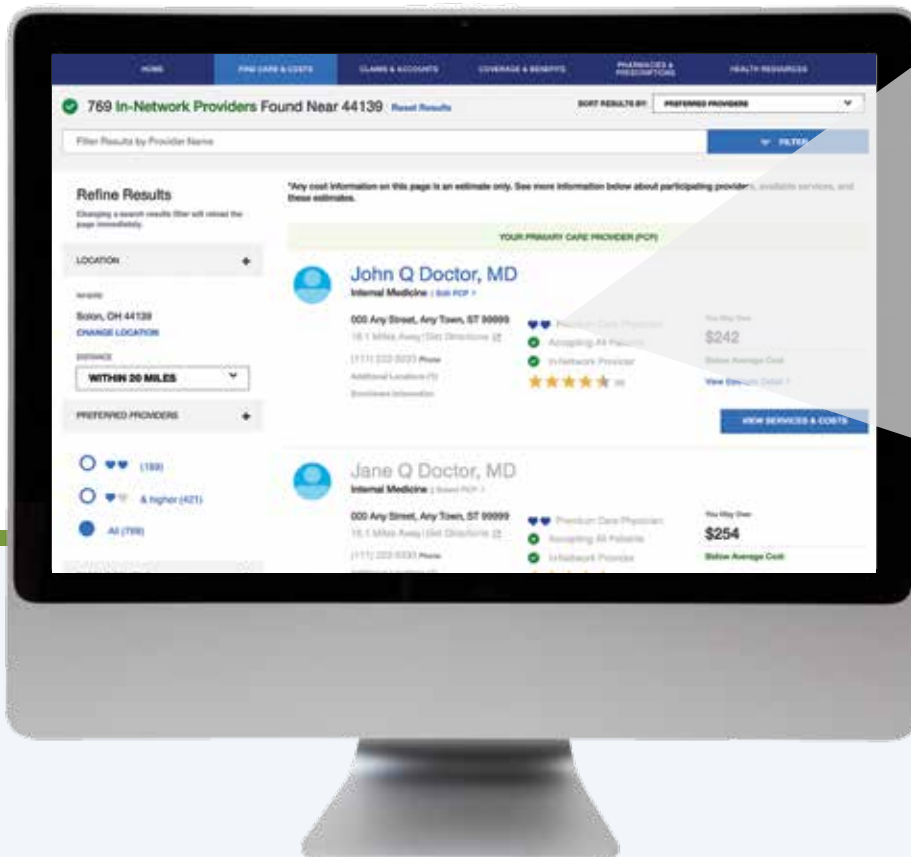
UnitedHealth Premium® program

Choosing a doctor is one of the most important health decisions you'll make. Studies show that people who actively engage in their health care decisions have fewer hospitalizations, fewer emergency visits, higher utilization of preventive care and overall lower medical costs. Take an active part in your health by seeking out and choosing providers with the help of the UnitedHealth Premium program.

Choosing a Premium Care Physician

The UnitedHealth Premium program makes it easy for you to find doctors who meet benchmarks based on national standards for quality and cost efficiency. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures. If a doctor does not have a Premium designation, it does not mean he or she provides a lower standard of care. It could mean that the data available to us was not sufficient to include the doctor in the program or that the doctor practices in a specialty not evaluated as a part of the Premium program. Learn more at unitedhealthpremium.com.

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



To find Premium Care Physician, look for two blue hearts on myuhc.com.

Mental health support

Sometimes a little extra help can go a long way. Your benefits include behavioral health support provided by United Behavioral Health, 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, visit myuhc.com > **Coverage & Benefits > Mental Health.**

Resource	How it works	How to access
Live and Work Well	Find support for a variety of concerns, including: <ul style="list-style-type: none"> • Anxiety and stress • Alcohol and drug use • Coping with grief and loss • Marital problems • Eating disorders • Compulsive spending or gambling • Medication management 	Visit liveandworkwell.com and enter access code: PEBC
Talkspace	Communicate with a licensed therapist via text or live video from your phone or desktop. It's private, confidential and convenient. Five days of unlimited texting via the Talkspace app equals one in-person office visit through either your EAP or behavioral health benefit.	Register at talkspace.com/connect
Virtual behavioral health visits	Talk to a psychiatrist or therapist without leaving your home. These providers can evaluate and treat general mental health conditions such as depression and anxiety.	<ul style="list-style-type: none"> • Sign in to liveandworkwell.com. • Select Find a Resource > virtual visits. • Choose Get Started. You can schedule an appointment online or by phone.
In-person behavioral health visits	From everyday challenges to more serious issues, you can receive confidential help with a psychiatrist or therapist for: <ul style="list-style-type: none"> • Depression, stress and anxiety • Substance use and recovery • Eating disorders • Parenting and family concerns 	Search for a provider near you on liveandworkwell.com .
Sanvello™	Dial down the symptoms of stress, anxiety and depression with an app that uses clinical techniques. Sanvello premium access is available at no extra cost as part of your behavioral health benefit.	Download the app at sanvello.com .
Substance Use Treatment Helpline	Speak with a substance use recovery advocate who will listen, provide support and develop personalized recovery plans. The helpline is available 24/7 as part of your benefits and is completely confidential – you can even choose to remain anonymous.	Call 1-855-780-5955 or visit liveandworkwell.com/recovery to find care options and resources.

These services and programs are for informational purposes only and should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. This content is for informational and/or educational purposes only. It is not meant to be used in place of professional clinical consultations for individual health needs. Certain treatments may not be covered in some benefit plans.

Employee Assistance Program

The EAP is completely confidential and is provided to employees at no cost, regardless of the medical plan you selected. Even if you opt out of medical coverage, the EAP is available to you. Dependents who live away from home are also eligible.

The EAP is staffed by licensed clinicians who know how to get you and your family the help you need – right away. When you call, the specialist will help identify the best resource for your specific situation by talking with you and asking questions. You can speak to an EAP specialist as often as you like at no extra cost.

As part of the program, you and your family also get **five face-to-face counseling sessions at no extra cost** with a network provider (per concern, per person, per year). First responders get eight sessions. You can also meet virtually through a telemental health visit. This service uses video-calling technology to provide real-time access to a behavioral health professional – with no travel and less wait time for appointments.

To learn more about your EAP benefits, go to myuhc.com > **Coverage & Benefits > Mental Health > liveandworkwell.com**. If you do not have medical coverage through PEBC, visit liveandworkwell.com, access code: PEBC.

These services and programs are for informational purposes only and should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. This content is for informational and/or educational purposes only. It is not meant to be used in place of professional clinical consultations for individual health needs. Certain treatments may not be covered in some benefit plans.

