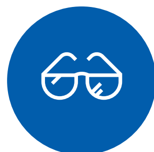
pebc
PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

Retiree Health Benefits

2024 ENROLLMENT GUIDE

Benefits that deliver choice, flexibility and value



Choice. Flexibility. Value.

The Public Employee Benefits Cooperative (PEBC) offers a variety of benefits and programs to protect your health while keeping benefit costs affordable. In this guide, you'll find information on your 2024 health plan benefits to help you choose the coverage that works best for you.

Questions? Please contact your Human Resources department.

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

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The information applies to all retirees.

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KEEP READING TO LEARN MORE >

NEW

What's changing for 2024

Here's an overview of what you can expect

HDP deductibles

For 2024, the HDP deductible for network services is $1,600 for individuals and $3,200 for families. The out-of-network HDP deductible is $3,000 for individuals and $6,000 for families, plus you pay charges exceeding the plan payment. Health savings account (HSA) contributions

The maximum contribution to an HSA for 2024 is $4,150 for individuals and $8,300 for families. If you are age 55 or older, you can make an extra catch-up deposit of $1,000 in 2024.

New medical coverage ID cards

If you are a non-Medicare-eligible or a Medicare-eligible retiree, you will get a new medical ID card in late December 2023. The ID card will have new group numbers and claims addresses, so plan to start using it in January. You can also print a temporary ID card, if needed, on UnitedHealthcare's website or access it in the UnitedHealthcare® app.

Retiree choices

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

- PPO plan (includes spouses and dependents enrolled in PMD/MPD)
- High-deductible plan (HDP) – you can contribute to an HSA as long as you are not enrolled in Medicare

Dental plans

- Delta Dental DPPO – Delta Dental PPO Plan
- DeltaCare USA DHMO – Delta Dental HMO Plan

Vision plan

- VSP® – VSP Advantage Plan

Medical plans – Retirees enrolled in Medicare Parts A & B

- UnitedHealthcare Group Medicare Advantage PPO (MPO) with Part D prescription drug coverage
- UnitedHealthcare Group Medicare Advantage HMO (PMA) with Part D prescription drug coverage

The PEBC PPO is available to non-Medicare dependents of retirees enrolled in either the UnitedHealthcare Medicare Advantage PPO (MPO) or HMO (PMA) plans. If your spouse and/or dependents are not eligible for Medicare, don't let that stop you from enrolling. Your non-Medicare spouse and/or dependents can enroll in the PEBC PPO plan. To enroll, select the PMD or MPD plan (with non-Medicare dependents).

Required enrollment action

Spouse Medical Plan Surcharge Affidavit

If your medical coverage includes your spouse, you must sign a "Spouse Medical Plan Surcharge Affidavit" during annual enrollment confirming their access to employer medical plan coverage through their employer – regardless of whether they enrolled in that coverage. Verify submission requirements and deadlines with your employer. A copy of the form is in your enrollment packet, or visit **pebcinfo.com** to get a copy of the form.

Medical plan spouse surcharge

If your spouse's employer offers a medical plan, your spouse did not enroll in that plan and you cover your spouse in your PPO medical plan or HDP, a **$200 per month spouse surcharge** will apply to your retiree premium, unless your spouse is enrolled in their employer medical plan and you turned in the Affidavit on time.

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

The medical plan spouse surcharge will not apply if:

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

PLEASE NOTE: The surcharge will apply for each month the Spouse Medical Plan Surcharge Affidavit was not submitted by your employer's deadline (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.

2024 enrollment overview

Annual enrollment is the only time of the year that you can change your benefit elections without a qualified change in status event. It's very important that you follow your employer's annual enrollment instructions and deadlines so that you can enroll in your chosen benefits in 2024.

Can you enroll in coverage you currently do not have?

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

Make an informed choice

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

Moving from active employee to retiree status?

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

Visit your Human Resources department at least 60 days before you retire to complete your Retiree Benefit Enrollment forms.

Retiree Health Benefit Enrollment forms must be signed and dated no more than 60 days before your retiree health benefits become effective.

Carefully review the retiree premium payment information included in this Retiree Enrollment Guide to understand exactly how and when to pay your premium.

As an active employee, if you chose to opt out of your employer's medical plan before you retire, you are not eligible for medical plan coverage as a retiree. Likewise, if you did not have dental or vision coverage as an active employee, you cannot elect dental or vision coverage as a retiree.

Don't forget to review your optional life insurance. You have 31 days after your active employee optional life coverage ends to apply for conversion or portability of your life insurance benefits. If you miss the deadline, you cannot continue your life insurance coverage.

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

- Your employer requires you to re-enroll (important deadlines apply)
- Anything changed, including dependent eligibility, your address or your plan choice

Dependent eligibility

Who is an eligible dependent?

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

Eligible spouse

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

Eligible child(ren)

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

Managing conservator

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

Dependent verification

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

Who is ***not*** an eligible dependent?

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

Ineligible spouse

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

Ineligible child(ren)

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

When a child's coverage ends

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

Change in status

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

The qualified change in status event must result in either becoming eligible for or losing eligibility under the plan. The change must correspond with the specific eligibility gain or loss.

Spouse enrollment after you retire

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

Examples of a spouse's **employment-related event** are spouse retirement (and spouse's employer does not offer retiree benefits), loss of job or employer cancellation of benefits. An **employment-related event** is not a spouse's voluntary cancellation of their employee or retiree benefits or termination from this benefit due to late or non-payment. You cannot add your spouse to your retiree coverage if your spouse is not on your plan when you retire unless they experience the loss of spouse coverage as described above. If you are enrolled in the PPO plan, HDP or the PMD/MPD, the spouse surcharge could apply. Refer to page 2 of this guide for more information.

Important deadlines apply

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

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

Qualified events

Change in family status

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

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

Examples of events that do not qualify:

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

Change in employment status

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

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

Retirement

Thinking about retirement?

If you are flipping through this guide because you are thinking about retiring, make sure you review your employer's retiree health plan policies before you retire. Your employer offers retiree health benefits, but retiree health benefits cost more than your active employee coverage. Make an appointment to discuss your retiree benefit options with your Human Resources department at least 60 days before you retire.

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

Countdown to retirement

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

Did you know?

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

Turning age 65 and still working

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

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

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

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

After you retire, Medicare becomes primary for you and your Medicare-eligible spouse. You may be eligible for your employer's retiree plan but only if you are enrolled in both Medicare Part A and Part B.

Helpful tools

pebcinfo.com

Go to **pebcinfo.com** and click the button for your employer group. Select "Retiree" from the top menu. This centralized benefits site offers plan information, forms and links to PEBC vendor sites.

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

myuhc.com

Register for an account on **myuhc.com®** and you'll be able to locate a network provider nearby, estimate costs for care, access your HSA and much more.

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

caremark.com

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

Retirees enrolled in the Medicare Advantage PPO (MPO) or HMO (PMA) plans

- Visit **retiree.uhc.com** to search for a network provider or pharmacy using the online directories. Once you're a member, register on our member website, **retiree.uhc.com**, to get specific plan information and materials, view claims and more. You can also view the plan drug list (Formulary) to see what drugs are covered and if there are any restrictions.
- Visit our virtual education center at **UHCVirtualRetiree.com/pebc** anytime to learn about the benefits and services offered for 2024 from the comfort of your home.

All retirees regardless of age

- 2024 Retiree Health Benefits Enrollment Guide – A quick summary guide that includes features of each plan available to you, contact information and other important information about your plan benefits
- 2024 Retiree Benefits Rate Sheet – Lists retiree contribution rates for each plan
- Important Notices – 2024

Retired public safety officers: The HELPS ACT

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

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

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

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

What is a self-funded health plan?

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

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

Life insurance

Continuing your life insurance

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

Portability

If your coverage terminates, you can continue an amount up to $250,000 of your Optional Term Life insurance (TLF) and the full amount of your Spouse Optional Term Life (SLF) and Dependent Group Life (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 Basic employee Term Life and AD&D (GLF), TLF/SLF and DGL to an individual whole life policy. Whole life costs more than group term life coverage. Contact The Hartford for cost information.

