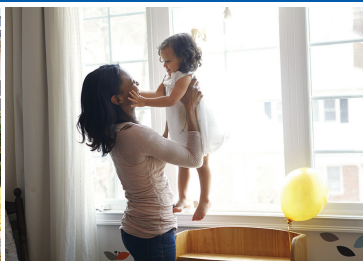




Employee Health Benefits

2021 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 2021 health plan benefits.

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Plan changes for 2021

Typically, there are changes to the benefit plans each year. Following is a list of changes for 2021.

HSA contributions

The maximum contribution to an HSA for 2021 is \$3,600 for individuals and \$7,200 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.

FSA contributions

If you intend to participate in an FSA, you must elect it each year during annual enrollment. The maximum employee election for 2021 is \$2,750. This amount includes general purpose and limited purpose employee elections. Employer contributions to your FSA(s) do not count toward the employee annual election limit. If you have qualifying day care expenses, you may consider enrolling in the dependent care FSA. This account is not for medical expenses.

Wellness Program

In 2021, you'll have new ways to earn your incentive. Active employees and their spouses enrolled in either the PPO or HDP medical plan are eligible to participate in the wellness program and earn an incentive. Activities must be completed between January 1 and October 31. The wellness program will continue to provide tools and skills to help you succeed and maintain healthy behaviors for life.

Bariatric Resource Services

Bariatric Resource Services offers support, education, resources and care from specialized bariatric nurse case managers and some of the top bariatric facilities in the country. If you are considering bariatric surgery, a UnitedHealthcare nurse will work with you to provide support guidance through the process. After surgery, the nurse will continue providing one-on-one support throughout your recovery.

Required enrollment action

During annual enrollment, an employee who covers a spouse must sign a Spouse Medical Plan Surcharge Affidavit attesting to the spouse's access to employer medical plan coverage through his/her employer, regardless if he/she enrolled in that coverage. A copy of the form may be found at pebcinfo.com. Please verify submission requirements and deadline with your employer.

Spouse surcharge (medical plans only)

A Spouse Medical Plan Surcharge Affidavit is required every year.

The spouse surcharge will apply if:

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

The spouse surcharge will not apply if:

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



Spouse Medical Plan Surcharge Affidavit

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

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).

Helpful tools

pebcinfo.com

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

- To compare plans, check the easy-to-understand Summary of Benefits and Coverage. The Summary helps you compare certain health plan provisions.
- 2021 Employee Benefits Rate Sheet — lists employee contribution rates for each plan along with the various "account" options available to you (HSA, FSA, LP-FSA).

myuhc.com®

Use for locating a provider, estimating costs, verifying FSA balances or transactions, and linking to the wellness site, Live and Work Well for mental health and EAP services, and Optum Bank® (HSA). Find other resourceful tools such as:

- **Cost estimator** helps estimate your out-of-pocket cost, compare treatment options and select a quality provider for a procedure.
- **myClaims Manager** helps you manage claims and understand your share of the plan cost. You can view your deductible, annual maximum out-of-pocket cost and your claims history.
- You can even pay your out-of-pocket costs from this site and find network providers (including Tier 1 and Premium Care physicians) by selecting the link "Find Physician, Laboratory or Facility."
- When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to access your health plan ID card, find nearby care and more.

caremark.com

Log into or download the CVS Caremark™ app to manage your prescription drug benefits.

cigna.com

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

mycigna.com

Once you enroll in either the Cigna Dental PPO or the HMO, you can register online at **mycigna.com**. View your plan benefits, use cost tools, search for a network dentist, print an ID card and more.

eyemed.com

Go online to find doctors and search the different frames that are available to you. At **eyemed.com** you can go online and register your account and print ID cards.

Enrollment overview

Annual enrollment is the only time during the year that you can change your benefit elections or dependents without first experiencing a qualified change in status event. Consider your annual enrollment choices carefully.

New hire enrollment

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

- You must return your enrollment documents to the Human Resources department within 14 days of the date you begin working. If you miss that deadline, your employer will automatically enroll you in a default medical plan, employee-only coverage.
- The PPO is the default medical plan. You cannot change from PPO default plan enrollment until the next annual enrollment period unless you first experience a qualified change in status event.
- Your health benefits coverage becomes effective on the first day of the month after 30 consecutive calendar days of active, regular employment.
- If you select optional term life insurance (TLF) when you are newly hired and enrolling for the first time, you do not have to provide Evidence of Insurability (EOI). If you select spouse optional term life (SLF) in an amount greater than \$25,000, EOI is required. Instructions are found on the back of the enrollment form, available at **pebcinfo.com**. TLF coverage requirements vary by employer. Check with your employer to confirm your EOI requirements.