**Call the EAP 24/7 at
1-866-248-4096**

Specialists will be able to connect you to support for help with:

- **Work and career** – including conflict management, stress management and career counseling
- **Family and relationships** – including pregnancy, adoption, separation or abuse
- **Legal and financial services** – including mediation, financial planning and financial aid assistance
- **Grief** – including the loss of a loved one, infertility, miscarriage and other difficult life changes
- **Child care and elder care** – including help for teens and Medicaid/Medicare
- **Life transitions** – including divorce, relocation and college selection
- **Local personal services** – including restaurant reservations, dog walkers, plumbers and more



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		
Office visits	\$25 primary care physician (PCP) \$25 Premium Care Specialist \$35 non-Premium Care Specialist	40% after deductible
24/7 Virtual Visits	\$0 copay	40% after deductible
Telehealth	\$25 PCP \$25 Premium Care Specialist \$35 non-Premium Care Specialist	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visit	\$35 copay	40% after deductible
Preventive care*		
Well-child care	Covered at 100%	40% after deductible
Well-woman exam	Covered at 100%	40% after deductible
Routine screening mammography	Covered at 100%	40% after deductible
Adult health assessments	Covered at 100%	40% after deductible
Immunizations	Covered at 100%	40% after deductible
Screening colonoscopy	Covered at 100%	40% after deductible
Maternity services		
Routine prenatal care	Covered at 100%	40% after deductible
Delivery in hospital	20% after deductible	40% after deductible
Newborn care in hospital (routine)	20% after deductible	40% after deductible

*Subject to Affordable Care Act requirements.

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*	\$1,500 individual/\$3,000 family	\$3,000 individual/\$6,000 family
Coinsurance (after the annual deductible is met)	20% after deductible	40% after deductible
Annual coinsurance maximum	\$1,500 individual/\$3,000 family	No limit
Annual out-of-pocket maximum (OOP)	\$3,000 individual/\$6,000 family Plan pays 100% after annual OOP	No limit
Physician services		
Office visits	20% after deductible	40% after deductible
24/7 Virtual Visits	20% after deductible	40% after deductible
Telehealth	20% after deductible	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visits	20% after deductible	40% after deductible
Preventive care**		
Well-child care	Covered at 100%	40% after deductible
Well-woman exam	Covered at 100%	40% after deductible
Routine screening mammography	Covered at 100%	40% after deductible
Adult health assessments	Covered at 100%	40% after deductible
Immunizations	Covered at 100%	40% after deductible
Screening colonoscopy	Covered at 100%	40% after deductible
Maternity services		
Routine prenatal care	Covered at 100%	40% after deductible
Delivery in hospital	20% after deductible	40% after deductible
Newborn care in hospital (routine)	20% after deductible	40% after deductible

*The entire family deductible must be met before benefits pay – unless you selected employee-only coverage.

**Subject to Affordable Care Act requirements.

PPO – medical plan (continued)

Feature	Your network cost	Your out-of-network cost PLUS you pay charges exceeding plan payment
Maternity services (continued)		
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
Lab & X-ray outpatient (minor)	Covered at 100% in physician office or network lab or radiological provider	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
Skilled nursing facility	20% after deductible; up to 60 days annually*	40% after deductible; up to 60 days annually*
Home health care	20% after deductible; up to 120 visits annually*	40% after deductible; up to 120 visits annually*
Allergy care services	\$25 PCP/\$25 Premium Care Specialist \$35 non-Premium Care Specialist	40% after deductible
Chiropractic	\$35 copay per visit; maximum 20 visits per year*	40% after deductible; maximum 20 visits per year*
Medical supply & equipment (DME)	20% after deductible	40% after deductible
Mental health services		
Outpatient visits	\$25 visit	40% after deductible
Inpatient	20% after deductible	40% after deductible
Serious mental illness	Treated like any other illness	Treated like any other illness
Substance abuse	Treated like any other illness	Treated like any other illness

*Limits apply for any combination of network and out-of-network benefits.

HDP – medical plan (continued)

Feature	Your network cost	Your out-of-network cost PLUS you pay charges exceeding plan payment
Maternity services (continued)		
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
Lab & X-ray outpatient (minor)	20% after deductible	40% after deductible
Hospital emergency care services (treated as network)	20% after deductible	20% after deductible
Skilled nursing facility	20% after deductible; up to 60 days annually*	40% after deductible; up to 60 days annually*
Home health care	20% after deductible; up to 120 visits annually*	40% after deductible; up to 120 visits annually*
Allergy care services	20% after deductible	40% after deductible
Chiropractic	20% after deductible; maximum 20 visits per year*	40% after deductible; maximum 20 visits per year*
Medical supply & equipment (DME)	20% after deductible	40% after deductible
Mental health services		
Outpatient visits	20% after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible
Serious mental illness	Treated like any other illness	Treated like any other illness
Substance abuse	Treated like any other illness	Treated like any other illness

*Limits apply for any combination of network and out-of-network benefits.



Saving on prescription medications



CVS Caremark

CVS Caremark has approximately 68,000 pharmacies in their national network, made up of major chains such as CVS Pharmacy, Kroger, Albertsons, Walmart, Costco and most independent pharmacies across the United States.

CVS Health's Standard Control Formulary

The formulary is the list of safe and effective medications available for you. Not all medications on the formulary are covered by your plan, and some medications are excluded entirely. Not seeing a specific medication on the formulary? Talk to your doctor about an alternative that can work for you. For questions, call CVS Caremark Customer Service at **1-855-335-7698**.

Out-of-pocket costs

Eligible pharmacy costs count toward your out-of-pocket maximum (OOP). There are certain prescription drug expenses that do not count toward the OOP, such as items excluded by the plans or the cost difference if you choose a brand-name drug instead of a generic.



Register at [caremark.com](https://www.caremark.com)

Manage your prescriptions online with tools available at [caremark.com](https://www.caremark.com).

- Check the cost of a drug
- Find available alternative medications
- See your prescription history
- View balances
- View the Preferred Drug List
- Locate a participating pharmacy
- And more

Generic medications

When it comes to choosing your medications, it pays to shop smart. You can often save (sometimes a lot) if you choose an available generic drug instead of the brand-name version.

PPO plan members: If you choose the brand-name drug and you are enrolled in the PPO plan, you'll pay the applicable copay plus the cost difference between the generic and brand-name drug. Only the generic copay will count toward your OOP.

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

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

For prior authorization or coverage review, contact CVS Caremark at **1-800-294-5979**. You can also visit pebcinfo.com.

CVS Specialty pharmacy

Specialty drugs are those that are typically more expensive, used to treat complex, chronic conditions, and require an enhanced level of care. CVS Specialty has a team of professionals that help you ensure the best possible outcomes from your specialty drugs.

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

Specialty medication

Unless your drug is needed on an emergency basis, all specialty drugs must be filled through CVS Specialty or you pay 100% of the cost without credit to your annual out-of-pocket limit. Many specialty drugs have a copay assistance program that reduces your copay or out-of-pocket cost. CVS Specialty will make you aware if a copay assistance program applies, and your actual lower cost will apply to your deductible and/or out-of-pocket limit.

If you have questions about specialty medications, call CVS Specialty at **1-800-237-2767** or visit cvsspecialty.com.

