

pebc
PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

Retiree Health Benefits Enrollment 2027

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 2027 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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This information applies to all retirees.

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Required Enrollment Action

MEDICAL PLAN SPOUSE SURCHARGE

If your spouse's employer offers a medical plan, your spouse did not enroll in that plan and you cover your spouse in your employer PPO medical plan or HDP 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 employer PPO medical plan or HDP 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 Veterans Affairs (VA) facility; and
- You turned in the required Spouse Medical Plan Surcharge Affidavit on time

For questions about the spousal surcharge or to obtain a copy of the required Spouse Medical Plan Surcharge Affidavit, please contact your HR/Benefits department.

Spousal surcharge will not apply to Tarrant County retirees in 2027.



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.



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 2027.

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?

After 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

Dependent Eligibility (cont.)

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

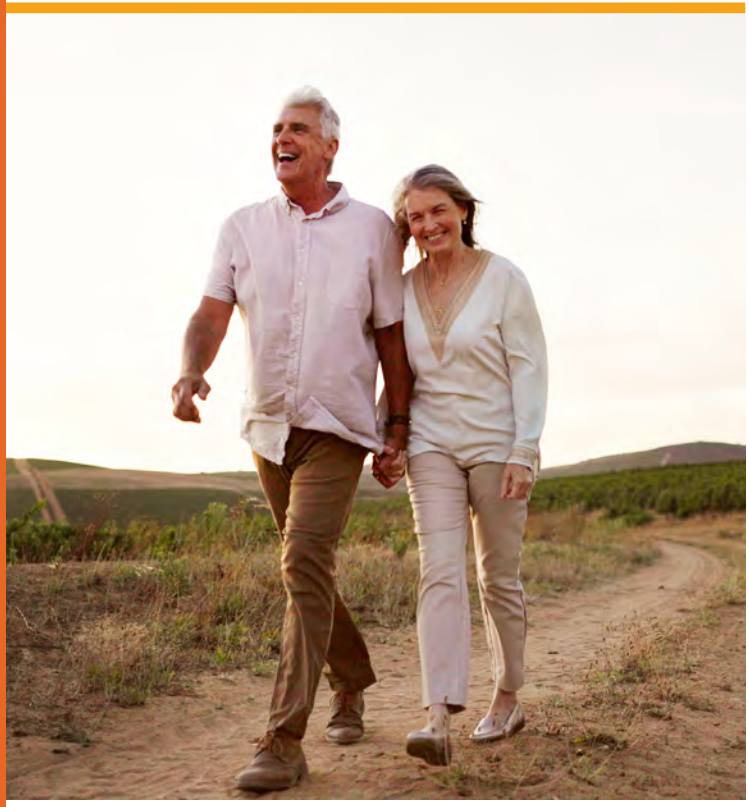
IRS regulations state that unless you experience a qualified change in status event (described below), you cannot change your benefit choices until the next annual enrollment period.

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 2 of this guide for more information.



IMPORTANT DEADLINES APPLY

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

Dependent Eligibility (cont.)

QUALIFIED EVENTS

Change in family status includes:

- 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

QUALIFIED EVENTS

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.



Helpful Tools

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

- 2027 Retiree Health Benefits Enrollment Guide
- 2027 Retiree Benefits Rate Sheet — Lists retiree contribution rates for each plan
- Important Notices — 2027



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 Standard. 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 Standard 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 have the ability to continue your Optional Term Life and Dependent Group Life Benefits through The Standard's portability feature. Portability rates are higher than the cost available to active members. Contact The Standard for cost information.

CONVERSION

Conversion allows employees and covered dependents to convert all or part of Basic Employee Life, Optional Term Life, and Dependent Group life to an individual whole life policy. Whole life costs more than group term coverage. Contact The Standard 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 administrator for automatic premium payments. HealthEquity will automatically deduct the correct 2027 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 2027 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 2027 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 2027, 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:**
$625 for individual (single) coverage	$1,000 for each individual (single)
$1,250 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 $1,250. If one family member reaches $625 but the combined family deductible of $1,250 has not been met, the member who met the $625 deductible can move to coinsurance until one more family member reaches the deductible. If no family member reaches the $625 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:

$1,750 individual (single) deductible

$3,500 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 $3,500. Even if one family member reaches the $1,750 deductible, that member cannot move to coinsurance.

