2017 COBRA BENEFITS RESOURCES GUIDEBOOK

Annual Enrollment: January 2, 2017 - January 23, 2017

Retain this document as a resource tool for the upcoming year

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HARRIS HEALTH SYSTEM EMPLOYEE BENEFITS/EMPLOYEE WELLNESS DEPARTMENT

Core Business Hours
Monday - Friday
8:00 a.m. - 4:30 p.m.

CONTACT INFORMATION

HEALTHCARE

Main Customer Service - Holly Hall Administration Office
Benefitsdepartment@harrishealth.org
Phone: 713-566-6451
Fax: 713-440-5575

Lyndon B. Johnson Hospital - HR Suite, UT Annex 214
Phone: 713-566-4830

Ben Taub—HR Suite, 1l-08
Phone: 713-566-4830

Kirby Location - 9240 Kirby
Phone: 713-634-1029

WELLNESS

Main Customer Service
EmployeeWellness@harrishealth.org
Phone: 713-566-6686
Fax: 832-487-2978

CIGNA HEALTHCARE ADVOCATE

Morgan Simmons
morgan.simmons@harrishealth.org
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January 2, 2017

Dear Harris Health System COBRA Participant:

Welcome to the 2017 Annual Enrollment! Annual Enrollment will run from January 2, 2017 to January 23, 2017. Our Benefits Resources Guidebook was developed to be a resource for you as you make benefit selections for yourself and your eligible dependents during Annual Enrollment. Harris Health has made the decision not to mail the Benefits Resources Guidebook out to participants this year, but instead will post the materials online for easier access. You can access the Benefits Resources Guidebook by visiting www.harrishealth.org and clicking on Employees in the top blue bar, from there select Retiree/COBRA Resources to access the 2017 Benefits Resources Guidebook and other important plan documents. **Your 2017 Annual Enrollment elections are scheduled to take effect March 1, 2017.**

We are pleased to continue to provide three Medical Plan options to our benefit eligible participants: a KelseyCare option, a Low Deductible option and a High Deductible option, all of which are administered through Cigna. More detailed information regarding the levels of coverage and premiums for these three medical options can be found in the guidebook on our website.

As a COBRA participant, you may add eligible dependents to your coverage during Annual Enrollment. Please pay special attention to the documentation requirements for adding dependents and remember to submit the documentation to the Benefits Office by **January 23, 2017**; otherwise, they will not be covered under any Harris Health Benefit Plan. Make sure that your name, employee ID and telephone number are submitted with the dependent documentation.

Most importantly, please be sure that your COBRA Annual Enrollment Form is either Faxed, emailed, hand-delivered or mailed to our office by January 23, 2017, (mailed forms must be postmarked by January 23, 2017). We will not accept any changes after this date. As always, our benefits representatives are here to answer your questions. Please reach out to us with any comments or concerns; we are here to serve you.

Sincerely,

Omar C. Reid
Sr. Vice President, Human Resources

Benefits Main Line Number: 713-566-6451
Benefits Fax Number: 713-440-5575/ 713-566-6445
Benefits Email Address: Benefitsdepartment@harrishealth.org
Benefits Mailing Address:
Harris Health System
HR Benefits Department
2525 Holly Hall, Suite 100, Houston, TX 77054
Walk-in Assistance Locations: **(Appointments Encouraged)**
Holly Hall - 2525 Holly Hall, Houston, TX 77054 ▮ Kirby - 9240 Kirby, Houston, TX 77054
LBJ - 5656 Kelley St. UT Annex 214, Houston, Texas 77026 ▮ Ben Taub - 1504 Ben Taub Loop, Houston, TX 77030

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ANNUAL ENROLLMENT 2017

NOW IS THE TIME TO SELECT YOUR BENEFIT PLANS
FOR MARCH 1, 2017 - FEBRUARY 28, 2018

At Harris Health System we are committed to offering a competitive benefits package that meets the diverse needs of our Benefit Eligible Participants. We know the importance of healthcare and recognize the significant costs associated with healthcare expenses for you and your family. We have worked diligently on ways to contain the ever-increasing costs for these benefit programs. We are pleased to share with you the following comprehensive benefits package for the upcoming plan year, which continues to provide you and your family with quality healthcare benefits.

Please read the information provided in this Benefits Resources Guidebook carefully and share it with your family. Then use this information to help make benefit elections that meet your personal healthcare needs.

