pebc
PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

Retiree Health Benefits 2025 Enrollment Guide

Benefits that deliver choice, flexibility and value

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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 2025 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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What's changing for 2025

Here's an overview of what you can expect

In ongoing efforts to provide benefits and programs that are comprehensive and cost effective for retirees, we consider many different factors. With the goal of maintaining current benefit plan offerings, we're pleased to announce the medical and pharmacy plans will be administered by Blue Cross and Blue Shield of Texas (BCBSTX). Please carefully review the enrollment guide for important transition information and to learn about the new tools available to help you manage and make the most of your benefits, visit **www.pebcinfo.com**.

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 2024. The ID card will have new group numbers and claims addresses, so plan to start using it in January. **Please note** that your medical ID card will indicate your level of coverage, but it will not list your dependents by name. You can also print a temporary ID card, if needed, on BCBSTX website or access it in the BCBSTX App.

Your New Health Insurance Plans Through BCBSTX

Blue Cross and Blue Shield of Texas is a statewide, customer-owned health insurer. They believe Texas consumers and employers deserve the best of both worlds: access to affordable, quality health care and top-notch service from a company that focuses solely on customers, not shareholders. Customer value is their cornerstone. For more than 90 years, they have forged alliances with local nonprofit organizations to show their commitment to help build healthy communities. They continue to foster health improvements through these alliances so that together they can offer sustainable, measurable programs that strengthen and enrich their communities.

Retirees will choose a BCBSTX plan based on their Medicare eligibility.

Retirees who are not yet 65 and those who are Medicare eligible have plan choices which are explained in this booklet. Please see the section that matches your eligibility.

Are you eligible for a Medicare plan?

- 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.

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 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 **www.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 or HMO medical plan, a **$200 per month spouse surcharge** may 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 may also apply if you fail to turn in the required Spouse Medical Plan Surcharge Affidavit or if you were late turning it in.

The medical plan spouse surcharge will not apply if:

- Your spouse is enrolled in dental and vision coverage
- Your spouse is enrolled in both their employer medical plan (proof of enrollment required) and your PPO or HMO plan
- Your spouse does not work outside the home and has no access to employer coverage; or
- Your spouse's employer does not offer medical coverage, or your spouse is not eligible for that coverage; 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 may 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.

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2025 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 2025.

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.

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 choose 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.

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

Dependents may be eligible if employee is the managing conservator with rights to make decisions about the child.

- Your stepchild (natural or adopted child of current spouse)
- Your unmarried grandchild (child of your child) under 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 or HMO plan, the spouse surcharge could apply. Refer to page 4 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. 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
- 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. You can also review the Frequently Asked Questions for people becoming eligible for Medicare on page 50 of this guide.

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 of 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

www.pebcinfo.com

Go to **www.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.

Download the Blue Cross and Blue Shield of Texas App to access your health plan ID card, find nearby care and more right on your phone or mobile device, anywhere, anytime.

Retirees enrolled in the Blue Cross and Blue Shield of Texas Medicare Open Access PPO or HMO plans can visit **www.bcbstx.com/retiree-medicare-tools** to access online finder tools for drugs, pharmacies and providers.

Once you're a member, register for Blue Access for Members (BAM℠) at **www.bluemembertx.com**.

BAM is a secure website and, along with the BCBSTX mobile app, is designed to give you quick, easy access to the health information you need.
You can:

- Access your Evidence of Coverage
- Search for providers and pharmacies
- See your prescription history
- Link to **www.myprime.com** to view your drug list/formulary
- View claims status and up to 18 months of activity
- Request an ID card or print a temporary ID
- and much more

All retirees regardless of age

- 2025 Retiree Health Benefits Enrollment Guide
- 2025 Retiree Benefits Rate Sheet — Lists retiree contribution rates for each plan
- Important Notices — 2025

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. Retiree group health premiums are not deducted from your Social Security check.

Automatic premium payment program

HealthEquity will be the new administrator for automatic premium payments. If you currently participate in the automatic bank draft program, you will need to enroll in the program anew with HealthEquity. Complete the form included in this packet and return it to your Human Resources department. HealthEquity will automatically deduct the correct 2025 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 2025 premium, mail the form to HealthEquity. If you change banks or your account number, you must contact HealthEquity immediately. Double-check your premium to make sure it is for the correct 2025 amount.

Where to mail your payment:

Mail Payments:
HealthEquity/WageWorks
PO Box 660212
Dallas, TX 75266-0212
Interactive Phone for Payments:
1-888-678-4881 TTY **711**
Monday - Friday, 7 a.m. - 7 p.m. CT.

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

Understanding how much you can expect to pay

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

Preferred Provider Organization (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 2025, your deductible for services in the network is:	**The individual out-of-network deductible applies to each enrolled family member and does not have a family deductible limit:**
$500 for individual (single) coverage	$1,000 for each individual (single)
$1,000 for family coverage*	Unlimited for family coverage

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

High Deductible Plan (HDP)

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

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

$1,650 individual (single) deductible

$3,300 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 $3,300. Even if one family member reaches the $1,650 deductible, that member cannot move to coinsurance until the full $3,300 family deductible is met.

Transition benefits

In certain circumstances, the health plan may authorize the member to continue receiving medical care from an out-of-network provider at the in-network level of benefit for covered services. It may be necessary to request medical information from your current provider(s).

There are certain circumstances when on the date of enrollment, a new member is already getting care for a certain health issue. Transition of care (also called continuation of care) provides a brief period of in-network coverage if you are new to BCBSTX and your doctor is outside your new plan's network. Transition of care also applies if your doctor leaves the network or changes network status. Transition of care may allow you to see an out-of-network provider at in-network rates for a certain amount of time if you have certain health conditions or in an active course of care.

Examples include pregnancy, hospitalization, terminal illness with life expectancy of less than six months, long term treatment of cancer, heart disease and transplants.

If you have transition of care concerns, please call BCBSTX at **1-888-306-5753**.

Find Better Care with Provider Finder®

Connecting You to High Quality, Cost-Effective Care.

BCBSTX is making it simpler than ever to find the right provider at the best price. The latest update to Provider Finder uses leading-edge data evaluation techniques to measure the care delivered by physicians. Primary care physicians and many specialists* are compared to their peers on three main measures of health care standards.

Quality of patient care: Holding physicians accountable for doing the right things for their patients, and doing them well.

Medical appropriateness: Comparing how well physicians follow clinical guidelines and making sure they are not giving patients low-value care.

Cost efficiency: Looking at the whole episode of care that physicians give their patients and comparing the cost of service versus national benchmarks.

Find Top Performing Physicians on Provider Finder

Top performing physicians are shown on the Provider Finder platform with an icon and a hover-over key explaining that "The Top Performing Physician designation highlights physicians who are highly rated for quality, cost-efficient care and appropriate treatment plans".

The Provider Profile pages will show a physician's performance scores on quality of patient care, medical appropriateness and cost efficiency. You can reach Provider Finder at **www.bcbstx.com** under the Find Care tab.

Provider Finder from BCBSTX helps you to quickly find in-network physicians, medical groups, hospitals, pharmacies and urgent care. You can search for physicians using ZIP code, gender, specialty, languages spoken and other factors. Through Provider Finder you can read or share physician reviews and view clinical certifications and recognitions, as well as quality awards, for physicians.

*Not all specialties are part of this program. PEAQ℠-related information is not presently available in Provider Finder. PEAQ-related information may not yet be available with respect to Texas-based physicians

To view top performing physicians you can use Provider Finder or, for best results, log into or make a Blue Access for Members℠ account at **www.bcbstx.com**.

Physician Quality Impacts Cost of Care

People diagnosed with colon cancer found by a colonoscopy had 70% lower total costs than those whose cancer was found when they had symptoms.

On average, women who received a screening mammogram that detected breast cancer had 27% lower outpatient costs than those who had cancer detected when they became symptomatic.

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 exc 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	$3,000 individual/$6,000 family Plan pays 100% after annual OOP	No limit
Physician services		
Office visits	$25 primary care physician (PCP) $35 specialist	40% after deductible
24/7 Virtual Visits (MDLIVE)	$0 copay	40% after deductible
Telehealth	$25 PCP $35 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.

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 exc plan payment
Maternity services (continued)		
Infertility services: 5 artificial insemination visits (lifetime)	20% after deductible (excludes in vitro and drug coverage)	40% after deductible (excludes in vitro and drug coverage)
Additional services		
Inpatient hospital	20% after deductible	40% after deductible
Outpatient surgery	20% after deductible	40% after deductible
Lab & X-ray outpatient (minor)	Covered at 100% in physician office or network lab or radiological provider	40% after deductible
Hospital emergency care services (treated as network)	$300 copay + 20% after deductible; copay waived if admitted	$300 copay + 20% after deductible; copay waived if admitted
Skilled nursing facility	20% after deductible; up to 60 days annually*	40% after deductible; up to 60 days annually*
Home health care	20% after deductible; up to 120 visits annually*	40% after deductible; up to 120 visits annually*
Allergy care services	$25 PCP $35 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 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 exc plan payment
Annual deductible	$1,650 individual/$3,300 family	$3,000 individual/$6,000 family
Coinsurance (after the annual deductible is met)	20% after deductible	40% after deductible
Annual coinsurance maximum	$1,350 individual/$2,700 family	No limit
Annual out-of-pocket maximum (OOP)	$3,000 individual/$6,000 family Plan pays 100% after annual OOP	No limit
Physician services		
Office visits	20% after deductible	40% after deductible
24/7 Virtual Visits	20% after deductible	40% after deductible
Telehealth	20% after deductible	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visits	20% after deductible	40% after deductible
Preventive care**		
Well-child care	Covered at 100%	40% after deductible
Well-woman exam	Covered at 100%	40% after deductible
Routine screening mammography	Covered at 100%	40% after deductible
Adult health assessments	Covered at 100%	40% after deductible
Immunizations	Covered at 100%	40% after deductible
Screening colonoscopy	Covered at 100%	40% after deductible
Maternity services		
Routine prenatal care	Covered at 100%	40% after deductible
Delivery in hospital	20% after deductible	40% after deductible
Newborn care in hospital (routine)	20% after deductible	40% after deductible

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

**Subject to Affordable Care Act requirements.

Feature	Your network cost	Your out-of network cost PLUS you pay charges exc plan payment
Maternity services (continued)		
Infertility services: 5 artificial insemination visits (lifetime)	20% after deductible (excludes in vitro and drug coverage)	40% after deductible (excludes in vitro and drug coverage)
Additional services		
Inpatient hospital	20% after deductible	40% after deductible
Outpatient surgery	20% after deductible	40% after deductible
Lab & X-ray outpatient (minor)	20% after deductible	40% after deductible
Hospital emergency care services (treated as network)	20% after deductible	20% after deductible
Skilled nursing facility	20% after deductible; up to 60 days annually*	40% after deductible; up to 60 days annually*
Home health care	20% after deductible; up to 120 visits annually*	40% after deductible; up to 120 visits annually*
Allergy care services	20% after deductible	40% after deductible
Chiropractic	20% after deductible; maximum 20 visits per year*	20% 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.