How to select a plan

- Compare the differences between the plans.
- Check which doctors, hospitals and providers are in the network. Both plans offered through PEBC use the large UnitedHealthcare Choice Plus network.
- Think about potential health needs in the coming



During annual enrollment, you must re-enroll if:

- Your employer requires you re-enroll (important deadlines apply).
- Anything changed, including dependent eligibility, your address or your plan choice.
- You want to contribute to an FSA or a LP-FSA. Remember — you have to re-enroll each year if you want to contribute to an FSA, even if you do not change your annual election amount. It's an IRS rule.

year. Estimate your out-of-pocket cost for each available plan for services you might receive as well as the premium cost.

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



you save even more. If you are not eligible for HSA contributions, the seed money goes to a LP-FSA.

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

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.
- Your newborn is not automatically enrolled in your medical plan. You are responsible for contacting the Human Resources department and completing the required enrollment paperwork to add your newborn. This is the only way you can add your newborn to your medical plan. If you enroll your newborn within 31 days from the date of birth, coverage is effective on the date of birth. If you do not add your newborn within 31 days from the date of birth, you cannot add your newborn until the next annual enrollment period.

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 the stepchild of a former spouse.
- A surviving child of a deceased retiree who was not covered as a dependent at the time of the retiree's death.
- A 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 below), you cannot change your benefit choices until the next annual enrollment period.

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

Qualified events

Change in family status

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

- Marriage, divorce or annulment.
- Death of your spouse or dependent.
- Child's birth, adoption or placement for adoption. Your newborn or adopted child is not automatically enrolled in your medical plan.
- An event causing a dependent to no longer meet eligibility requirements, such as reaching age 26.

Examples of events that do not qualify:

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

Change in employment status

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

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

- Start or return from an unpaid leave of absence.
- USERRA (military) leave.

Important deadlines apply

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

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

Retirement

Thinking about retirement?

Your employer offers retiree health benefits, but retiree health benefits cost more than your active employee coverage. Make an appointment to discuss your retiree benefit options with the Human Resources department at least 60 days before you retire. If you are age 65 or older, or if you are turning 65 soon, contact the Social Security Administration at least 90 days before you retire. Carefully review the Retiree Health Benefits Guide, available at pebcinfo.com or from your employer.

Turning age 65 and still working

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

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

- You are an active employee and you (and your

Retired public safety officers only: The HELPS ACT

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

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

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

spouse — regardless of spouse's age) are enrolled in the employer health plan.

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

Caution: If you are preparing to retire and you or your spouse are age 65 or older or turning 65 soon, it is critically important that you contact the Social Security Administration to enroll in Medicare Part A and Part B. If you delay, your Medicare enrollment can be delayed and you may be subject to a higher Part B premium. After you retire, Medicare becomes primary for you and your Medicare-eligible spouse. You may be eligible for your employer's retiree plan but only if you are enrolled in both Medicare Part A and Part B.

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.

2021 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 how they work, and copays.

Pre-certification

If care is provided by a network doctor, hospital or other health care provider, you do not need pre-certification for services. 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 the network, your annual OOP, including 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, 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 network out-of-pocket expenses count toward your OOP. After you meet your deductible, you pay 20% of eligible 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 network cost

For those services subject to coinsurance, after the network deductible is met, each plan pays 80% of 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 the network.



Choose the
medical plan that's
right for you.



Copays and out-of-pocket cost

PPO plans

The PPO plan has a fixed copay for many services. While copays count toward network out-of-pocket costs, copays do not count toward your deductible. Standard medical copays are listed on page 13. Check the prescription drug section for 2021 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 the network)

The HDP does not use copays. You pay 100% of the allowable cost until the applicable 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.

Network deductibles

PPO plan (copays do not count toward deductible)

\$500 individual (single) deductible
\$1,000 family deductible*

*If you cover family members, the 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 network deductible works similarly to the PPO plan, but there is an important distinction.

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

Out-of-network deductibles

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

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

Opt out of a medical plan

If you can show valid proof of other comparable medical plan coverage, such as another employer plan or TRICARE, you may choose to opt out of your employer's medical plan. In addition to providing valid proof of comparable medical plan coverage (must meet minimum essential coverage rules under the ACA), you must complete a "Certification of Other Coverage" form.

Both documents must be received by your employer's Human Resources department before the enrollment deadline. If you do not provide a Certification of Other Coverage form, or if your proof of coverage is found to be invalid, your employer can enroll you in the PPO plan, employee-only coverage. If you opt out, you are considered absent from the medical plans.

This means that you are not eligible for continuation of medical coverage (COBRA). Examples of other coverage that cannot be used to opt out of your employer's medical plan include Medicaid, TRICARE "supplemental" coverage, student insurance or coverage that does not meet minimum essential coverage requirements under the ACA. Your employer will confirm your other coverage. Check with your Human Resources department or Benefits Office if you have questions.