Pharmacy access options Refills allowed as prescribed	PPO plan	HDP
CVS Caremark National Network Pharmacy (network) up to a 30-day supply	\$15 generic \$30 preferred brand \$60 non-preferred brand	<ul style="list-style-type: none"> • For retail and home delivery pharmacy, you will pay 100% of the CVS Caremark/ CVS Specialty 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%.
CVS Caremark Mail Order Pharmacy up to a 90-day supply or CVS Caremark Retail-90 Network Pharmacies	\$30 generic \$60 preferred brand \$120 non-preferred brand	
CVS Specialty Pharmacy up to a 30-day supply	\$10 generic \$20 preferred brand \$40 non-preferred brand	

No-additional-cost contraceptives (prescription required)

The pharmacy benefit plan covers certain contraceptives at no additional cost to you, which can be filled through home delivery or at the retail pharmacy. This includes generic contraceptives and some brand-name drugs in certain cases. Not all drugs are covered. If you have questions, contact CVS Caremark.

The outpatient pharmacy benefit covers the following methods:

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

90-day prescriptions

Get up to a 90-day supply of your medicine for the prescriptions you take regularly. If you are enrolled in the PPO plan, the copay will mirror the home delivery copay. Home delivery allows you to get a three-month supply for the price of two copays. Specialty drugs are shipped in a 30-day supply. You will pay one-third the three-month supply copay for specialty drugs through CVS Specialty. Home delivery includes free standard shipping.

To get started with home delivery, get a 90-day prescription from your doctor plus refills for up to one year (if applicable). Complete the CVS Caremark mail-order form available at [caremark.com](https://www.caremark.com). Click on "Plan & Benefits" and select "Print Plan forms." Mail the form and prescription to Caremark at the address on the form. You can also ask your doctor to ePrescribe or fax your prescription. If you have questions about home delivery, call the CVS Caremark Mail Order Pharmacy at **1-855-335-7698**.



Preventive statin drugs

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

Included:	High-intensity doses that are not included:
<ul style="list-style-type: none">• Atorvastatin: 10–20 mg• Fluvastatin IR: 20–40 mg• Fluvastatin XL: 80 mg• Lovastatin: 10–40 mg• Pravastatin: 10–80 mg• Simvastatin: 5–40 mg• Rosuvastatin: 5–10 mg	<ul style="list-style-type: none">• Atorvastatin: 40–80 mg• Lovastatin: 60 mg• Rosuvastatin: 20–40 mg• Simvastatin: 80 mg

Excluded drugs

Check the list of drugs excluded from the CVS Caremark formulary. In many cases, the generic equivalent for the brand-name excluded drug is covered and will cost you less. In other cases, there is an alternative to the excluded medication. You pay 100% of the cost for any excluded drug, and that cost is not applied to the deductible or OOP. View the 2022 Excluded Drug list at [pebcinfo.com](https://www.pebcinfo.com).





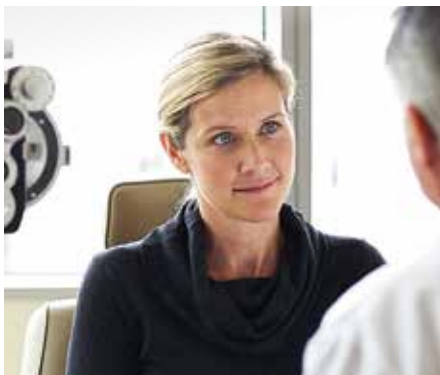
Enhancing well-being with vision and dental benefits



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](https://www.vsp.com) to learn more about your vision benefits and find an eye doctor near you.



To learn more about your vision benefits and find an eye doctor near you, create an account at [vsp.com](https://www.vsp.com).

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 1-800-877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed under the SunCare enhancement, if purchased by Client
- Two pair 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 (CRT) or Orthokeratology

VSP Advantage Plan

	High option		Low option for Denton County only	
	Network	Non-network reimbursement	Network	Non-network reimbursement
Vision exam	\$10	Up to \$43	\$10	Up to \$43
Eyeglass lenses				
Single vision	\$20	Up to \$30	\$25	Up to \$30
Bifocal	\$20	Up to \$45	\$25	Up to \$45
Trifocal	\$20	Up to \$62	\$25	Up to \$62
Lenticular	\$20	Up to \$100	\$25	Up to \$100
Standard progressive lenses	\$20	Up to \$45	\$25	Up to \$45
Frames*	\$200 allowance; 20% off balance over \$200 \$250 at Visionworks	Up to \$40	\$150 allowance; 20% off balance over \$150 \$200 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)		Contacts in lieu of glasses (12/12/24 frequency)	
Non-elective	Covered at 100%	Up to \$210	Covered at 100%	Up to \$210
Elective	\$200 allowance; not to exceed \$40 copay for contact lens exam	Up to \$185	\$150 allowance; not to exceed \$40 copay for contact lens exam	Up to \$185
Service frequency				
Exams	12 months	12 months	12 months	12 months
Prescription lenses	12 months	12 months	12 months	12 months
Frames	12 months	12 months	24 months	24 months
Contact lenses	12 months	12 months	12 months	12 months
Laser care	Average 15% off the regular price or 5% off the promotional price		Average 15% off the regular price or 5% off the promotional price	

*NOT in lieu of contacts on 12/12/12 High option; ARE in lieu of contacts on 12/12/24 Low option.

**In lieu of only eyeglass lenses on 12/12/12 High option; frames and contacts available; Low option alternative 12/12/24 – contacts are in lieu of glasses.

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

For 2022, 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. 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

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 any time. 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.

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.

The DPPO dental plan will cover eligible dental expenses after you meet any applicable waiting periods and meet any deductibles. The plan is based on coinsurance levels that determine the percentage of costs covered by the plan for different types of services.

Procedure	Network	Out-of-network
Deductible (per person)	\$50 (maximum of \$150)	\$50 (maximum of \$150)
Annual maximum benefit (per person)	\$2,000	\$2,000
Preventive	100%, no deductible	100%, no deductible
<ul style="list-style-type: none"> • 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 		
Basic restorative	80% after deductible	80% after deductible
<ul style="list-style-type: none"> • Fillings • Extractions • Oral surgery • Periodontal treatment • Endodontics: Root canal • General anesthesia: In conjunction with covered oral surgery, and select endodontic and periodontic procedures 		
Major restorative	50% after deductible	50% after deductible
<ul style="list-style-type: none"> • Benefits begin after 6 months of coverage • Crowns • Denture and bridges • Implants 		
Orthodontia	50% after lifetime deductible	50% after lifetime deductible
<ul style="list-style-type: none"> • Benefits begin after 12 months of coverage; orthodontic lifetime deductible and maximum (per person) 	\$1,750	\$1,750



Getting the right care at the right time



Your care options

When you need health care, you have a variety of options. It's important to remember that the emergency room is only for life-threatening or serious conditions that require immediate care. If you do not have a life-threatening condition, choosing another option will help you save time and money. View the care options chart to help you pick the right place to go.



