Retiree Health Benefits

2020 Enrollment Guide

BENEFITS THAT DELIVER CHOICE, FLEXIBILITY AND VALUE

pebc
PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

Providing Choice, Flexibility and Value

Since 1998, the Public Employee Benefits Cooperative (PEBC) has provided choice and flexibility while keeping health benefit costs affordable. We are pleased to offer an array of benefits and programs, all designed to further your health and well-being. This guide highlights the main features of many of the benefit plans sponsored by PEBC. If you have questions about the contents of this guide, please contact your Human Resources department.

Take time to learn about your 2020 health plan benefits.

Table of Contents

This guide has sections for each type of retiree. Take note of the headings on each page to determine if the information applies to you.

All Retirees	The information applies to all retirees.
Under 65 Retirees	The information applies to retirees under age 65 and covered spouses of any age.
Over 65 Retirees	The information applies to retirees over age 65.

Plan Changes for 2020

Typically, there are changes to the benefit plans each year. Following is a list of changes for 2020.

New pharmacy benefits provider

CVS Caremark™ is the vendor selected to provide pharmacy benefits effective Jan. 1, 2020. To view the Preferred Drug List with a list of the excluded medications and covered preferred alternatives, visit **caremark.com**.

New mental health provider

UnitedHealthcare is the vendor selected to provide mental health benefits effective Jan. 1, 2020. To view information on your mental health benefits coverage, search for a provider or access online resources, visit **myuhc.com>coverage & benefits>Mental Health Benefits Summary.**

New medical and pharmacy card

Effective 2020 members enrolled in the PPO and HDP will receive one card for both your medical and pharmacy benefits. Your new card will contain both your medical and CVS Caremark ID information.

New weight loss program

Real Appeal® is an online weight loss program available at no cost to eligible UnitedHealthcare members 18 years old and older. Visit **enroll.realappeal.com** to learn more and register.

New Billing information

UnitedHealthcare is the vendor selected to provide retiree billing services effective Jan. 1, 2020. Visit **uhcservices.com** for eligibility, payment status and account information 24 hours a day.

HSA contributions

The maximum contribution to a HSA for 2020 is $3,550 for individuals and $7,100 for families. Remember, the IRS also allows you to make an extra catch-up deposit of $1,000 if you are age 55 or older. Your deposits are made through payroll deduction.

Spouse surcharge (PPO/PMD/PSD plan or HDP)

A Spouse Medical Plan Surcharge Affidavit is required every year. Regardless of the medical plan you select, if you enroll your spouse in the 2020 medical plan, your premium cost could be higher. The spouse surcharge does not apply to dental or vision coverage.

The spouse surcharge *will apply* if:

1. Your spouse is still employed, his/her employer offers a medical plan and your spouse did not enroll in that plan; and
2. You cover your spouse in your PPO/PMD/PSD medical plan or HDP; then
3. A $200 per month spouse surcharge will apply to the cost of covering your spouse on your medical plan.
4. The surcharge will also apply if you fail to turn in the required Spouse Medical Plan Surcharge Affidavit or if you were late turning it in.
5. For purposes of the spouse surcharge, the spouse's employer plan must be an affordable medical plan with minimum essential coverage (MEC) as defined by the Affordable Care Act (ACA).

The spouse surcharge *will not apply* if:

1. Your spouse is enrolled in both his/her employer medical plan (proof of enrollment required) and your PPO/PMD/PSD plan or HDP; or
2. Your spouse does not work outside the home and has no access to employer coverage; or

Spouse Medical Plan Surcharge Affidavit

If your spouse is still employed and you enroll your spouse in the PPO/PMD/PSD plan or HDP, a spouse surcharge will apply to your retiree premium, unless your spouse is enrolled in his/her employer medical plan and you turned in the Affidavit on time. Don't delay. Turn in the Affidavit as soon as possible.

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

Dallas County retirees only
If you are already enrolled in a retiree medical plan and under age 65, you can choose either the PPO plan or the HDP for coverage effective January 1, 2020, or later, subject to all other plan and eligibility rules. If you are eligible for Medicare, you must be enrolled in Part A and Part B for maximum claims reimbursement.

3. Your spouse's employer does not offer medical coverage or your spouse is not eligible for that coverage; or
4. Your spouse's other coverage is Medicare, Medicaid, TRICARE® or care received at a VA facility;
5. You turned in the required Spouse Medical Plan Surcharge Affidavit on time.

Can you enroll in coverage you currently do not have?

You cannot enroll in coverage you do not already have. If you are already enrolled in a PEBC medical, dental or vision plan and you want to change that plan during annual enrollment, check the options available to you. Once you leave the plan, you cannot return.

Make an informed choice

As you know, the world of health benefits has changed. It's more important than ever to make the most of your health care dollars. To do that, use all of the resources available to you to learn more about your plan options. Consider how your coverage needs will change once you (and your covered spouse) turn 65, including how Medicare will change your benefits. Weigh the cost of each plan against your needs and determine the right benefits mix for you and your family. Making smart decisions about your health benefits helps you keep costs down while getting the coverage you need after you retire.

Helpful Tools

pebcinfo.com

The PEBC website is the central benefits information website with tools to help you choose a health plan, estimate your out-of-pocket costs and forms and links to locate important information.

Here are some tools to help you:

Retirees under age 65 and not enrolled in Medicare (PPO or HDP Plan)

- **pebcinfo.com** — the centralized benefits site with plan information, forms and links to PEBC vendor sites. Select Retiree from the top menu.
- **myuhc.com** — a great place for locating a provider and estimating costs.
- UnitedHealthcare® app puts your health plan at your fingertips when you're on the go. Download the app to access your health plan ID card, find nearby care and more.
- Cost estimator (**myuhc.com**) is a great tool to help you estimate your out-of-pocket costs, compare treatment options and select a quality provider for a procedure.
- myClaims Manager helps you manage your claims and understand your share of the plan cost. See where you are in meeting your deductible, your annual maximum out-of-pocket cost and view your claims history. You can even pay your out-of-pocket costs from this site.

Retiree choices

Medical plans — Retirees under age 65 and not enrolled in Medicare

- PPO plan (includes spouses and dependents enrolled in PMD/PSD)
- High deductible plan (HDP) — you can contribute to a HSA as long as you are not enrolled in Medicare.

Dental plans

- PEB — Cigna Dental PPO Dental Plan
- ANT — Cigna HMO Plan

Vision plan

- VIS — EyeMed Choice Plan

Retirees age 65 or older and enrolled in Medicare A & B

- UnitedHealthcare Senior Supplement Plan F with or without Medicare Rx for Groups (Part D) prescription drug coverage
- UnitedHealthcare Group Medicare Advantage HMO (includes Medicare Rx for Groups (Part D) prescription drug coverage)

If you are a dependent of a retiree enrolled in the Senior Supplement or Medicare Advantage Plans and you are not enrolled in Medicare, you may be eligible to enroll in the PEBC PPO Plan. If you choose this option, you are enrolled in the PSD or PMD plan. A signed Spouse Medical Plan Surcharge Affidavit is required.

- Find in-network providers (including Tier 1 and Premium Care physicians) by selecting the link "Find Physician, Laboratory or Facility."
- **caremark.com** Log into or download the CVS Caremark app to manage your prescription drug benefits.
- To compare plans, check the easy-to-understand Summary of Benefits and Coverage available at pebcinfo.com. The Summary helps you compare certain health plan provisions regardless if coverage is purchased privately or through your employer.

All Retirees regardless of age

- 2020 Retiree Health Benefits Enrollment Guide — a quick summary guide which includes features of each plan available to you, contact information and other important information about your plan benefits
- 2020 Retiree Benefits Rate Sheet — lists retiree contribution rates for each plan
- Important Notices — 2020

Enrollment overview

Annual enrollment is the only time during the year that you can change your benefit selections or drop dependents covered by the plan without first experiencing a qualified change in status event. It is very important that you follow your employer's annual enrollment instructions and deadlines so that you can enroll in your chosen benefits in 2020.