A home delivery (mail order) pharmacy service you can trust.

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

Savings and Convenience

- Express Scripts® Pharmacy delivers up to a 90-day supply of long-term medicines[1]
- Prescriptions are delivered to the address of your choice, within the U.S., with free standard shipping
- You can order from the comfort of your home — through your mobile device, online or over the phone. Your doctor can fax, call or send your prescription electronically to Express Scripts® Pharmacy
- Tamper-evident, unmarked packaging protects your privacy

Support and Service

- You can receive notices by phone, email or text — your choice — when your orders are placed and shipped. You will be contacted, if needed, to complete your order. To select your notice preference, register online at **www.express-scripts.com/rx** or call **1-833-715-0942.**
- 24/7 access to a team of knowledgeable pharmacists and support staff
- Choose to receive refill reminder notices by phone or email
- Multiple pharmacy locations are located across the U.S., for fast processing and dispensing

Medicines may take up to five business days to deliver after Express Scripts® Pharmacy receives and verifies your order.

Getting Started with Express Scripts® Pharmacy Mail Order

Online and Mobile

You have more than one option to fill or refill a prescription online or from a mobile device:

- Visit **www.express-scripts.com/rx.** Follow the instructions to register and create a profile. See your active prescriptions and/or send your refill order.
- Log in to **www.myprime.com** and follow the links to Express Scripts® Pharmacy.

Over the Phone

Call **1-833-715-0942**, 24/7, to refill, transfer a current prescription or get started with mail order. Please have your member ID card, prescription information and your doctor's contact information ready.

Through the Mail

To send a prescription order through the mail, visit **www.bcbstx.com** and log in to Blue Access for Members℠ (BAM℠). Complete the mail order form. Mail your prescription, completed order form and payment to Express Scripts® Pharmacy.

Talk to Your Doctor

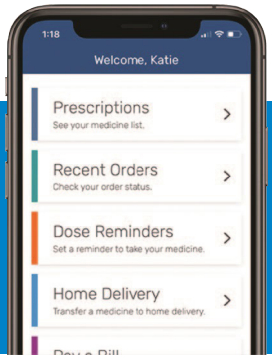
Ask your doctor for a prescription for up to a 90-day supply of each of your long-term medicines.[1] You can ask your doctor to send your prescription electronically to Express Scripts® Pharmacy, call **1-888-327-9791** for faxing instructions or call the pharmacy at **1-833-715-0942**. If you need to start your medicine right away, request a prescription for up to a one-month supply you can fill at a local retail pharmacy.

Refills Are Easy

Refill dates are shown on each prescription label. You can choose to have Express Scripts® Pharmacy remind you by phone or email when a refill is due. Choose the reminder option that best suits you.

Questions?

Visit **www.bcbstx.com**. Or call the phone number listed on your member ID card.



Use the mobile app to manage your prescriptions

- Refill prescriptions
- Track your order
- Make payments
- Set reminders to take medicines and more

Do You Need Specialty Medications?

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

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

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

Your plan may require you to get your self-administered specialty drugs through Accredo or another in-network pharmacy. If you do not use these pharmacies, you may pay higher out-of-pocket costs.2 Your doctor may also order select specialty drugs that must be given to you by a health professional through Accredo.

Examples of Self-administered Specialty Medications

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

Condition	Sample Medications[3]
Autoimmune Disorders	Cosentyx, Enbrel, Humira, Xeljanz
Osteoporosis	Forteo, Tymlos
Cancer (oral)	Gleevec, Nexavar, Sprycel, Sutent, Tarceva
Growth Hormones	Norditropin Flexpro, Nutropin AQ, Omnitrope
Hepatitis C	Daklinza, Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi
Multiple Sclerosis	Betaseron, Copaxone, Rebif

Blue Cross and Blue Shield of Texas (BCBSTX) supports members who need self-administered specialty medication and helps them manage their therapy. Accredo® is the specialty pharmacy chosen to do just that.

Support in Managing Your Condition: Accredo

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

- One-on-one counseling from 500+ condition-specific pharmacists and 600+ nurses
- Simple communication, including refill reminders, by your choice of phone, email, text or web
- An online member website to order refills, check order status and track shipments, view order and medication history, set profile preferences and learn more about your condition
- A mobile app that lets you refill and track prescriptions, make payments and set reminders to take your medicine4
- Free standard shipping
- 24/7 support

Ordering Through Accredo

You can order a new prescription or transfer your existing prescription for a self-administered specialty drug to Accredo.
To start using Accredo, call 1-833-721-1619. An Accredo representative will work with your doctor on the rest.

Once registered, you can manage your prescriptions on **www.accredo.com** or through the pharmacy's mobile app.

Receiving Specialty Medications

Since many specialty drugs have unique shipping or handling needs, shipments will be arranged with you through Accredo. Medications are shipped in plain, secure, tamper-evident packaging.

Before your scheduled fill date, you will be contacted to:

- Confirm your drugs, dose and the delivery location
- Check any prescription changes your doctor may have ordered
- Discuss any changes in your condition or answer any questions about your health

One-on-One Support

Accredo has 15 Therapeutic Resource Centers® (TRCs), each focused on a specific specialty condition. Through your one-on-one counseling sessions, they'll discuss how to reduce your disease progression and achieve your treatment goals, manage any side effects from your drugs, help you stick to your regimen and monitor your progress. They can also offer support with any financial or insurance concerns you may have.

Certain coverage exclusions and limits may apply, based on your health plan. For some medicines, members must meet certain criteria before prescription drug benefit coverage may be approved. Check your benefit materials for details, or call the customer service number listed on your ID card with questions.

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

No-additional-cost contraceptive services (prescription required)

The medical or pharmacy benefit plan covers certain contraceptives at no additional cost to you, when you use a network doctor or pharmacy. Pharmacies can be retail or home delivery. This includes generic contraceptives and some brand-name drugs in certain cases. Not all drugs or services are covered. If you have questions, call the number on your ID card.

Your plan covers the following methods:

- Hormonal methods, like birth control pills, patches, vaginal rings and injections
- Barrier methods, like diaphragms and cervical caps (covered under medical)
- Over-the-counter barrier methods (male and female condoms, spermicides and sponges, when prescribed by a doctor)
- Intrauterine contraceptives (Kyleena, Mirena®) (covered under medical)
- Implantable medications (Nexplanon) (covered under medical)
- Emergency contraceptives (Plan B, ella®)

Preventive drugs

Your health plan includes other drugs often used for preventive care at no additional cost to you when you use a pharmacy or doctor in your plan's network. Age limits, restrictions and other requirements may apply.

Examples of some drugs that may be covered are:

- aspirin
- bowel prep for a colonoscopy
- breast cancer primary prevention
- fluoride, folic acid and iron supplements
- HIV prevention
- single agent statins
- smoking cessation
- vaccines

Enhancing well-being with vision and dental benefits

Vision benefits

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

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

Exclusions and limitations

Some brands of spectacle frames may be unavailable for purchase as plan benefits, or may be subject to additional limitations. Covered persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at **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 pairs of glasses instead of bifocals
- Replacement of lenses, frames and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when plan benefits are otherwise available
- Orthoptics or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Replacement of lost or damaged contact lenses, except at normal intervals when services are otherwise available
- Contact lens modification, polishing or cleaning
- Local, state and/or federal taxes, except where VSP is required by law to pay
- Services associated with corneal refractive therapy (CRT) or orthokeratology

VSP Advantage Plan

	Your network cost		Your out-of network cost PLUS you pay charges exc plan payment	
	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.

Dental benefits

For 2025, you can choose between the DeltaCare USA (DHMO) and the Delta Dental PPO plans.

Delta Dental HMO Plan (DeltaCare USA DHMO)

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

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

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

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 a 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'

When you enroll in DeltaCare USA DHMO:

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

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

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.

Care option	When to use it
24/7 Nurseline	Call 24/7 Nurseline to connect with registered nurses at no additional cost. • Non-Medicare eligible: **1-877-370-2849** • Medicare Advantage Open Access PPO and HMO: **1-800-631-7023** (TTY 711). Nurses can assist you in deciding where to go for care, help you understand your treatment options and answer questions about medications
Virtual Visits	See and talk to a doctor or therapist via your smartphone, tablet or computer for non-emergency medical conditions To activate your account, free of charge, you can choose what is easiest for you: • Call MDLIVE at **1-866-954-3585** • TTY users call **1-800-770-5531** • Go to **www.mdlive.com/bcbstx-medicare** • Text **BCBSTXMEDICARE** to **635-483** • Download the MDLIVE 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. Check to see if your PCP provides virtual options.
Telehealth	See and talk to your PCP, specialist or some therapy providers via your smartphone, tablet or computer using your provider's telehealth system.
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.