IMPORTANT DATES

- Annual Enrollment Dates: January 2, 2017—January 23, 2017.
- The deadline for submitting the Retiree Benefit/Change Form is December 7, 2016.
- The documentation submission deadline for new dependents is January 23, 2017.

IMPORTANT INFORMATION ABOUT PLAN BENEFIT ELECTIONS

If you do not make an active election change for the 2017 enrollment period, your benefits will remain the same as noted on the enrollment statement mailed out to you.

ENROLLMENT HIGHLIGHTS

MEDICAL & PRESCRIPTION INSURANCE CARD

You will receive a new medical ID card upon enrollment. You can also print a medical card anytime at **myCigna.com**.

PRESCTIPTION CARD

You will receive a prescription insurance card from OptumRx upon enrollment.

DENTAL & VISION INSURANCE CARDS

- DHMO enrollees that are enrolling in the plan for the first time will be mailed a new ID card after enrollment. Current participants will not receive a card this plan year unless a change is made to their enrollment profile.
- A card is not required to receive services on the DPPO plan; therefore enrollees will not automatically receive a card. If you would like an ID card you may print one online at metlife.com/mybenefits.
- Current enrollees will not receive a new card, unless changes are made to your coverage. If you need a new vision card, you can request it by calling 800-999-5431 or by visiting davisvision.com/Member.

NETWORK DIRECTORIES

You may visit each carrier's website to access a network directory. Website information and each carrier customer service number is identified on page 35 of this booklet.

BENEFIT CHANGES OUTSIDE OF ANNUAL ENROLLMENT

If you miss this Annual Enrollment Period, you cannot change your benefit elections until your or your dependent's next Qualifying Event, or the next Annual Enrollment Period, whichever occurs first. A Qualifying Event may include: a change in marital status, the number or eligibility of dependents, employment status (i.e. hourly to salary or salary to hourly and part-time to full-time or vice versa) including retirement, geographic relocation (e.g. regional transfers), or an approved FMLA leave of absence. Changes in benefit enrollments may also result from court orders, gaining or losing coverage under another employer's plan, obtaining other coverage (e.g. enrolling under Part A or B of Medicare or Medicaid) or losing coverage under a governmental program including the Children's Health Insurance Program (CHIP), the Texas Healthy Kids Corporation (THKC), or the Exchange. Benefit Enrollment/ Change Form and supportive documentation must be submitted within 31 of a Qualifying Event.

A Special Qualifying Event window may apply to make benefit changes in certain situations, such as for Medicaid and CHIP eligibility, that may extend the traditional 31-day enrollment window to 60 days. Contact the Employee Benefits department at 713 -566-6451 about the specific event to determine the appropriate benefit enrollment timeframe. Proof of Benefit Eligible Dependent status must be timely submitted to enroll and continue coverage. Dependent eligibility will be determined by the Employee Benefits department.

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MEDICAL PLAN CHANGES

For the 2017-2018 plan year, there will be very few benefit changes. With the exception of the changes below, your benefit plans will remain the same.

Changes for 2017:

- Everyone enrolled in the medical plan will receive new insurance cards.
- Everyone will receive a separate prescription insurance card from OptumRx.
- Glumetza will now be excluded.

Pharmacy Plan Design Changes:

- Effective 3/1/2017 all "Me Too" drugs are being excluded. Me Too drugs include high cost drugs that have generic equivalents that include: Acne Products, Cough/Cold/Allergy Combo, NSAIDS, Biguanides & Combos (excludes Glumetza), AHDH, Analgesics, Estrogens, Vitamins, etc. Opiate Agonists are excluded from the "Me Too" exclusions list as this drug therapy class is currently under our Reference Based Pricing Structure.
- Also effective 3/1/2017 all non FDA approved pain patches and creams will be excluded.

Medical Plan Change:

- Telehealth— Telehealth is a new medical feature, which allows patients to consult with a health care professional at their convenience. Through Telehealth, licensed physicians are able to provide treatment plans and provide prescriptions for minor illnesses including but not limited to; cold, flu, sinuses, allergies, bronchitis, respiratory infections and ear infections. Addressing a minor health issue is now as easy as picking up the phone and making a call.