If you are enrolled in either the PEBC group Senior Supplement or Medicare Advantage Plan, during annual enrollment you can keep your current plan or change to the other senior plan.

Moving from active employee to retiree status?

If you are a new retiree selecting group retiree health benefits for the first time (not during annual enrollment), review your enrollment information with careful attention to deadlines. Enrollment cannot be retroactive and you are responsible for enrolling on time.

- Visit your Human Resources Department at least 60 days before you retire to complete your Retiree Benefit Enrollment forms.
- Retiree Health Benefit Enrollment forms must be signed and dated no more than 60 days before your retiree health benefits become effective.
- Carefully review the retiree premium payment information included in this Retiree Enrollment Guide to understand exactly how and when to pay your premium.
- Only those dependents enrolled in your medical, dental or vision plans on your last day of active employment can enroll in your retiree medical, dental or vision plans, subject to validation of eligibility. If your spouse is still working and has health benefits at work, read about spouse enrollment after you retire on page 6 of this guide. Your last annual enrollment as an active employee (before your retirement) is very important.
- As an active employee, if you chose to opt out of your employer's medical plan before you retire, you are not eligible for medical plan coverage as a retiree. Likewise, if you did not have dental or vision coverage as an active employee, you cannot elect dental or vision coverage as a retiree.
- Don't forget to review your optional life insurance. You have 31 days after your active employee optional life coverage ends to apply for conversion or portability of your life insurance benefits. If you miss the deadline, you cannot continue your life insurance coverage.

Retirees cannot add new coverage during annual enrollment. To illustrate, if you are not enrolled in the 2019 vision plan, you cannot add it during annual enrollment for 2020. However, if you are currently enrolled in a retiree medical plan and qualify to change to another retiree medical plan, you can. You can also change your current dental plan to another dental plan as well.

Premium payment information

IMPORTANT CHANGE: UnitedHealthcare Benefit Services is the new Retiree payment administrator effective Jan. 1, 2020.

Payment due date

Your monthly payment is due on the first day of the month and the grace period expires 30 days later. Your coverage is terminated if your payment is not received or postmarked by the last day of the grace period. Retiree group health premiums are not deducted from your Social Security check. *Premiums are deducted from your retirement benefit only if you are enrolled in the HELPS program.*

Automatic premium payment program

If you already participate in the automatic bank draft program, **you must sign up again.** UnitedHealthcare will automatically deduct the correct 2020 premium amount. If you are not signed up for the automatic premium payment program, consider enrolling soon. An Authorization form is included in your enrollment packet and is available at **pebcinfo.com** or from your Human Resources Department. If you want to start this program with your January 2020 premium, write that on the form and mail it to UnitedHealthcare no later than Dec. 7, 2019. If you change banks or your account number, you must contact UnitedHealthcare immediately. Double-check your premium to make sure it is for the correct 2020 amount.

Where to mail your payment

UnitedHealthcare Benefit Services
PO Box 713082, Cincinnati, OH 45271-3082

Need to contact UnitedHealthcare?

uhcservices.com
Phone: (866) 747-0048
Email: DirectBill_KYOperations@uhc.com
FAX: (866) 525-1740

Dependent eligibility summary

Who is an eligible dependent?

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

Eligible spouse

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

Eligible child(ren)

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

Managing conservator

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

Dependent verification

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

Who is NOT an eligible dependent?

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

Ineligible spouse

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

Ineligible child(ren)

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

When a child's coverage ends

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

Change in status

IRS regulations provide that unless you experience a qualified "change in status" event (described at right), 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 dependent life insurance elections or your health benefit elections.

Spouse enrollment after you retire

If your spouse is still working and enrolled in his/her benefits at work, you can delay your spouse's enrollment in your retiree plan if you wish. If your spouse then loses his/her employer health benefits due to an **employment-related event**, you can add your spouse to your applicable retiree benefits at that time, provided you meet the timing rules for a qualifying change in status event.

Examples of a spouse's **employment-related event** are spouse retirement (and spouse's employer does not offer retiree benefits), loss of job, or employer cancellation of benefits. An **employment-related event** is not a spouse's voluntary cancellation of his/her employee or retiree benefits or termination from this benefit due to late or non-payment. You cannot add your spouse to your retiree coverage if your spouse is not on your plan when you retire and does not experience the loss of spouse coverage as described above. If you are enrolled in the PPO/PMD/PSD plan or HDP, the spouse surcharge could apply. Refer to page 3 of this guide for more information.

Qualified events

Change in family status

Applies to retiree, retiree's spouse or retiree's dependents:

- Marriage, divorce or annulment
- Death of your spouse or dependent
- Child's birth, adoption or placement for adoption
- An event causing a dependent to no longer meet eligibility requirements, such as reaching age 26

Examples of events that do not qualify:

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

Change in employment status

Applies to any change in the employment status of a retiree, spouse or dependent that affects benefit eligibility under your benefit plan or the employer benefit plan of your spouse or your dependent:

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

Important deadlines apply

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

- **31-day notification rule** — You must notify your Human Resources department of the event AND you must complete and turn in required paperwork (including proof of the change) within 31 days of the event date. If you do not, you cannot make the change.
- **Effective date** — Provided you met the 31-day rule noted above, the change is effective the first day of the month following the date you notified your employer of the qualified change in status event. Effective date exception: Newborns are effective on the date of birth and adoptions are effective the date placed for adoption or on the adoption date.

Retirement

Thinking about retirement?

If you are flipping through this guide because you are thinking about retiring, make sure you review your employer's retiree health plan policies before you retire. 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 the Human Resources department at least 60 days before you retire. If you are planning to retire during 2020, pay particular attention to the annual enrollment period. Elections during your last active employee annual enrollment will affect the retiree benefits for which you may be eligible. If you are age 65 or older, or if you are turning 65 soon, contact the Social Security Administration at least 90 days before you retire. Carefully review the Retiree Health Benefits Guide, available at **pebcinfo.com** or from your employer.

Retired public safety officers only: The HELPS Act

If you are a retired public safety officer and you enroll in the retiree group health plan, you may benefit from a 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. If you already participate, you do not need to fill out another HELPS enrollment form, and the 2020 cost will be automatically deducted from your TCDRS monthly retirement benefit.

If you want to enroll in the HELPS program, contact the Human Resources Department (not TCDRS) for additional information and the required enrollment form. Information is also available at **pebcinfo.com** (select "employer member group," then select "retiree" from the top menu for retiree information specific to your employer).

Turning age 65 and still working

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

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

- You (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;
- Contributions can still be made to your HSA as long as you are not enrolled in Medicare (and you are enrolled in the HDP); and
- Your employer health plan is the primary plan for you and your covered spouse as long as you are actively employed (subject to spouse surcharge). Once you retire, Medicare is primary for both you and your covered spouse, if your spouse is enrolled in Medicare

Caution: If you are preparing to retire, it is critically important that you contact the Social Security Administration as soon as possible. If you collect Social Security benefits, you are automatically enrolled in Part A, even if you are still working. You must enroll in Part B once you retire to enroll in your employer's retiree plan. This applies to your spouse as well.

What is a self-funded health plan?

PEBC employer groups self-fund (or self-insure) the HDP, the PPO Plan and the PEBC Dental Plan. This means there is not an insurance company and your employer funds the cost of health claims. With self-funding, each PEBC employer group's experience stands on its own and is not combined with any other group. Your plan cost is based on your workforce alone — not on the claims of other member groups — and your cost is based on the experience of your employer group.

Countdown to retirement

- 60 to 90 days before you retire — Contact the Social Security office. If you are age 65 or older, sign up for Medicare Part A and Part B (you and your spouse).
- 60 days before you retire — Contact your Human Resources Department and complete retirement paperwork. Choose your retiree health benefits.
- 30 days before you retire — Make sure your retiree health benefits are chosen and your premium is paid.
- If you move — Let your Human Resources Department know as soon as possible.

Did you know?