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 are participating 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. PEAQSM-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**.



PPO Plan Quick Reference Guide

Refer to plan documents for limitations and additional information.

PPO Medical Plan		
Feature	**Your Network Cost**	**Your Out-Of-Network Cost** PLUS You Pay Charges Exceeding Plan Payment
Annual deductible	$625 individual/$1,250 family	$1,000 each person
Coinsurance (after the annual deductible is met)	20% after deductible	40% after deductible
Annual coinsurance maximum	$2,500 individual/$5,000 family	No limit
Annual out-of-pocket maximum (OOP)	$3,125 individual/$6,250 family Plan pays 100% after annual OOP	No limit
Physician Services		
Preventive Care	$0 — Plan pays 100%	40% after deductible
Office visits	$15 PCP/$25 specialist	40% after deductible
24/7 Virtual Visits (MDLIVE)	$0 — Plan pays 100%	$0 deductible does not apply
Telehealth	$15 PCP/$25 specialist	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visit	$35 copay	40% after deductible
Maternity Services		
Delivery and Newborn Care in hospital (routine)	20% after deductible	40% after deductible
Infertility services: 5 artificial insemination visits	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
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
Mental Health Services		
Outpatient visits	$25 visit	40% after deductible
Inpatient	20% after deductible	40% after deductible

NON-MEDICARE ELIGIBLE

HDP Quick Reference Guide

Refer to plan documents for limitations and additional information.

HDP Medical Plan		
Feature	**Your Network Cost**	**Your Out-Of-Network Cost** PLUS You Pay Charges Exceeding Plan Payment
Annual deductible	$1,750 individual/$3,500 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)	$3,100 individual/$6,200 family Plan pays 100% after annual OOP	No limit
Physician Services		
Preventive Care	$0 — Plan pays 100%	40% after deductible
Office visits	20% after deductible	40% after deductible
24/7 Virtual Visits (MDLIVE)	$0 — Plan pays 100%	40% after deductible
Telehealth	20% after deductible	40% after deductible
Hospital visits	20% after deductible	40% after deductible
Urgent care visit	20% after deductible	40% after deductible
Maternity Services		
Delivery and Newborn Care in hospital (routine)	20% after deductible	40% after deductible
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
Hospital emergency care services (treated as network)	20% after deductible	20% after deductible
Mental Health Services		
Outpatient visits	20% after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible

Using Your Prescription Benefits

Your prescription drug benefit helps you and your family access the medications you need, from everyday prescriptions to specialty drugs, at an affordable cost.

Below is a summary of your 2027 prescription drug benefits.

Rx Refill Options	PPO	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



Home Delivery by Express Scripts® Pharmacy

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.
- Prescriptions are delivered to the address of your choice, within the U.S., with free standard shipping.

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 **express-scripts.com/rx** or call **1-833-715-0942**.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

USE THE MOBILE APP TO MANAGE YOUR PRESCRIPTIONS



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

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. 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.

Prescription Benefits (cont.)

UNDERSTANDING SPECIALTY DRUGS

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 caregiver). 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. Your doctor may also order select specialty drugs that must be given to you by a health professional through Accredo.

DO YOU NEED SPECIALTY MEDICATIONS?

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 **bcbstx.com** to see the up-to-date list of specialty drugs.

Condition	Sample Medications
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

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 833-721-1619**.

An Accredo representative will work with your doctor on the rest. Once registered, you can manage your prescriptions on **accredo.com** or through the mobile app.

Important Information About Health Savings Accounts (HSA)

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

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

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

Once your account is open, contact your bank for detailed information about eligible expenses and your responsibilities regarding contributions and record keeping. Your employer cannot provide you tax advice.

If you enroll in Medicare, you are no longer eligible to contribute to an HSA; however, you can use the funds already in your HSA for qualified medical expenses (see IRS Publication 969). Contact the IRS or consult with a qualified tax advisor for specific advice about your situation.





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
- Piano 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 Vision

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.