Premium payment information

Payment due date

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

Automatic premium payment program

If you already participate in the automatic bank draft program, **and your payment information is the same for 2024, you do not need to re-enroll.** UnitedHealthcare will automatically deduct the correct 2024 premium amount. If you are not signed up for the automatic premium payment program, consider enrolling soon.

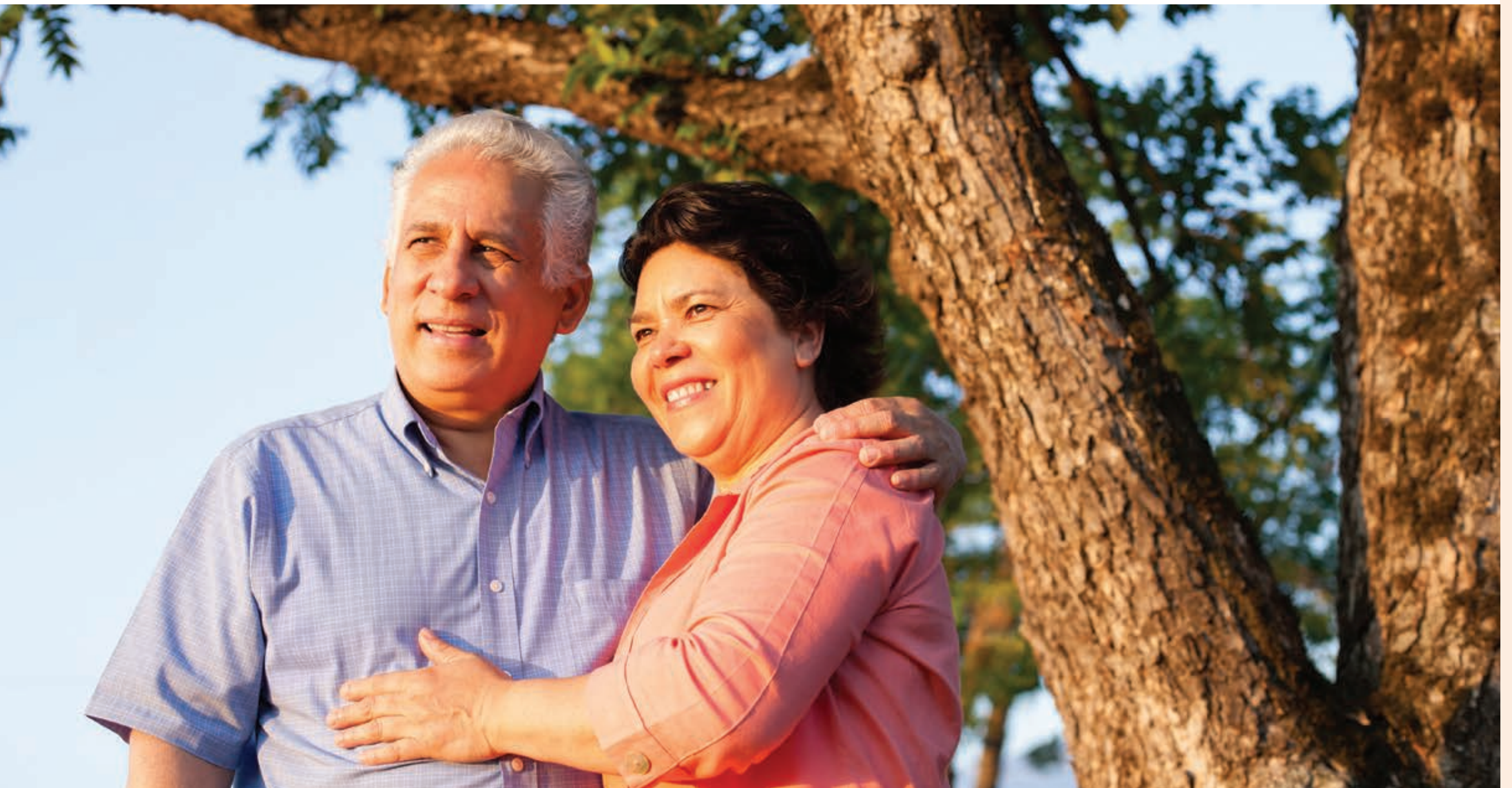
An authorization form is available at **pebcinfo.com** or from your Human Resources department. If you want to start this program with your January 2024 premium, enroll online at **UHCServices.com** or mail the form to UnitedHealthcare. If you change banks or your account number, you must contact UnitedHealthcare immediately. Double-check your premium to make sure it is for the correct 2024 amount.

Where to mail your payment:

UnitedHealthcare Benefit Services
P.O. Box 713082, Cincinnati, OH 45271-3082

Need to contact UnitedHealthcare?

UHCServices.com
Phone: **1-877-237-8576**, TTY **711**
Email: DirectBill_KYOperations@uhc.com
Fax: **1-866-525-1740**



Choosing the non-Medicare medical plan that's right for you

NON-MEDICARE ELIGIBLE

Understanding how much you can expect to pay

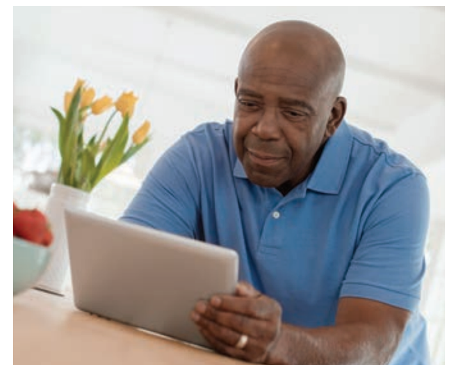
Your out-of-pocket costs and your deductible – the amount you must pay each year before the plan begins to pay – will be different, depending on the plan you choose.

PPO

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

Network deductibles	Out-of-network deductibles
For 2024, your deductible for services in the network is:	The individual out-of-network deductible applies to each enrolled family member and does not have a family deductible limit:
$500 for individual (single) coverage	**$1,000 for each individual (single)**
$1,000 for family coverage*	**Unlimited for family coverage**

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



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

HDP

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

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

- **$1,600 individual (single) deductible**
- **$3,200 family deductible***

*If you cover any family member, **the entire network family deductible must be met before any family member can move to coinsurance.** The HDP network family deductible is met when the combined eligible expenses for you and/or any covered family members reach $3,200. Even if 1 family member reaches the $1,600 deductible, that member cannot move to coinsurance until the full $3,200 family deductible is met.

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.

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.

Questions?
Talk to your Human Resources representative.

Health savings account (HSA)

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

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 an FSA. A big difference is that the HSA has triple-tax benefits:

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

For 2024, you can contribute $4,150 if you have individual coverage or $8,300 if you have family coverage. The IRS also allows catch-up contributions of $1,000 if you are age 55 or older.

Your HSA

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

Important information if you enroll in the HDP with HSA

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

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

- Determining your eligibility to contribute to 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
- Identifying tax implications and reporting distributions to the IRS

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

Why would a retiree consider an HSA?

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

Medicare and the HSA

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

Medicare and out-of-pocket expenses

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

Paying for insurance premiums with HSA funds

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

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

Enrolling in Medicare

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

Qualified medical expenses

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

Your HSA bank account

If you are newly enrolled in the HDP, your employer will automatically notify Optum Financial (affiliated with UnitedHealthcare) to open your HSA. After your account is opened, you will receive a Welcome Kit from Optum Financial. 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.