Medicare becomes effective on the first day of the month in which you turn 65, regardless if you are at full retirement age for Social Security benefits. If your 65th birthday is on the first day of the month, then Medicare becomes effective the first day of the prior month. This applies to your covered spouse as well.

Even with the administrative costs associated with self-funded plans, when compared to fully insured plans (e.g., an HMO plan), the savings can be significant. The PEBC consistently administers all PEBC employer health plans which drives savings even farther. Subject to benefit differences, to a member and health care provider, a self-funded insurance plan may feel no different than many insurance plans, even without an insurance company.

Subrogation requirements

Both the HDP and PPO plan have important subrogation requirements. Subrogation is the right of a party that has paid medical claims on your behalf to recover amounts paid if the beneficiary of those payments recovers funds from another source. For example, if you are in a car accident that results in medical claims paid by the HDP or PPO plan, then the plans have a right to recover amounts paid by the plan on your behalf if you receive a payment from the other driver's insurance company. If you are involved in an accident, you will receive an Accident Investigation Form from Optum®, a UnitedHealthcare company.

Life insurance

Continuing your life insurance

When you retire, you can choose to either carry over (port) or convert selected life insurance when employment ends, paying your premium directly to The Hartford. You cannot add or increase life insurance if you did not convert or port coverage when you retired. When your employment terminates, review your life insurance needs quickly. You must apply and pay a premium to The Hartford no later than 31 days after your active employee coverage ends. Visit **pebcinfo.com** for more information about portability and conversion.

Portability

When your active employee coverage terminates, you can continue life insurance up to the full amount of your Optional Term Life TLF, SLF and DGL benefit without Evidence of Insurability (EOI) and at the same low cost provided to active employees (without AD&D). Rates increase as you age in 5-year increments. You must be enrolled in life insurance for at least 12 months to carry over coverage. If your spouse is enrolled in SLF, the SLF coverage must be in place for at least 12 months to port SLF coverage.

Conversion

Conversion allows employees and covered dependents to convert all or part of GLF, TLF/SLF and DGL to an individual whole life policy. Whole life costs more than group term life coverage. Contact The Hartford for cost information. You do not have to be covered for at least one year to convert coverage and conversion locks your rate based on your age at the time of conversion.

Choose the medical plan that's right for you.

Under 65 Retirees

2020 Medical plans

Both medical plans have the same coinsurance levels, annual out-of-pocket maximums and offer limited out-of-network benefits. In other ways, the plans work differently, including deductibles and copays.

Pre-certification

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

Network

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

Out-of-pocket maximum limit (OOP)

If your medical care is delivered in-network, your annual OOP, including in-network deductible, coinsurance and copays, will not exceed $3,000/single and $6,000/family. After you meet the OOP, the plan then pays 100% of your eligible in-network expenses.

PPO plan: If you are enrolled in the PPO plan, in-network medical and prescription drug copays count toward your OOP but not toward your deductible. If you choose a brand-name drug when a generic is available, the cost difference between the brand-name and generic drugs will not count toward your deductible or OOP.

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

Coinsurance and in-network cost

For those services subject to coinsurance, after the in-network deductible is met, each plan pays 80% of in-network costs. Your 20% portion (coinsurance) applies to your annual OOP.

Coinsurance and out-of-network cost

Both the PPO plan and HDP allow limited out-of-network services. If you choose to receive covered services from an out-of-network doctor, hospital or other provider, you will pay more of the cost. Not only is the deductible higher, but the OOP is unlimited. This means that the plan will never pay 100% of your costs, even after the deductible is met.

When possible, use **myuhc.com** to confirm the in-network providers available; it is rare that you would have to seek services outside the network. Always check to make sure your doctors, facilities and other service providers are in-network.

Copays and out-of-pocket cost

PPO Plans

The PPO plan has a fixed copay for many services. While copays count toward in-network, out-of-pocket costs, copays do not count toward your deductible. Standard medical copays are listed on page 15. Check the prescription drug section for 2020 copays. Refer to the PPO plan Quick Reference Guide found later in this document, or visit **pebcinfo.com** for more information.

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

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

Deductibles

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

In-network deductibles

PPO plan (copays do not count toward deductible)
$500 individual (single) deductible
$1,000 family deductible*

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

HDP (an important difference)
$1,500 individual (single) deductible
$3,000 family deductible**

The HDP in-network deductible works similar to the PPO plan, but there is an important distinction.

**If you cover any family member, the entire in-network family deductible must be met before any family member can move to coinsurance. The HDP in-network family deductible is met when the combined eligible expenses for you and/or any covered family members reach $3,000. Even if one family member reaches the $1,500 deductible, that member cannot move to coinsurance until the full $3,000 family deductible is met.

Out-of-network deductibles

PPO plan — $1,000 each individual
HDP — $3,000 individual/$6,000 family

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

Health savings account (HSA)

You must be enrolled in the HDP to contribute to a HSA. Contributions cannot be made to a HSA if you are enrolled in Medicare.

What is a HSA?

A HSA is a savings account for health care expenses. Unlike an FSA (flexible spending account), your savings account can grow from year to year and there is no "use it or lose it" rule. The HSA works differently than an FSA. A big difference is that the HSA has triple-tax benefits:

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

Why would a retiree consider a HSA?

If you want to set aside money on a pretax basis before you enroll in Medicare, you may want to consider enrolling in the HDP with HSA. Once you enroll in Medicare you can no longer contribute to the HSA, but you can still use the money tax-free as long as funds are used to pay for qualified medical expenses. To have a HSA, the IRS requires you be enrolled in a qualified high-deductible health plan, like this High-Deductible Plan (HDP). Before enrolling in the HDP, you will want to compare the advantages of the plan with your specific situation. Consult your tax or financial advisor, or contact your HSA bank if you have questions about the HSA. Your employer cannot give you tax advice.

Medicare and the HSA

As long as you are not enrolled in Medicare (even if you have reached age 65), you can still contribute to a HSA until the month you enroll in Medicare. You can even continue to make catch-up contributions prior to your Medicare effective date. Once you are enrolled in Medicare, you cannot contribute to a HSA, but the money is still yours to save, spend or leave to your heirs.

Medicare and out-of-pocket expenses

While you cannot contribute to a HSA if you are enrolled in Medicare, you can use funds in your HSA to pay for out-of-pocket qualified medical expenses — even if you are enrolled in Medicare. To illustrate, if you are enrolled in the Medicare Advantage Plan, you can use HSA funds to pay an office visit copay.

Important information if you enroll in the HDP with HSA

You must file IRS Form 8889 with your annual tax return to report contributions to and distributions from your HSA. HSA contributions, investment earnings (if any) and withdrawals (if made for qualified medical expenses) are generally not taxable for federal (and, in most cases, state and local) income tax purposes. However, under certain circumstances, your HSA may be subject to taxes and/or penalties. And, if your HSA contributions for any year exceed the annual limit, you are responsible for contacting your HSA 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 a HSA;
- Keeping receipts to show you used your HSA for qualified medical expenses;
- Tracking contribution limits and withdrawing any excess contributions
- Making sure funds are transferred to a qualified HSA; and
- Identifying tax implications and reporting distributions to the IRS.

Contact your HSA bank for detailed information about eligible expenses and your responsibilities regarding contributions and record keeping. Since this is your personal account and you are responsible for compliance with the tax rules, it is recommended that you consult with your personal tax advisor about your personal situation. Your employer cannot provide you tax advice.

Paying for insurance premiums with HSA funds

Typically, you cannot use HSA funds to pay medical insurance premiums, but there are some exceptions that may apply to you. Here are a few examples of how HSA funds can (or cannot) be used to pay premiums.

