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PUBLIC EMPLOYEE
BENEFITS COOPERATIVE

Employee Benefits Guide 2027

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Use this Benefits Guide to see what's new and to learn about your benefit plan options.

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If you have benefits questions, please contact your Human Resources/Benefits Department.

Disclaimer: This guide provides a summary of plan highlights. This is not a binding contract. In the event of any difference between the information contained herein and the plan documents, the plan documents will supersede and control over this guide. Please consult the Summary Plan Description for information on covered charges, limitations, and exclusions.



Vendor Contacts



Benefit	Vendor	Phone	Email/Web Address
Medical	BCBSTX	888-306-5753	bcbstx.com/member
Virtual Visits	MDLIVE	888-680-8646	mdlive.com/bcbstx
24/7 NurseLine	BCBSTX	800-581-0368	bcbstx.com
Pharmacy Rx	Prime	888-306-5753	myprime.com
Mail-Order Pharmacy	Express Scripts	833-715-0942	expressscripts.com/rx
Specialty Pharmacy	Accredo	833-721-1619	accredo.com
Navigate Well-being Program	Navigate	888-282-0822	PEBCNavigatewellbeing.com
Employee Assistance Program (EAP)	ComPsych	844-213-8968	guidanceresources.com
Dental DPPO	Delta Dental	800-521-2651	deltadentalins.com
Dental DHMO	Delta Dental	800-422-4234	deltadentalins.com
Vision	VSP	800-877-7195	vsp.com
Life Insurance	The Standard	800-628-8600	standard.com
Long-Term Disability	The Standard	800-368-2859	standard.com
Health Savings Account (HSA)	HealthEquity	844-396-0226	my.healthequity.com
Flexible Spending Accounts (FSAs)	HealthEquity	844-396-0226	my.healthequity.com
Accident, Critical Illness, and Hospital Indemnity Insurance	The Standard	800-368-1135	standard.com
Health Insurance Marketplace	Department of Health & Human Services	800-318-2596	healthcare.gov





Eligibility and Enrollment

DEPENDENT ELIGIBILITY

Who is an eligible dependent? Your dependent can be enrolled in a plan only if they are an eligible dependent residing in the United States. If both you and your spouse work for the same employer, both of you need to enroll in your own insurance and one of you needs to cover your dependents.

ELIGIBLE SPOUSE

- Your lawful spouse (you must have a valid certificate of marriage considered lawful in the State of Texas or an assigned 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 CHILDREN

- Your natural child under age 26
- Your natural, mentally, or physically disabled child, if the child has reached age 26 and is dependent upon you for more than one-half of their support as defined by the Internal Revenue Code. To be eligible, the disability must occur before or within 31 days of the child's 26th birthday.

- Your legally adopted child, including a child who is living with you who has been placed for adoption or for whom legal adoption proceedings have been started, or a child for whom you are named permanent managing conservator
- Your grandchildren can be covered once you have completed a Grandchild Affidavit and it has been approved. Please contact your Human Resources/Benefits department for more information. You must provide your Form 1040 to prove grandchild dependent status.

Your newborn is not automatically enrolled in your medical plan. You are responsible for contacting your Human Resources department and completing the required enrollment paperwork to add your newborn.

If you enroll your newborn within 31 days from the date of birth, coverage is effective on the date of birth. If you do not add your newborn within 31 days from the date of birth, you cannot add your newborn until the next annual enrollment period.

Eligibility and Enrollment (cont.)

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 the age of 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/Benefits department for more information or help determining which dependents you can cover on your benefits.

WHEN A CHILD'S COVERAGE ENDS

You may cover your child (natural child, stepchild, adopted child) in a medical, dental, vision, and/or life insurance 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.



Eligibility and Enrollment (cont.)

NEW HIRE ENROLLMENT

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

- You must submit your enrollment documents to your Human Resources department within 14 days of the date you begin working. If you miss that deadline, you'll automatically be enrolled in a default medical plan, employee-only coverage.
- The PPO employee-only coverage is the default medical plan. You cannot change from PPO default plan enrollment until the next annual enrollment period unless you experience a qualified change in status event.
- Your coverage becomes effective on the first day of the month after 30 consecutive calendar days of active, regular employment.
- If you opt out of NTTA's medical plan, you may not enroll for the remainder of the plan year unless you experience a qualified life event.

OPTIONAL TERM LIFE

- If you select Optional Term Life insurance when you are newly hired and enrolling for the first time, you do not have to provide Evidence of Insurability (EOI).
- If you select Spouse Optional Term Life in an amount greater than \$25,000, EOI is required.

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. As long as the qualified change in status event is consistent, you may also change your corresponding FSA elections, dependent life insurance elections, or your health benefit elections.

Please contact your Human Resources Department for assistance with a Change in Status event.



Eligibility and Enrollment (cont.)

REQUIRED ENROLLMENT ACTION

Spouse Medical Plan Surcharge Affidavit

If your medical coverage includes your spouse, you must sign a “Spouse Medical Plan Surcharge Affidavit” during annual enrollment confirming their access to employer medical plan coverage through their employer - regardless of whether they enrolled in that coverage.

Contact your Human Resources/Benefits Department to verify submission requirements and deadlines for the Spouse Affidavit.

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 the medical plan, or HDP, a \$200 per month spouse surcharge may apply to the cost of covering your spouse on your employer medical plan (deducted from your paycheck).

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 only dental and vision coverage
- Your spouse is enrolled in both their employer medical plan (proof of enrollment required) and your medical 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
- Your spouse’s other coverage is Medicare, Medicaid, TRICARE® or care received at a Department of Veterans Affairs (VA) facility

PLEASE NOTE: The surcharge may apply for each month the Spouse Medical Plan Surcharge Affidavit was not submitted (even if the surcharge does not apply or if it was submitted late) or if you fail to notify your employer of a change, which would have triggered or stopped the surcharge.



Eligibility and Enrollment (cont.)

QUALIFIED EVENTS

Change in family status. Applies to employee, employee's spouse, or employee's dependents:

- Marriage, divorce, or annulment
- Death of your spouse or dependent
- Child's birth, adoption, or placement for adoption (your newborn or adopted child is not automatically enrolled in your medical plan)
- An event causing a dependent to no longer meet eligibility requirements, such as reaching age 26
- **If you experience a qualifying life event, you must notify your Human Resources department to request a benefits change and submit required documentation within 31 days of the event.**

CHANGE IN EMPLOYMENT STATUS

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

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



Eligibility and Enrollment (cont.)

RETIREMENT

Thinking about retirement?

Your employer offers retiree health benefits, but these cost more than your active employee coverage. Make an appointment to discuss your retiree benefit options with your Human Resources department at least 60 days before you retire.