Care option	When to use it
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 Blue Cross and Blue Shield of Texas using the number on the back of your member ID card.

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 Open Access PPO and HMO 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 Blue Cross and Blue Shield of Texas for reimbursement, less applicable copays.

Choosing the Medicare plan that's right for you

2025 Medical and Prescription Drug Plans

The PEBC offers two Blue Cross and Blue Shield of Texas Group Retiree Medicare Advantage plans: Blue Cross Group Medicare Advantage Open Access (PPO) and Blue Cross Group Medicare Advantage (HMO). Both plans offer Part D prescription drug benefits featuring the 5 Tier Premier Formulary. You'll be covered for routine vision, hearing, private duty nursing and more. See the Summaries of Benefits for details about each plan.

If you are enrolling for the first time, you must submit a completed Retiree Health Benefit Enrollment form to your Human Resources department before your Medicare Advantage plan would become effective. You may submit the form up to 60 days in advance.

Blue Cross Group Medicare Advantage Open Access (PPO)

This plan bundles Medicare Part A, Part B and Part D, plus extra health and wellness benefits not offered by Original Medicare. It covers most common services such as provider visits, inpatient hospital and outpatient services, emergency care, as well as prescription drugs. It coordinates your care and offers disease prevention and management resources. The plan also takes care of claims, and coordinates with Medicare.

How it works

This is a national plan covering all eligible beneficiaries regardless of where they reside in the U.S., and 5 U.S. territories.

Because this is an open access plan, you can visit doctors, specialists and hospitals in or out of the Blue Cross and Blue Shield of Texas network for the same cost share as long as the provider is willing to see you as a patient, participates in Medicare and agrees to submit claims to the plan.

Providers will send claims to their local BCBS plan. If a provider says they are out of network or do not take the plan, show them the `Your Providers, Your Personal Network' flyer included in this packet. It explains your group retiree plan and how to submit claims. Call before your visit to be sure your providers understand and will see you as a patient. Please note: Even providers that accept Medicare can decide which patients they want to see, except in an emergency. Some medical services may need prior authorization from the plan before the provider can proceed.

Referrals are not required to see a specialist.

Blue Cross Group Medicare Advantage (HMO)

This plan also bundles Medicare Part A, Part B and Part D, plus extra health and wellness benefits not offered by Original Medicare. It covers most common services such as provider visits, inpatient hospital and outpatient services, emergency care, as well as prescription drugs. It coordinates your care and offers disease prevention and management resources. The plan also takes care of claims, and coordinates with Medicare.

Your care is handled by one primary care provider who knows your health history. A PCP can get to know you over time and understand your unique health needs. This relationship can improve health outcomes and reduce care costs. You may need a referral from your PCP before visiting a specialist.

How it works

If you choose to enroll in the HMO plan, you must reside in the state of Texas. You are required to select a primary care provider (PCP) to coordinate your care. The HMO has a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in the network, the plan may not pay for those services. Visit **www.bcbstx.com/retiree-medicare-tools** to find a participating provider.
Referrals are required to see a specialist.

Prescription Drug Benefits

Both the Open Access PPO and HMO plans include prescription drug benefits, so you will not need a separate Medicare Part D plan. Prescription drug benefits cover common outpatient medications, like those used to treat blood pressure, cholesterol, depression and arthritis. You will have a copay for each Part D prescription. There is no Part D deductible to meet before your drugs are covered.

Due to Medicare reforms, the most you will pay in 2025 for Part D drugs is $2,000. In the years that follow, annual limits will be adjusted based on inflation. This cap does not apply to out-of-pocket spending on Part B drugs. Review the Summary of Benefits to understand your costs.

List of Covered Drugs (Formulary)

Your plan has the 5 Tier Premier Formulary. Within the formulary, you will see that prescription drugs are placed into tiers. The costs for drugs in each tier are different. Tier 1 includes the drugs prescribed for common conditions and usually cost the least.

Transition Benefit

You will have a copay for each Part D prescription. There is no Part D deductible to meet before your drugs are covered. You and your provider will be alerted via mail of the transition fill and the requirements needed to continue receiving your drug. Such requirements include your provider submitting a formulary exception by calling the number on your new member ID card or filling out the formulary exception form found on **www.myprime.com**. If the formulary exception is approved, you will pay the non-preferred drug tier cost-share.

Please note: Federal law forbids people who have Medicare from using coupons or other discounts with their Part D plan. These may only be used outside of your Part D benefit.

Insulin and Vaccine Costs

Insulin: You will not pay more than $35 for a one-month supply of each covered insulin product. It does not matter what cost-sharing tier it is on. **Vaccines:** Your plan covers most Part D vaccines at no cost to you. The following vaccines are covered under Medicare Part D: Shingles, Tetanus/diphtheria (Td), Tetanus, diphtheria, and pertussis (whooping cough) (Tdap), Hepatitis A and Hepatitis B.

You do not need to meet any required deductible for these items.

Pharmacies Near and Far

The BCBSTX national pharmacy network includes thousands of locations. All major national retail and grocery pharmacy chains participate in the network, including: Albertsons, Brookshire's, CVS, H-E-B, Kroger, Randalls, Tom Thumb, United Supermarkets, Walgreens, Walmart, and independents.

Mail order and specialty network pharmacies

Once you enroll in your new plan, you will want to bookmark these websites and save the numbers to your phone:

Mail-Order Pharmacies	Specialty Pharmacies

Walgreens Mail Service

Visit **walgreensmailservice.com**
Call **1-877-277-7895** TTY **711**

Amazon Pharmacy

Visit **pharmacy.amazon.com**
Call **1-855-393-4279** TTY **711**

Express Scripts Pharmacy

Visit **www.express-scripts.com/rx**
Call **1-833-599-0729** TTY **711**

Walgreens Specialty Pharmacy

Visit **walgreensspecialtyrx.com**
Call **1-877-627-6337** TTY **711**

Accredo

Visit **www.accredo.com**
Call **1-833-721-1619** TTY **711**

Managing your medications.

Your prescription drug plan includes programs designed to encourage safe, cost-effective and appropriate use of medications. These include prior authorization, step therapy and quantity limits. If a drug requires one or more of these programs, it will be noted in the formulary.

Medicare Prescription Payment Plan

You may opt to pay out-of-pocket drug costs, such as a copay or coinsurance, in installments instead of all at once at the pharmacy. This spreads what you pay over the course of the year. The payment plan may be helpful for people who have high cost-sharing early in the plan year. While the program is for anyone with Part D, it might not be right for everyone. Program details will be included in your welcome guide.

Do you need financial support for your drugs?

You can apply for Extra Help any time before or after you enroll in Part D. Visit Social Security to learn more at **www.ssa.gov**. Choose 'Medicare,' then 'Apply for Part D Extra Help.'

Before you enroll, you can search for your medicines online at **www.myprime.com**.

Select 'Medicines,' then:

- 'Find medicines,' followed by
- 'Continue without sign in'

Under 'Select Your Health Plan':

- Select BCBS Texas
- Answer 'Yes'
- Scroll to the bottom of the drop-down list and select Blue Cross Group Medicare Advantage (PPO) – 5T Complete
  or
  Blue Cross Group Medicare Advantage (HMO) – 5T Complete
- Click 'Continue'

Type your medicine and dosage.

- Review the drug tier and requirements
- Refer to the Summary of Benefits for your cost

Note: Formularies will not be available until October 1, 2024. You will not see the HMO plan as an option until then.

Spouse and dependent coverage

As long as a retiree enrolls in either Blue Cross Group Medicare Advantage plan, non-Medicare spouses and/or dependent(s) can remain enrolled in the PEBC PPO plan. If the non-Medicare dependent(s) are enrolled in the PEBC high deductible plan (HDP) at the time the retiree enrolls in the Medicare Advantage plan, the non-Medicare dependent(s) must change to the PEBC PPO plan to remain covered.

About diabetic test strips

0% cost sharing is limited to diabetic testing supplies (meters and strips) obtained through the pharmacy for Lifescan branded products (OneTouch Verio Flex, OneTouch Verio Reflect, OneTouch Verio IQ, OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra.)

Prior Authorization will be required for all other diabetic testing supplies (meters and strips) and will be subject to 0% cost sharing. All test strips will also be subject to a quantity limit of 204 per 30 days.

Additional benefits included with the Group plans.

The SilverSneakers®† Fitness Program

The SilverSneakers Fitness Program helps you achieve your health and fitness goals with access to thousands of fitness locations plus in-person and online classes led by certified instructors.

- Call **1-888-423-4632** (TTY **711**), Monday through Friday, 7 a.m. - 7 p.m. CT, or
- Visit **SilverSneakers.com/StartHere**, or
- Email **support@silversneakers.com**

Always talk with your doctor before starting an exercise program.

Private Duty Nursing

Private duty nursing is provided to individuals who need skilled care and require individualized and continuous 24–hour nursing care that's more intense than what is available under the home health care benefit.

You have a $0 copay for Medicare-covered services. (40 visits per year)

MDLIVE Virtual Visits

Make an appointment with an independently contracted, board-certified MDLIVE provider for non-emergency medical conditions and mental health support, including therapy and psychiatric care. You can meet by phone, mobile app or online video 24 hours a day, 7 days a week.

Note: Your primary care proider may also offer virtual visits. Visit **www.mdlive.com/bcbstx-medicare** or call **1-866-954-3585** (TTY **1-800-770-5531**).

Modivcare | Non-Emergency Transportation Services

Getting to the doctor or pharmacy is easier with transportation services through Modivcare. You have a $0 copay for up to 12 one-way visits to plan-approved locations per year. Arrange trips by calling the Customer Service number on the back of your member ID card.