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

EXCLUSIONS AND LIMITATIONS

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

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

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

Dental Benefits

For 2027, 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

DELTA DENTAL HMO PLAN (DELTACARE USA DHMO)

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



SEE WHICH NETWORK IS RIGHT FOR YOU:

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

Dental Benefits (cont.)

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.

Procedure	Network	Out-of-Network
Deductible (per person) Annual maximum benefit (per person)*	$50 (maximum of $150) $2,000	$50 (maximum of $150) $2,000
Preventive • 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 • Dentures and bridges • Implants	50%, after deductible	50%, after deductible
Orthodontia Benefits begin after 12 months of coverage; orthodontic lifetime deductible and maximum (per person)	50% after lifetime deductible $1,750	50% after lifetime deductible $1,750

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

Getting the Right Care at the Right Time

YOUR CARE OPTIONS

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

WE MAKE IT EASY TO FIND INDEPENDENTLY CONTRACTED, IN-NETWORK PROVIDERS NEAR YOU:

- Go to bcbstx.com and click Find Care
- For personalized search results, go to **bcbstx.com**, click Log In or Sign Up, choose Member Log In or Sign Up and search in Blue Access for Members
- Call BCBSTX Customer Service at the number on your ID card

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: **1-800-581-0393** • 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 Non-Medicare Eligible: **1-888-680-8646** Medicare Eligible: **1-866-954-3585 • TTY users call 1-800-770-5531** • Go online: Non-Medicare Eligible: **MDLIVE.com/bcbstx** Medicare Eligible: **www.mdlive.com/bcbstx-medicare**
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 other providers 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
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.

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

Getting the Right Care at the Right Time (cont.)

YOUR CARE OPTIONS

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

2027 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-tool**s to find a participating provider.

Referrals are required to see a specialist.



Choosing the Medicare Plan That's Right for You (cont.)

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 2027 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

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

SPECIALTY PHARMACIES

Walgreens Specialty Pharmacy
Visit walgreensspecialtyrx.com
Call 1-877-627-6337 TTY 711

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

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

Choosing the Medicare Plan That's Right for You (cont.)

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**.

1. Select 'Medicines,' then:
2. 'Find medicines,' followed by
3. 'Continue without sign in'
4. Under 'Select Your Health Plan':
5. Select BCBS Texas
6. Answer 'Yes'
7. 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
8. Click 'Continue'
9. Type your medicine and dosage.

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

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 Medicare 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 homehealth 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 provider 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**).

Additional Benefits Included with the Group Medicare Plans (cont.)

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 HealthyActions 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