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DEPENDENT RULES

ADDING OR RE-ENROLLING A DEPENDENT

- If you are adding or re-enrolling a dependent, you must provide proof of eligible dependent status at the time of enrollment but no later than the deadline.
- If you fail to timely submit the required proof of eligible dependent documents by the deadline, your dependent may not be added until your next Qualifying Event or Annual Enrollment Period, whichever occurs first.
- All dependents must meet proof of eligible dependent status as outlined in Policy 6.04 - Health & Related Benefits. All proof of eligible dependent documents must be received and approved by the Employee Benefits department at the time of enrollment but no later than the deadline.
- Harris Health is required to report on the minimum essential coverage offered to you and your dependents utilizing you and your dependent's social security number or taxpayer identification number. Review your dependent's information and make the necessary updates to ensure that your dependent is properly reported. If your dependent does not have a social security number or taxpayer identification number, please notify the Employee Benefits Department at the time of enrollment.
- Dependent Definitions and Requirements for Coverage are contained on Page 8 of this guidebook.
- Contact the Employee Benefits office for eligibility questions or assistance with enrolling your dependents. Refer to Page 1 of this document for contact information.

Note: Cigna will NOT verify coverage or process any Medical claims for dependents until a Coverage Questionnaire has been completed. Log into the Cigna web site, myCigna.com and click on *Review My Coverage*. Click on Enrollment and complete the Spouse/Partner Coverage Questionnaire or the Dependent Children Coverage Questionnaire before Medical services are rendered.

TERMINATION OF DEPENDENT COVERAGE

Group Medical, Dental and Vision Plan coverage terminates when premiums are not timely paid, which includes a 30 day premium grace period.

Dependent children are typically eligible to be covered by the Medical, Dental and Vision plans to age 26 regardless of student, employment or marital status. However, if employment or marital status occurs, either or both of these events would be considered a Qualifying Event, and you would be allowed to make benefit enrollment changes within 31 days of the Qualifying Event. If you fail to notify us of a qualifying event in a timely manner, you will not be able to make any benefit related changes until the next Qualifying Event or Annual Enrollment Period, whichever occurs first.

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DEPENDENT DEFINITIONS AND REQUIREMENTS FOR COVERAGE

Below is information regarding the term "dependent" as it is used in the Medical, Dental and Vision plans offered by Harris Health System.

A Spouse is: The person to whom the Enrollee is married.

Eligibility: The Enrollee's spouse is eligible.

Requirements:

A certified copy of a fully executed and valid Marriage License issued by a state, county or vital records office or a similar document from another country that is acceptable to the Employee Benefits Department; or

A certified copy of a Texas Declaration and Registration of Informal Marriage filed with the appropriate county clerk's office or a similar declaration that has been filed in another state that is acceptable to Benefits.

A Child is:

A natural child;

A stepchild;

A legally adopted child (including a child placed with the Enrollee and/or the Enrollee's Spouse pending finalization of adoption proceedings); or

A child for whom the Enrollee and/or the Enrollee's Spouse has obtained sole, permanent legal custody or permanent legal guardianship pursuant to a court order (for which no other person including the biological parent has any custodial rights).

Eligibility: Up to the end of the month in which the Child attains age twenty-six (26) or age twenty-six (26) or older who has a mental or physical disability of a permanent or of an indefinite but long duration.

Requirements:

Birth certificate issued by a state, county or vital records office (or substantially equivalent documents issued outside the United States and approved by the Employee Benefits department) that evidences that the individual is the qualifying "child" of the Benefit Eligible Participant or the spouse of the Benefit Eligible Participant.

A birth facts statement issued by the facility where the newborn was born may also be used to evidence that the newborn is the qualifying "child" of the Benefit Eligible Participant or the spouse of the Benefit Eligible Participant in the case of a newborn child (first 31 days from birth).

Additional Requirement For Disabled Child: Proof of the child's incapacity (in the form of a Social Security disability award letter) within 31 days of the end of the month in which the Child attains age 26 and at such other times as may be required by Harris Health or as allowed by applicable law.

A Grandchild is: A Grandchild is an unmarried Child of your Child and/or a Child of your Spouse's Child.

Eligibility: Up to the end of the month in which the grandchild turns age 26 and who is a dependent of the Benefit Eligible Participant for federal income tax purposes at the time application for coverage of the grandchild is made.

Requirements:

A copy of the birth certificate or birth facts sheet (for a newborn—first 31 days from birth) of the grandchild.