Mom's Meals | Post Discharge Meals at Home

Mom's Meals offers healthy meals to aid in your recovery for a limited period after getting discharged from an inpatient hospital stay. Your benefit includes up to 28 meals over 14 days a maximum of 3 times per year. Authorization is required after an inpatient stay. Call the Customer Service number on the back of your member ID card to arrange meals.

24/7 Nurseline

Your health questions can be answered by a registered nurse. This service is available 24 hours a day, 7 days a week. Get help with health concerns such as asthma, dizziness or severe headaches, high fever and more. You can reach the 24/7 Nurseline at **1-800-631-7023** (TTY **711**).

Blue365® Discount Program

With Blue365, you may save money on health and wellness products and services such as contacts, dental care, fitness devices, glasses, healthy meals, hearing aids, clothes and shoes, and more from trusted retailers. Availability of discounts is subject to change. See all the deals and learn more at **www.blue365deals.com/bcbstx**.

Rewards Program

The Rewards Program gives you a healthy and easy way to earn up to $100 in gift cards from national and local retailers. You can receive a gift card of your choice for completing Healthy Actions like having an annual check-up or getting a flu shot, throughout the year.
Visit **www.BlueRewardsTX.com** to register and learn more.

Voluntary programs for people with chronic or complex health needs

Complex Care Management Programs include:

- Alcohol and substance abuse disorders
- Anxiety and panic disorders
- Asthma/chronic obstructive pulmonary disease
- Cancer
- Congestive heart failure
- Coronary artery disease
- Depression
- Diabetes
- Hypertension
- Schizophrenia, other psychotic disorders and ESRD (End Stage Renal Disease)

Hearing Care

Your plan covers 1 routine hearing exam per year provided by TruHearing and a $500 hearing aid allowance for both ears over 36 months. Visit the TruHearing website at **www.truhearing.com** or call **1-844-855-9536** (TTY **711**) to learn more.

TruHearing®

1-844-855-9536 | TTY 711

Life's better when you're connected.

Better hearing helps you stay connected to the ones you love. That's why Blue Cross and Blue Shield of Texas partners with TruHearing® to give you a broad hearing care solution. Your 2025 hearing program saves you up to 60% off retail pricing.

Example Savings (per aid)

Product	Retail Price	Savings	TruHearing Price
TruHearing Advanced	$2,720	**$1,470**	**$1,250**
Signia 3IX	$2,113	**$763**	**$1,350**
Widex® SmartRIC™ 220	$2,332	**$982**	**$1,350**
ReSound NEXIA™ 9	$3,047	**$797**	**$2,250**
Starkey® Genesis® AI 1600	$2,129	**$579**	**$1,550**
Phonak® Lumity® L-RL 90	$3,349	**$1,099**	**$2,250**
Oticon® Real® 2	$3,018	**$1,243**	**$1,775**

Rechargeable | Listed products are smartphone-compatible[1]

You can use your 2025 TruHearing Aid Discount Program to purchase a new pair of hearing aids. See your Evidence of Coverage for hearing aid allowance and eye exam costs.

Your journey to better hearing made easy. Get Started with **Five Simple Steps**.

1. Call TruHearing
2. Schedule an exam
3. Go to your exam
4. Order hearing aids
5. Fitting and follow-up

Your hearing benefit includes:

- **60-day**, risk-free trial
- **1 year** of follow-up visits
- **80 free batteries** per non-rechargeable hearing aid
- **3-year** manufacturer warranty

Schedule an appointment

1-844-855-9536 | TTY **711**
Hours: 7 a.m. - 7 p.m. CST,
Monday - Friday

Learn more

www.truhearing.com/how-it-works/

Or scan with your smartphone to see how it works.

[1]Smartphone-compatible hearing aids connect directly to iPhone®, iPad®, and iPod® Touch devices. Some TruHearing models connect to Android® phones directly. Connectivity also available to many Android phones with use of an accessory. TV streaming available through most TVs with use of an accessory.

Prices and products subject to change.

 Savings and retail pricing based on a survey of national average hearing aid prices compared to TruHearing pricing. Savings may vary. Listed hearing aid prices are subject to change. Confirm hearing aid pricing at your appointment with your provider. Pricing of TruHearing-branded aids based on prices for comparable aids. Follow-up provider visits included for one year following hearing aid purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing Hearing Consultant. [505300-17-0424]

Blue Cross Group Medicare Advantage℠		
Medical Benefits	**Blue Cross Group Medicare Advantage Open Access (PPO)℠**	**Blue Cross Group Medicare Advantage (HMO)℠**
Annual Combined **Medical** Deductible	$0	$0
Annual Combined Out-of-Pocket Maximum	$0	$6,700
Referral Requirement	None	None
Inpatient Hospital		
Inpatient Hospital — Acute	$0 copay per stay	$250 copay per stay
Inpatient Mental Health Care *Limited to 190 lifetime days*	$0 copay per stay	$250 copay per stay
Skilled Nursing Facility		
Benefit Period 1–20 days *No prior hospitalization required*	$0 copay per day	$0 copay per day
Benefit Period 21–100 days *Limited to 100 days per Medicare Benefit Period*	$0 copay per day	$50 copay per day
Home Health/Hospice		
Home Health	$0 copay	$0 copay
Hospice (Medicare-covered)	Covered by Original Medicare at a Medicare certified hospice facility	Covered by Original Medicare at a Medicare certified hospice facility
Emergent & Urgent Care		
Emergency Care (Worldwide) *Cost share waived if admitted within 3 days for the same condition.*	$0 copay	$50 copay
Urgently Needed Services (Worldwide) *Cost share waived if admitted within 3 days for the same condition.*	$0 copay	$20 copay
Virtual Urgent Care — *Visit through MDLive*	$0 copay (through MDLive only)	$0 copay (through MDLive only)
Ambulance Services (Ground)	$0 copay	$50 copay
Ambulance Services (Air)	$0 copay	$50 copay

Blue Cross Group Medicare Advantage℠		
Medical Benefits	**Blue Cross Group Medicare Advantage Open Access (PPO)℠**	**Blue Cross Group Medicare Advantage (HMO)℠**
Health Care Professional Services		
Primary Care Physician Services	$0 copay	$20 copay
Physician Specialist Services *Excluding Psychiatric and Radiology Services*	$0 copay	$40 copay
Other Health Care Professional Services	$0 copay	$20 copay/PCP $40 copay/SPC
Medicare-Covered Specialist Visits		
Chiropractic Services (Medicare-covered) *Coverage limited to manual manipulation of the spine to correct for subluxation.*	$0 copay	50% coinsurance
Podiatry Services (Medicare-covered) *Coverage limited to foot exams or treatment for diabetes-related nerve damage or medically necessary treatment for foot injuries or diseases.*	$0 copay	$40 copay
Acupuncture (Medicare-covered) *Coverage for chronic low back pain up to 12 visits in 90 days. No more than 20 acupuncture treatments may be administered annually.*	$0 copay	20% coinsurance
Dental Services (Medicare-covered) *Coverage for inpatient hospital care for emergency or complicated dental procedures.*	$0 copay	$40 copay
Eye Exam (Medicare-covered) *Coverage for eye exams limited to specific condition.*	$0 copay	$40 copay
Eyewear (Medicare-covered) *Coverage for corrective lenses if you have cataract surgery to implant an intraocular lens - one pair of eyeglasses with standard frames or one set of contact lenses.*	$0 copay	$0 copay
Hearing Exam (Medicare-covered) *Coverage for diagnostic hearing and balance evaluations to determine if you need medical treatment.*	$0 copay	$40 copay

Blue Cross Group Medicare Advantage℠		
Medical Benefits	**Blue Cross Group Medicare Advantage Open Access (PPO)℠**	**Blue Cross Group Medicare Advantage (HMO)℠**
Outpatient Rehabilitation Services		
Cardiac Rehabilitation Services *Maximum of 2 one-hour sessions per day up to 36 sessions in 36 weeks.* *Limit to 36 per year.* *Medicare-covered Intensive Cardiac Rehab up to 72 sessions per year.*	$0 copay	$0 copay Medicare-covered Cardiac Rehab/ $10 copay for Medicare-covered Intensive Cardiac Rehab/ $10 copay Supplemental Cardiac Rehab - No limits
Pulmonary Rehabilitation Services *Limit to 36 sessions per year*	$0 copay	$0 copay Medicare-covered $0 copay Supplemental - No limits
Supervised Exercise Therapy for Peripheral Artery Disease *Up to 36 sessions in 12 weeks*	$0 copay	$0 copay
Occupational Therapy Services	$0 copay	$40 copay
Physical Therapy and Speech Language Pathology Services	$0 copay	$40 copay
Outpatient Mental Health Services		
Mental Health Specialty Services — *Individual Visit*	$0 copay	$40 copay
Mental Health Specialty Services — *Group Visit*	$0 copay	$40 copay
Virtual Mental Health Specialty Services — *Visit through MDLive*	$0 copay (through MDLive only)	$40 copay (through MDLive only)
Psychiatric Services — *Individual Visit*	$0 copay	$40 copay
Psychiatric Services — *Group Visit*	$0 copay	$40 copay
Virtual Psychiatric Services — *Visit through MDLive*	$0 copay (through MDLive only)	$40 copay (through MDLive only)
Partial Hospitalization	$0 copay	$0 copay
Outpatient Substance Abuse Services		
Outpatient Substance Abuse: *Individual Visit*	$0 copay	$40 copay
Outpatient Substance Abuse: *Group Visit*	$0 copay	$40 copay
Opioid Services	$0 copay	$0 copay