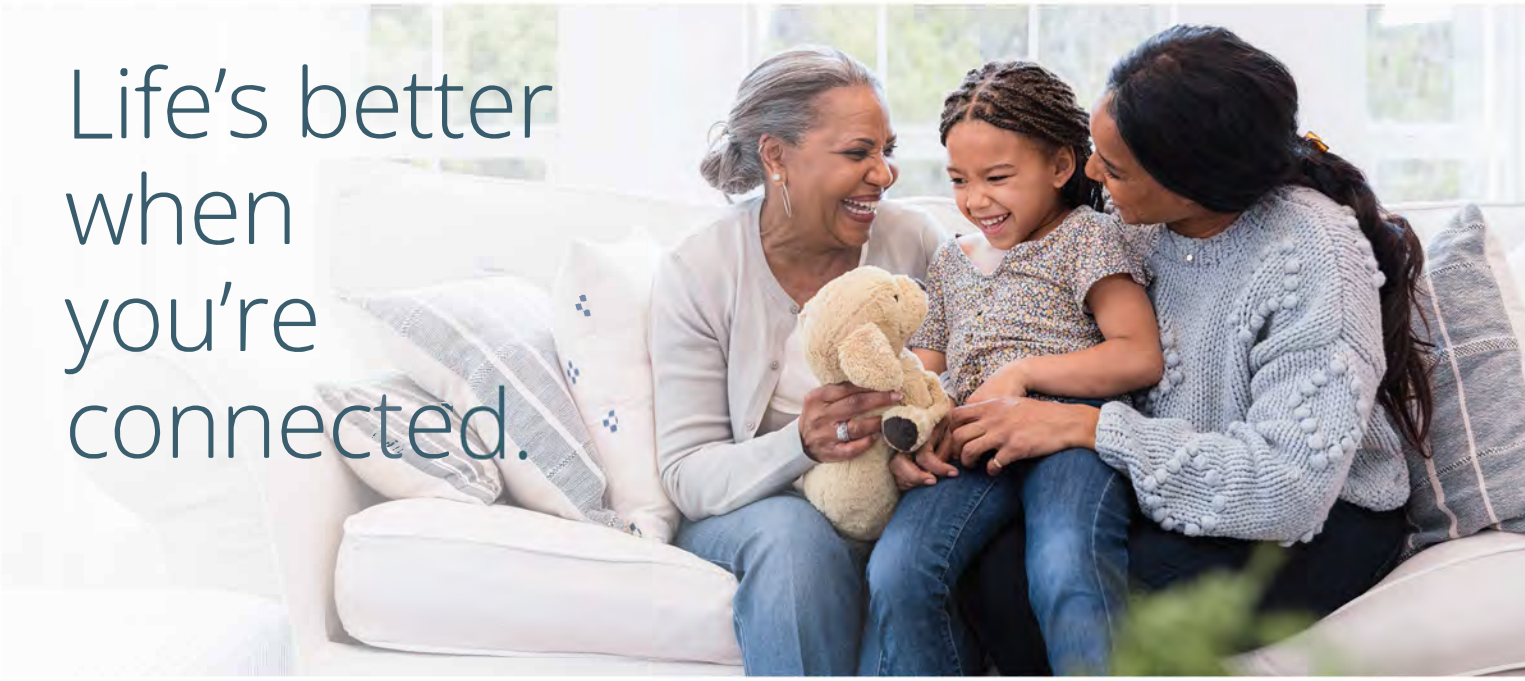
Your plan covers 1 routine hearing exam per year provided by TruHearing and a $500 hearing aid allowance for both ears over 36 months. Visit the TruHearing website at **www.truhearing.com** or call **1-844-855-9536** (TTY **711**) to learn more.



MEDICARE ELIGIBLE

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 2027 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 2027 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.

1Smartphone-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.

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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 stay	$0 copay per day
Benefit Period 21–100 days Limited to 100 days per Medicare Benefit Period	$0 copay per stay	$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 per day
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 per day

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
Eye Exam (Medicare-covered) Coverage for eye exams limited to specific condition.	$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	$0 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
Outpatient Surgery/Ambulatory Surgical Center (ACS) Services	$0 copay	$125 copay
OP Blood Services — Coverage begins with the first pint of blood	$0 copay	$125 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
Outpatient Substance Abuse: Group Visit	$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)℠**	
Other Supplemental Benefits continued				
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	$2,400			
Catastrophic Coverage Member Cost Share	$0			

Blue Cross Group Medicare Advantage℠ —60-day supply				
Pharmacy	**Blue Cross Group Medicare Advantage Open Access (PPO)℠**		**Blue Cross Group Medicare Advantage (HMO)℠**	
Other Supplemental Benefits continued				
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	$2,400			
Catastrophic Coverage Member Cost Share	$0			

Blue Cross Group Medicare Advantage℠ —90-day supply				
Pharmacy	**Blue Cross Group Medicare Advantage Open Access (PPO)℠**		**Blue Cross Group Medicare Advantage (HMO)℠**	
Other Supplemental Benefits continued				
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	$2,400			
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