A copy of the birth certificate for the Benefit Eligible Participant's child that is the birth parent of the grandchild.

A copy of the Benefit Eligible Participant's federal income tax return evidencing that the grandchild will qualify as a dependent for the initial period of coverage must be submitted to the Employee Benefits department at time of enrollment or such later time as it is available but no later than April 15th of the following year, to confirm initial plan eligibility. Failure to timely submit required proof of initial eligibility documentation will result in loss of coverage.

Additionally the Enrollee must complete an Affidavit to add the Grandchild at time of enrollment.

Proof of Dependent eligibility must be provided to the Employee Benefits Department within the eligibility timeframes.

2017-2018 PREMIUM RATE SCHEDULE

HEALTHCARE PREMIUMS: Effective March 1, 2017

Medical Plan	Individual Only	Individual and Spouse	Individual and Children	Individual and Family
KelseyCare	$640.50	$1,633.26	$1,479.53	$2,126.43
Low Deductible	$719.67	$1,835.12	$1,662.40	$2,389.25
High Deductible	$640.50	$1,633.26	$1,479.53	$2,126.43
Dental Plans				
HMO	$8.76	$18.92	$18.92	$26.78
PPO	$38.95	$62.76	$64.32	$117.99
Vision Plan	$5.10	$8.50	$8.50	$15.18

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MEDICAL SUMMARY

	KELSEYCARE	HIGH DEDUCTIBLE		LOW DEDUCTIBLE	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE- *per plan year, applies to most covered services* Individual / Family	None	$1,500 / $4,500	$3,000 / $9,000	$500 / $1,500	$1,000 / $3,000
ANNUAL OUT-OF-POCKET LIMIT Individual / Family	$750/ $1,500	$3,000 / $9,000	$6,600 / $19,800	$1,850 / $3,700	$6,000 / $18,000
PHYSICIAN VISIT COPAY	$15	$25	60% after deductible	$25	60% after deductible
SPECIALIST VISIT COPAY	$30	$35 CCN Specialist $55 Non CCN Specialist	60% after deductible	$35 CCN Specialist $55 Non CCN Specialist	60% after deductible
ROUTINE EXAMINATIONS/ IMMUNIZATIONS *Routine Examinations include; additional services outlined in the plan document. Contact Cigna for further information*	100%	100%	60% after deductible (Immunizations are covered at no charge for children ages 0—5.)	100%	60% after deductible (Immunizations are covered at no charge for children ages 0—5.)
HEARING AID - *1 pair per 36 months*	100%	80% after deductible	60% after deductible	90% after deductible	60% after deductible
OUTPATIENT SERVICES *(facility) - except in physician's office when office visit copay applies*	100%	80% after deductible, $100 copay for surgical treatment	60% after deductible	90% after deductible, $100 copay for surgical treatment	60% after deductible
ALLERGY TREATMENT - *allergy serum, allergy injections and injectable drugs*	$15/ $30 PCP or Specialist copay Serum is paid at 100% if dispensed in PCP office	$25/$35/$55-PCP or Specialist copay Serum is paid at 100% if dispensed in PCP office	60% after deductible	$25/$35/$55-PCP or Specialist copay Serum is paid at 100% if dispensed in PCP office	60% after deductible
DIAGNOSTIC X-RAY AND LABORATORY PCP or Specialist Outpatient Facility/Independent Lab	100% after office visit copay	100% after copay 80% after deductible	60% after deductible	100% after copay 90% after deductible	60% after deductible 60% after deductible
HIGH TECH RADIOLOGY - *Outpatient Facility & Emergency Room & Physicians Office* *CT/CTAs, MRI/MRA, PET scans, Nuclear Tests*	100%	80% after deductible	60% after deductible ER—80% after deductible	90% after deductible	60% after deductible ER - 90% after deductible
HOSPITAL SERVICES Inpatient Coverage Emergency Room	$100 per day copay up to 5 days, then 100% $200 per visit copay then 100% (copay waived if admitted)	$100 per day copay up to 5 days, then 80% after deductible 80% after deductible	$500 per confinement deductible then 60% after plan deductible 80% after deductible	$100 per day copay up to 5 days, then 90% after deductible 90% after deductible	$500 per confinement deductible then 60% after plan deductible 90% after deductible
URGENT CARE PROVIDER	$30 per visit then 100% (copay waived if admitted)	$55 copay per visit	$55 copay per visit	$55 copay per visit	$55 copay per visit
CONVENIENCE CARE	Not Covered	$25 PCP Copay	60% after deductible	$25 PCP copay	60% after deductible
SKILLED NURSING FACILITY - *up to 60 days per calendar year*	100%	80% after deductible	60% after deductible	90% after deductible	60% after deductible
HOME HEALTH CARE - *100 days per calendar year, 16 hour max per day*	100%	80% after deductible	60% after deductible	90% after deductible	60% after deductible