Blue Cross Group Medicare Advantage℠		
Medical Benefits	**Blue Cross Group Medicare Advantage Open Access (PPO)℠**	**Blue Cross Group Medicare Advantage (HMO)℠**
Outpatient Diagnostic/Therapeutic Radiation Services		
Lab Services	$0 copay	$0 copay
Diagnostic Procedures	$0 copay	$0 copay
Therapeutic Radiology	$0 copay	$0 copay
Diagnostic Radiology Services/ X-ray	$0 copay	$0 copay
Advanced Imaging (MRI, MRA, CT Scan, PET)	$0 copay	$0 copay
Other Outpatient Services		
Outpatient Observation	$0 copay	$0 copay
Outpatient Hospital Services	$0 copay	$125 copay
Ambulatory Surgical Center (ASC) Services	$0 copay	$125 copay
OP Blood Services — *Coverage begins with the first pint of blood*	$0 copay	$0 copay
End-Stage Renal Disease/ Dialysis Services	$0 copay	$0 copay
Kidney Disease Education Services	$0 copay	$0 copay
DME, Prosthetics, Diabetic Supplies		
Durable Medical Equipment (DME)	$0 copay	$0 copay
Prosthetics/Orthotics *Wig(s) w/Cancer Diagnosis*	$0 copay *Not Covered*	$0 copay *Not Covered*
Medical Supplies	$0 copay	$0 copay
Diabetes Supplies and Services — *Preferred Testing Supplies*	0% coinsurance	0% coinsurance
Diabetes Supplies and Services — *Non Preferred Testing Supplies*	0% coinsurance (prior authorization required)	0% coinsurance
Diabetes Supplies and Services — *All other supplies*	0% coinsurance	0% coinsurance
Therapeutic Shoes and Inserts *Limit to 1 pair of diabetic shoes per year; Limit to 2 pairs of inserts per year for custom fitted shoes; Limit to 3 pairs of inserts per year for off-the-shelf shoes*	0% coinsurance	0% coinsurance

Blue Cross Group Medicare Advantage℠		
Medical Benefits	**Blue Cross Group Medicare Advantage Open Access (PPO)℠**	**Blue Cross Group Medicare Advantage (HMO)℠**
Medicare Preventive Services		
Medicare-covered Preventive Services	$0 copay	$0 copay
Medicare Part B Rx Drugs		
Medicare Part B Rx Drugs: Chemotherapy/Radiation	0% coinsurance	0% coinsurance
Medicare Part B Rx Drugs: Other	0% coinsurance	0% coinsurance
Home Infusion Therapy Administration	$0 copay	$0 copay
Supplemental Benefits		
Routine Vision (Vendor: EyeMed)		
Routine Eye Exam *1 routine eye exam each year*	$0 copay	$40 copay
Routine Hearing (Vendor: TruHearing®)		
Routine Hearing Exam *1 routine hearing exam provided by TruHearing each year*	$0 copay	$0 copay
Hearing Aid Allowance	$500 Allowance	$500 Allowance
Benefit Per Ear or Both Ears	Both Ears	Both Ears
Hearing Aid Allowance Benefit Period	36 months	36 months
Other Supplemental Benefits		
Annual Physical Exam	$0 copay	$0 copay
Routine Podiatry Services	$0 copay (6 visits per year)	Not Covered
Private Duty Nursing	$0 copay (40 visits per year)	$0 copay (40 visits per year)
Post-Discharge Meal Benefit *(Provided by Mom's Meals)*	28 meals/14 days Max 3 times per year (Authorization required after inpatient stay)	28 meals/14 days Max 3 times per year (Authorization required after inpatient stay)

Blue Cross Group Medicare Advantage℠		
Medical Benefits	**Blue Cross Group Medicare Advantage Open Access (PPO)℠**	**Blue Cross Group Medicare Advantage (HMO)℠**
Other Supplemental Benefits *continued*		
Non-Emergency Transportation Services *(Provided by Modivcare Solutions LLC)*	$0 copay 12 one-way trip(s) to plan approved location per year	$0 copay 12 one-way trip(s) to plan approved location per year
Wellness/Clinical Programs		
Fitness Program *(Provided by SilverSneakers®)*	Included	Included
Member Rewards Program *(Provided by Healthmine)*	Up to $100 per year	Up to $100 per year
NurseLine	Included	Included
Blue365® *Discount Platform*	Included	Included
Intensive Case Management	Included	Included
Complex Care Management Programs	Included	Included
Transplant Management Program	Included	Included
Preferred Diabetic Supply Program	Included	Included
TruHearing Aid Discount Program	Included	Included
In-Home Health Evaluations (Signify Health)	Included	Included

Blue Cross Group Medicare Advantage—30-day supply				
Pharmacy	**Blue Cross Group Medicare Advantage Open Access (PPO)℠**		**Blue Cross Group Medicare Advantage (HMO)℠**	
Annual Part D Prescription Drug Deductible	$0		$0	
	Initial Coverage Stage			
	The following copays will apply up to the out-of-pocket cap			
	Retail Pharmacy	Mail Order Pharmacy	Retail Pharmacy	Mail Order Pharmacy
	30-day supply	30-day supply	30-day supply	30-day supply
	Standard	Standard	Standard	Standard
Tier 1: Preferred Generic	$10	$10	$10	$10
Tier 2: Generic	$10	$10	$10	$10
Tier 3: Preferred Brand	$20	$20	$20	$20
Tier 4: Non-Preferred Drug	$35	$35	$40	$40
Tier 5: Specialty Drug	$35	$35	$40	$40
Maximum Out-of-Pocket *When member reaches the maximum out-of-pocket limit, cost shares will no longer apply.*	$2,000			
Catastrophic Coverage *Member Cost Share*	$0			

Blue Cross Group Medicare Advantage—60-day supply				
Pharmacy	**Blue Cross Group Medicare Advantage Open Access (PPO)SM**		**Blue Cross Group Medicare Advantage (HMO)SM**	
Annual Part D Prescription Drug Deductible	$0		$0	
	Initial Coverage Stage			
	The following copays will apply up to the out-of-pocket cap			
	Retail Pharmacy	Mail Order Pharmacy	Retail Pharmacy	Mail Order Pharmacy
	60-day supply	60-day supply	60-day supply	60-day supply
	Standard	Standard	Standard	Standard
Tier 1: Preferred Generic	$20	$20	$20	$20
Tier 2: Generic	$20	$20	$20	$20
Tier 3: Preferred Brand	$40	$40	$40	$40
Tier 4: Non-Preferred Drug	$70	$70	$80	$80
Tier 5: Specialty Drug	$70	$70	$80	$80
Maximum Out-of-Pocket *When member reaches the maximum out-of-pocket limit, cost shares will no longer apply.*	$2,000			
Catastrophic Coverage *Member Cost Share*	$0			

Blue Cross Group Medicare Advantage—90-day supply				
Pharmacy	**Blue Cross Group Medicare Advantage Open Access (PPO)SM**		**Blue Cross Group Medicare Advantage (HMO)SM**	
Annual Part D Prescription Drug Deductible	$0		$0	
	Initial Coverage Stage			
	The following copays will apply up to the out-of-pocket cap			
	Retail Pharmacy	Mail Order Pharmacy	Retail Pharmacy	Mail Order Pharmacy
	90-day supply	90-day supply	90-day supply	90-day supply
	Standard	Standard	Standard	Standard
Tier 1: Preferred Generic	$30	$20	$30	$20
Tier 2: Generic	$30	$20	$30	$20
Tier 3: Preferred Brand	$60	$40	$60	$40
Tier 4: Non-Preferred Drug	$105	$70	$120	$80
Tier 5: Specialty Drug	$105	$70	$120	$80
Maximum Out-of-Pocket *When member reaches the maximum out-of-pocket limit, cost shares will no longer apply.*	$2,000			
Catastrophic Coverage *Member Cost Share*	$0			

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 at **www.bluemembertx.com**.

Blue Access for Members (BAM) is a secure website and, along with the mobile app, designed to give you quick, easy access to the health information you need.

You can:

- Access your Evidence of Coverage
- Search for providers and pharmacies
- See your prescription history
- Link to **www.myprime.com** to view your drug list/formulary
- View claims status and up to 18 months of activity
- Request an ID card or print a temporary ID and much more.

ID card information

Medical plans

Your new Medicare Advantage member ID card will be mailed to you. You can also find it on BAM. Your new member ID card it will have this information:

- Your name
- The name of your group retiree Medicare plan
- Your new member ID number - this number is unique to you
- Plan and Group numbers - these numbers are used by the plan only
- Copays - These are the fixed amounts you may have to pay when you visit a provider.
- Customer service phone number
- The BCBSTX website

Vision plan

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

Your member ID card

Be sure to show the new Medicare Advantage card to your providers and pharmacy. Remind them that your old ID and number are no longer valid.

If they do not use the new card and number, your benefits cannot be confirmed and there may be delays in processing your claims.

Remember to keep your ID card safe like you would a credit or debit card. You will not need to use your red, white and blue Medicare card to receive services, so don't carry it with you. Keep it secure, not in your wallet.

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.

Frequently Asked Questions for retirees transitioning to a new Medicare plan.

Q. I am already enrolled in a Medicare plan. Will it be canceled for me?

A. You can only be enrolled in one Medicare plan at a time. While Medicare usually cancels your previous Medicare Insurance plan coverage automatically when you enroll in a new plan, we recommend that you contact your current carrier to cancel your coverage. Be sure to continue coverage until the new plan's effective date to avoid any gaps in coverage.

Q. What do I need to know about switching insurance carriers?

A. Your previous carrier will likely share claims and care information with BCBSTX, so there will be no gap in understanding your needs. You will receive new plan documents and member ID card. Share the card with your providers and pharmacy so they have the information for filing your claims. If you choose the HMO plan, confirm that your PCP accepts the plan or select a new provider. If you choose the Open Access PPO, be sure to share the 'Your Provider, Your Personal Network' flyer with your providers. It explains the plan and how to submit claims. If you have a previous carrier's contact information links on your phone or tablet, be sure to update them. Register for Blue Access for Members and get the BCBSTX mobile app for easy access to documents and your member ID card. You'll also be able to access the provider finder tool and online pharmacy and formulary tools.