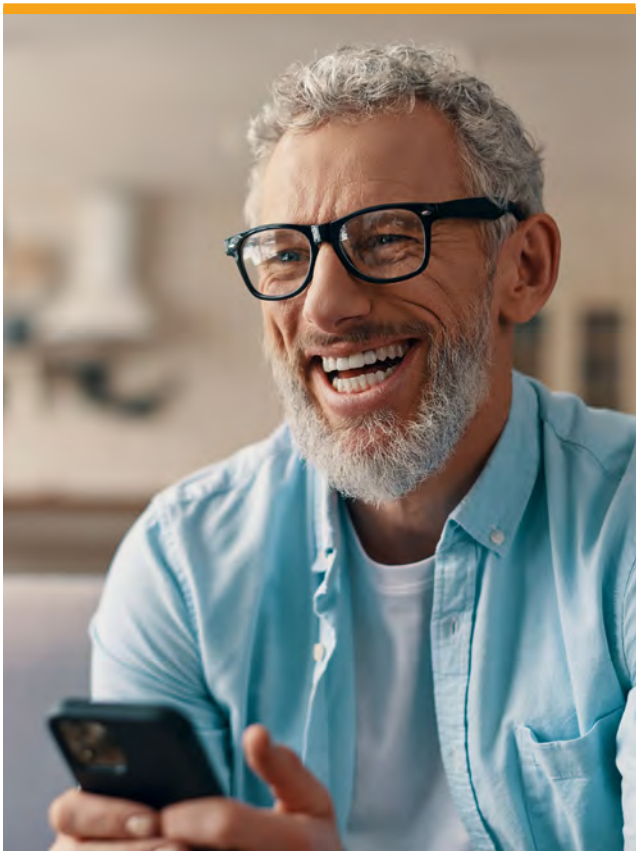
Be sure to show the new Medicare Advantage card to your providers and pharmacy. Remind them that your old ID and number are no longer valid.

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



Frequently Asked Questions for Retirees
Transitioning to a New Medicare Plan (cont.)

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.



Frequently Asked Questions for Retirees
Transitioning to a New Medicare Plan (cont.)

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.

Frequently Asked Questions for Retirees
Transitioning to a New Medicare Plan (cont.)

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 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**.

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.

Frequently Asked Questions for Retirees
Transitioning to a New Medicare Plan (cont.)

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.

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

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.

Frequently Asked Questions for Retirees
Transitioning to a New Medicare Plan (cont.)

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.**



Required Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment

Required Notices (cont.)

practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.

To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit **healthcare.gov/medicaid-chip/getting-medicaid-chip** for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description, guides, employer information and other plan materials available at pebcinfo.com and during your annual enrollment period. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see **irs.gov/pub/irs-drop/rp-22-34.pdf for 2023**.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Required Notices (cont.)

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact your employer.

Your Information. Your Rights. Our Responsibilities.

This notice describes:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH YOUR EMPLOYER IF YOU HAVE ANY QUESTIONS.

Please review it carefully.

YOUR RIGHTS

You have the right to:

- Consent to most uses and disclosures of your health information
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Discuss this notice with someone in our program
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

In these circumstances, we must protect your information and limit how we use and share it.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Required Notices (cont.)

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our health care operations after you have provided consent for all those purposes.
- We are not required to agree to your request, and we may say "no" if, for example, it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly upon such request.

Discuss this notice with someone in our program

You can ask questions or obtain more information about this notice and our privacy practices by calling or emailing the contact person at the top of this notice.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Required Notices (cont.)

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Example 2: A doctor treating you for a chronic condition asks a doctor at our program about your health condition and medications you are taking, for example, to avoid complications

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, or legislative investigations or proceedings against you without (1) your consent or (2) a court order or subpoena. For more information see: **https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence, only as required by applicable law
- Preventing or reducing a serious threat to anyone's health or safety

For your medical emergencies

We may use or share your health information with health care providers or emergency personnel when needed to provide you with emergency treatment or to respond to a serious and immediate threat to your health or safety, even when you are unable to consent. This is allowed under HIPAA's rules for treatment and emergency disclosures.

Do research

We can use or share your information for health research. Researchers cannot include any patient identifying information in their reports about the research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Legal Proceedings and Lawful Process

We may use or share your health information as permitted or required by law when responding to legal proceedings. This includes disclosures in response to a valid court order, warrant, subpoena, or other lawful process, consistent with HIPAA's rules for judicial and administrative proceedings (45 CFR §164.512(e)) and law enforcement requests (45 CFR §164.512(f)).When responding to legal requests, we disclose only the information required and follow all conditions and limitations imposed by HIPAA.

Required Notices (cont.)

Communicate within our program and with contractors
We may use and disclose your information within our health plan and with organizations that help us administer our program, including contractors and business associates who perform services for us. These disclosures occur only as permitted by HIPAA for health care operations.