Participating employers only

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

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

Health savings account (HSA)

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

What is an HSA?

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

- Deposits are income tax-free.

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

Things you need to know about an HSA

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

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

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

For 2021, you may contribute \$3,600 if you have individual coverage or \$7,200 if you have family coverage. The IRS also allows an extra catch-up deposit of \$1,000 if you are age 55 or older. Your deposits are made through payroll deduction.

Important information if you enroll in the HDP with HSA

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

Contact Optum Bank for detailed information about eligible expenses and your responsibilities regarding contributions and record keeping.

Your 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.

Employer “seed money”

If you enroll in the HDP during annual enrollment, your employer will make a one-time cash deposit to your HSA in January. If you are a newly hired employee, seed money contributions are available as soon as reasonably possible once your HDP becomes effective. Remember, your HSA balance builds even faster if you contribute funds through payroll deduction. The 2021 Employee Rate Sheet provides more employer “seed-money” information. If you are not eligible for HSA contributions (example — you are enrolled in Medicare), the seed money contribution will go to a Limited Purpose (LP) FSA. Seed money is not awarded for adding coverage in the high deductible plan as a result of a mid-year qualifying event.

UnitedHealth Premium[®] 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.

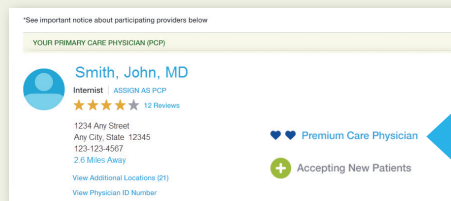
Find quality, cost-efficient care

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 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. If you or someone in your family is struggling with a situation that is having a negative impact on your mental health, don't go it alone. You have access to resources that can help, including ways to connect with mental health support from the comfort of home. From everyday challenges to more serious issues, you can receive confidential help.

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

Live and Work Well

Creating a healthy work-life balance can be challenging. Live and Work Well makes it easier with support for stressful situations including:

- Anxiety and stress
- Alcohol and drug use
- Coping with grief and loss
- Marital problems
- Eating disorders
- Compulsive spending or gambling
- Medication management

Visit liveandworkwell.com and enter the access code PEBC.

Talkspace

With Talkspace online therapy, you can regularly communicate with a licensed therapist via text or live video, safely and securely from your phone or desktop. No office visit is required and you can start therapy within hours of choosing your therapist. It's private, confidential and convenient. Five days of unlimited texting via the Talkspace app equals one in-person office visit through either your EAP or behavioral health benefit.

To get started, visit talkspace.com/connect. On your first visit, you'll go through a simple registration process.

Virtual behavioral health visits

Using behavioral health virtual visits, you can talk confidentially to a psychiatrist or therapist without leaving your home. These providers can evaluate and treat general mental health conditions such as depression and anxiety. To schedule an appointment:

- Sign in to liveandworkwell.com.
- Select "Find a Resource" > "virtual visits."
- Choose "Get Started." You can schedule an appointment online or by phone.

In-person behavioral health visits

From everyday challenges to more serious issues, you can receive confidential help with a psychiatrist or therapist for:

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

Sanvello

Dial down the symptoms of stress, anxiety and depression with an app that uses clinical techniques. Sanvello premium access is available at no extra cost as part of your behavioral health benefit.

Download the app today at sanvello.com.

Substance use disorders

If you or someone you love is struggling with substance abuse, call the Substance Use Treatment Helpline. It's available 24/7 as part of your benefits and is completely confidential — you can even choose to remain anonymous.

To speak with a substance use recovery advocate who will listen, provide support and develop personalized recovery plans, call **1-855-780-5955**. Or visit liveandworkwell.com/recovery to find care options and resources.



Employee assistance program (EAP)

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

The EAP is staffed by licensed clinicians who know how to get you and your family the help you need — right away. When you call, the specialist will help identify the best resource for your specific situation by talking with you and asking questions. You can speak to an EAP specialist as often as you like, free of charge.

As part of the program, you and your family also get 5 free, face-to-face counseling sessions with a network provider (per concern, per person, per year), and first responders get 8 free sessions. You can also meet virtually through a Telemental Health visit. This

service uses video-calling technology to provide real-time access to a behavioral health professional — with no travel and less wait time for appointments.

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

Call the EAP anytime day or night at 1-866-248-4096 for help with:

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

PPO plan quick reference guide

Refer to plan documents for limitations and additional information.