Q. I am already on a care plan. Will it continue?

A. As you move to your new Medicare Advantage plan, a team of Care Coordinators works to make sure you don't have any gaps in care or coverage. This is called Continuity of Care. It applies if you are being treated now or have treatments planned and ensures the services you receive now or have scheduled will continue by Medicare contracted providers for 90 days from your enrollment date.

Care Coordinators help by working with you to document and communicate established and scheduled services. They determine if a transition of care plan is necessary after 90 days and keep an active Care Management Plan that was already set up by a Health Advocate. Care Coordinators also work closely with the medical, mental health and pharmacy teams to support you as you receive needed care for sensitive health issues (e.g., cancer, heart disease, depression, etc.), even if your Medicare contracted providers are not in the network.

Q. Does my plan cover any prescription drugs?

A. Both Medicare Advantage plans cover drugs or services that are normally covered by Medicare Part B and Part D.

Q. Can I use manufacturer coupons and/or discount cards with this plan?

A. Federal law forbids people who have Medicare from using coupons or other discounts with their Part D plan. These may only be used outside of your Part D benefit.

Q. How do I know if a pharmacy is in-network or if my drug is covered?

A. Go to **www.myprime.com**. You can check to see if your chosen pharmacy is in-network or if a drug you take is listed in the formulary.

Q. What type of formulary does PEBC offer to its retirees?

A. 5 Tier Premier Formulary

Q. When will I get my new Medicare Advantage member ID card?

A. You should receive it in late December. If it doesn't arrive by mid January, call customer service at **1-877-299-1008** TTY **711**.

Q. When will my group retiree Medicare Advantage plan start?

A. As PEBC transitions to the new coverage under BCBSTX, the effective date will be 1/1/2025.

Frequently Asked Questions for people becoming eligible for Medicare.

Medicare Basics

Q. What is Medicare?

A. Medicare is the Federal government health care program designed for people ages 65 and over. Most U.S. citizens earn the right to enroll in Medicare by working and paying their taxes for a minimum of 10 years. The earliest someone who is turning age 65 can sign up for Original Medicare Parts A and B is three months before the month they will turn age 65. Under certain circumstances, people under 65 may be eligible for Medicare.

There are four parts of Medicare related to specific services:

Part A — Hospital coverage.

Part B — Medical coverage.

Part C — Medicare Advantage Plans (private insurers like BCBSTX that contract with the government to provide Medicare coverage through a variety of insurance products).

Part D — Prescription drug coverage.

IMPORTANT: To participate in a group retiree Medicare plan, you will need to enroll in both Parts A and B. If you do not enroll in Medicare Parts A, B and D when you are first eligible, you may be subject to late enrollment penalties.

Q. Where can I find additional Medicare resources?

A. The following web sites may be helpful: **www.medicare.gov; www.ssa.gov; www.cms.gov**.

Q. How do I enroll in Medicare?

A. Medicare enrollment is done through the Social Security Administration. It takes time to process. If you plan to retire at 65, we recommend enrolling three months prior to your 65th birthday.

Most people should enroll in Medicare Part A (hospital coverage) during the Initial Enrollment Period (IEP). This is the period during which you can enroll in Medicare for the first time. It is a 7-month period that begins three months before the month you turn 65, includes the month you turn 65, and runs for three months after the month you turned 65. For example, if you were born in June, your window to enroll is March 1 through September 30. SSA will send you enrollment instructions at the beginning of your IEP.

If you're already receiving Social Security benefits, you will be automatically enrolled in Medicare Part A at the start of your Initial Enrollment Period. However, you will need to contact SSA to sign up for Part B. If you do not receive instructions from the SSA, please call **1-800-772-1213** (TTY **1-800-325-0778**) or go to **www.ssa.gov** to enroll in Medicare.

Medicare Advantage (Part C)

Q. What are the advantages of a group Medicare plan over an individual Medicare plan?

A. As a rule, group Medicare plans have better benefits than individual plans. And, because many employers or unions offer a defined contribution plan or subsidy (paying part of the cost you would pay wholly on your own with an individual plan), the cost is likely less as well.

Q. Do I need to enroll in both Original Medicare and this Medicare Advantage plan?

A. You have two separate enrollments: Original Medicare and this plan. Enrollment in Medicare Part A and Part B through the Federal government is required to be eligible for any Medicare plans, including this group retiree plan. To have full coverage, you must sign up for Medicare Parts A and B and continue to pay any required Part A or Part B premiums. You will need to do this first and get your 11-character Medicare Beneficiary Identifier before you can enroll in your group retiree plan.

When enrolling in your Medicare Advantage plan, you will provide your MBI located on your red, white and blue Medicare card, along with your effective date.

Q. What is a Medicare Advantage Plan? How does it work with Original Medicare?

A. Medicare Advantage plans bundle your Part A, Part B, and usually Part D coverage into one plan. Medicare Advantage, also known as 'Medicare Part C', must cover all emergency and urgent care, and almost all medically necessary services Original Medicare covers. Your rights and protections are the same.

Medicare Advantage plans like this one may offer some extra benefits such as a fitness membership, 24-hour nurse advice line, or discount program. Plans also coordinate care and offer disease prevention and management resources. The plan takes care of all claims and coordinates Original Medicare benefits for you. You won't need your Medicare card to receive services or prescription drugs, just your BCBSTX member ID card. Costs for monthly premiums and the services you receive vary depending on your group retiree plan. You must continue to pay your Part B premium.

For more information about Medicare Advantage plans, visit **Medicare.gov** or refer to your Medicare & You handbook mailed annually by the Federal government.

Medicare Prescription Drug Plan (Part D)

Q. Does my plan cover any prescription drugs?

A. Both plans cover drugs or services that are normally covered by Medicare Part B and Part D.

Q. Can I continue to use manufacturer coupons and/or discount cards with this plan?

A. Federal law forbids people who have Medicare from using coupons or other discounts with their Part D plan. These may only be used outside of your Part D benefit.

Q. How do I know if a pharmacy is in-network or if my drug is covered?

A. Go to **www.myprime.com/**. You can check to see if your chosen pharmacy is in-network or if a drug you take is listed in the formulary.

Q. What type of formulary does PEBC offer to its retirees?

A. 5 Tier Premier Formulary

Dates and Timing

Q. When will my Medicare Parts A and B coverage be effective?

A. Coverage is effective on the first day of the month following the date the application was processed or the Medicare Parts A and B effective date, whichever is later.

Q. When will I get my new Medicare Advantage member ID card?

A. You should receive it within 10-14 days after Medicare approves your enrollment. You will receive three separate mailings: an acknowledgment letter followed by a confirmation letter and then your new card.

Q. When will my Medicare Advantage plan start?

A. For people aging into Medicare throughout the year, coverage is effective on the first day of the month following the date your application was processed or your Medicare Part A and Part B effective date, whichever is later.

Providers

Q. Will I be able to see my current providers?

A. Under the Medicare Advantage Open Access PPO plan, which is a 'non-differentiated' or 'passive' PPO, you can go to any providers who: 1) accept Medicare; 2) agree to see you as a patient; and 3) will send claims to the plan. Providers do not need to be part of any Blue Cross and Blue Shield network. Members' coverage levels are the same inside and outside their plan service area nationwide for covered benefits. Referrals aren't required for office visits. Prior authorization may be required for certain services from providers

who are Medicare Advantage-contracted with BCBSTX. Please note: Even providers who accept Medicare can decide which patients they want to see, except in an emergency. We recommend that you confirm that yours will accept and submit claims to this Open Access plan. Share the enclosed 'Your Providers, Your Personal Network' flyer with your providers. It explains your plan and how to submit claims.

Under the Medicare Advantage HMO plan, you can only continue to see your current providers if they are in our network. If you choose a PCP or use providers outside the network, you may pay full cost for your care. If your current PCP is not in the network but would like to join, they can call the customer service number on the back of your ID card.

Q. Will my provider be able to submit claims easily to the plan?

A. We make the claims process simple. We take care of any interactions with Medicare. Instead of submitting claims to Medicare, your providers will send them directly to the plan. If you choose the Open Access PPO plan, providers outside of Texas will file claims with their local BCBS plan. They are familiar with how to do this. If you choose the HMO plan, your providers will follow their normal process when filing claims with BCBSTX. The customer service number listed on the back of your member ID card is for you or your provider to call with any questions.

Q. How do I find out if my provider is in-network?

A. You can go to Provider Finder on our website at **www.bcbstx.com/retiree-medicare-tools** and select the plan in which you want to enroll. The Provider Finder will open in a new window. Follow the prompts (you can search as a guest, without signing in) or call customer service.

Costs

Q. What are the costs of Medicare outside my group retiree plan?

A. Part A will not cost you anything if you or your spouse paid into Social Security for a minimum of 10 years. You pay a premium each month for **Part B**. Most people will pay the standard premium amount. Your Part B premium will be automatically deducted from your benefit payment if you get benefits from one of these:

- Social Security
- Railroad Retirement Board
- Office of Personnel Management

If you don't get these benefit payments, you will receive a Part B premium bill.

Part B and Part D monthly premiums change each year. And, if your income is above a certain limit, you'll pay a surcharge to the government in addition to your premium. This is called **IRMAA**: Income-Related Monthly Adjustment Amount. Any Part B and Part D IRMAA surcharge is based on the modified adjusted gross income reported on your IRS tax return from two years ago. A notice from Medicare will be mailed to those who will pay the IRMAA surcharge(s).

If you've had a life-changing event that reduced your household income, you can ask Social Security to lower the additional amount you'll pay.