Respond to audits and program oversight
We may use and share your information for health oversight and health care operations. This includes sharing with government agencies that are authorized by law to conduct audits, inspections, and licensure activities, and with accrediting organizations to support accreditation, quality assessment and improvement, and program evaluation of our health plan. We share only the minimum necessary information as required by law.

Disclosure to Law Enforcement
We may disclose information to law enforcement if we believe, in good faith, that it is evidence of a crime that occurred on our premises, or to report certain crimes during a medical emergency that did not occur on our premises. In these situations, we will disclose only what the law allows in these situations.

OUR RESPONSIBILITIES

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Important Notice from PEBC 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 with PEBC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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 (like an HMO or PPO) 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. **PEBC has determined that the prescription drug coverage offered by the PEBC Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

Required Notices (cont.)

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage will not be affected. If you decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with PEBC and 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 creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare 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 join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Note: 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 this coverage through PEBC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed 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 **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- 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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: 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, therefore, whether or not you are required to pay a higher premium (a penalty).

Continuation Coverage Rights Under COBRA

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it**. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

Required Notices (cont.)

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started

Required Notices (cont.)

at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

You should contact your Employer's Human Resources department first with any questions regarding COBRA continuation coverage. The COBRA Benefit Administrator is HealthEquity. The COBRA Benefit Administrator is responsible for administering COBRA continuation coverage. HealthEquity COBRA Member Services can be reached at 877-722-2667

https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

Required Notices (cont.)

Women's Health and Cancer Rights Act

ENROLLMENT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

- PPO Deductible: $500 individual / $1,000 family
- HDP Deductible: $1,700 individual / $3,400 family
- PPO Coinsurance: 20% after deductible
- HDP Coinsurance: 20% after deductible.

If you would like more information on WHCRA benefits, call your plan administrator.

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the **Frequently Asked Questions (FAQs)** About the Newborns' and Mothers' Health Protection Act.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

Required Notices (cont.)

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your Plan Administrator.

Visit www.bcbstx.com for more information about your rights under federal law.

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 **www.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.

Required Notices (cont.)

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 **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 January 31, 2026. Contact your State for more information on eligibility –

State	Website/Email	Phone
Alabama Medicaid	**myalhipp.com**	855-692-5447
Alaska Medicaid	Premium Payment Program: **myakhipp.com** Medicaid Eligibility: **health.alaska.gov/dpa** Email: **customerservice@myakhipp.com**	866-251-4861
Arkansas Medicaid	**http://myarhipp.com/**	855-MyARHIPP (855-692-7447)
California Medicaid	**dhcs.ca.gov/hipp** Email: **hipp@dhcs.ca.gov**	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: **healthfirstcolorado.com** CHIP: **hcpf.colorado.gov/child-health-plan-plus** HIBI: **mycohibi.com**	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida Medicaid	**flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**	877-357-3268
Georgia Medicaid	HIPP: **medicaid.georgia.gov/health-insurance-premium-payment- program-hipp** CHIPRA: **medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**	678-564-1162, press 1 678-564-1162, press 2
Indiana Medicaid	HIPP: **https://www.in.gov/fssa/dfr/** All other Medicaid: **in.gov/medicaid**	800-403-0864 800-457-4584
Iowa Medicaid and CHIP (Hawki)	Medicaid: **hhs.iowa.gov/programs/welcome-iowa-medicaid** Hawki: **hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki** HIPP: **hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp**	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	**kancare.ks.gov**	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: **chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** KI-HIPP Email: **KIHIPP.PROGRAM@ky.gov** KCHIP: **kynect.ky.gov** Medicaid: **chfs.ky.gov/agencies/dms**	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	Medicaid: **ldh.la.gov/healthy-louisiana or email: healthy@la.gov** LaHIPP: **www.ldh.la.gov/lahipp or email: La.HIPP@la.gov**	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: **mymaineconnection.gov/benefits** Private health insurance premium: **maine.gov/dhhs/ofi/applications-forms**	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711

Required Notices (cont.)