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MEDICAL SUMMARY

	KELSEYCARE	HIGH DEDUCTIBLE		LOW DEDUCTIBLE	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
HOSPICE CARE Inpatient Coverage Outpatient Coverage	100%	80% after deductible 80% after deductible	60% after deductible 60% after deductible	90% after deductible 90% after deductible	60% after deductible 60% after deductible
SHORT-TERM REHAB *includes physical therapy, occupational therapy, and speech therapy 60 days per calendar year*	$15/ $30 PCP or Specialist copay, then 100%	$35 copay, then 100%	60% after deductible	$35 copay, then 100%	60% after deductible
REHAB PERFORMED AT QUENTIN MEASE, BEN TAUB, LBJ HOSPITALS	Not Covered	100%	N/A	100%	N/A
CHIROPRACTIC OUTPATIENT CARE *up to 20 days per calendar year*	$15/ $30 PCP or Specialist copay, then 100%	$35 copay, then 100%	60% after deductible	$35 copay then 100%	60% after deductible
CARDIAC REHAB - *unlimited days per year*	$15/ $30 PCP or Specialist copay, then 100%	$35 copay, then 100%	60% after deductible	$35 copay then 100%	60% after deductible
ACUPUNCTURE COVERAGE *$500 maximum per calendar year*	Not Covered	$25/$35/$55 PCP or Specialist copay, then 100%	60% after deductible	$25/$35/$55 PCP or Specialist copay, then 100%	60% after deductible
AMBULANCE	100%	80% after deductible	60% after deductible	90% after deductible	90% after deductible
DIALYSIS	100%	80% after deductible	Not covered	90% after deductible	Not Covered
DURABLE MEDICAL EQUIPMENT *unlimited max per calendar year*	100%	80% after deductible	60% after deductible	90% after deductible	60% after deductible
MOUTH, JAWS AND TEETH Physicians office Inpatient coverage Outpatient coverage	$15/ $30 PCP or Specialist copay, then 100%	$25/$35/$55 PCP or Specialist copay, applies to office visits $100 per day copay up to 5 days, then 80% coinsurance after deductible $100 per facility copay, then 80% coinsurance after deductible	60% after deductible $500 per confinement deductible then 60% after plan deductible 60% after deductible	$25/$35/$55 PCP or Specialist copay, applies to office visits $100 per day copay up to 5 days, then 90% coinsurance after deductible $100 per facility copay, then 90% coinsurance after deductible	60% after deductible $500 per confinement deductible then 60% after plan deductible 60% after deductible
MATERNITY Physician Services All subsequent Prenatal and Postnatal visits *(Delivery is covered the same as plan's hospital benefit)*	Payable as any other covered expense/costs vary based on facility in which it is performed	$25/$35/$55 PCP or Specialist copay, then 100% 80% after deductible	60% after deductible 60% after deductible	$25/$35/$55 PCP or Specialist copay, then 100% 90% after deductible	60% after deductible 60% after deductible
INFERTILITY TREATMENT *excludes in-Vitro, GIFT, ZIFT, etc.* Physician Services Inpatient Coverage Outpatient Coverage	$15/ $30 PCP or Specialist copay, then 100%	70% after deductible $100 per day copay up to 5 days, then 70% coinsurance after deductible $100 per facility copay, then 70% coinsurance after deductible	50% after deductible $500 per confinement deductible then 60% after plan deductible 50% after deductible	70% after deductible $100 per day copay up to 5 days, then 70% coinsurance after deductible $100 per facility copay, then 70% coinsurance after deductible	50% after deductible $500 per confinement deductible then 60% after plan deductible 50% after deductible
ALCOHOL & SUBSTANCE ABUSE SERVICES AND MENTAL HEALTH SERVICES *unlimited visits per calendar year* Inpatient Coverage Outpatient Coverage Office Visit	$100 copay per day up to 5 days, then 100% 100% $15 copay	$100 copay per day up to 5 days, then 80% after deductible 80% after deductible $25 copay	$500 per confinement deductible, then 60% after plan deductible 60% after deductible 60% after deductible	$100 copay per day up to 5 days, then 90% after deductible 90% after deductible $25 copay	$500 per confinement deductible, then 60% after plan deductible 60% after deductible 60% after deductible