Q. What happens if I do not pay my Part B premiums?

A. Non-payment of Part B premiums and/or IRMAA surcharges will result in termination of coverage

Spouse and Dependent Eligibility

Q. Can my spouse or partner be on a different plan?

A. Retirees and Medicare-eligible dependents will be enrolled in the same plan option.

Q. Are my dependents eligible?

A. Dependents are defined as a spouse, a child under the age of 26, or an eligible, incapacitated

dependent over the age of 26 who is included under the retiree's medical coverage through PEBC. Check with your employer about your dependent needs. Different plan scenarios apply depending on Medicare eligibility:

- If the retiree and dependents are all eligible for Medicare, then all can be enrolled in the plan.
- If a spouse or dependent is not eligible for Medicare, then the retiree is enrolled in the Medicare plan and the dependents are enrolled in the PEBC PPO plan.
- If the retiree is not eligible for Medicare but dependents are, then all will remain on the PEBC PPO plan until all are eligible for Medicare.
- If neither the retiree nor dependents are eligible for Medicare, then all will remain on the PEBC PPO plan until all are eligible for Medicare.

Q. Will I be able to see my current providers?

A. Under the **Medicare Advantage Open Access PPO plan**, which is a 'non-differentiated' or 'passive' PPO, you can go to any providers who: 1) accept Medicare; 2) agree to see you as a patient; and 3) will send claims the plan. Providers do not need to be part of any Blue Cross and Blue Shield network.

Members' coverage levels are the same inside and outside their plan service area nationwide for covered benefits. Referrals aren't required for office visits. Prior authorization may be required for certain services from providers who are Medicare Advantage-contracted with BCBSTX.

Please note: Even providers who accept Medicare can decide which patients they want to see, except in an emergency. We recommend that you confirm that yours will accept and submit claims to this Open Access plan. Share the enclosed 'Your Providers, Your Personal Network' flyer with your providers. It explains your plan and how to submit claims.

Under the **Medicare Advantage HMO plan**, you can only continue to see your current providers if they are in the network. If you choose a PCP or use providers outside the network, you may pay full cost for your care. If your current PCP is not in the network but would like to join, they can call the customer service number on the back of your ID card.

Q. Will my provider be able to submit claims easily to the plan?

A. We make the claims process simple. We take care of any interactions with Medicare. Instead of submitting claims to Medicare, your providers will send them directly to the plan. If you choose the Open Access PPO plan, providers outside of Texas will file claims with their local BCBS plan. They are familiar with how to do this. If you choose the HMO plan, your providers will follow their normal process when filing claims with BCBSTX. The customer service number listed on the back of your member ID card is for you or your provider to call with any questions.

Q. How do I find out if my provider is in-network?

A. You can go to Provider Finder on the website at **www.bcbstx.com/retiree-medicare-tools** and select the plan in which you want to enroll. The Provider Finder will open in a new window. Follow the prompts (you can search as a guest, without signing in) or call customer service.

The pre-enrollment Education Helpline can be reached at **1-877-842-7564** TTY **711**.

Post-enrollment Customer Service can be reached at **1-877-299-1008** TTY **711**.

Low-Income Subsidy for Part D

Q. Are there resources to help with the high cost of drugs?

A. Financial assistance to help with the costs of prescription drugs, like deductibles and copays, may be available through the government's Low Income Subsidy program, also called Extra Help. You can apply for it any time. Visit the Social Security web site at www.ssa.gov and click "Medicare," then "Apply for Part D Extra Help."

Q. What is a Low-Income Subsidy?

A. A low-income subsidy is a CMS-initiated program to help those with lower incomes pay their premiums. You are not automatically enrolled for a low-income subsidy.

International Travel

Q. Will I be covered if I travel internationally?

A. The Blue Cross and Blue Shield Global Core program gives members traveling outside of the United States and its territories access to urgent and emergency medical assistance services and doctors and hospitals in more than 200 countries around the world.

Communications

Q. Will I receive a periodic Medicare statement based on the plan I select?

A. You will receive your Explanation of Benefits (EOB) from Blue Cross and Blue Shield of Texas. How often you receive one depends on how often you see a provider or fill a prescription. The EOB is a statement, not a bill. It simply details what you have paid and indicates the level of benefits you've used.

Q. What happens if I have a pre-existing condition?

A. If you have a pre-existing condition, you cannot be refused coverage, your coverage cannot be canceled, and your claims for covered services cannot be denied.

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

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.

Prior Authorizations

Q. Which medical services need prior authorization?

A. Prior Authorization (PA) is when a contracted provider needs to get approval from the health plan to deliver a service. The goal is to make sure the treatment or service is covered by Medicare, the best for the member, medically necessary and safe. PA is needed for:

- Advanced Imaging (MRI, MRA, CT scans and PET scans)
- Lab Management Solutions – molecular and genomic lab testing
- Musculoskeletal – pain/joint/spine services – excludes exams, physical therapy, and occupational therapy
- Inpatient stay that is not the result of an emergency
- Outpatient medical oncology, radiation therapy, sleep study, and specialty drugs
- Select Durable Medical Equipment
- Some procedures that are performed as part of an inpatient stay

Twenty-three (23) hour observation and emergency room visits do not need PA. Your provider will work with the plan to get any PA you may need and may talk with you about other options, if necessary.

Q. What happens if a PA is not completed?

A. Your provider is responsible for getting a PA for you. If they fail to get a PA before providing a service, the plan may not pay the claim and the provider would have to absorb the cost of the service. You are not required to pay for the service if the provider fails to get a required PA. Providers can request a PA by calling the customer service number listed on your member ID card, or via fax. They may also use our provider service through Availity® Essentials.*

*Availity is a trademark of Availity, LLC, a separate company that operates a health information administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

Miscellaneous

Q. What is an LEP or Late Enrollment Penalty?

A. A Late Enrollment Penalty is a monetary penalty incurred if the prospective member does not enroll within three months of turning 65.

Q. What is an RFI or Request for Information?

A. An RFI, or Request for Information, is a CMS-directed request regarding a prospective member's enrollment. It means either their application is missing information or more context is needed regarding their individual situation. A prospective member has 21 days to respond to the RFI.

Q. What happens if I do not have or cannot enroll in Medicare Parts A and/or B?

A. Medicare Advantage requires you have both Medicare Parts A and B before you can enroll in Part C. You will need both to enroll in either the Open Access PPO or HMO plan.

Q. What is the BCBSTX Customer Service number?

A. The pre-enrollment Education Helpline can be reached at **1-877-842-7564** TTY **711**.

Post-enrollment Customer Service can be reached at **1-877-299-1008** TTY **711**.

Q. What is the BCBSTX group retiree website?

A. Please visit **www.bcbstx.com/retiree-medicare-pebc.**

2025 Important notices

The following notices are intended for benefits-eligible members enrolled in a PEBC health plan for the 2025 plan year. If you are not eligible for or enrolled in a PEBC plan, the notices will not apply to you.

Contents

Uniform Summary of Benefits and Coverage (SBC)

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

Genetic Information 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 Open Access Plan and the HMO 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. 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.
- 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 2025 plan year, beginning Jan. 1, 2025, and ending Dec. 31, 2025. The exemption may be renewed for subsequent plan years. Please note that PEBC employer groups currently voluntarily provide coverage that substantially complies with the requirements of the Newborn and Mother's Protection Act and the WHCRA.

Medicare Part D Notice of Creditable Coverage

Important notice from your employer about your prescription drug coverage and Medicare. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage offered through your Employer's group benefit plans and about your options under Medicare's prescription drug coverage.

This information can help you decide whether or not you want to keep only your Employer's group benefit plans and about your options under Medicare's prescription drug 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: **myalhipp.com/**

Phone: **1-855-692-5447**

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website: **myakhipp.com/**

Phone: **1-866-251-4861**

Email: **CustomerService@MyAKHIPP.com**

Medicaid Eligibility:
health.alaska.gov/dpa/Pages/ default.aspx

ARKANSAS – Medicaid

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

California – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program **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:
www.healthfirstcolorado.com/

Health First Colorado Member Contact Center:
1-800-221-3943 | State Relay **711**

CHP+: **hcpf.colorado.gov/child-health-plan-plus**

CHP+ Customer Service: **1-800-359-1991**

State Relay **711**

Health Insurance Buy-In Program (HIBI):
www.mycohibi.com/
HIBI Customer Service: **1-855-692-6442**

FLORIDA – Medicaid

Website:
www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html

Phone: **1-877-357-3268**

GEORGIA – Medicaid

Website:
medicaid.georgia.gov/health-insurance- premium-payment-program-hipp

Phone: **1-678-564-1162** Press **1**

GA CHIPRA website: **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: **www.in.gov/fssa/hip/**
Phone: **1-877-438-4479**

All other Medicaid

HIPP Website: **www.in.gov/medicaid/**

HIPP Phone **1-800-457-4584**

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: **dhs.iowa.gov/ime/members**

Medicaid Phone: **1-800-338-8366**

Hawki Website: **dhs.iowa.gov/Hawki**

Hawki Phone: **1-800-257-8563**

HIPP Website:
dhs.iowa.gov/ime/members/ medicaid-a-to-z/hipp

HIPP Phone: **1-888-346-9562**

KANSAS – Medicaid

Website: **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: **chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**

Phone: **1-855-459-6328**

Email: **KIHIPP.PROGRAM@ky.gov**

KCHIP Website: **kidshealth.ky.gov/Pages/index.aspx**

Phone: **1-877-524-4718**

Kentucky Medicaid Website: **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: **www.mymaineconnection.gov/benefits/s/?language=e n_US**

Phone: **1-800-442-6003** TTY: Maine relay **711**

Private Health Insurance Premium Website: **www.maine.gov/dhhs/ofi/applications-forms** Phone: **1-800-977-6740** TTY: Maine relay **711**

MASSACHUSETTS – Medicaid and CHIP

Website: **www.mass.gov/masshealth/pa**

Phone: **1-800-862-4840** TTY: **(617) 886-8102**

MINNESOTA – Medicaid

Website: **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: **www.dss.mo.gov/mhd/participants/ pages/hipp.htm**