Turning age 65 and still working

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

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

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



CAUTION:

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

After you retire, Medicare becomes primary for you and your Medicare-eligible spouse. You may be eligible for Blue Cross and Blue Shield of Texas Medicare Advantage HMO or PPO retiree plans, but only if you are enrolled in both Medicare Part A and Part B.





Medical Benefits

CHOOSING THE MEDICAL PLAN THAT IS 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.

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

For 2027, your deductible for services in the network is:

\$625 for individual (single) coverage

\$1,250 for family coverage*

OUT-OF-NETWORK DEDUCTIBLES

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

\$1,000 for each individual (single)

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.

Need more details? Visit pebcinfo.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 Primary Care Physician (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		
Routine Prenatal Care	\$0—Plan pays 100%	40% after deductible
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	\$15 visit	40% after deductible
Inpatient	20% after deductible	40% after deductible



Medical Benefits (cont.)

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*

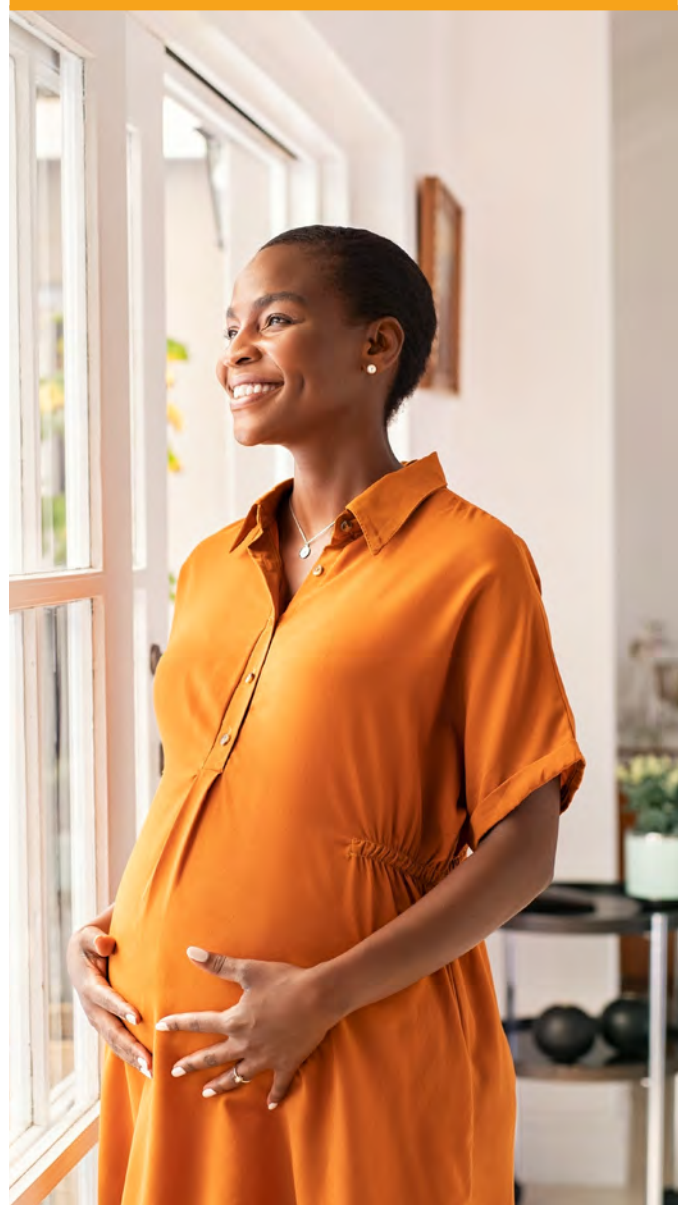
* If you cover any family member, the entire network family deductible must be met before any family member can move to coinsurance. The HDP network family deductible is met when the combined eligible expenses for you and/or any covered family members reach \$3,500. Even if one family member reaches the \$1,750 deductible, that member cannot move to coinsurance until the full \$3,500 family deductible is met.

OPTING OUT OF A MEDICAL PLAN

You may be able to opt out of your employer's medical plan if you submit the following to your Human Resources department before the enrollment deadline:

- Valid proof of other comparable medical plan coverage that meets minimum essential coverage rules under the Affordable Care Act (ACA), confirmed by your employer
- A completed "certification of other coverage" form

Participation or continuation of any employer contribution program is at the discretion of the employer. Coverage obtained through the Health Care Marketplace (Exchange) is not eligible for employer opt-out contributions.



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		
Routine Prenatal Care	\$0—Plan pays 100%	40% after deductible
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



HDP vs PPO Plan

WHAT'S THE DIFFERENCE?

WHAT'S THE HDP?

A high-deductible health plan, also known as an HSA-eligible health plan, requires you to meet your deductible before the Plan begins to pay for coverage. Employees will pay for most health care services at the time of service until you reach your deductible. The IRS sets deductible limits that determine what is an HDHP. Participation in the HDP plan typically comes with additional tax breaks. You must be enrolled in an HDP to be eligible to participate in a health savings account (HSA), which allows employees to contribute pre-tax dollars to be spent on eligible health care services and items.

PROS:

- Lower monthly premiums, which are paid through payroll deductions.
- They come with an HSA to help offset the cost of deductibles
- You can benefit from tax advantages with an HSA attached to a high-deductible plan.
- Your employer contributes funds to an HSA at the beginning of the calendar year.
- You can take an HSA with you when you change jobs.

CONS:

- Individual deductibles are higher.
- HSA accounts are not front loaded – the funds are available as you contribute throughout the year.
 - This can be hard if you have a tight financial situation – the employer's full contribution at the start of the year can help.
- Can be more expensive than anticipated if you face unexpected medical bills and need to max out your annual out-of-pocket costs.
- The HDP can be more costly if you have many medical issues.

WHAT'S A PPO?

A PPO plan is a common traditional health plan in which the carrier contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Members share the cost with the insurance provider in the form of copays due at the time of service.

PROS:

- Health care spending is typically easier to budget and consistent throughout the year.
- Lower costs at time of service, especially at the beginning of the year.
- Individual deductible is slightly lower than HDP plan.

CONS:

- Monthly premiums are more expensive.
- Deductible is required for unexpected emergencies and diagnostic testing – which can significantly increase your spending.
- Can only be combined with the general-purpose FSA account which has significantly lower contribution limits.



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	



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 **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

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 that 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 medicine
- 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.

Health Savings Account

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA is a savings account that you can use to help cover qualified health care expenses. To be eligible to contribute to an HSA, you must:

- Be enrolled in a high-deductible health plan
- Not have health coverage except for a high-deductible health plan
- Not be claimed as a dependent on someone's tax return
- Not be enrolled in Medicare
- Not have received Veterans Affairs benefits in past 3 months

Unlike an FSA, there is no "use it or lose it" rule and it comes with triple-tax benefits:

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

For 2027, the IRS maximum HSA contribution limit is \$4,500 if you have individual coverage or \$9,000 if you have family coverage. The IRS also allows catch-up contributions of \$1,000 if you are age 55 or older.