4 things you need to know about HSAs

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

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

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

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

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

Build your balance

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

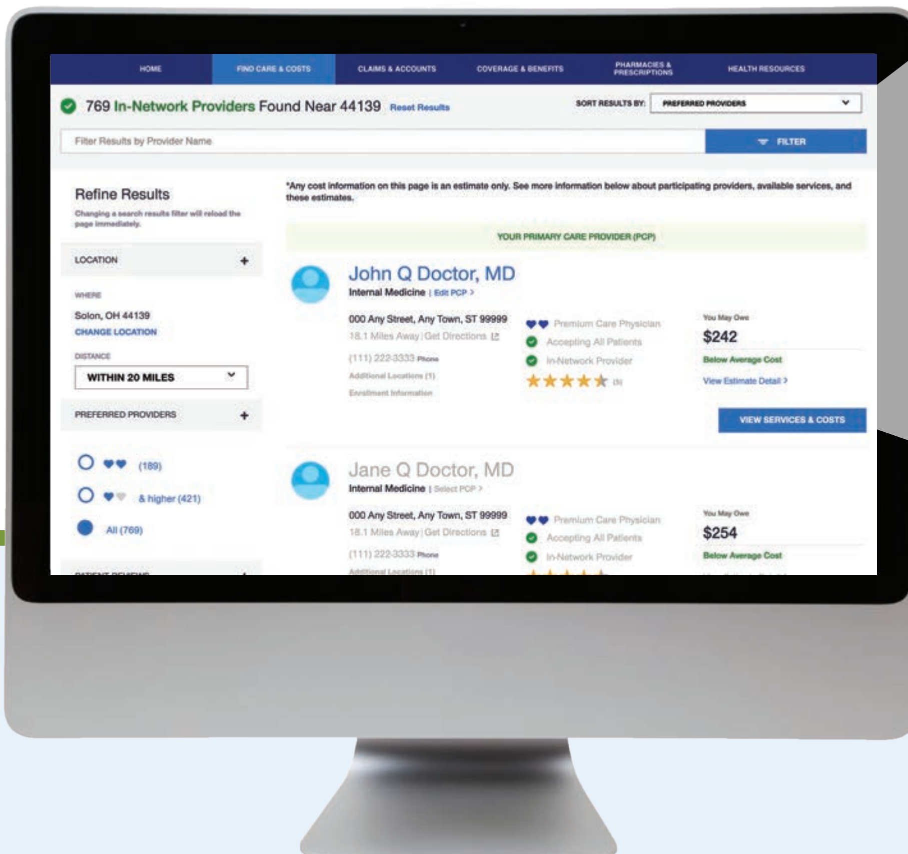
UnitedHealth Premium program

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

Choosing a Premium Care Physician

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

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



To find a Premium Care Physician, look for 2 blue hearts on **myuhc.com.**

Mental health support

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

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

Resource	How it works	How to access
Live and Work Well	Find support for a variety of concerns, including: • Anxiety and stress • Alcohol and drug use • Coping with grief and loss • Marital problems • Eating disorders • Compulsive spending or gambling • Medication management	Visit **liveandworkwell.com** and enter access code: PEBC
Talkspace	Communicate with a licensed therapist via text or live video from your phone or desktop. It's private, confidential and convenient. Five days of unlimited texting via the Talkspace app equals 1 in-person office visit through either your EAP or behavioral health benefit.	Register at **talkspace.com/connect**
Virtual behavioral health visits	Talk to a psychiatrist or therapist without leaving your home. These providers can evaluate and treat general mental health conditions, such as depression and anxiety.	• 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 from a psychiatrist or therapist for: • Depression, stress and anxiety • Substance use and recovery • Eating disorders • Parenting and family concerns	Search for a provider near you on **liveandworkwell.com.**
Self Care by AbleTo®	Get access to self-care techniques, coping tools, meditations, and more – anytime, anywhere. With Self Care, you'll get new, personalized content each week that's designed to help you boost your mood and shift your perspectives. Tap into clinician-created tools – all here to help support your self-guided journey to better mental health.*	Get to know Self Care at **ableto.com/begin.**
Substance Use Treatment Helpline	Speak with a substance use recovery advocate who will listen, provide support and develop personalized recovery plans. The helpline is available 24/7 as part of your benefits and is completely confidential – you can even choose to remain anonymous.	Call **1-855-780-5955** or visit **liveandworkwell.com/recovery** to find care options and resources.

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

*The AbleTo mobile application should not be used for urgent care needs. If you are experiencing a crisis or need emergency care, call 911 or go to the nearest emergency room. The Self Care information contained in the AbleTo mobile application is for educational purposes only; it is not intended to diagnose problems or provide treatment and should not be used on its own as a substitute for care from a provider. AbleTo Self Care is available to all members ages 13+ at no additional cost. Self Care is not available for all groups in District of Columbia, Maryland, New York, Pennsylvania, Virginia or West Virginia and is subject to change. Refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card. Participation in the program is voluntary and subject to the terms of use contained in the mobile application.

Real Appeal

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

Receive up to a year of support

A Transformation Coach will lead online group sessions with simple steps on nutrition, exercise and information on 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.

Tools for success

You'll get tools and resources like weight and food scales, food guides and more.

Real benefits

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

Get started

Register today at **enroll.realappeal.com.**

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

[1] 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); and 3. Improving clinical markers for individuals who already have type 2 diabetes (Espeland MA, Glick HA, Bertoni A, et al., for the Look AHEAD Research Group, 2014). Talk to your doctor before starting any weight-loss program.

Preventive care

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

Preventive care vs. diagnostic care

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

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

Preventive services covered at no extra cost

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

Contraception, prenatal and breastfeeding

The plan covers, at no additional cost to you, at least 1 form of contraception in each of the 18 methods identified and approved by the FDA, including necessary clinical services, patient education and counseling. Certain prenatal and breastfeeding supplies and services are also covered. To view a summary of covered preventive services, visit **pebcinfo.com.**

Flu shots and vaccines

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

CVS/Caremark retail pharmacy vaccines

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

CVS Caremark National Network retail pharmacies:

- Albertsons
- Brookshire
- Costco®
- CVS
- H-E-B
- Kroger
- Minyard
- RiteCare®
- Tom Thumb
- Walmart®/Sam's Club®

Covered vaccines include:

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

*Additional cost may apply.

UnitedHealthcare retail pharmacy vaccines

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

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

Convenience care clinics

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

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

PPO plan quick-reference guide

Refer to plan documents for limitations and additional information.

PPO – medical plan

Feature	Your network cost	Your out-of-network cost **PLUS** you pay charges exceeding plan payment
Annual deductible	$500 individual/$1,000 family	$1,000 each person
Coinsurance (after the annual deductible is met)	20% after deductible	40% after deductible
Annual coinsurance maximum	$2,500 individual/$5,000 family	No limit
Annual out-of-pocket maximum (OOP)	$3,000 individual/$6,000 family Plan pays 100% after annual OOP	No limit
Physician services		
Office visits	$25 primary care physician (PCP) $25 Premium Care Specialist $35 non-Premium Care Specialist	40% after deductible
24/7 Virtual Visits	$0 copay	40% after deductible
Telehealth	$25 PCP/$25 Premium Care Specialist $35 non-Premium Care Specialist	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visit	$35 copay	40% after deductible
Preventive care*		
Well-child care	Covered at 100%	40% after deductible
Well-woman exam	Covered at 100%	40% after deductible
Routine screening mammography	Covered at 100%	40% after deductible
Adult health assessments	Covered at 100%	40% after deductible
Immunizations	Covered at 100%	40% after deductible
Screening colonoscopy	Covered at 100%	40% after deductible
Maternity services		
Routine prenatal care	Covered at 100%	40% after deductible
Delivery in hospital	20% after deductible	40% after deductible
Newborn care in hospital (routine)	20% after deductible	40% after deductible

*Subject to Affordable Care Act requirements.

HDP quick-reference guide

Refer to plan documents for limitations and additional information.