Feature	PPO — medical plan Your 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
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)
Additional Services		
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Lab & X-ray Outpatient (Minor)	Covered at 100% in physician office or network lab or radiological provider	40% after deductible
Hospital Emergency Care Services (Treated as network)	\$300 copay + 20% after deductible; copay waived if admitted	\$300 copay + 20% after deductible; copay waived if admitted
Skilled Nursing Facility	20% after deductible; up to 60 days annually**	40% after deductible; up to 60 days annually**
Home Health Care	20% after deductible; up to 120 visits annually**	40% after deductible; up to 120 visits annually**
Allergy Care Services	\$25 PCP/\$25 Premium Care Specialist \$35 non-Premium Care Specialist	40% after deductible
Chiropractic	\$35 copay per visit; maximum 20 visits per year**	40% after deductible; maximum 20 visits per year**
Medical Supply & Equipment (DME)	20% after deductible	40% after deductible
Mental Health Services		
Outpatient Visits	\$25 visit	40% after deductible
Inpatient	20% after deductible	40% after deductible
Serious Mental Illness	Treated like any other illness	Treated like any other illness
Substance Abuse	Treated like any other illness	Treated like any other illness

* Subject to Affordable Care Act requirements

** Limits apply for any combination of Network and Non-Network benefits

HDP quick reference guide

Refer to plan documents for limitations and additional information.

Feature	HDP — medical plan Your 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
Coinurance (After the annual deductible is met)	20% after deductible	40% after deductible
Annual Coinurance 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 Visits	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
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)
Additional Services		
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Lab & X-ray Outpatient (Minor)	20% after deductible	40% after deductible
Hospital Emergency Care Services (Treated as network)	20% after deductible	20% after deductible
Skilled Nursing Facility	20% after deductible; up to 60 days annually**	40% after deductible; up to 60 days annually**
Home Health Care	20% after deductible; up to 120 visits annually**	40% after deductible; up to 120 visits annually**
Allergy Care Services	20% after deductible	40% after deductible
Chiropractic	20% after deductible; maximum 20 visits per year**	40% after deductible; maximum 20 visits per year**
Medical Supply & Equipment (DME)	20% after deductible	40% after deductible
Mental Health Services		
Outpatient Visits	20% after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible
Serious Mental Illness	Treated like any other illness	Treated like any other illness
Substance Abuse	Treated like any other illness	Treated like any other illness

* Subject to Affordable Care Act requirements

** Limits apply for any combination of Network and Non-Network benefits



Save on prescription medications.



CVS Caremark National Network

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

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

Manage your prescriptions online with tools available at [caremark.com](https://www.caremark.com). You can check the cost of a drug, view available alternative medications, view your prescription history, balances, view the Preferred Drug List, locate a participating pharmacy 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 at **1-855-335-7698** 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.

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.

Pharmacy Access Options Refills allowed as Prescribed	PPO Plan	HDP
CVS Caremark National Network Pharmacy (network) up to a 30-day supply	\$15 generic \$30 preferred brand \$60 non-preferred brand	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	

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 drop off your prescription(s) at a local CVS Pharmacy, or visit **CVSSpecialty.com** for more information and registration. 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.

No-cost contraceptives (prescription required)

The 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 2021 Excluded Drug list at [pebcinfo.com](https://www.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.

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

You can also visit [pebcinfo.com](https://www.pebcinfo.com) for more information.



Vision and dental benefits to enhance your well-being.



Vision benefits

Vision benefits are available through EyeMed Vision Care®. Employees can go to any Target 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.

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 network providers

Frames — \$0 copay

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

Contact lenses — \$0 copay

(Contact lens allowance includes material only)

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

Laser vision correction

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

Out-of-network benefits

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

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 2021, you can choose between the Cigna Dental HMO and the Cigna Dental PPO plans.

Which network is right for me? Go to [Cigna.com](https://www.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."

Remember — When you enroll in Cigna DHMO:

- 1 After Jan. 1, 2021, you will need 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 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!**

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

Cigna Dental PPO Plan (Cigna DPPO)

The Dental PPO Plan offers access to both 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	Network	Out-of-Network
Deductible (per person)	\$50 (maximum of \$150)	\$50 (maximum of \$150)
Annual Maximum Benefit (per person)	\$2,000	\$2,000
Preventive <ul style="list-style-type: none"> • 2 cleanings in 12 months • 2 exams per calendar year • 2 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Benefits begin after 6 months of coverage • Crown installation • Denture and bridges • Endodontics 	50% after deductible	50% after deductible
Orthodontia <ul style="list-style-type: none"> • 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.



Virtual Visits

Virtual Visits provide you with personalized care anytime you need it by phone or video so you can talk to a doctor who can treat conditions like sinus infections, headaches, sore throats and more, 24/7.

Getting started is easy! Just log in to get started. It only takes a few minutes to complete your health profile.

1. Log in at myuhc.com/virtualvisits or download the UnitedHealthcare app.
2. Complete a brief health profile in minutes.
3. Start a Virtual Visit with just one click.

You do not have to be enrolled in a medical plan to use Virtual Visits, but if you are enrolled in the PPO or HDP, your visit will coordinate with your insurance.