Your employer contributes to your HSA annually*:

- \$1,050 Employee-Only medical coverage
- \$1,550 Employee + Spouse medical coverage
- \$2,050 Employee + Child(ren) or Family medical coverage

*Employer contributions will be prorated for new hires.

Please keep in mind the amount you plan to contribute for the year, as your contribution and your employer's contribution together cannot exceed the IRS maximum limit. The HSA provider for 2027 is HealthEquity.

CONTRIBUTIONS FROM YOUR EMPLOYER

If you enroll in the HDP during annual enrollment, your employer will make a one-time cash deposit to your HSA in January. For the months of February–December, prorated employer contributions are available after your HDP becomes effective. Qualifying life events do not trigger an increase or reduction in employer contributions.

HSA TAX BENEFITS

HSAs are the only benefit to offer triple-tax savings:

- Tax-free contributions – You don't pay taxes on the money you put into the account.
- Tax-free account growth – Invest your HSA and any growth is tax-free.
- Tax-free spending – Use HSA funds for HSA-qualified expenses, and you never pay taxes on that money.

Flexible Spending Accounts

WHAT IS A FLEXIBLE SPENDING ACCOUNT (FSA)?

An FSA is a way to set aside money from your earnings before taxes are withheld to pay eligible out-of-pocket health care expenses and qualifying dependent daycare expenses.

Here's how it works:

- Use your HealthEquity Visa Card to pay for eligible health care expenses, or submit a claim for reimbursement of eligible expenses from your account
- Expenses must be incurred by Dec. 31
- Expenses must be submitted to HealthEquity by April 30 of the following year to avoid loss of funds
- Your active employee FSA ends on the date your coverage ends, unless you elect COBRA benefits.
- If you enroll in COBRA coverage, your FSA will continue.

There are three types of FSAs:

- **General-purpose FSA.** If you enroll in the PPO plan or if you opt out of medical coverage and your comparable coverage is through a traditional plan (non-HDP), you can select the general-purpose FSA.
- **Limited-purpose FSA (LP-FSA).** If you enroll in the HDP with contributions to an HSA, you cannot elect a general-purpose FSA, but you can elect an LP-FSA.
- **Dependent Care FSA.** To help pay for qualifying daycare expenses, you can set aside up to \$7,500 annually (or \$3,750 if filing your taxes separately) in the dependent care FSA in 2027. Remember, Dependent Care FSA funds cannot be used for medical expenses.

Note: You must elect an FSA every year you intend to participate. The maximum amount you can set aside for 2027 is \$3,400—including general-purpose FSAs and limited-purpose FSAs (LP-FSAs).

ROLLOVER FUNDS

The IRS allows employees with a health care FLEX account to roll over up to \$680 of their unused funds to the next plan year.

MANAGE YOUR ACCOUNTS ONLINE

Visit healthequity.com to manage your FSA.

ATTENTION HIGHLY COMPENSATED EMPLOYEES

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

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

When you enroll in DeltaCare USA DHMO:

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



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.

Vision 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 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 **800-877-7195**.

VSP Advantage Plan	NETWORK	NON-NETWORK REIMBURSEMENT
Vision exam	\$10	Up to \$43
Eyeglass lenses		
Single vision	\$20	Up to \$30
Bifocal	\$20	Up to \$45
Trifocal	\$20	Up to \$62
Lenticular	\$20	Up to \$100
Standard progressive lenses	\$20	Up to \$45
Frames	\$200 allowance; 20% off balance over \$200 \$250 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)	
Non-elective	Covered at 100%	Up to \$210
Elective	\$200 allowance; not to exceed \$40 copay for contact lens exam	Up to \$185
Service frequency		
Exams	12 months	12 months
Prescription lenses	12 months	12 months
Frames	12 months	12 months
Contact lenses	12 months	12 months
Laser care	Average 15% off the regular price or 5% off the promotional price	

SERVICES NOT COVERED

- Services and/or materials not specifically included in this schedule as covered plan benefits
- Plano lenses (lenses with refractive correction of less than + .50 diopter)
- 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 (CRD or orthokeratology)

BCBS Texas Free App

FIND INFORMATION ABOUT DOCTORS

Our online directory is the quick and easy way to find doctors, hospitals, or other health care providers in your network. Follow these steps:

1. Go to **bcbstx.com**
2. Click *Find Care*
3. Click *Find a Doctor or Hospital* and then search for "Doctors" as a Guest
4. **Answer** a few questions and follow the prompts

MORE INFORMATION

After you receive your member ID card, go to **bcbstx.com/member** to sign up for Blue Access for MembersSM. You can use this secure website from your desktop or mobile device to:

- **Find** in-network doctors, facilities, and pharmacies
- **Access** your digital ID card
- **View** your coverage and plan documents
- **Estimate** service costs, and much more

Download our Free App

Access all of our mobile websites and services in one spot. Text **BCBSTXAPP** to **33633** to learn more.



NOTE: DURING ANNUAL ENROLLMENT, YOU MUST RE-ENROLL IF:

- Anything changed, including dependent eligibility or your plan choice
- You want to contribute to a Health Care FSA, a limited purpose FSA (LP-FSA), or Dependent Care FSA. You have to re-enroll each year if you want to contribute to an FSA, even if you do not change your annual election amount.

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

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

Where to Go for Care



What do you do if your clutch player breaks an arm in the big game? Or you slice your finger chopping veggies? Or have stomach cramps after last night's sushi date? Often the choice is clear. If you have signs of a heart attack, it's best to go to the emergency room. But what if you have a sore throat? Or lower back pain? Knowing where to go can make a big difference in the cost of your care—especially when you use in-network providers.

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.



24/7 NURSELINE

Wonder if your heartburn needs an antacid or trip to the ER? Is your child's fever 102 degrees? Confused about a health test? Talk confidentially with a registered nurse in English or Spanish—anytime. Call 800-581-0368.

Good for: Health questions and health advice
Average Wait: None
Cost: PPO & HDP - None



VIRTUAL VISITS

Do you have an itchy rash or sinus problems? Fighting a fever? Talk with a doctor—24/7. Online appointments via MDLIVE® put care at your fingertips. Call 888-680-8646 or go to **MDLIVE.com/bcbstx**.

Good for: Health exams, colds, flu, minor injuries
Average Wait: Less than 20 minutes
Cost: In-network PPO & HDP - None



DOCTOR

Is your blood pressure high? Are allergies making you miserable? Can't sleep? Your go-to provider is a good place to start. Some even offer telemedicine. If you need a specialist, your doctor will tell you. Your annual physical exam is at no cost for both plans.