- **Senior Supplement Plan** — You cannot use HSA funds to pay Senior Supplement (or Medigap) premium
- **Medicare Advantage Plan** — If you are age 65 or older, you can use HSA funds to pay premiums (known as Part C coverage)
- **Medicare Part B** — If you are age 65 or older, you can use HSA funds to reimburse yourself for the cost of Part B coverage
- **Medicare Part D** — If you are age 65 or older, you can use HSA funds to reimburse yourself for the cost of Part D coverage
- **If you are age 65 or older and still working,** you can use HSA funds to pay your employer group premium (you cannot pay for these premiums before age 65)
- **If you are age 65 or older and not working,** you can use HSA funds to pay your employer-sponsored retiree group premium

Enrolling in Medicare

Before you enroll in the HDP with HSA, double-check your Medicare status. Generally, you have to contact the Social Security Administration (SSA) to enroll in Medicare (Part A/Part B). You are automatically enrolled in Medicare if you are already collecting Social Security benefits. If you are enrolled in Medicare, you cannot contribute to a HSA. In that case, you probably should not enroll in the HDP Plan.

Qualified medical expenses

The IRS determines which expenses can be paid with a HSA. Check IRS Publication 969 for more HSA information. If you are under age 65 and use funds for something other than a qualified medical expense, you are subject to a 20% penalty and the funds become taxable as income. If you are age 65 or older, while a distribution may be considered income, the 20% penalty does not apply to you. You can use the funds as you wish.

Your HSA bank account

If you are newly enrolled in the HDP, your employer will automatically notify Optum Bank® (affiliated with UnitedHealthcare) to open your HSA account. After your account is opened, you will receive a Welcome Kit from Optum Bank. As long as you maintain an account balance of $500 or more, you will not be charged the $1 monthly account maintenance fee. If your account balance is $2,000 or more, you can choose to invest funds if you wish. More information is included in your Welcome Kit.

Premium care program

Choosing a doctor is one of the most important health decisions you'll make.

UnitedHealthcare can help you find doctors who are right for you and your family.

Look for blue hearts.

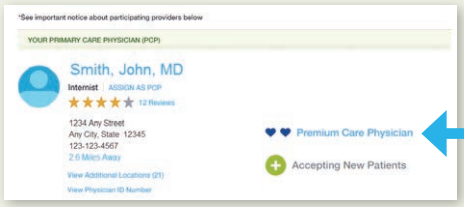
The UnitedHealth Premium® program makes it easy for you to find doctors who meet benchmarks based on national standards for quality and local market cost efficiency. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate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

Find quality, cost-efficient care.

Studies show that people who actively engage in their health care decisions have fewer hospitalizations, fewer emergency visits, higher utilization of preventive care and overall lower medical costs. Take an active part in your health by seeking out and choosing providers, with the help of the UnitedHealth Premium program. Learn more at **UnitedHealthPremium.com.**

Premium Care Physician

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



Here's how it looks on myuhc.com.

Transition benefits

Are you new to the HDP or PPO plan? Transition of care is a service that enables new enrollees to receive time-limited care for specific medical conditions from an out-of-network doctor but at the in-network benefit level. 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.

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.

Get mental health support.

Sometimes the challenges you face can feel like too much to handle. Your benefits include behavioral health support provided by United Behavioral Health. From everyday challenges to more serious issues, you can receive confidential help for:

- Depression, stress and anxiety
- Substance use and recovery
- Eating disorders
- Parenting and family problems.

To find out more, visit To view information on your mental health benefits coverage, search for a provider or access online resources, visit **myuhc.com>coverage & benefits>Mental Health Benefits Summary**.

Get free, confidential alcohol and drug addiction help — whenever you need it.

Whether you're concerned about yourself or a loved one, you can call the 24-hour Substance Use Helpline at **1-855-780-5955, TTY 711** to talk to a specialized substance use recovery advocate. You'll get confidential support, guidance on treatment options, help finding a network provider and answers to your questions — including concerns about your personal health or care for a family member, coverage, cost of care and more.

PPO plan quick-reference guide

Refer to plan documents for limitations and additional information.

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

* Subject to Affordable Care Act requirements

HDP quick-reference guide

Refer to plan documents for limitations and additional information.

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

* Subject to Affordable Care Act requirements

Save on prescription medications.

Under 65 Retirees

CVS Caremark National Network

If you are currently filling your prescription at a retail pharmacy, you will save by filling the prescription at a CVS Caremark National Network pharmacy. CVS Caremark National Network pharmacies include many national grocery and big-box chains such as Kroger, Albertsons, Costco, Sam's Club, Tom Thumb and Walmart.

Register at caremark.com

Manage your prescriptions online with tools available at **caremark.com**. You can check the cost of a drug, view available alternative medications, view your prescription history, balances, view the Preferred Drug List and more.

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. A national panel of doctors and pharmacists reviews and compares prescription drugs to ensure the formulary includes proven medications to treat every condition.

Talk to your doctor about an alternative that can work for you. Call CVS Caremark Customer Service **1-800-364-6331** if you have any questions.

Generics first

If you choose a brand-name drug when a generic is available, your cost will dramatically increase.

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

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

Out-of-pocket cost

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

CVS Specialty pharmacy

CVS Specialty has a specific team of pharmacists, nurses, patient care advocates and others to make sure you have the best possible outcomes from your specialty drug therapy. Specialty drugs are those that are typically expensive and used to treat complex, chronic conditions and require an enhanced level of care.

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.

CVS Specialty also offers members expanded choice and greater access. You can also choose to drop off or pick up your specialty prescriptions at any of the 9,800 CVS Pharmacy locations, including those locations within Target stores and will receive dispensing, Drug Utilization Report, 24/7 clinical support and copay assistance counseling through CVS Specialty. Members

Pharmacy Access Options **Refills allowed as Prescribed**	PPO Plan	HDP
CVS Caremark National Network Pharmacy (in-network) up to a 30-day supply.	$15 generic $30 preferred brand $60 non-preferred brand	For retail and home delivery pharmacy you will pay 100% of the CVS Caremark/CVS Specialty cost until you meet your deductible. After deductible, you pay 20% of the cost until the in-network OOP is met. After in-network OOP, plan pays 100%
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	

can also choose the delivery location, including CVS Pharmacy, home delivery, the doctor's office or another location of their choice.

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.

How to get started with CVS Specialty

Call CVS Specialty at **1-800-237-2767** to register and explain your prescription needs. You can also visit **cvsspecialty.com** for more information and to register. CVS Specialty will contact your doctor and start the arrangements to move your specialty prescriptions to CVS Specialty. Most supplies, like syringes, needles and sharps containers, will be provided with your medication at no additional cost.

For prior authorization or coverage review, you or your doctor can contact CVS CareMark at 1-800-294-5979.

No-cost contraceptives (prescription required)

The outpatient pharmacy benefit plan covers certain contraceptives at no cost to you, which can be filled through home delivery or at the retail pharmacy. Generic contraceptives are available with zero cost to the member. In certain situations, if your prescriber indicates a brand product must be dispensed, after prior authorization review, the brand product may also be available at zero copay. Not all drugs are covered. 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. Remember, you can fill maintenance medications at select CVS Caremark National Network pharmacies. If you are enrolled in the PPO plan, the copay will mirror the home delivery copay. Home delivery allows you to get a 3-month supply for the price of two copays. Specialty drugs are shipped in a 30-day supply. You will pay one-third the 3-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**. 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 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 cost to PPO plan and HDP members who meet certain criteria and do not have a history of cardiovascular disease. This list is subject to change.

The list includes:

Atorvastatin: 10–20 mg

Fluvastatin IR 20-40mg

Fluvastatin XL–80mg

Lovastatin: 10–40 mg

Pravastatin: 10–80 mg

Simvastatin: 5–40 mg

Rosuvastatin: 5–10 mg

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

Atorvastatin: 40–80 mg

Lovastatin: 60–mg

Rosuvastatin: 20–40 mg

Simvastatin: 80 mg

Excluded drugs

Check the list of drugs excluded from the 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 2020 Excluded Drug list at **pebcinfo.com.**

Shop smart

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

Vision and dental benefits to enhance your well-being.