State	Website/Email	Phone
Massachusetts Medicaid and CHIP	**mass.gov/masshealth/pa** Email: **masspremassistance@accenture.com**	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	**mn.gov/dhs/health-care-coverage**	800-657-3672
Missouri Medicaid	**dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana Medicaid	HIPP: **dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** HIPP Email: **HHSHIPPProgram@mt.gov**	800-694-3084
Nebraska Medicaid	**ACCESSNebraska.ne.gov**	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: **dhcfp.nv.gov**	800-992-0900
New Hampshire Medicaid	**dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program** Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**	603-271-5218 or 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: **state.nj.gov/humanservices/dmahs/clients/medicaid** CHIP: **njfamilycare.org/index.html**	Medicaid: 800-356-1561
New York Medicaid	**health.ny.gov/health_care/medicaid**	800-541-2831
North Carolina Medicaid	**medicaid.ncdhhs.gov**	919-855-4100
North Dakota Medicaid	**hhs.nd.gov/healthcare**	844-854-4825
Oklahoma Medicaid and CHIP	**insureoklahoma.org**	888-365-3742
Oregon Medicaid	**healthcare.oregon.gov/Pages/index.aspx**	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: **pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html** CHIP: **dhs.pa.gov/CHIP/Pages/CHIP.aspx**	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	**eohhs.ri.gov**	855-697-4347 or 401-462-0311 (Direct RIte Share Line)
South Carolina Medicaid	**scdhhs.gov**	888-549-0820
South Dakota Medicaid	**dss.sd.gov**	888-828-0059
Texas Medicaid	**hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**	800-440-0493
Utah Medicaid and CHIP	UPP: **medicaid.utah.gov/upp/** UPP Email: **upp@utah.gov** Adult Expansion: **medicaid.utah.gov/expansion/** Utah Medicaid Buyout Program: **medicaid.utah.gov/buyout-program/** CHIP: **chip.utah.gov**	UPP: 877-222-2542
Vermont Medicaid	**dvha.vermont.gov/members/medicaid/hipp-program**	800-250-8427

Required Notices (cont.)

State	Website/Email	Phone
Virginia Medicaid and CHIP	**coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs**	Medicaid/CHIP: 800-432-5924
Washington Medicaid	**hca.wa.gov**	800-562-3022
West Virginia Medicaid and CHIP	**dhhr.wv.gov/bms/ mywvhipp.com/**	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	**dhs.wisconsin.gov/badgercareplus/p-10095.htm**	800-362-3002
Wyoming Medicaid	**health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**	800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

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

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.

Wellness Program Notices

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

However, employees who choose to participate in the wellness program will receive an incentive for completing wellness activities. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities such

Required Notices (cont.)

as having recommended preventive care screenings based on your age and gender, completing wellness learning modules, or participating in fitness activities. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Navigate at **PEBCNavigateWellbeing.com**.

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

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

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

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

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

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

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

ACCOMMODATIONS

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at your HR department and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Important Vendor Contacts

	Benefit	Vendor	Phone number	Email/web address
All Retirees	**Dental DPPO**	Delta Dental	1-800-521-2651	deltadentalins.com
	Dental DHMO	Delta Dental	1-800-422-4234	deltadentalins.com
	Vision	VSP	1-800-877-7195	vsp.com
	Health Insurance Marketplace	Department of Health & Human Services	1-800-318-2596	healthcare.gov
	Retiree premium billing	HealthEquity	1-888-678-4881	mybenefits.wageworks.com
Non-Medicare Eligible	**Medical**	BCBSTX	1-888-306-5753	myprime.com
	Pharmacy Rx	Prime	1-888-306-5753	accredo.com
	Specialty pharmacy	Accredo	1-833-721-1619	bluemembertx.com
	Mental health	BCBSTX	1-888-306-5753	mdlive.com/bcbstx
	Virtual visits	MDLive	1-888-680-8646	mdlive.com/bcbstx
	NurseLine	BCBSTX	1-800-581-0368	bcbstx.com
Non-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	
	Virtual visits	MD Live	1-866-954-3585 TTY 1-800-770-5531	mdlive.com/bcbstx-medicare
	NurseLine	BCBSTX	1-800-631-7023 TTY 711	bcbstx.com

Retiree Health Benefits Enrollment 2027

PUBLIC EMPLOYEE
BENEFITS COOPERATIVE