HDP – medical plan

Feature	Your network cost	Your out-of-network cost **PLUS** you pay charges exceeding plan payment
Annual deductible (the entire family deductible must be met before benefits pay – unless you selected employee only)	$1,600 individual/$3,200 family	$3,000 individual/$6,000 family
Coinsurance (after the annual deductible is met)	20% after deductible	40% after deductible
Annual coinsurance maximum	$1,400 individual/$2,800 family	No limit
Annual out-of-pocket maximum (OOP)	$3,000 individual/$6,000 family Plan pays 100% after annual OOP	No limit
Physician services		
Office visits	20% after deductible	40% after deductible
24/7 Virtual Visits	20% after deductible	40% after deductible
Telehealth	20% after deductible	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visits	20% after deductible	40% after deductible
Preventive care*		
Well-child care	Covered at 100%	40% after deductible
Well-woman exam	Covered at 100%	40% after deductible
Routine screening mammography	Covered at 100%	40% after deductible
Adult health assessments	Covered at 100%	40% after deductible
Immunizations	Covered at 100%	40% after deductible
Screening colonoscopy	Covered at 100%	40% after deductible
Maternity services		
Routine prenatal care	Covered at 100%	40% after deductible
Delivery in hospital	20% after deductible	40% after deductible
Newborn care in hospital (routine)	20% after deductible	40% after deductible

*Subject to Affordable Care Act requirements.

PPO – medical plan (continued)

Feature	Your network cost	Your out-of-network cost **PLUS** you pay charges exceeding plan payment
Infertility services: 5 artificial insemination visits (lifetime)	20% after deductible (excludes in vitro and drug coverage)	40% after deductible (excludes in vitro and drug coverage)
Additional services		
Inpatient hospital	20% after deductible	40% after deductible
Outpatient surgery	20% after deductible	40% after deductible
Lab & X-ray outpatient (minor)	Covered at 100% in physician office or network lab or radiological provider	40% after deductible
Hospital emergency care services (treated as network)	$300 copay + 20% after deductible; copay waived if admitted	$300 copay + 20% after deductible; copay waived if admitted
Skilled nursing facility	20% after deductible; up to 60 days annually*	40% after deductible; up to 60 days annually*
Home health care	20% after deductible; up to 120 visits annually*	40% after deductible; up to 120 visits annually*
Allergy care services	$25 PCP/$25 Premium Care Specialist $35 non-Premium Care Specialist	40% after deductible
Chiropractic	$35 copay per visit; maximum 20 visits per year*	40% after deductible; maximum 20 visits per year*
Medical supply & equipment (DME)	20% after deductible	40% after deductible
Mental health services		
Outpatient visits	$25 visit	40% after deductible
Inpatient	20% after deductible	40% after deductible
Serious mental illness	Treated like any other illness	Treated like any other illness
Substance abuse	Treated like any other illness	Treated like any other illness

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

HDP – medical plan (continued)

Feature	Your network cost	Your out-of-network cost **PLUS** you pay charges exceeding plan payment
Infertility services: 5 artificial insemination visits (lifetime)	20% after deductible (excludes in vitro and drug coverage)	40% after deductible (excludes in vitro and drug coverage)
Additional services		
Inpatient hospital	20% after deductible	40% after deductible
Outpatient surgery	20% after deductible	40% after deductible
Lab & X-ray outpatient (minor)	20% after deductible	40% after deductible
Hospital emergency care services (treated as network)	20% after deductible	20% after deductible
Skilled nursing facility	20% after deductible; up to 60 days annually*	40% after deductible; up to 60 days annually*
Home health care	20% after deductible; up to 120 visits annually*	40% after deductible; up to 120 visits annually*
Allergy care services	20% after deductible	40% after deductible
Chiropractic	20% after deductible; maximum 20 visits per year*	40% after deductible; maximum 20 visits per year*
Medical supply & equipment (DME)	20% after deductible	40% after deductible
Mental health services		
Outpatient visits	20% after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible
Serious mental illness	Treated like any other illness	Treated like any other illness
Substance abuse	Treated like any other illness	Treated like any other illness

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

Saving on prescription medications

NON-MEDICARE ELIGIBLE

CVS/Caremark

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

CVS Health's Standard Control Formulary

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

Out-of-pocket costs

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

Register at **caremark.com**

Manage your prescriptions online with tools available at **caremark.com.**

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

Generic medications

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

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

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

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

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

CVS Specialty pharmacy

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

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

Specialty medication

Unless your drug is needed on an emergency basis, all specialty drugs must be filled through CVS Specialty or you pay 100% of the cost without credit to your annual out-of-pocket limit. Many specialty drugs have a copay assistance program that reduces your copay or out-of-pocket cost. If you are enrolled in a copay assistance program, let your pharmacy know at the time you fill the prescription.

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

Pharmacy access options Refills allowed as prescribed	PPO plan	HDP
CVS Caremark National Network Pharmacy (network) up to a 30-day supply	**$15** generic **$30** preferred brand **$60** non-preferred brand	• For retail and home delivery pharmacy, you will pay 100% of the CVS/Caremark/CVS Specialty cost until you meet your deductible • After deductible, you pay 20% of the cost until the network OOP is met • After network OOP, plan pays 100%
CVS Caremark Mail Order Pharmacy up to a 90-day supply or CVS Caremark Retail-90 Network Pharmacies	**$30** generic **$60** preferred brand **$120** non-preferred brand	
CVS Specialty Pharmacy up to a 30-day supply	**$10** generic **$20** preferred brand **$40** non-preferred brand	

No-additional-cost contraceptives (prescription required)

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

The outpatient pharmacy benefit covers the following methods:

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

90-day prescriptions

Get up to a 90-day supply of your medicine for the prescriptions you take regularly. If you are enrolled in the PPO plan, the copay will mirror the home delivery copay. Home delivery allows you to get a 3-month supply for the price of 2 copays. Specialty drugs are shipped in a 30-day supply. You will pay one-third of 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 1 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 the CVS Caremark Mail Order Pharmacy at **1-855-335-7698.**

Preventive statin drugs

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

Included:	High-intensity doses that are not included:
• Atorvastatin: 10–20 mg • Fluvastatin IR: 20–40 mg • Fluvastatin XL: 80 mg • Lovastatin: 10–40 mg • Pravastatin: 10–80 mg • Simvastatin: 5–40 mg • Rosuvastatin: 5–10 mg	• 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 2024 Excluded Drug list at **pebcinfo.com.**

Enhancing well-being with vision and dental benefits

ALL RETIREES

Vision benefits

Vision benefits are available through VSP. It's easy to find a nearby network doctor. Get the most from your coverage with bonus offers and savings that are exclusive to Premier Program locations — including thousands of private practice doctors and over 700 Visionworks retail locations nationwide. Create an account on **vsp.com** to learn more about your vision benefits and find an eye doctor near you.

To learn more about your vision benefits and find an eye doctor near you, create an account at **vsp.com.**

Note that the UnitedHealthcare Medicare Advantage PPO (MPO) and HMO (PMA) plans include Medicare-covered and routine vision benefits. See the Summary of Benefits on pages 39–44 or refer to the plan documents for additional details.

Exclusions and limitations

Some brands of spectacle frames may be unavailable for purchase as plan benefits, or may be subject to additional limitations. Covered persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at **1-800-877-7195.**

NOT COVERED

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

VSP Advantage Plan

	High option		Low option for Denton County only	
	Network	Non-network reimbursement	Network	Non-network reimbursement
Vision exam	$10	Up to $43	$10	Up to $43
Eyeglass lenses				
Single vision	$20	Up to $30	$25	Up to $30
Bifocal	$20	Up to $45	$25	Up to $45
Trifocal	$20	Up to $62	$25	Up to $62
Lenticular	$20	Up to $100	$25	Up to $100
Standard progressive lenses	$20	Up to $45	$25	Up to $45
Frames*	$200 allowance; 20% off balance over $200 $250 at Visionworks	Up to $40	$150 allowance; 20% off balance over $150 $200 at Visionworks	Up to $40
Contact lenses**	Frames and contacts BOTH available in same plan year in lieu of eyeglass lenses (12/12/12 frequency)		Contacts in lieu of glasses (12/12/24 frequency)	
Non-elective	Covered at 100%	Up to $210	Covered at 100%	Up to $210
Elective	$200 allowance; not to exceed $40 copay for contact lens exam	Up to $185	$150 allowance; not to exceed $40 copay for contact lens exam	Up to $135
Service frequency				
Exams	12 months	12 months	12 months	12 months
Prescription lenses	12 months	12 months	12 months	12 months
Frames	12 months	12 months	24 months	24 months
Contact lenses	12 months	12 months	12 months	12 months
Laser care	Average 15% off the regular price or 5% off the promotional price		Average 15% off the regular price or 5% off the promotional price	

*NOT in lieu of contacts on 12/12/12 High option; ARE in lieu of contacts on 12/12/24 Low option.
**In lieu of only eyeglass lenses on 12/12/12 High option; frames and contacts available; Low option alternative 12/12/24 – contacts are in lieu of glasses.