Conditions commonly treated include:

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

Cost

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

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 a 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:

- Anything requiring a physical exam or test.
- Complex or chronic conditions.
- Injuries requiring bandaging or sprains/broken bones.

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. When using UnitedHealthcare's Virtual Visits service, PPO members pay a \$0 copay. HDHP members pay a \$49 service cost until the deductible is met, then pay 20% of that service.

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

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.

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. HDP members pay the cost of the service until your deductible is met, then you pay 20% of the service cost.

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. HDP members pay the cost of the service until your deductible is met, then you pay 20% of the service cost.

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) 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 uhc.com/preventivecare.

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 CVS Caremark National Network retail pharmacies. Contact CVS Caremark or visit pebcinfo.com for more CVS Caremark National Network options (UnitedHealthcare ID card with CVS Caremark information card required).

CVS Caremark National Network retail pharmacies:

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

Covered vaccines include:

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

UnitedHealthcare retail pharmacy vaccines

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

- Albertsons
- 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.

Maternity Support Program

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

Personal attention

A registered nurse will consult with you by phone to determine if there are any risks or complications to be aware of, teach you healthy pregnancy habits and provide one-on-one support to help you make informed decisions throughout your pregnancy and after giving birth.

Enroll at your convenience

To get the most from the program, it's best to enroll during your first trimester, but you can enroll whenever you like, up through the end of your pregnancy. Enroll in UnitedHealthcare maternity programs by calling or downloading the UnitedHealthcare Healthy Pregnancy® app and completing an assessment.

Educational materials and resources

The UnitedHealthcare Healthy Pregnancy app provides personalized support. Use the app to track personalized pregnancy milestones, set reminders,



get daily tips, find resources and more. At myuhc.phs.com/maternitysupport, you can also access a full range of articles covering nutrition, exercise, childbirth preparation, tips for dads and more.

To enroll in the Maternity Support Program, call 1-877-201-5328, TTY 711, Monday through Thursday, 8 a.m. to 8 p.m. and Friday, 8 a.m. to 5 p.m. CT. For more information about a healthy pregnancy, visit myuhc.phs.com/maternitysupport.

Adding newborn to benefits

Your newborn is not automatically enrolled in your medical plan. You are responsible for contacting the Human Resources department and completing the required enrollment paperwork to add your newborn. This is the only way you can add your newborn to your medical plan. If you enroll your newborn within 31 days from the date of birth, coverage is effective on the date of birth. If you do not add your newborn within 31 days from the date of birth, you cannot add your newborn until the next annual enrollment period.

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.

*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 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.

The PEBC Wellness Program

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

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

Get Started with Rally®

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

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

Timing and earning points

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

How is the reward paid?

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

When is your reward paid?

Rewards are paid 3 times during the year based on when you earn 300 points individually or 600 points when participating with a spouse. You must be an employee (or a covered spouse) at the time of payout to receive your reward.

Date Points Are Earned	Date Reward Is Paid By
Jan. 1 — March 31	May 31
April 1 — June 30	Aug. 31
July 1 — Oct. 31	Dec. 31

Earning points

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



Earn 300 points

Between Jan. 1, 2021, and Oct. 31, 2021, using any combination of the options below.

Earn 100 points

Once per year either at a:

- Biometric screening onsite — your employer may sponsor screening events at work.
- Or, have your doctor identify your biometrics during

an office visit (cholesterol, blood sugar, etc.). Points are triggered via UnitedHealthcare claims; they generally appear within 21 business days from the date of service, depending on when the provider submits the claim.

Earn 100 points

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

Earn 75 points

Complete 3 Rally Missions. Each Mission takes 4 weeks. You must complete 3 Missions to earn 75 points. If you want, you can do all 3 at the same time. Complete a private or public Challenge on Rally for 25 points.

Earn 50 points

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

- Complete **Personal Wellness Coaching** — this can be either telephonic, email or chat. It can be done once per week. Minimum of 3 sessions over 6 weeks.
- Complete **Quit For Life®**.
- Complete **9 sessions of Real Appeal**.
- Enroll in **Maternity Support Program**.
- Complete 1 of the following: annual physical or preventive mammogram, colorectal or cervical cancer screening.
- Complete an annual physical or annual screening.
- Complete the Find and Price Care tool.
- Complete a Virtual Visit.

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



Save money using pretax dollars with a FLEX account.



Flexible spending accounts

A health care flexible spending account (FSA) is a way to set aside money from your earnings before taxes are withheld in order to pay eligible out-of-pocket health care expenses and qualifying dependent day care expenses. Use your UnitedHealthcare Health Care Spending Card to pay for eligible health care expenses, or submit a claim for reimbursement of eligible expenses from your UnitedHealthcare account. Expenses must be incurred by Dec. 31 and submitted to UnitedHealthcare by April 30 of the following year to avoid loss of funds. Claims must also be submitted within one year of the date of service. Your active employee FSA ends the date your employment ends.