All Retirees

Vision benefits

Vision benefits are available through EyeMed Vision Care®. EyeMed members can go to any Target Optical or Sears Optical and select any frame, any brand, at any price point with no out of pocket cost. You can also choose from thousands of independent providers, top optical retailers and online options. EyeMed makes it easy, too, with tools that help you find an eye doctor, schedule an appointment and manage your benefits.

In-network benefits

Eye exam with dilation as necessary — $10 copay

(Once every 12 months)

A simple eye exam can help protect your vision while also detecting signs of health problems, like diabetic retinopathy, high blood pressure or high cholesterol. Schedule an eye exam today.

Prescription lenses

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

Frames — $0 copay

- $150 allowance
- 20% off balance over $150

Contact lenses — $0 copay

(Contact lens allowance includes material only)

- Conventional — $0 copay, $200 allowance, 15% balance over $200
- Disposable — $0 copay, $200 allowance, plus balance over $200
- Medically necessary — $0 copay, paid-in-full

Laser vision correction

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

Out-of-network benefits

While EyeMed's network gives you plenty of options, there may still be times when you choose to go out-of-network. Before you go, you'll want to check your out-of-network reimbursement.

Out-of-network reimbursement

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

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

Plan exclusions

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

Dental Benefits

For 2020, you can choose between the Cigna Dental HMO and the Cigna Dental PPO plans.

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

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

Cigna Dental HMO Plan (Cigna DHMO)

The DHMO Plan offers a wide range of dental benefits through a network of participating dentists. Your Cigna Dental Care plan is a **copayment** plan. With your Cigna DHMO plan, some preventive services are covered at 100%. Your plan also covers many other dental services at a set copay. There are no **annual maximums** and **no deductibles**!

Remember — When you enroll in Cigna DHMO

1. After Jan. 1, 2020, you will want to select your DHMO dentist
2. Log in to **mycigna.com**
3. Select "Cigna Dental Care Access Network"
4. Choose your DHMO dentist
5. A new ID card with your dentist selection will be mailed to you

Cigna Dental PPO Plan (Cigna DPPO)

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

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

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

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

Get the right care at the right time.

All Retirees

Virtual Visits

A Virtual Visit lets you see and talk to a doctor from your smartphone, tablet or computer. Most visits take about 10 – 15 minutes. You can find a network provider at **myuhc.com/virtualvisits** or the UnitedHealthcare® app.

Teledoc Virtual Visits are in network and require no separate account registration or apps to download. Just log in the **myuhc.com/virtualvisits** and complete a brief health profile before your first visit. **Doctor on Demand** and **Amwell** are also still in-network Virtual Visit providers, but you need to set up an account or download an app. You do not have to be enrolled in a medical plan to use Virtual Visits, but if you are enrolled in the PPO plan or HDP, your visit will coordinate with your insurance.

Conditions commonly treated include:

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

Cost

PPO plan members do not pay a copay for in-network Virtual Visits. If you are not enrolled in the PPO plan, a $49 service cost applies until your deductible is met, then you pay 20% of the service cost.

Medicare Advantage/Senior Supplement:
No copay for Virtual Visits! Registration and visit request required. Please visit **uhcretiree.com** for information on Virtual Visits.

Prescriptions

If a prescription is written, it is electronically transmitted to your selected retail pharmacy where you can pick it up and pay your out-of-pocket prescription cost. Remember, you save more if you use an CVS Caremark National Network pharmacy.

Use Virtual Visits when:

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

Do not use Virtual Visits when experiencing:

- Any life-threatening or disabling condition
- Sudden or unexplained loss of consciousness
- Chest pain, numbness in face, arm or leg; difficulty speaking
- Severe shortness of breath
- High fever with stiff neck, mental confusion or difficulty breathing
- Coughing up or vomiting blood
- Anything requiring a physical exam or test
- Complex or chronic conditions
- Injuries requiring bandaging or sprains/broken bones

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

Your care options

When you need health care, you have a variety of options. It is important to remember that the hospital emergency room is for life-threatening or very serious conditions that require immediate care. If you do not have a life-threatening condition, choose another option below.

Virtual Visits — See and talk to a doctor via your smartphone, tablet or computer for non-emergency medical conditions. PPO members pay a $0 copay. Others pay a $49 service cost.

Doctor's office — Your primary doctor knows you and your health history and can provide routine and preventive care and treatment for a current health issue or refer you to a specialist. PPO members pay a $25 copay.

Convenience care clinic — These clinics — such as MinuteClinic® or Baylor Scott & White — are located inside retail stores. If you can't get to the doctor's office and the condition is not urgent or an emergency, you may find this a great alternative for minor health conditions. PPO members pay a $25 copay.

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

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

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

There are other lower-cost alternatives available. Contact NurseLine at **1-877-370-2849** to help determine where to go for care, or use the UnitedHealthcare app to locate the nearest urgent care or convenience care location.

Emergency outside the U.S.

If a covered member traveling outside the United States experiences a life-threatening emergency, the member should go to the nearest emergency room and contact UnitedHealthcare's Personal Health Support within 24 hours. To reach Personal Health Support, call the Customer Service telephone number on the back of the 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)**, which provides information about emergency medical coverage for U.S. citizens traveling outside the U.S. and includes a list of U.S.-owned insurance companies that offer coverage.

NurseLine

NurseLine connects you with registered nurses 24/7 and at no additional cost. To connect with NurseLine, call **1-877-370-2849**. You can also chat with a registered nurse live at **myuhc.com**. The nurses can assist you in deciding where to go for medical care, help you understand your treatment options and answer questions about medications.

Preventive care

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

What health services are NOT considered preventive care?

Medical treatment for specific health issues or conditions, ongoing care, laboratory tests or other health screenings necessary to diagnose, manage or treat an already-identified medical issue or health condition are considered diagnostic care, not preventive care. During a preventive care visit, if you discuss abnormal symptoms or treatment of a health concern, your visit will no longer be considered a preventive visit and you may be charged a copay, coinsurance or deductible. You are encouraged to

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.

Preventive services at no cost to you

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

Contraception, prenatal and breast-feeding

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

Flu shots and vaccines

Whether you visit your doctor, stop at the retail pharmacy, get immunized at work or at your local health department, the flu shot and many other vaccines are available to you at no cost. 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 (CVS Caremark) 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 North Texas 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).

North Texas CVS Caremark National Network retail pharmacies:

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

Covered vaccines include:

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

*Additional cost may apply

UnitedHealthcare retail pharmacy vaccines

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

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

Convenience care clinics

You can receive your flu shot or pneumonia vaccine at a convenience care clinic. 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.

Real Appeal

Real Appeal is an online program that can help you lose weight and improve your health at no cost to you.

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 4 or more sessions during the program lose 10 pounds on average. Talk to your doctor before starting any weight loss program.

Tools made for real life

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.[3]

- This is an online program, so you can conveniently access it from your desktop, tablet or mobile device.
- Backed by decades of proven clinical research.*
- Covered at no additional cost as part of your medical benefits plan.
- Become a member for free at **enroll.realappeal.com.**

*In the past 20 years, researchers have demonstrated that structured weight-loss and lifestyle-change programs can accomplish 3 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) 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).

Tools to help you manage the details

Under 65 Retirees

Managing your claims

Medical claims

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

Payment resources

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

Prescription drug claims

Manage your prescription drug claims at **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 for your HSA spending. Visit **caremark.com** to check specific costs for drugs covered by your plan. You can see CVS Specialty 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 non-custodial parent.

Medical plans (Retirees age 65 and older)

UnitedHealthcare Group Medicare Advantage (HMO)

How it works:

Here are some highlights about this plan. Refer to the plan documents for additional details. This plan is a Medicare Advantage Plan (HMO). You must select a PCP to coordinate your care. Prescription drug coverage (Part D) is included and you pay copays for some services. Out-of-pocket costs are generally lower than in the original Medicare plan but vary by the services you use. You must see network providers in order to receive covered services and plan benefits are for Medicare-approved services/visits only.

Are you eligible?