See which network is right for you:

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

Dental benefits

For 2024, you can choose between the DeltaCare USA (DHMO) and the Delta Dental PPO plans.

Delta Dental HMO Plan (DeltaCare USA DHMO)

The DHMO Plan offers a wide range of dental benefits through a network of participating dentists. Your DeltaCare USA plan is a copayment plan. With your DeltaCare USA DHMO plan, some preventive services are covered at 100%. Your plan also covers many other dental services at a set copay. The DHMO plan is available in AL, MO, OK, OR, TN, TX and WI. **There are no annual maximums and no deductibles.**

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

When you enroll in DeltaCare USA DHMO:

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

Delta Dental PPO Plan (Delta Dental DPPO)

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

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

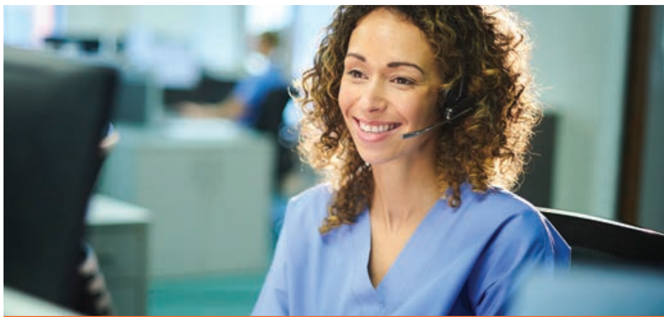
Procedure	Network	Out-of-network
Deductible (per person)	$50 (maximum of $150)	$50 (maximum of $150)
Annual maximum benefit (per person)*	$2,000	$2,000
Preventive • 2 cleanings per calendar year • 2 exams per calendar year • 2 fluoride treatments per calendar year for dependent children under age 19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

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

Getting the right care at the right time

Your care options

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

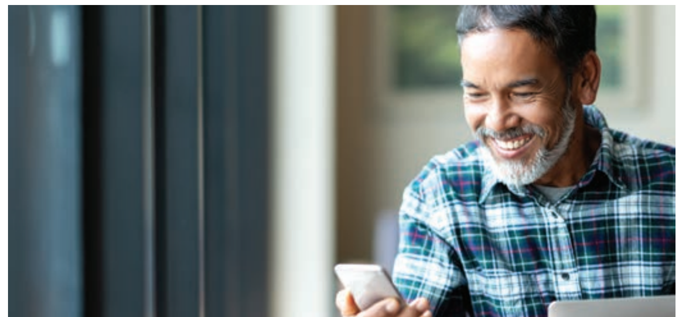


NurseLine

Call NurseLine to connect with registered nurses 24/7 at no additional cost.

- Non-Medicare eligible: **1-877-370-2849**
- Medicare Advantage PPO (MPO) and HMO (PMA): **1-877-365-7949**

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



When to use 24/7 Virtual Visits

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

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

Care option	When to use it
24/7 Virtual Visits	See and talk to a doctor via your smartphone, tablet or computer for non-emergency medical conditions. To start a 24/7 Virtual Visit, register or sign in at **myuhc.com/ virtualvisits** or download the UnitedHealthcare app.
Virtual primary care	A primary care provider (PCP) is the doctor who knows you best, the one you turn to for everything from routine checkups to help with chronic or complex health conditions. Establish an online PCP relationship with appointments via **myuhc.com** or the UnitedHealthcare app. You can see the same virtual PCP for preventive care, follow-up visits, or checkups for ongoing conditions.
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. For telehealth with your own doctors, check their telehealth options when scheduling an appointment. You will use their telehealth system.
Convenience care clinic	Clinics like MinuteClinic or Baylor Scott & White are located inside retail stores. If you can't get to the doctor's office and the need is not urgent, this is a great option for minor health conditions.
Telehealth	See and talk to your PCP, specialist or some therapy providers via your smartphone, tablet or computer using your provider's telehealth system.
Urgent care center	Centers such as PrimaCare offer treatment for non-life-threatening injuries or illnesses, including sprains, minor infections and minor burns.
Emergency room (ER)	If you need immediate treatment for a life-threatening or critical condition, go to the nearest ER (network benefits apply). Do not ignore an emergency – call 911 if the situation is life threatening.
Freestanding emergency room	A freestanding ER is not to be confused with an urgent care center or convenience care clinic. It is for immediate treatment for a life-threatening or critical condition just like a regular ER.

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

Emergencies outside the U.S.

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

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

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

Medicare Advantage PPO (MPO) and HMO (PMA) members have emergency and urgent care coverage when outside the United States. Simply pay for your care out of pocket and, when you return home, submit a direct member reimbursement form with receipts for care to UnitedHealthcare for reimbursement, less applicable copays.

Choosing the Medicare plan that's right for you

MEDICARE ELIGIBLE

2024 medical and prescription drug plans

The PEBC offers 2 different Group Medicare Advantage plans: PPO (MPO) and HMO (PMA).

UnitedHealthcare Group Medicare Advantage PPO (MPO) plan

How it works

Here are some highlights about this plan. Refer to the plan documents for additional details.

- This is a national plan covering all eligible beneficiaries regardless of where they reside in the U.S., D.C. and 5 U.S. territories
- You can visit doctors, specialists and hospitals in or out of the UnitedHealthcare network for the same cost share as long as the provider participates in Medicare and accepts the plan
- Referrals are not required to see a specialist
- Part D prescription drug coverage is included
- Routine vision, hearing, podiatry and many other benefits are included

See the Summary of Benefits on pages 39–44 or refer to the plan documents for additional details.

Are you eligible?

- Retirees and eligible spouses, ages 65 or older, and enrolled in Medicare Part A and Part B
- Those under 65 who qualify for Medicare due to disability or other special circumstances
- You must reside in the United States, District of Columbia or U.S. territories
- If you are enrolling for the first time, you must complete a Retiree Health Benefit Enrollment form no more than 60 days before your retiree health benefits become effective
- If you are already enrolled in this group plan, you do not need to take any action

UnitedHealthcare Group Medicare Advantage HMO (PMA) plan

How it works

Here are some highlights about this plan. Refer to the plan documents for additional details.

- You must reside in the 1 of the Texas counties listed at right to be eligible for this plan
- You are required to select a primary care provider (PCP) to coordinate your care
- You must utilize providers participating in the UnitedHealthcare Group Medicare Advantage HMO (PMA) network to receive covered services. Go to **retiree.uhc.com** to find a participating provider.
- Referrals are required to see a specialist
- Part D prescription drug coverage is included
- Routine vision, hearing, podiatry and many other benefits are included

See the Summary of Benefits on pages 39–44 or refer to the plan documents for additional details.

Are you eligible?

- Retirees and eligible spouses, ages 65 or older, and enrolled in Medicare Part A and Part B
- Those under 65 who qualify for Medicare due to disability or other special circumstances
- You must reside in 1 of these Texas counties: Angelina, Aransas, Atascosa, Bandera, Bee, Bexar, Collin, Comal, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Gregg, Guadalupe, Henderson, Hood, Houston, Hunt, Jim Wells, Johnson, Kaufman, Kendall, Kerr, Kleberg, Medina, Nacogdoches, Navarro, Nueces, Panola, Parker, Polk, Rockwall, Rusk, San Augustine, San Jacinto, San Patricio, Shelby, Smith, Tarrant, Trinity, Tyler, Van Zandt, Victoria, Walker, Wilson and Wise
- If you are enrolling for the first time, you must complete a Retiree Health Benefit Enrollment form and UnitedHealthcare Group Medicare Advantage HMO (PMA) Enrollment Request form (included in your enrollment packet) prior to your coverage becoming effective. If you are already enrolled in this group plan, you do not need to complete another Group Medicare Advantage Enrollment Request form.