Good for: Health exams, shots, cough, sore throat
Average Wait: None
Cost: PPO - PCP - \$15 copay, Specialist - \$25 copay
HDP - 20% after deductible



RETAIL HEALTH CLINIC

Need a flu shot? Feel queasy? Have an earache or rash? Many grocery stores and pharmacies have on-site medical clinics. Some may even see patients evenings, weekends, and holidays.

Good for: Headache, stomachache, sinus pain
Average Wait: Variable
Cost: PPO - \$35 copay, HDP - 20% after deductible



URGENT CARE CENTER

Sprain your ankle? Have a monster migraine? Can't stop coughing? Need non-emergency care right away, but your doctor's office isn't open? These centers offer care evenings, weekends, and holidays.

Good for: Back pain, vomiting, animal bite, asthma
Average Wait: 30 minutes or less
Cost: PPO - \$35 copay, HDP - 20% after deductible



HOSPITAL ER

Worried you may be having a heart attack? Did you black out after a nasty fall? ER doctors and staff treat serious and life-threatening health issues 24/7. If you receive ER care from an out-of-network provider, you may have to pay more.

Good for: Chest pain, bleeding, broken bones
Average Wait: 1 hour or more
Cost: PPO - \$300 copay, HDP - 20% after deductible



Connect with the EAP!

Don't be afraid to reach out for help. Your personal records are kept private from your employer, as required by law.

- Call: **844-213-8968**
- Online: **GuidanceResources.com**
- App: **GuidanceNow**
- Web ID: **TXEAP**

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

To view information on your mental health benefits coverage, search for a provider, or access online resources, log in to Blue Access for Members at **bcbstx.com**, and click on *Healthy Living* and *Digital Mental Health*.

LEARN TO LIVE

Learn to Live is a behavioral health digital platform which offers condition-specific programs, each delivered in a user-paced multimedia experience. Services are also available on demand with the options for one-to-one clinician coaching services. Go to **learntolive.com/welcome/bcbstx** and enter access code **BETTERME** to get started.

VIRTUAL VISITS—POWERED BY MDLIVE®

Get care when and where you need it through MDLIVE—available 24 hours a day, seven days a week, 365 days a year. Behavioral health services are included. Visit **mdlive.com/bcbstx** for more information and to activate your account.

If you are in crisis, call the national suicide prevention lifeline at **1-800-273-TALK (8255)** or call **911** if you feel you are in immediate danger.





Additional Programs

OVIA HEALTH: A DIGITAL SUPPORT PROGRAM

Ovia Health provides maternity and family apps to support you through the entire parenthood journey. These apps are included in your health plan, offered through BCBSTX.

Download the app that's right for you:

Ovia – Reproductive Health, Fertility and Menopause

Ovia Pregnancy – Pregnancy & Postpartum

Ovia Parenting – Family & Working Parents

To create an account, choose “I have Ovia Health as a benefit” before tapping “Sign up.” Select BCBSTX as your health plan and enter your employer name.

DIABETES MANAGEMENT BY TELADOC® HEALTH

Teladoc Health's Diabetes Management program is designed to help you manage your diabetes better by providing a coach who can help support your efforts. You'll get a blood glucose meter that you can use to upload your blood sugar readings.

Get access to readings, along with graphs and insights, from a mobile app and website. You'll also get unlimited, no-cost strips and lancets shipped to your door.

HYPERTENSION MANAGEMENT BY TELADOC HEALTH

The Hypertension Management program from Teladoc Health offers a blood pressure monitor combined with the power of personalized coaching. Your coach can help you stabilize your blood pressure, make sense of your readings and give feedback to easily track your progress.

You'll also learn to eat healthier and discover new ways to lose weight as well as better manage your medications.

WONDR™

Wondr is a weekly, self-paced, online program that teaches you how to manage your weight and improve your health without giving up your favorite foods. Wondr is based on Eatology™, the study of when, why, and how we eat. It teaches common-sense skills to help you lose weight and keep it off in the real world, which leads to feeling your best. It can also reduce your risk for serious conditions like diabetes and heart disease. For more information, visit wondrhealth.com/pebc.

VIDA

Vida Health is a virtual health program offered as part of your Blue Cross and Blue Shield of Texas insurance. It is available at no additional cost to eligible members and their covered dependents. If you have a goal of losing a lot of weight, you may be eligible for this program. Vida offers access to a registered dietitian and medical provider who can help you: lose weight – and still eat the foods you love, exercise in a way that works for you, sleep better, and reduce stress.

HINGE HEALTH

With the Hinge Health program, you'll have access to a new innovative digital program for chronic back, shoulder, neck, hip or knee pain. Use the app and wearable sensors for personalized exercise therapy (done in your own home) that is shown to reduce pain from chronic conditions. You'll also get unlimited one-on-one coaching to help support you.

VIRTUAL VISITS BY MDLIVE

Whether you're at home or traveling, you and your covered dependents have access to 24/7 non-emergency care from a board-certified doctor or therapist through MDLIVE. The average wait time is less than 20 minutes.

FITNESS PROGRAM

Fitness can be easy, fun, and affordable. The Fitness Program gives you unlimited access to a nationwide network of more than 10,000 fitness locations. You can visit locations while you're on vacation or traveling for work.

Fitness program perks include:

No long-term contract: Membership is month to month. Flexible plans from \$19 to \$129 per month and studio classes are available.





NTTA Wellbeing Program



Join Your Program

Ready to get started? Sign up today to take your first steps toward better wellbeing.

KEY DATES

Program year: Jan. 1, 2027 – Oct. 31, 2027

Deadline: Complete your activities by **Oct. 31, 2027.**

YOUR REWARDS

Medically covered employees and spouses can each earn a \$500 incentive. Choose to receive your reward as an FSA contribution, HSA contribution, or through payroll.

YOUR PROGRAM: PURPOSE & BENEFITS

The NTTA Wellbeing Program is designed to support your health journey and help you build lasting healthy habits. This program works alongside your existing health care benefits, encouraging preventive care while offering valuable rewards for your participation.

HOW TO PARTICIPATE

Eligibility

All medically covered employees and spouses are eligible to participate and earn rewards.

How to complete your program

To earn your full incentive, you need to:

1. Complete the Total Health Survey (required, 75 points)
2. Earn an additional 225 points from other wellbeing activities
3. Reach a total of 300 points by October 31, 2027

The portal offers many ways to earn your remaining points! From preventive care like annual exams and screenings to group challenges and video courses, you can choose activities that fit your lifestyle and interests.

How is the reward paid?

The default payment method is cash, which means the funds will be included in a payroll check on a post-tax basis. You can also choose to have your reward deposited to your established health care FSA or, if you have not exceeded the annual HSA contribution limit, to your HSA.

When is your reward paid?

Rewards are paid 3 times during the year based on when you earn 300 points. You must be an employee (or a covered spouse) at the time of payout to receive your reward. Spouses must utilize their own portal to earn points for activities, and a spouse reward will not be paid until the employee has earned 300 points.