- You must be enrolled in Medicare Part A and Part B.
- You must reside in one of these Texas counties: Angelina, Atascosa, Bee, Bexar, Collin, Comal, Cooke, Dallas, Denton, Ellis, Fannin, Grayson, Gregg, Guadalupe, Henderson, Hood, Houston, Hunt, Jim Wells, Johnson, Kaufman, Kendall, Kleberg, Nacogdoches, Navarro, Nueces, Panola, Parker, Polk, Rockwall, Rusk, San Augustine, San Jacinto, San Patricio, Shelby, Smith, Tarrant, Trinity, Tyler, Van Zandt, Walker, Wilson and Wise.
- You must not currently have ESRD or receive routine kidney dialysis. If you develop ESRD after you enroll in this plan, you may be eligible to continue your coverage.
- If you are enrolling for the first time, you must complete a UnitedHealthcare Group Medicare Advantage Enrollment Request form (included in your enrollment packet) prior to your coverage becoming effective. If you are already enrolled in this group plan, you do not need to complete another Group Medicare Advantage Enrollment Request form.

Network

You must see a participating UnitedHealthcare Group Medicare Advantage (HMO) provider. Go to **uhcretiree.com** to find a participating provider.

Office Visit Copays

$20 PCP/$40 specialist

Annual Out-of-Pocket Maximum

$6,700

Emergency Room

$50 copay for each Medicare-covered ER visit (worldwide) — waived if admitted within 24 hours

Virtual Visits

$0 copay (Doctor on Demand or AmWell)

Urgent Care Center

$20 copay (worldwide)

HouseCalls — Medicare Advantage Enrollees

$0 copay home health and wellness visit by health care practitioner once annually. Does not replace your regular doctor visits or exams.

If you're already a member, schedule a HouseCalls visit today by calling **1-800-457-8506,** TTY 711, 8 a.m. to 8 p.m. local time, Monday – Friday.

If you'll be a member soon and you have questions, call **1-877-714-0178,** TTY 711, 8 a.m. to 8 p.m. local time, 7 days a week

Hospitalization (per admission)

$250 inpatient copay/$125 outpatient copay

Home Health Care

Medicare pays all approved amounts

Programs for people with chronic or complex health needs

Your medical plan includes no cost programs to help members who are living with chronic conditions, like diabetes or heart disease. Patients get personal attention, and their doctors get up-to-date information to help them make care decisions.

Health & Wellness Experience

Renew by UnitedHealthcare can be your guide to living a healthier, happier life. Renew, our member-only Health & Wellness Experience, includes:

- Inspiring lifestyle tips, coloring pages, recipe library, streaming music
- Interactive quizzes & tools
- Learning courses, health news, articles & videos, health topic library
- Rewards

As a UnitedHealthcare member, you can explore all that Renew has to offer by logging in to **uhcretiree.com.**

Retail Pharmacy: UnitedHealthcare Network Pharmacy

30-day supply: $10 generic; $20 preferred brand; $40 non-preferred brand/specialty

Mail Order Pharmacy: OptumRx® Mail Service Pharmacy

90-day supply; for cost of 2 retail copays

Vision

$50 copay for routine vision eye exam every 12 months

Hearing Aids

The plan allows up to $500 toward the purchase of hearing aids once every 36 months (per ear).

UnitedHealthcare Senior Supplement Plan F

How it works:

Here are some highlights about this plan. Refer to the plan documents for additional details. In most cases, the plan pays Medicare-eligible expenses only. In general, the UnitedHealthcare Senior Supplement Plan F pays certain costs not covered by Medicare, including Medicare Part A hospital deductibles, your Medicare Part B deductible and 20% coinsurance amount. The plan also covers certain medical expenses not covered by Medicare while you are outside the U.S. The foreign travel benefit pays 80% (after $250 annual deductible) up to a lifetime benefit of $50,000 for medically necessary emergency care due to an accidental injury or sudden and unexpected illness beginning during the first six months of each trip outside the U.S. You can select this plan with or without the Prescription Drug Plan (PDP).

Are you eligible?

Retirees and eligible spouses ages 65 or older only and enrolled in Medicare Part A and Part B

Network

You can see any provider who accepts Medicare. If the provider accepts Medicare assignment, you will reduce your up-front out-of-pocket costs.

Office Visit Copays

After Medicare pays, the plan pays 100% of Medicare-eligible expenses

Out-of-Pocket Maximum

Does not apply

Emergency Room

See Inpatient/Outpatient Hospitalization

Virtual Visits

$0 copay (Doctor on Demand or AmWell)

Urgent Care Center

See Office Visit Copays

Inpatient Hospitalization

(subject to Medicare lifetime reserve day rules)
After Medicare pays, the plan pays 100% of Medicare-eligible expenses

Home Health Care

Medicare pays all approved amounts

Outpatient Hospitalization

After Medicare pays, the plan pays 100% of Medicare-eligible expenses

Retail Pharmacy: UnitedHealthcare Network Pharmacy

30-day supply; $10 preferred generic; $20 preferred brand (includes some generic); $35 non-preferred brand/specialty drugs

Mail-order Pharmacy: OptumRx Mail Service Pharmacy

90-day supply; for cost of 2 retail copays

Vision

This plan covers Medicare-covered eye exams and Medicare-covered eyewear following cataract surgery only — at no cost to you. Refer to the UnitedHealthcare Senior Supplement Plan F information in your enrollment packet.

Hearing Aids

UnitedHealthcare provides you access to hi HealthInnovations, a program with audiology and discount hearing aid options. Call **1-855-523-9355** for more information. The Senior Supplement Plan does not cover hearing aids.

PEBC PPO Plan

Available only to non-Medicare dependents of retirees enrolled in either the UnitedHealthcare Senior Supplement Plan F or the UnitedHealthcare Medicare Advantage Plan (HMO)

If your spouse and/or dependents are not eligible for Medicare and therefore not enrolled in Medicare, don't let that stop you from enrolling in one of the PEBC group senior plans. Your non-Medicare spouse and/or dependents can enroll in the PEBC PPO Plan. Members must see in-network providers for the highest level of benefits. To enroll, select the PSD Plan (Senior Supplement with non-Medicare dependents) or the PMD Plan (UnitedHealthcare Group Medicare Advantage (HMO) with non-Medicare dependents).

Healthways SilverSneakers fitness program

SilverSneakers® is a fun, energizing fitness program that helps you take greater control of your health. As a member of the UnitedHealthcare Medicare Advantage Plan HMO and Senior Supplement Plan F, you can have SilverSneakers right where you are and at no additional cost. Check all the ways to use SilverSneakers.

Participating locations

SilverSneakers members receive a basic fitness membership and access to more than 15,000 fitness locations.

Visit **silversneakers.com** to find your closest location. Present your SilverSneakers ID card at the front desk.

No SilverSneakers ID card? Just call SilverSneakers Customer Service at **1-888-423-4632** (TTY:711).

Your membership may include access to features such as:

- Weights, treadmills and a pool
- Optional group SilverSneakers classes led by certified instructors
- Health education seminars and fun social events

Step it up wherever you are

SilverSneakers Steps is a personalized fitness program for workouts at home or on the go. Once you enroll in Steps, you can select one of four kits that best fits your lifestyle and fitness level — general fitness, strength, walking or yoga.

Go outside with FLEX

- Tai chi, yoga, walking groups and more
- At places you may already go
- Online sign-up

Connect online

Be part of a secure online community at **silversneakers.com/member.** This easy-to-use wellness resource gives you access to:

- Tools to check your health and track your activity
- Support from other SilverSneakers members
- Fitness advice plus meal plans and healthy recipes

Solutions for Caregivers

Caring for someone is rewarding and challenging. As a member of the UnitedHealthcare Medicare Advantage Plan (HMO) and Senior Supplement Plan F, Solutions for Caregivers can help you coordinate care for someone living close by or far away, including these services:

- **In-person assessment.** An assessment of your loved one's situation by a registered nurse, with concerns and recommendations.
- **Individualized consultation.** Telephonic consultations with a case manager who can assist you in finding services and programs.
- **Care resource center.** Toll-free access to caregiver coaches and a list of local services such as meal delivery, transportation and housekeeping.
- **Personalized care plan.** The case manager can identify helpful services and provide information on service providers such as home care agencies, meal providers and transportation.
- **Caregiver coaching.** The case manager can act as an advocate for you and your loved one in dealing with service and medical providers and insurance companies.
- **Coordination of services.** The case manager can help get services started and monitor effectiveness.