Rollover funds

The IRS allows employees with a health care FSA to roll over up to \$500 of their unused funds to the next plan year. Whether you enroll in the general purpose FSA or the LP-FSA, and regardless if the contribution is from you or your employer, a combined total up to \$500 of unused funds will automatically roll over for use in the next plan year. Automatic rollover will occur after the end of the run-out period. The run-out period ends April 30, 2021, which means 2020 rollover funds will be available in May 2021.

Health care FSAs

General purpose health care FSA

If you enroll in the PPO plan or if you opt out of medical coverage and your comparable coverage is through a traditional plan (non-HDP), you can select the general purpose health care FSA. The general purpose health care FSA can be used to pay your eligible out-of-pocket health care expenses, including dental and vision costs. Expenses paid by insurance or another source are not eligible for reimbursement.

You have until April 30, 2021, to submit claims for expenses incurred during 2020.

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

A note for highly compensated employees

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

Manage your accounts online

Visit myuhc.com to manage your FSA. If you have more than one 2021 FSA type, you will see more than one 2021 account listed. The combined total represents your available funds. You can file your claims electronically and either upload or fax your claims substantiation.

Limited-purpose health care FSA (LP-FSA)

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



Manage your account

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

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

FSA claims must be incurred by you or your federal tax dependents only.

FSAs are ONLY for those eligible claims incurred by you or your dependents for federal income-tax purposes, without regard to income limitations. Claims must be submitted within one year of the date of service. Do not risk IRS difficulties. Contact your tax or financial advisor for information about your specific situation. Visit **myuhc.com** and use your UnitedHealthcare credentials to log in and manage your accounts online.

To mail or fax a claim

Use the claim form available at **myuhc.com**. Submit it to the address shown on the form.

Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506
VOICE: 1-866-262-6354
FAX: 1-915-231-1709

Employer contributions

In some cases, employers may contribute to an employee FSA or LP-FSA. If your employer contributes, you will find the maximum contribution amounts on the back of the 2021 Employee Benefit Plan Rates document included in your enrollment packet. Employer contributions are in addition to and do not count toward the employee \$2,750 health care FSA annual election limit.

Dependent care FSA

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

	General Purpose FSA	LP-FSA
Medical plan enrollment required	PEBC PPO plan or opt out with a traditional plan as comparable coverage	HDP or opt out with an HDP as comparable coverage
What can be reimbursed?	Eligible qualified expenses including out-of-pocket medical, dental and vision expenses	Eligible qualified dental and vision expenses, and out-of-pocket eligible medical expenses after your deductible is met
Can I use an account debit card?	Yes — Health Care Spending Card	Yes — Health Care Spending Card
What is the maximum amount an employee can elect annually?	\$2,750 general purpose or limited purpose	
Can I be enrolled in both accounts at the same time?	You cannot be actively enrolled in a LP-FSA if you're enrolled in a general purpose FSA at the same time.	You cannot be actively enrolled in a general purpose FSA if you are enrolled in the LP-FSA at the same time.
Does "use it or lose it" apply?	\$500 of unused funds will automatically roll over to the next plan year and is in addition to the annual plan maximum of \$2,750. You will forfeit unused funds exceeding \$500.	

Health Care Spending Card

All newly participating members will receive a UnitedHealthcare Health Care Spending Card account debit card, at no cost, which makes it easy to access your health care FSA funds. Members with an existing card can continue to use it up until the card's expiration date. Your entire health care FSA election amount is available for claims incurred at the later of either Jan. 1, 2021, or your effective date.

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

Claims substantiation and receipts

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

Contact customer service

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

- Activate a new card.
- Report a lost or stolen card and request card deactivation and/or a new card.
- Check account balance information and card transaction history.
- Report fraud.
- Dispute card transactions up to 90 days from date of charge.



Support for you and your family with life insurance and AD&D.



Life insurance and AD&D

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

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

Basic Life (GLF) insurance amount

Your Jan. 1, 2021, Basic Life insurance amount is based on the later of either your annual salary at Dec. 31, 2020, or your 2021 hire date. Basic Life and AD&D coverage varies by employer. Check with your employer to confirm the coverage amount available to you.

NTTA employees — Your Basic Life insurance is salary times 3, up to a maximum of \$300,000. Premiums for coverage over \$50,000 may result in additional taxable income to you.

Optional Term Life (TLF)

Employee TLF is voluntary and is based on your annual salary times your selected coverage level. Use the Optional Rate Chart (Column A) on the following page to calculate your monthly cost.