HOW TO JOIN

Step 1: Go to **PEBCNavigateWellbeing.com**

Step 2: Click **JOIN NOW** and enter the group code: NTTA.

Step 3: Verify your eligibility with your name, SSN and DOB.

Step 4: Enable multi-factor authentication (MFA). Instructions are available on the portal after you log in.

QUESTIONS? CONTACT:

info@navigatewell.com

888-282-0822

DOWNLOAD APP



Download the Navigate Wellbeing app for a convenient way to track your activities.

Powered by Navigate Wellbeing Solutions

Date points earned	Date reward is paid by
Jan. 1 – Mar. 31	May 31
Apr. 1 – June 30	Aug. 31
July 1 – Oct. 31	Dec. 31



Navigate Wellness Platform

Healthy choices build lasting positive change.



You can visit PEBCNavigateWellbeing.com or use this QR code to get started.

You can also **download** the Navigate app!



Your well-being goes beyond physical health—it includes your mental, emotional, and financial wellness, too. The **Navigate Wellness Platform** brings it all together in one easy-to-use app and website, giving you the tools, resources, and motivation to take charge of your health. Code: NTTA

WHAT YOU GET

- **Personalized Challenges & Rewards:** Stay motivated with wellness challenges, track your progress, and earn rewards along the way.
- **Health Tracking Tools:** Monitor activity, nutrition, sleep, and more with easy integrations to your favorite devices and apps.
- **Educational Resources:** Access articles, videos, and tips on fitness, nutrition, stress management, and financial wellness.
- **Team Engagement:** Join group challenges, connect with colleagues, and build a culture of well-being together.
- **24/7 Access:** Available anytime on desktop or through the Navigate mobile app.

The Navigate Wellness Platform is designed to help you **live well, feel supported, and stay engaged**. Whether you're setting new health goals, managing stress, or just looking for a boost of motivation, Navigate makes it simple and rewarding to stay on track.





Tools to Help You Manage the Details

Get the most from your health plan. Below are some other helpful resources you should know about. Take advantage of these services to get the most from your benefits.

MANAGING YOUR MEDICAL CLAIMS

Medical claims

Get started by signing in to Blue Access for Members (BAM) at bcbstx.com/member. You can understand your benefits and claims, find a doctor, estimate future treatment costs, and much more.

Prefer mobile? The BCBSTX App provides access to these features as well.

Account balances

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

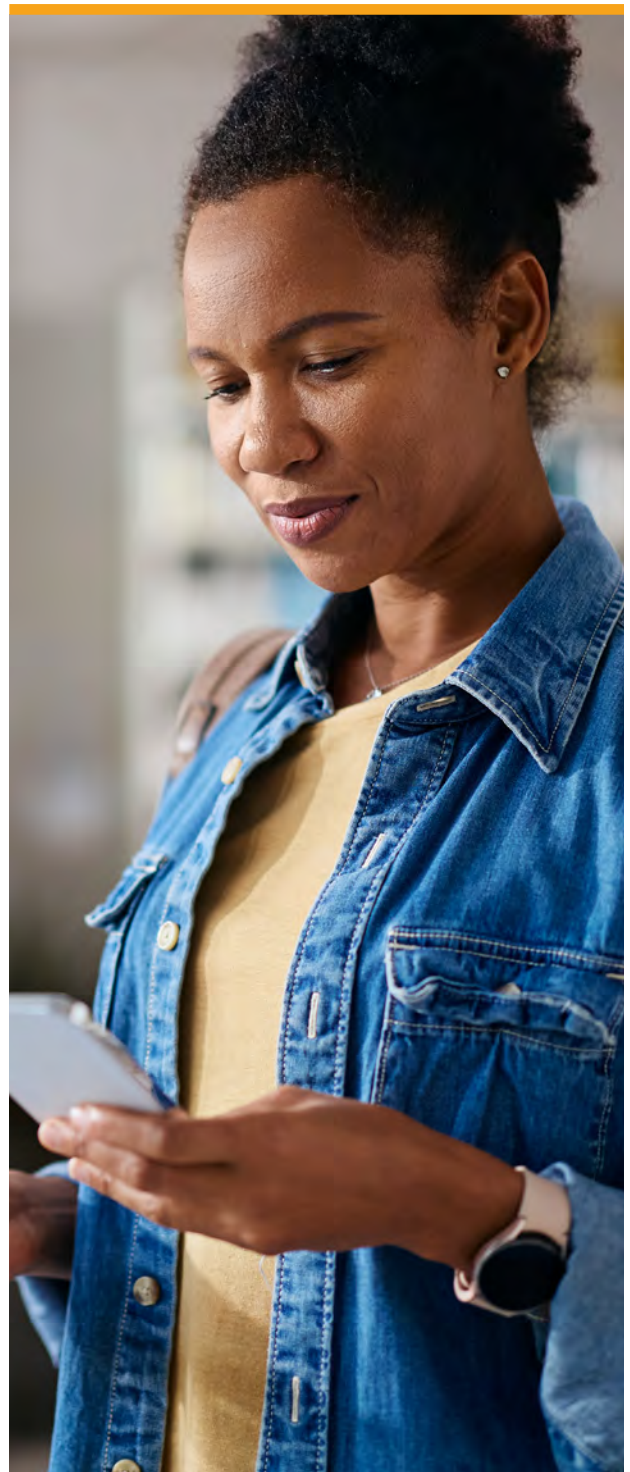
MANAGING YOUR PRESCRIPTIONS

MYPRIME.COM helps you manage your pharmacy benefits when you're at home or on the go. You can visit the website to:

- **Check** medicine cost and coverage details
- **See** your prescription claims history
- **Find** in-network pharmacies
- **Connect** with the pharmacy delivery services
- **Compare** pricing for drugs and pharmacies
- **Get** any forms you may need
- **Learn** about drug interactions, possible side effects, and more

If you select Rx History Claims and Balances, you can view and print a prescription drug claims history by date range. The information and cost (by date range) is excellent documentation to submit for an FSA reimbursement or to document your HSA spending.

Manage your specialty drug prescriptions with accredo.com or the mobile app.



Life & AD&D Insurance



SUPPORTING FINANCIAL SECURITY

Basic Life Benefits

Basic Life and Accidental Death & Dismemberment (AD&D) insurance provides a benefit in the event of your death. This benefit is paid for by your employer. Your Basic Life Benefit is one times your annual salary, rounded to the next \$1,000 up to \$300,000. Your AD&D benefit automatically matches your Basic Life benefit.

Basic Term Life

- Coverage Amount: Annual Earnings rounded to the next \$1,000 up to a maximum of \$300,000
- Minimum coverage is \$20,000 regardless of salary
- AD&D coverage matches Basic Term Life coverage

Optional Term Life Benefits

Employee Optional Term Life is voluntary and based on your annual salary times your selected coverage level, rounded to the next higher \$1,000. Use the Optional Rate Chart on page 38 to calculate your monthly cost. AD&D automatically matches your optional term life benefit.