NurseLine

NurseLine connects you with registered nurses 24/7 at no additional cost.

To connect, call 1-877-370-2849.

You can also chat with a registered nurse at **myuhc.com**. Nurses can assist you in deciding where to go for care, help you understand your treatment options and answer questions about medications.



When should you use 24/7 Virtual Visits?

24/7 Virtual Visits are a convenient option that may save you time and money. They're a great choice for these non-emergency conditions:

- Allergies
- Cold/flu
- Cough
- Pink eye
- Rash
- Bladder infection
- Migraine/headache
- Many others

Emergencies outside the U.S.

If you are traveling outside the United States and experience a life-threatening emergency, you should go to the nearest emergency room and contact UnitedHealthcare's Personal Health Support within 24 hours. To reach Personal Health Support, call the number on your health plan ID card and select the prompt for "Personal Health Support."

When traveling outside the United States, you are strongly encouraged to obtain medical travel insurance.

The U.S. State Department website (**travel.state.gov**) provides information about emergency medical coverage for U.S. citizens traveling outside the country and includes a list of insurance companies that offer coverage.

Care option	When to use it	How much it costs
24/7 Virtual Visits	See and talk to a doctor via your smartphone, tablet or computer for non-emergency medical conditions. To start a 24/7 Virtual Visit, register or sign in at myuhc.com/virtualvisits or download the UnitedHealthcare app.	PPO plan members pay a \$0 copay. HDP members pay the full service cost until the deductible is met, then pay 20% of that service.
Telehealth	See and talk to your PCP, specialist or some therapy providers via your smartphone, tablet or computer using your provider's telehealth system. For telehealth with your own doctors, check their telehealth options when scheduling an appointment. You will use their telehealth system.	Preventive care telehealth: Covered at 100% for both PPO and HDP. Members pay \$0. Diagnostic/Treatment telehealth visits: PPO plan members pay a \$25 copay for PCP and Premium Care (PC) specialist visits and \$35 for non-PC specialist visits. HDP members pay the cost of the service until the deductible is met, then pay 20% of that service.
Doctor's office	Your primary doctor knows you and your health history and can provide routine and preventive care and treatment for a current health issue or refer you to a specialist.	Preventive care visits: Covered at 100% for both PPO and HDP. Members pay \$0. Diagnostic/Treatment office visits: PPO plan members pay a \$25 copay for PCP and PC visits and \$35 for non-PC specialist visits. HDP members pay the cost of the service until the deductible is met, then pay 20% of that service.
Convenience care clinic	Clinics like MinuteClinic® or Baylor Scott & White are located inside retail stores. If you can't get to the doctor's office and the need is not urgent, this is a great option for minor health conditions.	PPO plan members pay a \$25 copay. HDP members pay the cost of the service until your deductible is met, then you pay 20% of the service cost.
Urgent care center	Centers such as PrimaCare offer treatment for non-life-threatening injuries or illnesses, including sprains, minor infections and minor burns.	PPO plan members pay a \$35 copay. HDP members pay the cost of the service until your deductible is met, then you pay 20% of the service cost.
Emergency room (ER)	If you need immediate treatment for a life-threatening or critical condition, go to the nearest ER (network benefits apply). Do not ignore an emergency – call 911 if the situation is life threatening.	PPO plan members pay a \$300 ER copay (copay waived if admitted) plus 20% coinsurance (after deductible). HDP members pay 20% coinsurance (after deductible) for ER services.
Freestanding emergency room	A freestanding ER is not to be confused with an urgent care center or convenience care clinic. It is for immediate treatment for a life-threatening or critical condition just like a regular ER.	Visiting a freestanding ER can result in higher out-of-pocket costs for you, including balance billing charges, especially if you are out of network.

24/7 Virtual Visits are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations.

Preventive care

Both the PPO plan and HDP cover preventive care at 100% as long as services are performed by a network provider. Preventive care services may include physical examinations, immunizations, laboratory tests and other types of screening tests. To see which preventive care services may be right for you, visit uhc.com/preventivecare.

Preventive care vs. diagnostic care

During a preventive care visit, if you discuss symptoms or treatment of a health concern, your visit will become diagnostic. For diagnostic care, you may be charged a copay, coinsurance or deductible. Discuss all of your health concerns with your provider but be aware that you will be billed based on the type of visit – preventive or diagnostic. Examples of diagnostic care may include:

- Medical treatment for specific health issues or conditions
- Ongoing care for a health condition
- Lab tests or other screenings necessary to diagnose, manage or treat an identified health issue

Preventive services covered at no extra cost

Covered preventive services are based on the recommendations of the United States Preventive Services Task Force (USPSTF), the U.S. Department of Health and Human Services, the Advisory Committee on Immunization Practices (ACIP) of the CDC and the HRSA Guidelines for women and children, including the American Academy of Pediatrics Bright Futures periodicity guidelines.

Contraception, prenatal and breastfeeding

The plan covers, at no additional cost to you, at least one form of contraception in each of the 18 methods identified and approved by the FDA, including necessary clinical services, patient education and counseling. Certain prenatal and breastfeeding supplies and services are also covered. To view a summary of covered preventive services, visit pebcinfo.com.



Flu shots and vaccines

Flu shots and many other vaccines are available to you at no extra cost. Age-appropriate immunizations are available at many retail pharmacy locations. Always ask the pharmacist to check your plan coverage before the immunization is administered to make sure the immunization is covered.

CVS Caremark retail pharmacy vaccines

Your pharmacy benefits will cover many vaccines under the 100% preventive benefit when administered at a participating retail pharmacy. While flu shots do not require a prescription, other vaccines may require a prescription. Save even more by using a CVS Caremark National Network retail pharmacy. Here are a few of the many CVS Caremark National Network retail pharmacies. Contact CVS Caremark or visit pebcinfo.com for more CVS Caremark National Network options (UnitedHealthcare ID card with CVS Caremark information card required).

CVS Caremark National Network retail pharmacies:

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

Covered vaccines include:

- Flu
- COVID-19
- Zoster (shingles)
- Tdap (whooping cough)
- Tetanus booster
- Meningitis
- Pneumonia
- Hepatitis B
- Childhood diseases (MMR, etc.)
- Rabies*
- Travel vaccines*

*Additional cost may apply.

UnitedHealthcare retail pharmacy vaccines

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

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

Convenience care clinics

You can receive your flu shot or pneumonia vaccine at a convenience care clinic. DFW-area locations include MinuteClinic located at certain CVS Pharmacy locations and Baylor Scott & White Convenient Care Clinics located at certain Tom Thumb stores. If you receive additional services, a copay or out-of-pocket expense may apply.

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



Maternity Support Program

When you enroll in the Maternity Support Program, you ensure you have support through every stage of your pregnancy. The program is provided at no additional cost to you.

Enroll at your convenience

To get the most from the program, it's best to enroll during your first trimester, but you can enroll whenever you like, up through the end of your pregnancy. Enroll in UnitedHealthcare maternity programs by completing an assessment on myuhc.com.