Prescription drug benefits

Retirees age 65 and older

PEBC's UnitedHealthcare Group Medicare Advantage PPO (MPO) and Medicare Advantage HMO (PMA) plans include prescription drug benefits. During annual enrollment, if you are changing from the PPO plan or HDP to 1 of the PEBC Medicare Advantage plans and you use a mail order pharmacy, make sure you have a supply of medication on hand to carry you through the month of January. If you use home delivery, mail a new prescription to Optum Rx® – even if your current CVS prescription is not expired.

UnitedHealthcare Group Medicare Advantage plans

When you enroll in the UnitedHealthcare Medicare Advantage PPO (MPO) and Medicare Advantage HMO (PMA) plans, you are automatically enrolled in a Medicare-approved Part D prescription drug benefit offered through UnitedHealthcare.

No coverage gap or deductible

The PEBC group Medicare Advantage PPO (MPO) and Medicare Advantage HMO (PMA) plans include Part D coverage, but it may not be the same Part D plan offered elsewhere. Your prescription drug benefits are not subject to the coverage gap or deductible. In 2024, your standard copay remains in place until you pay $8,000 in total drug costs. After that, your copay will be $0 for the remainder of the calendar year. These amounts are subject to change based on federal Part D requirements.

Spouse and dependent coverage

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

About diabetic test strips

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

Glucose meters: OneTouch Verio Flex, OneTouch Verio Reflect, Accu-Chek Guide Me, Accu-Chek Guide

Test strips: OneTouch Verio, OneTouch Ultra, Accu-Chek Guide, Accu-Chek Aviva Plus, Accu-Chek SmartView

Summary of Benefits Public Employee Benefits Cooperative (PEBC)

Effective: Jan. 1, 2024, through Dec. 31, 2024

Overview of your plans		UnitedHealthcare Group Medicare Advantage PPO (MPO)	UnitedHealthcare Group Medicare Advantage HMO (PMA)
Monthly plan premium		Contact your group plan benefit administrator to determine your actual premium amount, if applicable	
Plan eligibility	**General requirements**	You must be entitled to Medicare Part A, be enrolled in Medicare Part B, be a United States citizen or lawfully present in the United States, and meet the eligibility requirements of your former employer, union group or trust administrator.	
	Area of residence	Includes the 50 United States, the District of Columbia and all U.S. territories	You must reside in these counties in Texas: Angelina, Aransas, Atascosa, Bandera, Bee, Bexar, Collin, Comal, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Gregg, Guadalupe, Henderson, Hood, Houston, Hunt, Jim Wells, Johnson, Kaufman, Kendall, Kerr, Kleberg, Medina, Nacogdoches, Navarro, Nueces, Panola, Parker, Polk, Rockwall, Rusk, San Augustine, San Jacinto, San Patricio, Shelby, Smith, Tarrant, Trinity, Tyler, Van Zandt, Victoria, Walker, Wilson and Wise
	Network	You can see any provider (network or out of network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded or precluded from the Medicare Program. You are not required to select a primary care provider (PCP) from the network.	You must use network providers. This health plan requires you to select a primary care provider (PCP) from the network. If you need to see a network specialist or other network provider, you may need to get a referral from your PCP.

Summary of Benefits Public Employee Benefits Cooperative (PEBC) (continued)

Overview of your plans		UnitedHealthcare Group Medicare Advantage PPO (MPO)	UnitedHealthcare Group Medicare Advantage HMO (PMA)
Benefits and coverage		**Network and out of network**	**Network only**
Annual medical deductible		None	None
Annual medical out-of-pocket maximum (does not include prescription drugs)		None	$6,700
Inpatient hospital stay*	Per admission. Covers an unlimited number of days for an inpatient hospital stay.	$0	$250
Outpatient hospital*	Ambulatory Surgical Center (ASC)	$0	$125
	Outpatient surgery	$0	$125
	Outpatient hospital services, including observation	$0	$125
Doctor visits	PCP office visit (includes non-MD office visits)	$0	$20
Preventive care (Medicare-covered)	Specialist office visit*	$0	$40
	Cardiovascular screenings	$0	$0
	Immunizations (flu, pneumococcal, hepatitis B vaccines)	$0	$0
	Pap smears and pelvic exams	$0	$0
	Prostate cancer screening	$0	$0
	Colorectal cancer screenings	$0	$0
	Bone mass measurement (bone density)	$0	$0
	Mammography	$0	$0
	Diabetes – self-management training	$0	$0
	Medical nutrition therapy and counseling	$0	$0
	Annual wellness exam and 1-time welcome-to-Medicare exam	$0	$0

*Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan-covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.

Overview of your plans		UnitedHealthcare Group Medicare Advantage PPO (MPO)	UnitedHealthcare Group Medicare Advantage HMO (PMA)
Benefits and coverage		**Network and out of network**	**Network only**
Preventive care (Medicare-covered)	Smoking cessation visit	$0	$0
	Abdominal Aortic Aneurysm (AAA) screenings	$0	$0
	Diabetes screening	$0	$0
	HIV screening	$0	$0
	Screening and behavioral counseling interventions in primary care to reduce alcohol misuse	$0	$0
	Screening for depression in adults	$0	$0
	Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling to prevent STIs (Medicare-covered)	$0	$0
	Intensive behavioral therapy to reduce cardiovascular disease risk (Medicare-covered)	$0	$0
	Screening and counseling for obesity	$0	$0
	Glaucoma screening	$0	$0
	Kidney disease education	$0	$0
	Dialysis training	$0	$0
	Hepatitis C screening	$0	$0
	Lung cancer screening	$0	$0
	Routine physical	$0, 1 per plan year	$0, 1 per plan year
Emergency room (includes worldwide coverage)	If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the emergency copay	$0	$50

Summary of Benefits Public Employee Benefits Cooperative (PEBC) (continued)

Overview of your plans		UnitedHealthcare Group Medicare Advantage PPO (MPO)	UnitedHealthcare Group Medicare Advantage HMO (PMA)
Benefits and coverage		**Network and out of network**	**Network only**
Urgent care (includes worldwide coverage)	If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the urgently needed services copay	$0	$20
Diagnostic tests, lab and radiology services, and X-rays	Diagnostic radiology services (e.g., MRI)*	$0	$0
	Lab services*	$0	$0
	Diagnostic tests and procedures*	$0	$0
	Therapeutic radiology*	$0	$0
	Outpatient X-rays*	$0	$0
Hearing services	Exam to diagnose and treat hearing and balance issues*	$0	$40
	Routine hearing exam (1 exam every 12 months)	$0	$0
	Hearing aid allowance	$500	$500
	Hearing aid period in years	3	3
Vision services	Exam to diagnose and treat diseases and conditions of the eye*	$0	$40
	Eyewear after cataract surgery	$0	$0
	Routine eye exam (1 exam every 12 months)	$0	$40

*Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan-covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.

Overview of your plans		UnitedHealthcare Group Medicare Advantage PPO (MPO)	UnitedHealthcare Group Medicare Advantage HMO (PMA)
Benefits and coverage		**Network and out of network**	**Network only**
Mental health	Inpatient Visit, up to 190 days*	$0	$250 copay per stay
	Outpatient Group Therapy Visit*	$0	$40
	Outpatient Individual Therapy Visit*	$0	$40
Skilled Nursing Facility (SNF)*		$0	$0 days 1–20; $50 days 21–100
Physical therapy and speech and language therapy visit*		$0	$40
Ambulance services**		$0	$50
Meal delivery program	Includes post-discharge meal delivery of 2 meals per day for a 2-week period immediately following all inpatient or skilled nursing facility discharges when referred by a UnitedHealthcare Advocate	Included	Included
Post-discharge routine transportation	Includes 12 rides to and from medically related appointments and pharmacies up to 30 days following inpatient or skilled nursing facility discharges	Included	Included
In-home personal care	Includes up to 6 hours of personal care post-discharge, provided by a CareLinx® professional caregiver; this may include grocery shopping, meal preparation, light housekeeping, personal care, medication reminders and more	Included	Included
Medicare Part B drugs	Chemotherapy drugs*	$0	$0
	Other Part B drugs*	$0	$0
Chiropractic visit	Manual manipulation of the spine to correct subluxation*	$0	50%
Podiatry visit	Foot exams and treatment*	$0	$40

*Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan-covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.