Employee Optional Term Life

- 1x annual salary
- 2x annual salary
- 3x annual salary
- 4x annual salary
- Up to a maximum of \$500,000

Optional Spouse Term Life Benefits

Optional Spouse Term Life Benefits cannot exceed 50% of an employee's Optional Term Life coverage amount. Any amounts elected over \$25,000 will require Evidence of Insurability (EOI).

Optional Spouse Term Life

Levels:

- \$10,000
- \$25,000
- \$50,000
- \$75,000
- \$100,000
- Spouse Term Life cannot exceed 50% of Employee Optional Term Life.

Dependent Group Life Benefits

You can select Dependent Group Life coverage for your spouse and dependent child(ren), even if you already elected optional spouse life coverage. Dependent Group Life provides a fixed amount of coverage for all eligible dependents.

Dependent Group Life

Option 1	Option 2
• \$5,000 spouse • \$2,500 each dependent	• \$10,000 spouse • \$5,000 each dependent

Reduction and Termination

Your Basic Life & AD&D benefits and the additional Optional Term Life and Optional Spouse Life coverage you select reduce beginning at age 70, and end at employment termination or retirement, unless you elect to port or convert all or part of your optional life coverage. Reduced % of coverage amount by age:

- To 65% at age 70
- To 40% at age 75
- To 25% at age 80
- To 15% at age 85
- To 10% at age 90

All Optional Term Life and Dependent Group Life benefits are voluntary and employee-paid.

Voluntary Accidental Death & Dismemberment (AD&D)

AD&D insurance provides extra financial protection for you and your family in the event of a serious accident. This coverage pays a benefit if you suffer certain injuries or loss of life due to an accident—helping ease financial stress during a difficult time.

Voluntary AD&D Insurance

	Employee	Spouse	Child
Benefit Schedule	Increments of \$5,000	Option 1: 100% of Employee Amount Option 2: 50% of Employee Amount	10% of Employee Amount
Maximum Benefit	\$300,000 or 10x annual earnings	\$300,000 or 10x annual earnings	\$30,000
Minimum Benefit	\$25,000	\$12,500	\$2,500

Disability Insurance

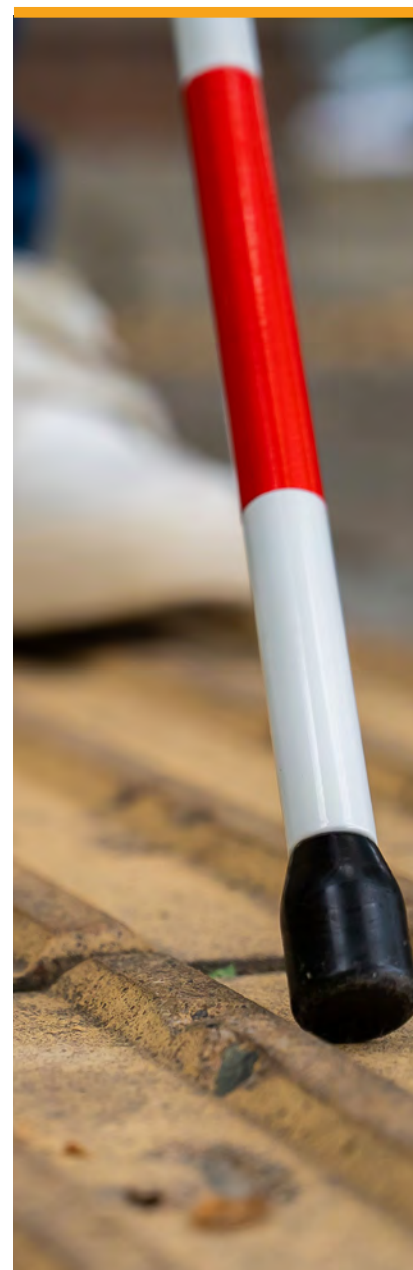


In the event you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Through your employer, you have access to both Short-Term and Long-Term Disability Benefits.

SHORT-TERM DISABILITY (STD)

Your employer provides base STD coverage that offers income protection if you're unable to work due to a covered illness, off-the-job injury, or recovery from surgery. This benefit replaces a portion of your weekly pay—helping you keep up with everyday expenses like rent, groceries, and bills while you focus on getting well.

If your annual salary is over \$43,300, you also have the option of enrolling in additional "buy-up" coverage.



Base STD (Employer-Paid)	Optional STD Buy-up (Employee-Paid)
60% of weekly earnings to a maximum \$500 weekly benefit	60% of weekly earnings to a maximum \$3,000 weekly benefit
14-day waiting period	14-day waiting period
22-week maximum benefit period	22-week maximum benefit period

LONG-TERM DISABILITY (LTD)

Long-Term Disability (LTD) benefits are available at no cost to you. LTD benefits are a type of insurance policy that provides financial assistance to individuals who become unable to work for an extended period due to a medical condition.

Long-Term Disability Benefits (Employer-Paid)	
Monthly Benefit Amount	60% of the first \$9,167 of your pre-disability earnings, reduced by deductible income.
Monthly Benefit Min/Max	Minimum: \$100 Maximum: \$5,500
Benefit Waiting Period	180 days
Maximum Benefit Period	Determined by your age when your disability begins.

Voluntary Benefits



You can elect Voluntary Benefits such as Hospital Indemnity, Accident, and Critical Illness insurance.

HOSPITAL INDEMNITY INSURANCE

Unexpected hospital stays can happen when you least expect them—and the costs can add up quickly. Even with medical insurance, you may face out-of-pocket expenses such as deductibles, copays, transportation, or lost wages. Hospital Indemnity Insurance through The Standard helps you stay financially protected during these challenging times.

How It Works

- Pays cash benefits directly to you (unless assigned to a provider).
- Benefits are paid when you or a covered family member are admitted to the hospital, confined for multiple days, or need intensive care.
- You can use the money however you need—whether that's to help cover medical bills, childcare, transportation, or everyday living expenses.

Highlights of Coverage

- **Hospital Admission Benefit:** A lump-sum payment for each covered hospital admission.
- **Daily Hospital Confinement Benefit:** A set amount paid for each day you remain in the hospital (up to plan limits).
- **Intensive Care Benefit:** Additional payments if confined to an intensive care unit.
- **Family Coverage:** Options available for your spouse/partner and dependent children.
- **Portability:** Take your coverage with you if you change jobs or retire (with certain conditions).
- **No Pre-Existing Condition Limitations:** Coverage includes pregnancy and other common conditions.

Two Plan Options

You will be able to choose from two coverage options when you enroll.