Educational materials and resources

Access maternity support content on myuhc.com, including information on:

- Preparing for a healthy pregnancy
- Pregnancy by trimester
- Postpartum
- Pregnancy nutrition and exercise
- Exploring breastfeeding

You can also access a full range of articles covering nutrition, exercise, childbirth preparation, tips for parents and more at myuhc.phs.com/maternitysupport.

Personal attention

If you have a high-risk pregnancy, a registered nurse will consult with you by phone to determine risks or complications to be aware of, teach you healthy pregnancy habits and provide one-on-one support to help you make informed decisions throughout your pregnancy and after giving birth.

Adding newborns to benefits

Your newborn is not automatically enrolled in your medical plan. Contact your Human Resources department and complete 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.



To enroll in the Maternity Support Program, go to myuhc.com or call **1-877-201-5328**, **TTY 711**

Monday through Thursday, 8 a.m. to 8 p.m. and Friday, 8 a.m. to 5 p.m. CT



Real Appeal®

Real Appeal is an online program that can help you lose weight and improve your health at no additional cost to you. Conveniently access Real Appeal from your desktop, tablet or mobile device.

Receive up to a year of support

A Transformation Coach will lead online group sessions with simple steps on nutrition, exercise and how to break through barriers to reach your goals.

Proven weight loss

Real Appeal members who attend four or more sessions during the program lose 10 pounds on average.

Tools for success

You'll receive a Success Kit containing food and weight scales, delicious recipes, workout DVDs and more. Monitor your progress with online food and activity trackers – available anywhere, anytime.

Real benefits

Real Appeal will help you learn how to live a healthy, balanced life. Research shows that losing just 5% of your body weight can help reduce the risk of type 2 diabetes and heart disease.¹

¹ In the past 20 years, researchers have demonstrated that structured weight-loss and lifestyle-change programs can accomplish three critical employee and population health goals: 1. Improving overall health outcomes for individuals who are overweight and obese but do not yet have prediabetes or diabetes (Jensen MD, Ryan DH, Donato KA, et al., 2014); 2. Reducing the progression to diabetes in those who have prediabetes (Williamson DA, Bray CA, Ryan DH, 2015); and 3. Improving clinical markers for individuals who already have type 2 diabetes (Espeland MA, Glick HA, Bertoni A, et al., for the Look AHEAD Research Group, 2014). Talk to your doctor before starting any weight-loss program.



Get started

Register today at
enroll.realappeal.com.

Real Appeal is a voluntary weight-loss program that is offered to eligible participants over the age of 18 at no additional cost as part of their plan benefits. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program. Talk to your doctor before starting any weight-loss program.

Get started with Rally®



To access Rally and start earning points toward your rewards, follow these simple steps:

1. Log in at myuhc.com.
2. Select the icon “Visit Rally Health and Wellness” in Quick Links.
3. Register for your Rally account.
4. Take your Rally Health Survey (required to earn rewards).
5. Download the Rally app on your phone.

Opted out of your employer’s medical plan?

You can still access the Rally wellness portal at werally.com/client/pebc/register.

Although you can’t earn points or a reward, you can take the Health Survey, participate in online activities and more.

PEBC Wellness Program

Active employees and their spouses enrolled in either the PPO plan or HDP are eligible to participate in the wellness program and earn an incentive.

- Employees can earn a \$300 reward for achieving 300 points.
- Spouses can earn a \$300 reward for achieving 300 points – as long as the employee has earned 300 points.
- The spouse must be enrolled in the plan to participate and remain enrolled at the time of payout for additional reward payout.

Timing and earning points

- The rewards earning period runs from Jan. 1 through Oct. 31.
- Coaching programs, Missions and Disease Management take time to complete – plan accordingly to complete by Oct. 31.
- Points are not awarded for partially completed programs and do not roll over to another year.

How is the reward paid?

The default payment method is cash, which means the funds will be included in a payroll check on a post-tax basis. Denton, Dallas, Parker and Tarrant County participants can choose to have your reward deposited to your health care FSA or, if you have not exceeded the annual HSA contribution limit, to your HSA. You may select your preferred payment options when you qualify for a reward.

When is your reward paid?

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

Date points earned	Date reward is paid by
Jan. 1 – March 31	May 31
April 1 – June 30	Aug. 31
July 1 – Oct. 31	Dec. 31

Earning points

EARN 300 POINTS

Between Jan. 1, 2022, and Oct. 31, 2022, earn 300 points by using any combination of the options below.

REQUIRED

First, complete the Health Survey and **earn 75 points**. Then earn additional points as follows.

EARN 100 POINTS

Once per year, get a biometric screening at either:

- An onsite biometric screening (your employer may sponsor screening events at work), or;
- A doctor's office visit, where your doctor identifies your biometrics (cholesterol, blood sugar, etc.).

Points are triggered via UnitedHealthcare claims; they generally appear within 21 business days from the date of service, depending on when the provider submits the claim.

EARN 100 POINTS

If you complete a Personal Health Action, you can earn 100 points. Examples of Personal Health Actions include condition management compliance, avoided readmission, hospital discharge planning and medication compliance. You can call in to a condition management nurse regarding relevant health actions, or a nurse may reach out to you to initiate conditional management and related health actions.

EARN 75 POINTS

Complete three Rally Missions. Each Mission takes four weeks. If you want, you can do all three at the same time. Complete a private or public Challenge on Rally for 25 points.

You must complete three Missions to receive your reward.

EARN 50 POINTS

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

- Complete personal wellness coaching – telephonic, email or chat. It can be done once per week. Minimum of three sessions over six weeks.
- Complete Quit For Life® tobacco cessation program
- Complete nine sessions of Real Appeal
- Enroll in the Maternity Support Program
- Complete one of the following:
 - Annual physical
 - Mammogram
 - Colon cancer screening
 - Cervical cancer screening
- Complete an annual physical or annual screening
- Use the Find and Price Care tool
- Complete a 24/7 Virtual Visit

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



Saving money using pretax dollars



Flexible spending accounts

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 day care expenses. Here's how it works:

- Use your UnitedHealthcare Health Care Spending Card to pay for eligible health care expenses, or submit a claim for reimbursement of eligible expenses from your UnitedHealthcare account.
- Expenses must be incurred by Dec. 31.
- Expenses must be submitted to UnitedHealthcare by April 30 of the following year to avoid loss of funds.
- Claims must be submitted within one year of the date of service.
- Your active employee FSA ends the date your employment ends.

Rollover funds

For information on FSA rollover eligibility, contact your employer's Human Resources department.

You have until April 30, 2022, to submit claims for expenses incurred during 2021

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

A note for highly compensated employees

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

Manage your accounts online

Visit myuhc.com to manage your FSA. If you have more than one type of 2022 FSA, you will see more than one account listed. The combined total represents your available funds. You can file your claims electronically and either upload or fax your claims substantiation.