Phone: **1-573-751-2005**

MONTANA – Medicaid

Website: **dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**

Phone: **1-800-694-3084**

Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – Medicaid

Website: **www.ACCESSNebraska.ne.gov**

Phone: **1-855-632-7633**

Lincoln: **1-402-473-7000**

Omaha: **1-402-595-1178**

NEVADA – Medicaid

Medicaid Website: **dhcfp.nv.gov**

Medicaid Phone: **1-800-992-0900**

NEW HAMPSHIRE – Medicaid

Website: **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: **www.state.nj.us/humanservices/ dmahs/clients/medicaid/**

Medicaid Phone: **1-609-631-2392**

CHIP Website: **www.njfamilycare.org/index.html**

CHIP Phone: **1-800-701-0710**

NEW YORK – Medicaid

Website: **www.health.ny.gov/health_care/medicaid/**

Phone: **1-800-541-2831**

NORTH CAROLINA – Medicaid

Website: **medicaid.ncdhhs.gov/**

Phone: **1-919-855-4100**

NORTH DAKOTA – Medicaid

Website: **www.nd.gov/dhs/services/medicalserv/medicaid/**

Phone: **1-844-854-4825**

OKLAHOMA – Medicaid and CHIP

Website: **www.insureoklahoma.org**

Phone: **1-888-365-3742**

OREGON – Medicaid

Website:
healthcare.oregon.gov/Pages/index.aspx
www.oregonhealthcare.gov/index-es.html

Phone: **1-800-699-9075**

PENNSYLVANIA – Medicaid and CHIP

Website:
www.dhs.pa.gov/Services/Assistance/ Pages/HIPP-Program.aspx

Phone: **1-800-692-7462**

CHIP Website: **www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP**

Phone: **1-800-986-KIDS** (**5437**)

SOUTH CAROLINA – Medicaid

Website: **www.scdhhs.gov**

Phone: **1-888-549-0820**

SOUTH DAKOTA – Medicaid

Website: **dss.sd.gov**

Phone: **1-888-828-0059**

TEXAS – Medicaid

Website: **www.hhs.texas.gov/services/health/medicaid-chip**

Phone: **1-800-440-0493**

UTAH – Medicaid and CHIP

Medicaid Website: **medicaid.utah.gov/**

CHIP Website: **health.utah.gov/chip**

Phone: **1-877-543-7669**

VERMONT– Medicaid

Website: **dvha.vermont.gov/members/medicaid/hipp-program**

Phone: **1-800-250-8427**

VIRGINIA – Medicaid and CHIP

Website:
www.coverva.org/en/famis-select
www.coverva.org/en/hipp

Medicaid Phone: **1-800-432-5924**

CHIP Phone: **1-800-432-5924**

WASHINGTON – Medicaid

Website: **www.hca.wa.gov/**

Phone: **1-800-562-3022**

WEST VIRGINIA – Medicaid and CHIP

Website: **dhhr.wv.gov/bms/ mywvhipp.com/**

Medicaid Phone: **1-304-558-1700**

CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: **www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**

Phone: **1-800-362-3002**

WYOMING – Medicaid

Website:
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, 2024, 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

2025 Important Notices

PEBC Privacy Notice

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 providers consults with a specialist about 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);
- For Workers' Compensation or other similar programs established by law that provide benefits for work- related injuries or illness without regard to fault;
- In special situations, the Plan may disclose to one of your family members, to a relative, to a close personal friend or to any other person identified by you, Protected Health Information that is directly relevant to the person's involvement with your care or payment related to your care. In addition, the Plan may use or disclose the Protected Health Information to notify a member of your family, your personal representative, another person responsible for

your care, or certain disaster relief agencies of your location, general condition or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, those involved in Plan administration will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your health care.

Uses and disclosures for which an authorization is required

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

Your rights regarding Protected Health Information

You have the right to:

Inspect and Copy Your Protected Health Information: Upon written request, you have the right to inspect and get copies of your Protected Health Information (and that of an individual for whom you are a legal guardian). There are some limited exceptions.

Request an Amendment: You have the right to amend or correct inaccurate or incomplete Protected Health Information. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Receive an Accounting of Non-Routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your Protected Health Information. However, you are not entitled to an accounting of several types of disclosures including, but not limited to:

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

Request Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your Protected Health Information as we carry out payment, treatment or health care operations. You may also ask us to restrict how we use and disclose your Protected Health Information to your family members, relatives, friends or other persons you identify who are involved in your care or payment for your care. We do not have to agree to these additional restrictions, but if we do, we must abide by our agreement (except in emergencies).

Request Confidential Communications: You may request to receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may want to have Protected Health Information sent only by mail or to an address other than your home.

Receive Notice of a Breach: You have the right to be notified upon a breach of your unsecured Protected Health Information, if a disclosure occurs that meets the definition and thresholds of a breach under the law.

Receive a Paper Copy of This Notice: You have the right to a paper copy of this Notice, even if you have agreed to receive this notice electronically.

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

About this Notice

The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all Protected

Health Information maintained. If this Notice is changed, you will receive a new Notice by mail or by a Notice posted on the PEBC website, at **pebcinfo.com.**

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

Contacting the plan administrator

You may exercise the rights described in this Notice by contacting the office identified below. They willprovide 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.

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

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**.

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 Blue Cross and Blue Shield of Texas 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.

This is not a complete description of benefits. Please refer to your plan documents for details. The relationship between these vendors and Blue Cross and Blue Shield of Texas is that of independent contractors. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by the above-mentioned vendors.

Important vendor contacts

	Benefit	Vendor	Phone number	Email/web address
All Retrees	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
Non-Medicare Eligible	Retiree premium billing	BCBSTX	1-877-237-8576	
	Medical	BCBSTX	1-888-306-5753	bluemembertx.com
	Pharmacy Rx	Prime	1-888-306-5753	myprime.com
	Specialty pharmacy	Acredo	1-833-721-1619	accredo.com
	Mental health	BCBSTX	1-888-306-5753	bluemembertx.com
	NurseLine	BCBSTX	1-800-581-0393	
Medicare Eligible	Medicare Advantage Customer Service/BAM	BCBSTX	1-877-299-1008 TTY 711	bluemembertx.com
	Hearing aids	TruHearing	1-844-855-9536 TTY 711	truhearing.com/how-it-works
	Fitness benefit	SilverSneakers	1-888-423-4632 TTY 711	silversneakers.com/starthere
	Post-discharge meal delivery	Mom's Meals	1-877-299-1008 TTY 711	momsmeals.com
	Post-discharge transportation	ModivCare	1-877-299-1008 TTY 711	
	Private Duty Nursing		1-877-299-1008 TTY 711	
	NurseLine	BCBSTX	1-800-631-7023 TTY 711	

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.

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.

Disclaimers

Prime Therapeutics LLC is a pharmacy benefit management company, contracted by Blue Cross and Blue Shield of Texas (BCBSTX) to provide pharmacy benefit management services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Accredo is a specialty pharmacy that is contracted to provide services to members of Blue Cross and Blue Shield of Texas. Accredo is a trademark of Express Scripts Strategic Development, Inc.

Amazon Pharmacy is contracted to provide pharmacy home delivery services to Blue Cross and Blue Shield of Texas.

Walgreens Mail Service is contracted to provide mail pharmacy services to members of Blue Cross and Blue Shield of Texas.

Walgreens Specialty Pharmacy is contracted to provide specialty pharmacy services to members of Blue Cross and Blue Shield of Texas.

Prime Therapeutics LLC provides pharmacy benefit management services for Blue Cross and Blue Shield of Texas and is owned by 19 Blue Cross and Blue Shield Plans, subsidiaries or affiliates of those plans.

Virtual Visits may be limited by plan. For providers licensed in New Mexico and the District of Columbia, Urgent Care service is limited to interactive online video; Behavioral Health service requires video for the initial visit but may use video or audio for follow-up visits, based on the provider's clinical judgment. MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Modivcare, formerly LogistiCare, is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide transportation services for members with coverage through BCBSTX.

Blue365 is a discount program only for BCBSTX members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Employees should check their benefit booklet or call the Customer Service number on the back of their ID card for specific benefit facts. Use of Blue365 does not change monthly payments, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors that take part in this program. BCBSTX does not guarantee or make any claims or recommendations about the program's services or products. Members should consult their doctor before using these services and products. BCBSTX reserves the right to stop or change this program at any time without notice.

The Healthy Activity Portal is a website owned and operated by HealthMine, Inc., an independent company, that has contracted with Blue Cross and Blue Shield of Texas to provide digital health and personal clinical engagement tools and services for members with coverage through BCBSTX.

SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company. Tivity Health and SilverSneakers® are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries.

Express Scripts® Pharmacy is a pharmacy that is contracted to provide mail pharmacy services to members of Blue Cross and Blue Shield of Texas. Express Scripts® Pharmacy is a trademark of Express Scripts Strategic Development, Inc.

HMO and PPO plans provided by Blue Cross and Blue Shield of Texas, which refers to HCSC Insurance Services Company (HISC) and GHS Insurance Company (GHSIC). HMO and PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC, HISC and GHSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC, HISC and GHSIC are Medicare Advantage organizations with a Medicare contract. Enrollment in these plans depends on contract renewal.

pebc
PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

If you are eligible for Medicare and have questions about your PEBC retiree Medicare plan options, call the Education Helpline

1-877-842-7564 TTY **711**

We are open October 1 – March 31: Daily, 8:00 a.m. to 8:00 p.m., Local Time
April 1 – September 30: Monday through Friday, 8:00 a.m. to 8:00 p.m., Local Time.
Alternate technologies (for example, voicemail) will be used on weekends and holidays.

Or visit **www.bcbstx.com/retiree-medicare-pebc**.