Benefit	High Option	Low Option
Hospital Admission	\$1,500/calendar year	\$500/calendar year
Hospital confinement benefit	\$350/day	\$100/day
Critical care unit confinement (in addition to hospital confinement benefit)	\$350/day	\$100/day
Number of covered days per hospital confinement	15 days	15 days
Number of covered days per critical care unit confinement	15 days	15 days
Health maintenance screening	\$50	\$50



Voluntary Benefits (cont.)



ACCIDENT INSURANCE

Accidents can happen anytime—on the job, at home, or while playing sports—and the costs may not be fully covered by your health insurance. The Standard's Accident Insurance helps protect your finances when the unexpected occurs.

How It Works

- Pays cash benefits directly to you (unless you choose otherwise).
- Benefits are triggered by covered injuries, treatments, or services resulting from an accident.
- You decide how to use the money—whether it's for medical bills, household expenses, transportation, or other needs.

Highlights of Coverage

- **Emergency Care:** Cash benefits for ER visits, urgent care, ambulance services, or physician visits related to an accident.
- **Injury Benefits:** Payments for broken bones, burns, concussions, dislocations, lacerations, and more.

- **Hospitalization:** Additional benefits if you're admitted, confined, or require intensive care due to an accident.
- **Follow-Up Care:** Coverage extends to physical therapy, follow-up doctor visits, and medical devices like crutches or wheelchairs.
- **Family Coverage:** Options for spouses/partners and dependent children.
- **Portability:** Take coverage with you if you leave or retire, subject to plan rules.
- **No Pre-Existing Condition Limitations:** Benefits are payable regardless of your prior health status.

Two Plan Options

You will be able to choose from two coverage options when you enroll. Below are highlights of key accident benefits. To view all the accident benefits, go to pebcinfo.com.

Benefit	High Option	Low Option
Emergency Care Benefits		
Emergency Room	\$200	\$150
Air ambulance	\$1,500	\$1,000
Ground ambulance	\$400	\$300
Urgent care	\$200	\$150
X-ray	\$50	\$35
Hospital Benefits		
Hospital Admission	\$2,000	\$1,000
Hospital confinement benefit	\$400/day up to 365 days	\$250/day up to 365 days
Critical care unit admission	\$2,000	\$1,250
Critical care unit confinement (in addition to hospital confinement benefit)	\$400/day up to 15 days	\$300/day up to 15 days
Follow-Up Care Benefits		
Medical appliance	\$100	\$75
Chiropractic	\$50 up to 6 days	\$35 up to 6 days
Therapy services	\$65 up to 6 days	\$50 up to 6 days
Additional Benefits		
Lodging	\$175/day	\$150/day
Transportation	\$150/day	\$100/day

Voluntary Benefits (cont.)



CRITICAL ILLNESS INSURANCE

A serious illness can affect more than your health—it can impact your finances, too. Even with medical coverage, you may face high deductibles, copays, or ongoing expenses. The Standard's Critical Illness Insurance provides a lump-sum cash benefit to help ease the financial burden so you can focus on recovery.

How It Works

- Pays a lump-sum benefit directly to you upon diagnosis of a covered condition.
- You can use the money however you need—medical costs, household bills, travel, or everyday living expenses.
- Coverage is available for you, and you can add protection for your spouse and dependent children.

Highlights of Coverage

- **Covered Conditions:** Includes many common and serious illnesses such as cancer, heart attack, stroke, major organ failure, kidney failure, and more.
- **Family Coverage:** Options for dependents so your loved ones are also protected.
- **Portability:** Keep your coverage if you change jobs or retire (subject to plan rules).
- **No Pre-Existing Condition Limitations:** Coverage begins immediately for eligible diagnoses.

Below are highlights of key critical illness benefits. To view all the critical illness benefits, go to pebcinfo.com.

Covered Conditions

Covered Condition	Coverage Percentage
Cancer	100%
Carcinoma In Situ (Non-Invasive Cancer)	25%
Major Organ Failure	100%
Heart Attack	100%
Stroke	100%
Coma	100%
Paralysis	100%
Alzheimer's	100%

VOLUNTARY PLAN RATES

All rates below are per month.

Hospital Indemnity Insurance (Monthly)

Coverage Tier	High Option	Low Option
Employee	\$22.21	\$6.89
Employee + Spouse	\$37.70	\$11.86
Employee + Child(ren)	\$33.81	\$9.93
Family	\$56.35	\$17.52

Accident Insurance (Monthly)

Coverage Tier	High Option	Low Option
Employee	\$7.21	\$5.68
Employee + Spouse	\$13.66	\$10.88
Employee + Child(ren)	\$18.06	\$14.07
Family	\$27.36	\$21.30



Voluntary Benefits (cont.)



CRITICAL ILLNESS INSURANCE — EMPLOYEE (MONTHLY)

Blended rates, by attained age. Amounts shown are the elected benefit amount.

Benefit Amount	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$10,000	\$3.10	\$3.70	\$4.30	\$5.70	\$7.90	\$11.20	\$16.30	\$22.50	\$32.00	\$44.70	\$87.90
\$20,000	\$6.20	\$7.40	\$8.60	\$11.40	\$15.80	\$22.40	\$32.60	\$45.00	\$64.00	\$89.40	\$175.80
\$30,000	\$9.30	\$11.10	\$12.90	\$17.10	\$23.70	\$33.60	\$48.90	\$67.50	\$96.00	\$134.10	\$263.70

CRITICAL ILLNESS INSURANCE — SPOUSE (MONTHLY)

Blended rates, by attained age. Amounts shown are the elected benefit amount.

Benefit Amount	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$10,000	\$3.10	\$3.70	\$4.30	\$5.70	\$7.90	\$11.20	\$16.30	\$22.50	\$32.00	\$44.70	\$87.90
\$20,000	\$6.20	\$7.40	\$8.60	\$11.40	\$15.80	\$22.40	\$32.60	\$45.00	\$64.00	\$89.40	\$175.80
\$30,000	\$9.30	\$11.10	\$12.90	\$17.10	\$23.70	\$33.60	\$48.90	\$67.50	\$96.00	\$134.10	\$263.70



Additional Benefits

EDUCATIONAL ASSISTANCE



NTTA UNIVERSITY

NTTA University provides employees with a great opportunity to expand your learning opportunities.

PUBLIC SERVICE LOAN FORGIVENESS

Can I have my federal student loans forgiven or canceled if I work in a public service job?

Yes, some or all of your remaining federal student loans may be canceled after ten years of working in public service while making required loan payments if you are eligible for the **Public Service Loan Forgiveness Program (PSLF)**.

After you meet all of the requirements, you can apply to have your remaining loan balances forgiven.

To qualify for PSLF, you must:

- have **Direct Loans**,
- work full-time in a **qualifying public service job**,
- be in a **qualifying repayment plan**, and
- make **120 monthly payments** (10 years).