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. The general-purpose FSA can be used to pay your eligible out-of-pocket health care expenses, including dental and vision costs. Expenses paid by insurance or another source are not eligible for reimbursement.

Limited-purpose 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. The LP-FSA reimburses you for eligible vision and dental expenses and eligible out-of-pocket medical expenses after your deductible is met.

	General-purpose FSA	LP-FSA
Medical plan enrollment required	PEBC PPO plan or opt out with a traditional plan as comparable coverage.	HDP or opt out with an HDP as comparable coverage.
What can be reimbursed?	Eligible qualified expenses including out-of-pocket medical, dental and vision expenses.	Eligible qualified dental and vision expenses, and out-of-pocket eligible medical expenses after your deductible is met.
Can I use an account debit card?	Yes – Health Care Spending Card	Yes – Health Care Spending Card
What is the maximum amount an employee can elect annually?	\$2,750 general purpose or LP-FSA	
Can I be enrolled in both accounts at the same time?	You cannot be actively enrolled in an LP-FSA if you're enrolled in a general-purpose FSA at the same time.	You cannot be actively enrolled in a general-purpose FSA if you are enrolled in the LP-FSA at the same time.
Does "use it or lose it" apply?	Plan FSA elections carefully due to IRS "use it or lose it" guidelines.	



Health Care Spending Card

All newly participating members will receive a UnitedHealthcare Health Care Spending Card account debit card at no cost, which makes it easy to access your health care FSA funds. Members with an existing card can continue to use it until the card's expiration date. Your entire health care FSA election amount is available for claims incurred at either Jan. 1, 2022, or your effective date, whichever is later.

IRS requirements apply when you use a UnitedHealthcare card, and every cardholder agrees to follow IRS rules. Read the cardholder agreement that accompanied your Health Care Spending Card.

Claims substantiation and receipts

The IRS requires claims substantiation for debit card transactions. We only request receipts for transactions where the merchant did not receive an authorization from Mastercard®. If you are unable to use your Health Care Spending Card, you will need to submit a claim for reimbursement.

Employer contributions

In some cases, employers may contribute to an employee FSA or LP-FSA. If your employer contributes, you will find the maximum contribution amounts on the back of the 2022 Employee Benefit Plan Rates document included in your enrollment packet. Employer contributions are in addition to and do not count toward the employee \$2,750 health care FSA annual election limit.



Managing your account

Visit myuhc.com and use your UnitedHealthcare credentials to log in and manage your accounts online.

- Check debit card status
- File a claim
- Upload claim substantiation
- Review your account(s)
- Download forms
- Learn more about the plan

FSA's are ONLY for those eligible claims incurred by you or your dependents for federal income-tax purposes, without regard to income limitations. Claims must be submitted within one year of the date of service. Contact your tax or financial advisor for information about your specific situation.

To mail or fax in an FSA claim

Use the claim form available on myuhc.com and mail to the address indicated on the form.

Dependent care FSA

This account primarily benefits those with a qualifying child (under age 13) or qualifying dependent by reimbursing eligible day care expenses to allow a parent to work or attend school. This account is NOT for reimbursement of dependent health care expenses. The annual dependent care FSA maximum annual election is \$5,000 (married and filing a joint tax return) or \$2,500 (single or married and filing a separate tax return).

Customer service

Call Health Care Spending Card customer service 24/7 at **1-866-755-2648** for help with a variety of topics:

- Activating a new card
- Reporting a lost or stolen card and requesting card deactivation and/or a new card
- Checking account balance information and card transaction history
- Reporting fraud
- Disputing card transactions up to 90 days from date of charge





Supporting financial security



Life insurance and accidental death & dismemberment (AD&D)

Basic employee Term Life and AD&D (GLF); employer paid

If you are a benefits-eligible employee, your employer provides this coverage at no cost to you. Under the Basic Term Life plan, your beneficiary receives a single payment from the plan when you die. If the cause of death is due to an accident, your beneficiary is eligible for an additional AD&D insurance benefit. You could qualify to receive partial AD&D benefits if you suffer serious injuries from an accident.

Basic Life (GLF) insurance amount

Your Jan. 1, 2022, Basic Life insurance amount is based on the later of either your annual salary at Dec. 31, 2021, or your 2022 hire date. Basic Life and AD&D coverage varies by employer. Check with your employer to confirm the coverage amount available to you.

NTTA employees – Your Basic Life insurance is salary times three, up to a maximum of \$300,000. Premiums for coverage over \$50,000 may result in additional taxable income to you.

Employee premiums (basic + optional) greater than \$50,000 cannot be offered on a pretax basis and may result in additional taxable income to you. Life insurance coverage begins to reduce at age 70.

Dependent Group Life (DGL)

Even if you selected SLF coverage, you can also select DGL coverage for your spouse and dependent child(ren). DGL provides a fixed amount of coverage for all of your dependents and does not require Evidence of Insurability (EOI). The employee is the beneficiary when DGL coverage is selected.

Optional Term Life (TLF)

Employee TLF is voluntary and is based on your annual salary times your selected coverage level. Use the Optional Rate Chart on page 41 (Column A) to calculate your monthly cost. AD&D automatically matches the elected TLF.

Spouse optional Term Life (SLF)

SLF coverage amount cannot exceed 50% of an employee's TLF coverage amount. During a newly hired employee's initial enrollment period, both the \$10,000 and \$25,000 coverage levels are available without EOI. At all other times, whether you are selecting SLF for the first time or you are increasing the SLF coverage amount, EOI is required and acceptance is not guaranteed. The employee is the beneficiary when SLF coverage is selected. Use the Optional Term Life Rate Chart on page 41 (Column B) to determine SLF monthly cost. SLF coverage does not include AD&D.

Evidence of Insurability (EOI)

During annual enrollment, you must complete the EOI process if you are increasing your TLF or SLF amount. If you are adding TLF or SLF for the first time, EOI will be required. The EOI process is not required if you are not requesting a change. Contact your Human Resources department for more information.

Designate a beneficiary

The Hartford's Beneficiary Designation website makes it easy to designate beneficiaries for your life insurance benefits. It's important to keep your beneficiaries updated, and you can add or change your beneficiaries at any time. A good practice is to review your beneficiary designations each year, and also when a life event occurs, such as a marriage, divorce or birth of a child. Call **1-855-396-7655** or contact your Human Resources department/Benefits Office for login instructions.

Continuing your life insurance

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

Portability

If your coverage terminates, you can continue an amount up to \$250,000 of your TLF and the full amount of your SLF and DGL benefit without EOI at The Hartford's portability rates (without AD&D). Portability rates are higher than the cost available to active employees. Contact The Hartford for cost information.

Conversion

Conversion allows employees and covered dependents to convert all or part of GLF, TLF/SLF or DGL to an individual whole-life policy. Whole life costs more than group Term Life coverage. Contact The Hartford for cost information. Conversion locks you into a specific rate based on your age at the time of conversion.

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

- Coverage amount varies by employer.
- Minimum coverage is \$20,000 regardless of salary.
- AD&D coverage matches Basic Term Life coverage.