Spouse optional Term Life (SLF)

SLF coverage amount cannot exceed 50% of an employee's TLF coverage amount. During a newly hired employee's initial enrollment period, both the \$10,000 and \$25,000 coverage levels are available without evidence of insurance (EOI). At all other times,

whether you are selecting SLF for the first time or you are increasing SLF coverage amount, EOI is required and acceptance is not guaranteed. The employee is the beneficiary when SLF coverage is selected. Use the Optional Term Life Rate Chart (Column B) on the following page to determine SLF monthly cost. SLF coverage does not include AD&D.

Evidence of insurability (EOI)

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

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

- Coverage amount varies by employer.
- Minimum coverage is \$20,000 regardless of salary.
- AD&D coverage matches basic term life coverage.

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

County employees

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

NTTA employees

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

Dependent optional Term Life (DGL)

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

* Dependents up to age 26.

Spouse optional Term Life (SLF)

SLF cannot exceed 50% of employee TLF.

SLF coverage levels

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

Calculate monthly premium cost (TLF/SLF)

Using your annual salary on Dec. 31, 2020, and your age on Jan. 1, 2021, calculate your monthly TLF premium cost. To calculate your per-paycheck cost, simply multiply the monthly cost by 12 and divide by the number of 2021 payroll checks from which benefits are deducted (24 or 26).

County employees

Step 1 Select coverage level (50%, 100%, 200%). _____%

Step 2 Multiply annual salary at Dec. 31, 2020, by coverage level. \$ _____

Step 3 Round Step 2 amount to the next highest \$1,000. \$ _____

Step 4 Divide Step 3 amount by \$1,000. \$ _____

Step 5 Multiply Step 4 amount by appropriate rate for your age at Jan. 1, 2021 (Optional Term Life Rate Chart, Column A).

This is your monthly TLF premium amount. \$ _____

NTTA employees

Step 1 Annual salary at Dec. 31, 2020, rounded up to next \$1,000. \$ _____

Step 2 Select coverage level (100%, 200%, 300%, 400%). _____%

Step 3 Multiply Step 1 amount by Step 2 coverage amount. \$ _____

Step 4 Divide Step 3 amount by \$1,000. \$ _____

Step 5 Multiply Step 4 amount by appropriate rate for your age at Jan. 1, 2021 (Optional Term Life Rate Chart, Column A).

This is your monthly TLF premium amount. \$ _____

Continuing your life insurance

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

Portability

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

Conversion

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

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

Optional Term Life rate chart

Rates listed are per \$1,000 of coverage

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

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

** AD&D not available.



Tools to help you manage the details.



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

Account balances

The account balances page shows current 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 to submit for an FSA reimbursement or to document your HSA spending. Visit **caremark.com** to check specific costs for drugs covered by your plan. You can see 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.

ID card and debit card information

Medical plans

You will not receive a new ID card unless you are new to the plan and/or changed benefits for 2021. Members with an existing card who are not changing plans can continue to use their existing ID card.

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.

Vision plan

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

What about my debit cards?

- **Optum Bank HSA** — If you are newly enrolled in the HSA, in about 7–10 days after your account is opened you will receive a UnitedHealthcare Health Savings Account Mastercard® (debit card from Optum Bank) in the mail. The card does not have an annual card fee. If you are currently enrolled, as long as the card is not expired, your current Optum Bank debit card will work in 2021.

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.

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

Did you move?

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.

Important provider contacts

Benefit	Vendor	Phone Number	Email /Web Address
Medical	UnitedHealthcare	1-877-370-2849	myuhc.com
Pharmacy RX	CVS Caremark	1-855-335-7698	caremark.com
Specialty Pharmacy	CVS Specialty	1-800-237-2767	cvsspecialty.com
Mental Health	UnitedHealthcare	1-877-370-2849	myuhc.com
EAP	UnitedHealthcare	1-866-248-4096	myuhc.com
Dental DPPO	Cigna	1-800-244-6224	mycigna.com
Dental DHMO	Cigna	1-800-244-6224	mycigna.com
Vision	EyeMed	1-866-804-0982	eyemedvisioncare.com/PEBC
Life Insurance	The Hartford	1-888-563-1124	mybenefits.thehartford.com
Flexible Spending Account (FSA)	UnitedHealthcare	1-877-370-2849	myuhc.com
Health Savings Account (HSA)	Optum Bank	1-800-791-9361	optumbank.com
PEBC Wellness Plan	Optum	1-877-779-2225	myuhc.com
NurseLine	UnitedHealthcare	1-877-370-2849	myuhc.com
Health Insurance Marketplace		1-800-318-2596	healthcare.gov

2021 Important Notices

The following Notices are intended for benefits-eligible members enrolled in a PEBC health plan for the 2021 Plan year. If you are not eligible for or enrolled in a PEBC Plan, the Notices will not apply to you.