Call Solutions for Caregivers at **1-866-256-7917** Monday through Friday: 8 a.m. to 5 p.m. Central Time, to learn more about the support available to you.

Go online to access educational resources, discounted products and services anytime at **UHCforCaregivers.com/welcome/uhcretiree.** Please use code uhcretiree when creating an account. Explore myCommunity, a helpful task and calendar tool to manage support and care.

Prescription drug benefits

Retirees age 65 and older

PEBC group senior plan prescription drug benefits are provided by UnitedHealthcare. During annual enrollment, if you are changing from the PPO plan or HDP to one of the PEBC group senior plans and you use mail order pharmacy, make sure you have a supply of medication on hand to carry you through the month of January. If you use home delivery, mail a new prescription to OptumRx — even if your current CVS prescription is not expired.

UnitedHealthcare Group HMO

When you enroll in this plan, you are automatically enrolled in the Medicare Advantage Prescription Drug (MAPD) plan, a Medicare-approved Part D prescription drug benefit offered through UnitedHealthcare.

UnitedHealthcare Senior Supplement Plan F

When you select the Senior Supplement Plan, you are enrolled in UnitedHealthcare MedicareRx for Groups Prescription Drug Plan (PDP). You can opt out of the prescription drug portion of this plan by checking the appropriate box on your employer's Retiree Benefits Enrollment form. Your monthly premium is reduced if you choose to opt out of this Part D benefit. You can have prescription drug coverage under one Part D plan only. If you enroll in another Medicare Part D plan or a medical plan that includes Part D prescription drug coverage, you will be disenrolled from this plan.

PEBC PPO Plan (non-Medicare spouse and dependents only)

As long as a retiree enrolls in either the UnitedHealthcare Medicare Advantage Plan or the UnitedHealthcare Senior Supplement Plan F, the non-Medicare spouse and/or dependent(s) can enroll in the PEBC PPO Plan. Spouses and dependents enrolled in the PPO plan or HDP use the CVS Caremark National Preferred Formulary.

PEBC group retiree pharmacy coverage

No coverage gap or deductible. The PEBC group MAPD HMO and Senior Supplement Plan F include Part D coverage, but it may not be the same Part D plan offered elsewhere. PEBC senior plan prescription drug benefits do not work like many other Part D plans. You do not pay more during the coverage gap. If you enroll in one of the PEBC group senior medical plans, your prescription drug benefits are not subject to the coverage gap or deductible. In 2020, your standard copay remains in place until you pay $6,350 in total drug costs. After that, your copay reduces to $3.60 for generic and $8.95 for all other drugs. These amounts are subject to change based on federal Part D requirements. Check for the $4 generic drug program at your retail pharmacy.

About diabetic test strips

Only the preferred test strips and meters manufactured by OneTouch and ACCU-CHEK® (listed below) are covered by the plan. If you use a different product, watch your mail for more information or contact Customer Service (number is on the back of your ID card). You may also want to discuss with your doctor.

- OneTouch® Ultra 2
- OneTouch® Verio
- OneTouch® UltraMini
- ACCU-CHEK® Aviva
- ACCU-CHEK® SmartView

Pharmacy Saver program

Some retail pharmacies participate in the Pharmacy Saver program. You can pay as little as $1.50 for certain medications included in the program. Visit **UnitedPharmacySaver.com** for a list of low-cost drugs at a pharmacy near you (enter your ZIP code).

Prescription Drug Benefits from UnitedHealthcare MedicareRx for Groups	MA — Medicare Advantage (MAPD) SS — Senior Supplement (PDP)
Retail network pharmacy (30-day supply)	MA You pay $10/$20/$40* / SS You pay $10/$20/$35*
Mail order (90-day supply)	MA You pay $20/$40/$80* / SS You pay $20/$40/$70*
Quantity limits (selected drugs) and/or prior authorization	Yes
Non-network retail pharmacy copay/cost (file claim with receipt for reimbursement)	MA Medicare Advantage — NOT COVERED SS Senior Supplement — 80% after copay
Preferred drug list (Formulary)	MA — UnitedHealthcare Medicare Advantage Formulary SS — UnitedHealthcare MedicareRx for Groups Formulary
Online refills, preferred drug lists	**uhcretiree.com**
Diabetic supplies	Fill at a network pharmacy, OptumRx Mail Order or contracted national DME provider

*$ Preferred generic/$ Preferred brand/$ Non-preferred brand and specialty drugs

Medicare and coordination of benefits (COB)

If you are under age 65, retired and covered by the PPO plan or HDP, carefully read this information. It may help you as you consider your plan choices, especially as you turn 65 and qualify for and enroll in Medicare. If your dependents are enrolled in the plans, the rules below may apply to them depending on their age. Refer to the "2020 Medicare & You" handbook for more information about how your insurance works with Medicare.

If Medicare is primary — Your medical bills must be submitted to Medicare first. After Medicare pays benefits, you and your medical provider receive a Medicare Summary Notice (MSN). The claim is also submitted to your secondary plan. In many cases, your doctor or provider handles this for you.

If Medicare is secondary — The bill is submitted to your primary medical plan first. Once your medical plan processes the claim, it is submitted to Medicare. In many cases, your doctor or provider will handle this for you.

Which plan pays first? — If you are under age 65, retired and enrolled in your employer group medical plan and not eligible for Medicare, benefits will be coordinated and paid just as they are for active employees.

If you are under age 65, retired and enrolled in Medicare — You likely became eligible for Medicare after 24 consecutive months of entitlement to Social Security disability-income benefits. The PPO plan or HDP is primary only during the 24-month waiting period for entitlement to Social Security. If you are retired, once Medicare is effective, Medicare is primary. Disability is determined by the Social Security Administration. (Special rules apply if you have ESRD or another condition Medicare covers differently. Refer to the plan documents for additional details.)

If you are age 65 or older, retired and enrolled in Medicare — Medicare is the primary plan (it pays claims first). If you are an under age 65 retiree whose spouse is age 65 or older, Medicare is primary for your spouse. If you are still actively working and age 65 or older, your employer plan is primary and Medicare is secondary for both you and your covered spouse.

Military retiree benefits — TRICARE is a health care program for active duty and retired uniformed services members and their families. It includes TRICARE Prime®, TRICARE Extra®, TRICARE Standard® and TRICARE for Life® (TFL). Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors and certain former spouses have access to expanded medical coverage known as TRICARE for Life. You must have Medicare Part A and Part B to get TFL benefits. TRICARE never pays first for services that are covered by Medicare. Medicare pays first for Medicare-covered services. If Medicare doesn't pay all of the bill, TRICARE may pay some of the costs as the secondary payer. TRICARE will also pay the Medicare deductible and coinsurance amounts, and for any services not covered by Medicare that TRICARE covers. You may be eligible for pharmacy benefits. For more information, call TRICARE at **1-866-773-0404.**

Important information about your other coverage and Medicare — If you have other insurance, tell your doctor, hospital and pharmacy so your bills are paid correctly. If you have questions about who pays first, or you need to update your other insurance information, call Medicare's Coordination of Benefits contractor at **1-800-999-1118.** If you have other coverage that pays first and you retire or lose this coverage, call **1-800-MEDICARE (800-633-4227)** so Medicare can change your records and your bills can be paid correctly.

2020 Medicare & You

The "2020 Medicare & You" handbook is now available. If you have not yet received yours in the mail, visit medicare.gov to view it online. You can even sign up to get your copy electronically at **medicare.gov/gopaperless**. If you have an EReader (iPad®, NOOK®, Kindle®, etc.), you can download a digital version at the Medicare website. The Medicare website is a valuable resource and easy to navigate. Register at **mymedicare.gov** to view your specific claims information, view your Medicare enrollment and get Medicare information electronically.