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

County employees	NTTA employees
<ul style="list-style-type: none"> • 1/2x annual salary • 1x annual salary • 2x annual salary • Select no optional coverage (prior-year grandfathered amounts may apply) 	<ul style="list-style-type: none"> • 1x annual salary • 2x annual salary • 3x annual salary • 4x annual salary • Select no optional coverage

Dependent optional Term Life (DGL)

Option 1	Option 2
<ul style="list-style-type: none"> • \$5,000 spouse • \$2,500 each dependent* 	<ul style="list-style-type: none"> • \$10,000 spouse • \$5,000 each dependent*

*Dependents up to age 26.

Spouse optional Term Life (SLF)

SLF coverage levels:

- | | |
|------------|-------------|
| • \$10,000 | • \$75,000 |
| • \$25,000 | • \$100,000 |
| • \$50,000 | |

SLF cannot exceed 50% of employee TLF.



Calculate monthly premium cost (TLF/SLF)

Using your annual salary on Dec. 31, 2021, and your age on Jan. 1, 2022, calculate your monthly TLF premium cost. To calculate your per-paycheck cost, simply multiply the monthly cost by 12 and divide by the number of 2022 payroll checks from which benefits are deducted (24 or 26).

County employees

- Step 1.** Select coverage level (50%, 100%, 200%)..... %
- Step 2.** Multiply annual salary at Dec. 31, 2021, by coverage level \$ _____
- Step 3.** Round Step 2 amount to next \$1,000..... \$ _____
- Step 4.** Divide Step 3 amount by \$1,000 \$ _____
- Step 5.** Multiply Step 4 amount by appropriate rate for your age on Jan. 1, 2022 (Optional Term Life Rate Chart, Column A)

This is your monthly TLF premium amount \$ _____

NTTA employees

- Step 1.** Annual salary at Dec. 31, 2021, rounded up to next \$1,000..... \$ _____
- Step 2.** Select coverage level (100%, 200%, 300%, 400%)..... %
- Step 3.** Multiply Step 1 amount by Step 2 coverage amount..... \$ _____
- Step 4.** Divide Step 3 amount by \$1,000 \$ _____
- Step 5.** Multiply Step 4 amount by appropriate rate for your age on Jan. 1, 2022 (Optional Term Life Rate Chart, Column A)

This is your monthly TLF premium amount \$ _____



Optional Term Life rate chart

Rates listed are per \$1,000 of coverage

Age	Column A* Active Employee (TLF) Includes AD&D	Column B** Spouse (SLF)
Less than 30	\$.07	\$.04
30-34	\$.09	\$.06
35-39	\$.11	\$.08
40-44	\$.15	\$.12
45-49	\$.22	\$.19
50-54	\$.32	\$.29
55-59	\$.50	\$.47
60-64	\$.82	\$.79
65-69	\$1.33	\$1.30
70 and over	\$2.25	\$2.22

*Includes AD&D of \$.025/\$1,000.

**AD&D not available.



Tools to help you manage the details



Managing your medical claims

Medical claims

Get started by logging in to **myuhc.com**. You can understand your benefits and claims, find a doctor, estimate future treatment costs and much more. Prefer mobile? The UnitedHealthcare app provides access to these features as well.

Payment resources

If you do owe your provider, you may be able to send payment from **myuhc.com**. Payment processing is managed by InstaMed®. After a payment is made, your claim on **myuhc.com** will be updated. With My Claim Payments, you can review a history of payments you've made on the InstaMed site, sort by payment date and family member, or export data to Microsoft Excel.

Account balances

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

Prescription drug claims

Manage your prescription drug claims at **caremark.com**. You can order prescriptions and check the status of your order. If you select "Rx History Claims and Balances," you can view and print a prescription drug claims history by date range. The information and cost (by date range) is excellent documentation to submit for an FSA reimbursement or to document your HSA spending.

Visit **caremark.com** to check specific costs for drugs covered by your plan. You can see specialty drug information here as well.

Coordination of benefits non-duplicating plan

If you or your enrolled dependents are covered by more than one plan (such as your spouse's group plan), the plans coordinate benefits to avoid duplication of payment. This ensures your total benefit amount is no larger than the amount you would have received from the PEBC plan.

To coordinate benefits, one plan must be "primary" and pay benefits first. If you and your family are covered by only one plan, that plan is primary. Your employer plan (the HDP, PPO plan or PEBC Dental plan) is primary for you if you are an active employee, regardless of your age or your Medicare eligibility. (See Medicare rules for certain exceptions such as end-stage renal disease.) You can update your coordination of benefits information at any time at **myuhc.com**.

If your spouse has coverage through your plan AND his or her employer's plan, your plan is primary for you and secondary for your spouse. For a child covered under both parents' plans (each parent covered under his or her own employer plan), the plan that covers the parent whose birthday comes first in the calendar year is primary. In a divorce situation, the plan of the parent with custody usually pays benefits first, unless a court order places financial responsibility on the noncustodial parent.

Subrogation requirements

Both the HDP and PPO plan have important subrogation requirements. Subrogation is the right of a party that has paid medical claims on your behalf to recover amounts paid if the beneficiary of those payments recovers funds from another source.

For example, if you are in a car accident that results in medical claims paid by the HDP or PPO plan, then the plans have a right to recover amounts paid by the plan on your behalf if you receive a payment from the other driver's insurance company. If you are involved in an accident, you will receive an Accident Investigation Form from Optum®, a UnitedHealthcare company.

ID card and debit card information

Medical plans

You will not receive a new ID card unless you are new to the plan, added dependents and/or changed benefits for 2022. Members with an existing card who are not changing plans can continue to use their existing ID card.

Dental plans

DeltaCare USA DHMO – You will receive a new dental ID card for 2022.

Delta Dental PPO – You will receive a new dental ID card for 2022.

Vision plan

VSP – You will receive a new vision plan ID card for 2022.

Optum Bank HSA debit card

If you are newly enrolled in the HSA, in about 7-10 days after your account is opened you will receive a UnitedHealthcare Health Savings Account Mastercard® (debit card from Optum Bank) in the mail. The card does not have an annual card fee. If you are currently enrolled, as long as the card is not expired, your current Optum Bank debit card will work in 2022.

UnitedHealthcare FSA debit card

If you are newly enrolled in the FSA, you will receive a Health Care Savings Account Mastercard from UnitedHealthcare in the mail in about 7-10 days after your account is opened. The card does not have an annual card fee.

Did you move?

Be sure to provide your Human Resources department/Benefits Office your new address as soon as possible. This will help avoid delays in receiving your ID cards, EOB forms and other information.



If you do not receive your ID card by late January, print a temporary ID card or call the plan's Customer Service department.

Providers can confirm eligibility by contacting the appropriate plan. As long as you are enrolled in a plan, a provider can electronically confirm your eligibility and that of your covered dependents.