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- 45 Notice Regarding the PEBC Wellness Program for the Americans with Disabilities Act (ADA)

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 2021 plan year, beginning Jan. 1, 2021, and ending Dec. 31, 2021. The exemption may be renewed for subsequent plan years. Please note that PEBC employer groups currently voluntarily provide coverage that substantially complies with the requirements of the Newborn and Mother's Protection Act and the WHCRA.

Medicare Part D Notice of Creditable Coverage

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

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

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

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

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

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

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from Oct. 15 through Dec. 7. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a

penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a 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 January 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555
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 and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563
KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
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 [Under ELIGIBILITY tab, see “what if I have other health insurance?”] 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://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 1-603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct lte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: http://www.coverva.org Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-Free Phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/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 January 31, 2020, or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Continuation of Group Coverage (COBRA) Initial Notice

Continuation coverage rights under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan

because either one of the following qualifying events happens:

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

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

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

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

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

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

When is COBRA coverage available?

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

You must give notice of some qualifying events

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

How is COBRA coverage provided?

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

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

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

to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are 2 ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

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

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

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

Are there other coverage options besides COBRA continuation coverage?

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

If you have questions

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

Keep your plan informed of address changes

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

Plan contact information

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

The COBRA Benefit Administrator is:

UnitedHealthcare

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

Employer Notice of Exchange

Health Insurance Marketplace coverage options and your health coverage

General information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace runs from Nov. 1, 2020, through Dec. 15, 2020, for 2021 coverage. This is not your employer's annual enrollment period.

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

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

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

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

- If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% of your household income for the year 2021, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

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

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

How can I get more information?

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

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

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

PEBC Privacy Notice

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

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

Effective date of notice: 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 PHI with each other as necessary to carry out treatment, payment, or health care operations. For example, your requests for claim payment may automatically be sent from a PEBC Medical Plan to the Health Care Spending Account Plan, in order to simplify and accelerate claims payment.

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

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

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

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

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

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

Uses and disclosures for which an authorization is required

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

Your rights regarding Protected Health Information

You have the right to:

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

- **Request Confidential Communications:** You may request to receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may want to have Protected Health Information sent only by mail or to an address other than your home.
- **Receive Notice of a Breach:** You have the right to be notified upon a breach of your unsecured Protected Health Information, if a disclosure occurs that meets the definition and thresholds of a breach under the law.
- **Receive a Paper Copy of This Notice:** You have the right to a paper copy of this Notice, even if you have agreed to receive this notice electronically.

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

About this notice

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

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

Contacting the plan administrator

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

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

Patriot Act Notice

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

Important information about procedures for opening a new account

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

What this means for you:

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

Important Health Savings Account Information

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

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

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

Once your account is open, contact your bank for detailed information about eligible expenses and

your responsibilities regarding contributions and record keeping. Also, contact the IRS or consult with a qualified tax advisor for specific advice about your situation. Your employer cannot provide you tax advice.

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

Notice Regarding the PEBC Wellness Program

For the Americans with Disabilities Act (ADA)

The PEBC Wellness Program is a voluntary wellness program available to all active employees participating in a PEBC medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include a blood test to check for cholesterol levels, blood sugar levels or other measures to help identify medical risk factors. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

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

Incentives may be available for employees who participate in certain health-related activities, such as having recommended preventive care screenings based

on your age and gender, completing wellness learning modules, or participating in fitness activities. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Optum (part of UnitedHealthcare) at 1-877-818-5826.

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

Protections from disclosure of medical information

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

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

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

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

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

Important provider contacts

Benefit	Vendor	Phone Number	Email/Web Address
Medical	UnitedHealthcare	1-877-370-2849	myuhc.com
Pharmacy RX	CVS Caremark	1-855-335-7698	caremark.com
Specialty Pharmacy	CVS Specialty	1-800-237-2767	cvsspecialty.com
Mental Health	UnitedHealthcare	1-877-370-2849	myuhc.com
EAP	UnitedHealthcare	1-866-248-4096	myuhc.com
Dental PPO	Cigna	1-800-244-6224	mycigna.com
Dental HMO	Cigna	1-800-244-6224	mycigna.com
Vision	EyeMed	1-866-804-0982	eyemedvisioncare.com/PEBC
Life Insurance	The Hartford	1-888-563-1124	mybenefits.thehartford.com
Flexible Spending Account (FSA)	UnitedHealthcare	1-877-370-2849	myuhc.com
Health Savings Account (HSA)	Optum Bank	1-800-791-9361	optumbank.com
PEBC Wellness Plan	Optum	1-877-779-2225	myuhc.com
NurseLine	UnitedHealthcare	1-877-370-2849	myuhc.com
Health Insurance Marketplace		1-800-318-2596	healthcare.gov

2021 Enrollment 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.



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