TUITION REIMBURSEMENT

- **Eligibility:** Begins the first of the month after 30 days of employment; employee must be in good standing.
- **Covered education:** Required accredited degree courses and TEA-approved GED courses; certifications and licenses are excluded.
- **Coverage:** Tuition, labs, and books, up to \$5,250 per calendar year.
- Grades: A, B, C, or Pass earn 100% reimbursement; D, F, or Fail earns none. A failed course may be resubmitted after it is retaken and passed.
- **Employment commitment:** Remain employed 365 days after each class ends or repay tuition NTTA paid during the prior 365 days.
- **Documentation:** Submit one application per semester with required course verification, cost statement, proof of payment, and final grade within 60 days.
- **Availability:** First-come, first-served and subject to budget.



Retirement



TEXAS COUNTY DISTRICT RETIREMENT SYSTEM (TCDRS)

At the Texas County & District Retirement System (TCDRS), we help hard-working Texans plan for their future. To do that, we partner with counties and districts to provide retirement, disability, and survivor benefits. TCERS was created by the Texas Legislature in 1967. Since that time, we've grown into a financially strong, multibillion-dollar trust.

The Fund is subject to county/district and state legislative oversight from the TCERS Board of Trustees and State Pension Review Board.

RETIREMENT ELIGIBILITY

- Age 60 with 10 years of service
- Any age with 30 years of service
- Age + Years of service = 75

Employee Deposit Rate	Employer Matching	Interest Rate	Vesting
6%	250%	7%	10 Years
This percentage of a paycheck is deposited into your TCERS account. This money is tax-deferred.	At retirement, this employer matches an employee's account balance and they receive a lifetime monthly benefit.	Savings grow at an annual, compounded rate of 7% interest based on the employee's beginning year balance.	When enough service time is earned, employees are eligible for a lifetime monthly benefit upon retirement.

PROPORTIONATE RETIREMENT SYSTEM

The Proportionate Retirement Program lets you use service time from any of the systems listed below to qualify for retirement benefits (not disability benefits or the Survivor Benefit). Those systems are:

- Texas Municipal Retirement System (TMRS)
- Employees Retirement System (ERS)
- Judicial Retirement System of Texas (JRS)
- Teacher Retirement System of Texas (TRS)
- City of Austin Employees Retirement System (COAERS)

If you have service time with the above entities, coordinate with TCERS to complete documentation for service credit.



Retirement

ALTERNATIVE TO SOCIAL SECURITY



NTTA provides 401K retirement plan in lieu of Social Security. This plan requires 4% employee and 3.5% Employer contribution(s). The vesting period for this plan is 20% per year with full vesting after five (5) years of contribution.

OPTIONAL 401K & 457 DEFERRED COMPENSATION

NTTA permits you to contribute in whole percentages or flat dollar amounts a portion of your base pay on a before-tax or Roth after-tax contributions to the NTTA 401(k) plan and/or 457(b) Deferred Compensation Plan ("457(b) Plan"). Both plans also permits certain participants to make additional before-tax or Roth after-tax contributions. The additional contribution is called a "catch-up contribution" and is available to participants who will be at least age 50 by the end of the plan year.

Year	Maximum Contribution	Age 50 Catch-Up
2027	\$24,500	\$8,000 (\$32,500 total)



Leave Programs

VACATION

All full-time employees accrue vacation leave monthly based on years of service and the schedule below. Key executives earn at a higher rate.

Years of Service	Hours Accrued Per Month	Maximum Carry Forward Hours
0 but less than 2 years	7	168
2 but less than 5 years	8	232
5 but less than 10 years	9	256
10 but less than 15 years	10	280
15 but less than 20 years	12	328
20 or more years	14	376

SICK LEAVE

NTTA provides full-time employees sick leave with pay, which can be used by an employee when sickness, injury, health-related appointments, or pregnancy prevents the employee's performance of duty. Sick leave with pay also may be taken to care or to ensure care for a sick or injured child, foster child, spouse, or parent.

Accrual: 8 hours per month with carry forward from year to year on an unlimited basis.



2027 Benefit Costs



MEDICAL - Per Pay Period (24 pay periods)

	PPO	HDP
Employee	\$61.65	\$35.33
Employee + Spouse	\$261.36	\$213.42
Employee + Child(ren)	\$203.89	\$165.98
Family	\$336.66	\$276.09

DENTAL

	DPPO	DHMO
Employee	\$20.27	\$4.67
Employee + Spouse	\$38.27	\$7.96
Employee + Child(ren)	\$47.29	\$10.50
Family	\$65.28	\$13.42

VISION

	VISION
Employee	\$3.12
Employee + Spouse	\$5.85
Employee + Child(ren)	\$6.22
Family	\$9.70



Calculating Your Optional Term Life Premium Cost

Using your annual salary on December 31, 2025, and your age on January 1, 2027, calculate your monthly Optional Term Life premium cost. To calculate your per-paycheck cost, simply multiply the monthly cost by 12 and divide by the number of 2027 payroll checks from which benefits are deducted (24).

Age	Monthly Rate - Employee Coverage	Monthly Rate - Spouse Coverage
< 25	\$0.059	\$0.034
25-29	\$0.059	\$0.034
30-34	\$0.075	\$0.050
35-39	\$0.093	\$0.068
40-44	\$0.125	\$0.100
45-49	\$0.175	\$0.150
50-54	\$0.255	\$0.230
55-59	\$0.425	\$0.400
60-64	\$0.685	\$0.660
65-69	\$0.995	\$0.970
70+	\$1.775	\$1.750



How to Calculate 
Step 1. Annual salary at December 31, 2025 rounded up to next \$1,000
Step 2. Select coverage level (100%, 200%, 300%, 400%)
Step 3. Multiply Step 1 amount by Step 2 coverage amount
Step 4. Divide Step 3 amount by \$1,000
Step 5. Multiply Step 4 amount by appropriate rate for your age on January 1, 2027 (Optional Term Life Rate Chart, Column A)
This is your monthly TLF premium amount

Example
You are 35 years old and have an annual salary of \$70,800. \$70,800 – Round to the nearest \$1,000 — \$71,000
You elect 1x your salary in Optional Term Life coverage
$\$71,000 \times 1 = \$71,000$
$\$71,000 / \$1,000 = 71$
$71 \times \$0.093 = \6.60
You will pay \$6.60 each month for your Optional Term Life coverage.

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: \$625 individual / \$1,250 family
- HDP Deductible: \$1,750 individual / \$3,500 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 balance 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: KIHIPPPROGRAM@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: HSHIPPProgram@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 Rlte 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](https://www.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.

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**NORTH TEXAS
TOLLWAY AUTHORITY**

Employee Benefits Guide 2027



pebc

PUBLIC EMPLOYEE
BENEFITS COOPERATIVE