2022 important notices

The following notices are intended for benefits-eligible members enrolled in a PEBC health plan for the 2022 plan year. If you are not eligible for or enrolled in a PEBC plan, the notices will not apply to you.



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Uniform Summary of Benefits and Coverage (SBC)

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

Genetic Information 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 performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

4 Coverage of dependent students on medically necessary leave of absence

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

The exemption from these federal requirements will be in effect for the 2022 plan year, beginning Jan. 1, 2022, and ending Dec. 31, 2022. 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 Oct. 15 through Dec. 7. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) to join a Part D plan because you lost creditable coverage. In addition, if you lose or decide to leave your employer's sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

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

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

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

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

More information about your options under Medicare prescription drug coverage

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

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.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](https://www.socialsecurity.gov), or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

KEEP THIS CREDITABLE COVERAGE NOTICE

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

PEBC Health Plans Notice

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of Jan. 31, 2021. Contact your State for more information on eligibility.

ALABAMA - Medicaid

Website: <http://myalhipp.com/>

Phone: 1-855-692-5447

ALASKA - Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS - Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

California - Medicaid

Website: Health Insurance Premium Payment (HIPP) Program

<http://dhcs.ca.gov/hipp>

Phone: 1-916-445-8322

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://www.colorado.gov/pacific/hcpf/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991 | State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www>

[.colorado.gov/pacific/hcpf/health-insurance-buy-program](https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program)

HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.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 ext 2131

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

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: KIHIPPROGRAM@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.maine.gov/dhhs/ofi/applications-forms>

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

MASSACHUSETTS - Medicaid and CHIP

Website: <https://www.mass.gov/info-details/masshealth-premium-assistance-pa>

Phone: 1-800-862-4840

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](http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP)

Phone: 1-800-694-3084

NEBRASKA - Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
NEVADA - Medicaid
Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE - Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm 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: 1-609-631-2392 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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org 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
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH - Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT- Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA - Medicaid and CHIP
Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA - Medicaid
Website: http://mywvhipp.com/ Toll-Free Phone: 1-855-MyWVHIPP (1-855-699-8447)
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: 1-800-251-1269

To see if any more states have added a premium assistance program since Jan. 31, 2021, or for more information on special enrollment rights, you can 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 one of the following qualifying events happens:

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

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

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

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

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

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

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator

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

You must give notice of some qualifying events

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

How is COBRA coverage provided?

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

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

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before

the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 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 eight months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

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

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

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

Are there other coverage options besides COBRA continuation coverage?

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

UnitedHealthcare

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

Employer Notice of Exchange

Health Insurance Marketplace coverage options and your health coverage

General information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace runs from Nov. 1, 2021, through Dec. 15, 2021, for 2022 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 2022, 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

Privacy of your information NOTICE OF PRIVACY PRACTICES PEBC Group Health Plans

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

Effective date of notice: Sept. 23, 2013

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

dental HMO plan, you will receive a separate notice from that HMO.

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

Use and disclosure of protected health information

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

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

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

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

For health care **operations** purposes, use and disclosure may take place in a number of ways involving plan administration, including for quality assessment and improvement, vendor review, and underwriting activities. Your information could be used, for example, to assist in the evaluation of one or more vendors who support the Plan, or our vendors may contact you to provide reminders or information about treatment

alternatives or other health-related benefits and services available under the Plan. Health care operations may also include, but are not limited to, disease management, case management, legal reviews, handling appeals and grievances, plan or claims audits, fraud and abuse compliance programs, and other general administrative activities.

The Plans covered by this Notice may share 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); and
- For Workers' Compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

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

Uses and disclosures for which an authorization is required

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

Your rights regarding Protected Health Information

You have the right to:

- **Inspect and Copy Your Protected Health Information:** Upon written request, you have the right to inspect and get copies of your Protected Health Information (and that of an individual for whom you are a legal guardian). There are some limited exceptions.
- **Request an Amendment:** You have the right to amend or correct inaccurate or incomplete Protected Health Information. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
- **Receive an Accounting of Non-Routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your Protected Health Information. However, you are not entitled to an accounting of several types of disclosures including, but not limited to:
 - Disclosures made for payment, treatment or health care operations;
 - Disclosures you authorized in writing; or
 - Disclosures made before April 14, 2003.
- **Request Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your Protected Health Information as we carry out payment, treatment or health care operations. You may also ask us to restrict how we use and disclose your Protected Health Information to your family members, relatives, friends or other persons you identify who are involved in your care or payment for your care. We do not have to agree to these additional restrictions, but if we do, we must abide by our agreement (except in emergencies).
- **Request Confidential Communications:** You may request to receive your Protected Health Information by alternative means or at an alternative location if

you reasonably believe that other disclosure could pose a danger to you. For example, you may want to have Protected Health Information sent only by mail or to an address other than your home.

- **Receive Notice of a Breach:** You have the right to be notified upon a breach of your unsecured Protected Health Information, if a disclosure occurs that meets the definition and thresholds of a breach under the law.
- **Receive a Paper Copy of This Notice:** You have the right to a paper copy of this Notice, even if you have agreed to receive this notice electronically.

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

About this Notice

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

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

Contacting the plan administrator

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

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

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

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 **1-877-818-5826** 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 Optum (part of UnitedHealthcare) which administers this program, in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be

used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

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

Paperwork Reduction Act Statement

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

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

Important provider contacts

Benefit	Vendor	Phone number	Email/web address
Medical	UnitedHealthcare	1-877-370-2849	myuhc.com
Pharmacy Rx	CVS Caremark	1-855-335-7698	caremark.com
Specialty pharmacy	CVS Specialty	1-800-237-2767	cvsspecialty.com
Mental health	UnitedHealthcare	1-877-370-2849	myuhc.com
EAP	UnitedHealthcare	1-866-248-4096	myuhc.com
Dental DPPO	Delta Dental	1-800-521-2651	deltadentalins.com
Dental DHMO	Delta Dental	1-800-422-4234	deltadentalins.com
Vision	VSP	1-800-877-7195	vsp.com
Life insurance	The Hartford	1-888-563-1124	mybenefits.thehartford.com
FSA	UnitedHealthcare	1-866-755-2648	myuhc.com
HSA	Optum Bank	1-800-791-9361	optumbank.com
PEBC Wellness Program	Optum	1-877-818-5826	myuhc.com
NurseLine	UnitedHealthcare	1-877-370-2849	myuhc.com
Health Insurance Marketplace		1-800-318-2596	healthcare.gov

2022 enrollment guide

Summaries of Benefits and Coverage (SBC)

The government-required SBCs, which summarize important information about your PEBC medical plan options, are available online at pebcinfo.com.

Benefits that deliver choice, flexibility and value

This information is a general description of your coverage. It is not a contract and does not replace the official benefit coverage documents which may include a Summary Plan Description. If descriptions, percentages and dollar amounts in this guide differ from what is in the official benefit coverage documents, the official benefits coverage documents prevail. This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. This outline is intended as a summary only. For a detailed description of the benefits available please refer to the official plan documents.