**Authorization is required for non-emergency, Medicare-covered ambulance ground and air transportation. Emergency ambulance does not require authorization.

Summary of Benefits Public Employee Benefits Cooperative (PEBC) (continued)

Overview of your plans	UnitedHealthcare Group Medicare Advantage PPO (MPO)	UnitedHealthcare Group Medicare Advantage HMO (PMA)
Benefits and coverage	**Network and out of network**	**Network only**
Outpatient prescription drug coverage		
Stage 1: Annual prescription deductible	Since you have no deductible, this payment stage doesn't apply	
Stage 2: Initial coverage	Part D Retail Copay (up to 30-day supply)	
Tier 1: Preferred Generic (most generic drugs)	$10	$10
Tier 2: Preferred Brand (many common brand-name drugs, called preferred brands, and some higher-cost generic drugs)	$20	$20
Tier 3: Non-Preferred Brand (non-preferred generic and non-preferred brand-name drugs)	$35	$40
Tier 4: Specialty Tier (unique and/or very-high-cost drugs)	$35	$40
Stage 2: Initial coverage	Part D Preferred Mail-Order Copay (up to a 90-day supply)	
Tier 1: Preferred Generic (most generic drugs)	$20	$20
Tier 2: Preferred Brand (many common brand-name drugs, called preferred brands, and some higher-cost generic drugs)	$40	$40
Tier 3: Non-Preferred Brand (non-preferred generic and non-preferred brand-name drugs)	$70	$80
Tier 4: Specialty Tier (unique and/or very-high-cost drugs)	$70	$80
Stage 3: Coverage gap stage	After your total drug costs reach $5,030, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost	
Stage 4: Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay $0 for the remainder of the calendar year.	
Evidence of Coverage (EOC)	The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. The EOC provides a complete list of services we cover. You can see it online at **retiree.uhc.com** or you can call Customer Service for help. When you enroll in the plan, you will get information that tells you where you can go online to view your EOC.	
UnitedHealthcare Customer Service (Medicare-eligible retirees)	Toll-free **1-866-519-3813**, TTY **711**, 8 a.m. – 8 p.m. local time, 7 days a week	

Additional benefits included with the Group Medicare Advantage PPO (MPO) and HMO (PMA) plans, not covered by Medicare

Fitness program

Renew Active® is the gold standard in Medicare fitness programs for body and mind. And it's available with your Medicare Advantage PPO (MPO) and Medicare Advantage HMO (PMA) plan at no additional cost.

Stay fit

Work out where you want, whether that's at a gym or fitness location or from your home.

- A free gym membership
- Access to our extensive, nationwide network of gyms and fitness locations. It's the largest of all Medicare fitness programs[1]
- A personalized fitness plan
- Allows you to bring your caregiver to the gym with you at no additional cost
- Access to thousands of workout videos with Fitbit Premium™ – no Fitbit® device is needed

Stay focused

An online brain health program from AARP® Staying Sharp® with exclusive content for Renew Active members.

- Online brain health assessment
- Brain health content and tools
- The Brain Health Staycation and Find Your Calm guides

Stay connected

Connect with other health-minded members.

- Social activities at local health and wellness classes and events
- Step challenges with other members through the Fitbit Community for Renew Active – no Fitbit device is needed.

Participating locations

Stay active with a free gym membership at a gym or fitness location you select from our extensive, nationwide network. It's the largest of all Medicare fitness programs and includes many premium gyms and fitness locations.[1]

To find your closest location, visit **UHCRenewActive.com** or call Customer Service at the number on your health plan ID card.

Members can request to have a new gym added to our extensive network of partnering gyms and fitness locations by nominating facilities on the Renew Active website or by calling the Customer Service number found on their health plan ID card.

Your code is key

Every Renew Active member has a unique confirmation code to access your gym membership, create an account on AARP® Staying Sharp®, join the Fitbit Community for Renew Active and gain access to Fitbit Premium. How to find your unique Renew Active confirmation code:

1. Sign in to your plan website at **retiree.uhc.com.**
2. Click "Health & Wellness" in the upper-right-hand corner.
3. Look for Renew Active on the right side of the page.
4. Your Renew Active Confirmation Code will start with a letter, followed by 9 digits. You will see it at the bottom of the screen.
5. If you are unable to log in to your plan website or if you have any questions, please call Customer Service at the number on your health plan ID card.

[1]Renew Active gym and fitness location network size, based on internal market research conducted June 2020. The largest gym network of all Medicare fitness programs is based upon comparison of competitors' website data as of September 2020.

UnitedHealthcare Healthy at Home

We are excited to introduce UnitedHealthcare Healthy at Home, a new program that is now included in your benefits at no additional cost, designed to help retirees safely transition back home after being discharged from a hospital or skilled nursing facility.

Designed to help members transition back home after an inpatient admission or a convalescent stay, this new, unique post-discharge support program delivers needed support, care and measurable results to the members we serve. Our market-leading program, UnitedHealthcare® Healthy at Home, provides a combination of meal delivery, transportation and in-home personal care benefits to members in an easy-to-use, comprehensive program:

- Our post-discharge meal delivery benefit administered through Mom's Meals® includes 2 meals per day for 2 weeks for members following all inpatient or skilled nursing facility discharges when referred by a UnitedHealthcare advocate.
- Our post-discharge transportation benefit includes 12 rides to and from medically related appointments and pharmacies for our members up to 30 days following inpatient or skilled nursing facility discharges.
- Our in-home personal care benefit administered through our national partner CareLinx and offered exclusively to UnitedHealthcare Group Medicare Advantage members includes up to 6 hours of personal care post-discharge, provided by a CareLinx professional caregiver. This may include grocery shopping, meal preparation, light housekeeping, personal care, medication reminders and more. CareLinx is our national vendor providing a network of over 300,000 background-checked professional caregivers.

Hearing aids

As part of your health plan, you have a $500 allowance every 3 years to use toward the maintenance and purchase of hearing aids through UnitedHealthcare Hearing. With a large selection of private-labeled and name-brand hearing aids and convenient home delivery or in-person care options, you can choose what works best for your hearing loss needs. Call **1-855-523-9355**, TTY **711**, or visit **UHCHearing.com/retiree** to learn more.

Voluntary programs for people with chronic or complex health needs

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

Health and wellness experience

Renew by UnitedHealthcare® can be your guide to living a healthier, happier life. Renew, our members-only health and wellness experience, includes inspiring lifestyle tips, coloring pages, a recipe library, streaming music, interactive quizzes and tools, learning courses, health news, articles and videos, a health topic library and rewards.

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

UnitedHealthcare® HouseCalls

Enjoy a preventive care visit in the privacy of your own home.

With the HouseCalls program, you can get an annual in-home preventive care visit from 1 of our health care practitioners at no extra cost. A HouseCalls visit is designed to support but not take the place of your regular doctor's care. What to expect from a HouseCalls visit:

- A knowledgeable health care practitioner will review your health history and current medications, perform health screenings, help identify health risks and provide health education
- You can talk about health concerns and ask questions you haven't had time to ask before
- HouseCalls will send a summary of the visit to you and your primary care provider so you have this additional information regarding your health
- You may even be eligible for a reward when you complete a HouseCalls visit

Tools to help you manage the details

Managing your medical claims

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

Medical claims

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

Payment resources

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

Account balances

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

Prescription drug claims

Manage your prescription drug claims at **caremark.com.** You can order prescriptions and check the status of your order. If you select Rx History Claims and Balances, you can view and print a prescription drug claims history by date range. The information and cost (by date range) is excellent to document your HSA spending. Visit **caremark.com** to check specific costs for drugs covered by your plan. You can see specialty drug information here as well.