Questions?

Medicare

1-800-633-4227 (1-800-MEDICARE)
1-855-798-2627 (Benefits Coordination & Recovery Center) **medicare.gov**

Social Security

1-800-772-1213 | socialsecurity.gov

Department of Defense

1-866-773-0404 (TRICARE for Life)
1-877-363-1303 (Pharmacy)
tricare.mil/mybenefit

Preventive care can help you stay healthy

Understanding preventive care

Preventive care may help you and those you love discover a health issue before it becomes a serious problem. Taking steps like following the recommended guidelines and listening to your doctor may help you and your family stay healthy.

Your medical plan covers certain preventive care services at 100% whether you are enrolled in the UnitedHealthcare Medicare Advantage HMO, Senior Supplement Plan F, PPO plan or HDP as long as services are performed by an in-network provider. Note that you can see any provider that accepts Medicare with Senior Supplement Plan F. For more information about preventive care services that might be right for you, visit **uhcpreventivecare.com**.

What is preventive care?

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

What health services are NOT considered preventive care?

Medical treatment for specific health issues or conditions, ongoing care, laboratory tests or other health screenings necessary to diagnose, manage or treat an already-identified medical issue or health condition are considered diagnostic care, not preventive care.

During a preventive care visit, if you discuss any other health concerns such as abnormal symptoms or treatment of a health concern, your visit will no longer be considered a preventive visit, and the visit may no longer be covered at 100%. You may be charged a copay, coinsurance or deductible, even if the service is provided at the same time a preventive care service is performed.

Preventive services at no cost to you

Covered, no-cost, preventive services are based on the recommendations of the United States Preventive Services Task Force (USPSTF), the U.S. Department of Health and Human Services, the Advisory Committee on Immunization Practices (ACIP) of the CDC and the HRSA Guidelines for women and children, including the American Academy of Pediatrics Bright Futures periodicity guidelines. The plan also covers, at no cost to the member, at least one form of contraception in each of the 18 methods identified and approved by the FDA, including necessary clinical services, patient education and counseling. Certain prenatal and breastfeeding supplies and services are also covered at no cost to you. Visit **pebcinfo.com** to view a summary of no-cost preventive services.

ID card information

When will my ID card arrive?

If you changed plans during annual enrollment and if the plan issues ID cards, you should receive your new ID card in early January 2020. You can also print a temporary ID card if needed.

Medical plans

Effective 2020, if you are enrolled in the PPO or HDP you will receive a new card that contains both your UnitedHealthcare medical and your CVS Caremark ID information for your pharmacy benefits. The new card will also have information about accessing your mental health services with UnitedHeathcare.

Dental plans

- **Cigna DHMO** — You will not receive a new ID card unless you are new to the plan or changed dependents. Your current ID card will work.
- **Cigna PPO** — You will not receive a new ID card unless you are new to the plan or changed dependents. Your current ID card will work.

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.

Vision plan

- **EyeMed** — When you visit a network provider, the provider's office will confirm your eligibility electronically.

Did you move?

If you move, be sure to provide your Human Resources department/Benefits Office your new address as soon as possible. This is the best way to ensure that you avoid delays in receiving your ID cards, EOB forms and other valuable information.

Resources at your fingertips

Depending on your medical plan, we encourage you to register for online access as soon as possible. If you are enrolled in the PPO plan or HDP, register at **myuhc.com.** If you are enrolled in the Medicare Advantage or Senior Supplement, register at **UHCRetiree.com.** Once you register, you will have access to personalized tools, information and answers for managing your health care.

Important provider contacts

Benefit	Vendor	Phone Number	Email /Web Address
Under 65 Retirees			
Medical	UnitedHealthcare	1-877-370-2849	**myuhc.com**
Pharmacy RX	CVS Caremark	1-800-364-6331	**caremark.com**
Specialty Pharmacy	CVS Specialty	1-800-237-2767	**cvsspecialty.com**
Mental Health	UnitedHealthcare	1-877-370-2849	**myuhc.com**
HSA Account	Optum Bank	1-800-791-9361	**optumbank.com**
NurseLine	UnitedHealthcare	1-877-370-2849	**myuhc.com**
Over 65 Retirees			
Medicare Advantage (HMO)	UnitedHealthcare	1-800-457-8506	**uhcretiree.com**
Hearing Aids	hi HealthInnovations	1-855-523-9355	**hihealthinnovations.com**
Healthways SilverSneakers	Healthways SilverSneakers	1-888-423-4632	**silversneakers.com/member**
Solutions for Caregivers	UnitedHealthcare	1-866-256-7917	**uhcforcaregivers.com**
Senior Supplement Plan F	UnitedHealthcare	1-800-698-0822	**uhcretiree.com**
NurseLine	UnitedHealthcare	1-877-365-7949	**uhcretiree.com**
All Retirees			
Dental PPO	Cigna	1-800-244-6224	**mycigna.com**
Dental HMO	Cigna	1-800-244-6224	**mycigna.com**
Vision	EyeMed	1-866-804-0982	**eyemedvisioncare.com/PEBC**

2020 Important Notices

The following Notices are intended for benefits-eligible members enrolled in a PEBC health plan for the 2020 Plan year. If you are not eligible for or enrolled in a PEBC Plan, the Notices will not apply to you.

Contents

Uniform Summary of Benefits and Coverage (SBC)

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

Genetic Information Non-Discrimination Act of 2008

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

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

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

1 Standards related to benefits for mothers and newborns

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

2 Parity in the application of certain limits to mental health benefits

Protection against having benefits for mental health and substance abuse disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

3 Required coverage for reconstructive surgery following mastectomies

Certain requirements to provide benefits for breast reconstruction after a mastectomy. (Women's Health & Cancer Rights Act [WHCRA])

4 Coverage of dependent students on medically necessary leave of absence

Continued coverage for up to 1 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 2020 plan year, beginning Jan. 1, 2020, and ending Dec. 31, 2020. 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.

1 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 sixty (60) day Special Enrollment Period (SEP) to join a Part D plan because you lost creditable coverage. In addition, if you lose or decide to leave your employer's sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

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

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

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

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

More information about your options under Medicare prescription drug coverage

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

For more information about Medicare prescription drug coverage:

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

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

KEEP THIS CREDITABLE COVERAGE NOTICE

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

PEBC Health Plans Notice

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. 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 (1-855-692-7447)

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

FLORIDA – Medicaid

Website: **http://flmedicaidtplrecovery.com/hipp/**
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
Website: **http://www.indianamedicaid.com**
Phone 1-800-403-0864

IOWA – Medicaid

Website: **http://dhs.iowa.gov/Hawki**
Phone: 1-800-257-8563

KANSAS – Medicaid

Website: **http://www.kdheks.gov/hcf/**
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: **https://chfs.ky.gov**
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: **http://dhh.louisiana.gov/index.cfm/subhome/1/n/331**
Phone: 1-888-695-2447

MAINE – Medicaid

Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html**
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: **http://www.mass.gov/eohhs/gov/departments/masshealth/**
Phone: 1-800-862-4840

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: 1-800-694-3084

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://dhcfp.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**
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:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: **http://www.eohhs.ri.gov/**
Phone: 1-855-697-4347

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

Medicaid Website: **http://www.coverva.org**
Medicaid Phone: 1-800-432-5924

CHIP Website: **http://www.coverva.org**
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: **https://www.hca.wa.gov/**
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: **http://mywvhipp.com/**
Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: **https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf**
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: **https://wyequalitycare.acs-inc.com/**
Phone: 1-307-777-7531

To see if any more states have added a premium assistance program since July 31, 2019, 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

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
PO Box 5888
Arlington, TX 76005-5888
1-817-608-2317

Notes

Notes

Notes

2020 Retiree Guide

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

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.

pebc
PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

UnitedHealthcare®