Coordination of benefits non-duplicating plan

If you or your enrolled dependents are covered by more than 1 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, 1 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** or **retiree.uhc.com.**

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

Subrogation requirements

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

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

ID card information

Medical plans

If you are a non-Medicare-eligible or a Medicare-eligible retiree, you will get a new medical ID card whether or not you changed plans during open enrollment. You should receive your new ID card in late December 2023. Plan to use your new ID card starting in January, as it will have new group numbers and claims addresses. You can also print a temporary ID card, if needed, on UnitedHealthcare's website.

Dental plans

DeltaCare USA DHMO and Delta Dental PPO – you will not receive a new ID card unless you are new to the plan and/or changed plans for 2024. Members with an existing card who are not changing plans can continue to use their existing ID card. If you need a new card, you can contact customer service and request one or log in to your online account and download an electronic version.

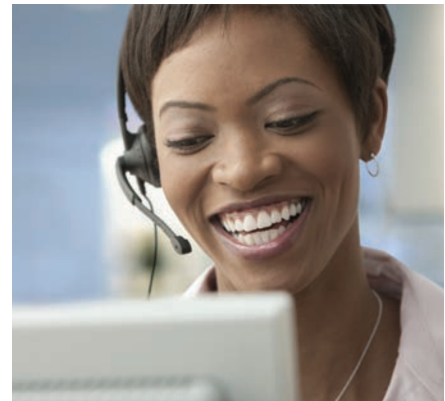
For new DeltaCare members, your assigned provider will be listed on your welcome letter.

Vision plan

ID cards are not necessary to obtain services. If you prefer to carry an ID card, you can register on vsp.com to download and print an ID card.

Did you move?

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



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

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

2024 important notices

The following notices are intended for benefits-eligible members enrolled in a PEBC health plan for the 2024 plan year. If you are not eligible for or enrolled in a PEBC plan, the notices will not apply to you.

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Uniform Summary of Benefits and Coverage (SBC)

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

Genetic Information Nondiscrimination Act of 2008

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

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

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

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

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

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

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

The exemption from these federal requirements will be in effect for the 2024 plan year, beginning Jan. 1, 2024, and ending Dec. 31, 2024. The exemption may be renewed for subsequent plan years. Please note that PEBC employer groups currently voluntarily provide coverage that substantially complies with the requirements of the Newborn and Mother's Protection Act and the WHCRA.

Medicare Part D Notice of Creditable Coverage

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

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

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

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

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

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

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

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

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

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

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

More information about your options under Medicare prescription drug coverage

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

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov.**
- 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, contact your state Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of Jan. 31, 2023. 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: **https://health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – Medicaid

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

California – Medicaid

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

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

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

FLORIDA – Medicaid

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

GEORGIA – Medicaid

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

INDIANA – Medicaid

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

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

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

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

Website: **http://www.ACCESSNebraska.ne.gov**
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**
Medicaid Phone: 1-609-631-2392
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:
https://www.hhs.nd.gov/healthcare/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 and CHIP

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

RHODE ISLAND – Medicaid and CHIP

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

SOUTH CAROLINA – Medicaid

Website: **https://www.scdhhs.gov**
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: **http://dss.sd.gov**
Phone: 1-888-828-0059

TEXAS – Medicaid

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

UTAH – Medicaid and CHIP

Medicaid Website: **https://medicaid.utah.gov/**
CHIP Website: **http://health.utah.gov/chip**
Phone: 1-877-543-7669

VERMONT– Medicaid

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

VIRGINIA – Medicaid and CHIP

Website: **https://www.coverva.org/en/famis-select**
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid and CHIP

Website: **https://dhhr.wv.gov/bms/**
http://mywvhipp.com/
Medicaid Phone: 1-304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

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

WYOMING – Medicaid

Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**
Phone: 1-800-251-1269

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

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

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

PEBC Privacy Notice

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

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

Effective date of notice: Sept. 23, 2013

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

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

Use and disclosure of protected health information

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

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

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

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

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

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

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

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

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

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

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

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

Uses and disclosures for which an authorization is required

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

Your rights regarding Protected Health Information

You have the right to:

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

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

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

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

About this Notice

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

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

Contacting the plan administrator

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

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

Patriot Act Notice

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

Important information about procedures for opening a new account

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

What this means for you:

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

Important Health Savings Account Information

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

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

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

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

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

Paperwork Reduction Act Statement

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

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

Group Medicare Advantage PPO and HMO Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C and Part D benefits. Optum Home Delivery is a service of Optum Rx pharmacy. Optum Rx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery for a 90- or 100-day supply of your maintenance medication. If you have not used Optum Home Delivery, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. Prescriptions from the pharmacy should arrive within 5 business days after we receive the complete order. Contact Optum Rx anytime at 1-888-279-1828, TTY 711.

Other pharmacies are available in our network. Members may use any pharmacy in the network but may not receive preferred retail pharmacy pricing. Copays apply after deductible.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. **TTY** users should call **1-877-486-2048**.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as letters in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-877-298-2341 for additional information (TTY users should call 711). Hours are 8 a.m. - 8 p.m. local time, 7 days a week.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, cartas en otros idiomas, braille, letra grande, audio o bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al 1-877-298-2341, para obtener información adicional (los usuarios de TTY deben comunicarse al 711). Los horarios de atención son de 8 a.m. a 8 p.m., hora local, los 7 días de la semana.

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

Benefits, features and/or devices vary by plan/area. Limitations and exclusions may apply.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The Telephonic Nurse Services should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only.

The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.

Participation in the Renew Active® program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership and other offerings. Fitness membership, equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Certain services, classes, events and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services are subject to your acceptance of their respective terms and policies. AARP® Staying Sharp is the registered trademark of AARP. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor.

The Renew Active program varies by plan/area. Access to gym and fitness location network may vary by location and plan.

Important provider contacts

	Benefit	Vendor	Phone number	Email/web address
ALL RETIREES	Dental DPPO	Delta Dental	**1-800-521-2651**	**deltadentalins.com**
	Dental DHMO	Delta Dental	**1-800-422-4234**	**deltadentalins.com**
	Vision	VSP	**1-800-877-7195**	**vsp.com**
	Health Insurance Marketplace		**1-800-318-2596**	**healthcare.gov**
	Retiree premium billing	UnitedHealthcare	**1-877-237-8576**	**uhcservices.com**
NON-MEDICARE ELIGIBLE	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**
	HSA	Optum Bank	**1-800-791-9361**	**optumbank.com**
	NurseLine	UnitedHealthcare	**1-877-370-2849**	**myuhc.com**
MEDICARE ELIGIBLE	Medicare Advantage PPO (MPO)	UnitedHealthcare	**1-866-519-3813**	**retiree.uhc.com** and **UHCVirtualRetiree.com/pebc**
	Medicare Advantage HMO (PMA)	UnitedHealthcare	**1-866-519-3813**	**retiree.uhc.com**
	Hearing aids	UnitedHealthcare Hearing	**1-855-523-9355**	**UHCHearing.com/retiree**
	Fitness benefit PPO (MPO)	Renew Active	**1-866-519-3813**	**UHCRenewActive.com**
	Fitness benefit HMO (PMA)	Renew Active	**1-866-519-3813**	**UHCRenewActive.com**
	Post-discharge meal delivery	Mom's Meals	**1-866-204-6111**	**retiree.uhc.com**
	Post-discharge transportation	ModivCare	**1-833-219-1182**	**retiree.uhc.com**
	In-home personal care	CareLinx	**1-844-383-0411**	**carelinx.com/UHC-retiree-post-discharge**
	NurseLine	UnitedHealthcare	**1-877-365-7949**	**retiree.uhc.com**

2024 enrollment guide

Summaries of Benefits and Coverage (SBC)

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

Benefits that deliver choice, flexibility and value

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

pebc
PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

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