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PRESCRIPTION DRUG SUMMARY

Your prescription drug benefits are part of your medical plan benefits and are administered by OptumRx. If you are enrolled in one of our medical plan options administered through Cigna you will automatically be enrolled in the prescription drug coverage through OptumRx. You may reach OptumRx at **1-800-880-1188** or via web at OptumRx.com. Please review the OptumRx benefit information below.

Rx OUT OF POCKET MAXIMUM—Annual amounts of $3,600 for individual and $4,200 for family , apply to all three options.
Once the out of pocket limit is reached, copays will no longer apply and the plan will pay 100% of allowable amount.

MANDATORY GENERIC NOTE—If there is a Generic equivalent to your prescription, you will be required to either use the Generic equivalent or pay the copay plus the difference in cost of the Brand name drug. If Generic equivalent is available and you fill Brand, you pay regular copay plus cost difference between Brand and Generic.

BRIOVA Rx SPECIALTY DRUGS—The Briova Rx is a mandatory program. After one fill you will be required to use the program, paying a $90 copay for a 30-day supply.

BREAST CANCER PREVENTIVE DRUGS—Breast Cancer Drugs for women may now be covered at 100%, if pre-authorized and approved by OptumRx.

SMOKING CESSATION DRUGS—Smoking cessation drugs are covered at 100% after a $30 copay up to a 90-day limit per calendar year.

RETAIL (30 - DAY SUPPLY)

Generic
10% copay
Minimum $3—Maximum $9

Brand name formulary
20% copay
Minimum $15—Maximum $45

Brand name non-formulary
30% copay
Minimum $30—Maximum $90

MAIL ORDER (31 - 90 DAY SUPPLY)

Generic
10% copay
Minimum $6 - maximum $18

Brand name formulary
20% copay
Minimum $30 - maximum $90

Brand name non-formulary
30% copay
Minimum $60 - maximum $180

REFERENCE BASED PRICED DRUGS—Effective 3/1/2014, Brand name and Generic prescription products in some categories of drugs have limited coverage under a "reference based pricing" arrangement. The plan will limit the amount it pays for a prescription for one of these products to a set dollar amount per pill or unit dose. There will not be a fixed dollar co-payment associated with these products. The portion that is the member's responsibility will depend on the number of pills dispensed.

If you find that your prescription has a reference based price, you may wish to talk to your physician about changing to a less expensive alternative. If you have any questions regarding your plan copay for one of these drugs, please call the OptumRx Customer Care Department at 1-800-880-1188.

Referenced Based Pricing

Drug Therapy Name	RBP	Drug Therapy Name	RBP
Nonsteroidal Anti-Inflammatory Agents	$.50	Opioid Agonists	$1.00
Anti-hyperintensive Combinations	$1.00	Proton Pump Inhibitors	$2.00
Fibric Acid Derivatives	$1.00	Statins	$2.00
Anti-Inflammatory Agents—Topical	$1.00		

STEP THERAPY PROGRAM—Proton Pump Inhibitors will be subject to a Step Therapy Program where members must first use a generic or over the counter drug if available.

PREFERRED DIABETIC SUPPLIES—In conjunction with Diabetes America not only is your office visit copay waived, so is your prescription drug copay for preferred diabetic supplies (BD lancets, Accu-chek test strips and One Touch Ultra test strips). Please be certain to visit an in network pharmacy to obtain these specific diabetic supplies at a $0 copay.

SPECIALTY DRUGS—Special drugs that are used to treat complex conditions such as multiple sclerosis, cancer and HIV/ AIDS.

COMPOUND DRUGS—Drugs which require a prescription from a doctor, and are prepared by a pharmacist who mixes or adjusts drug ingredients to customize a medication to meet a patient's individual needs.

FORMULARY—A formulary, or preferred drug list, is the list of prescription drugs covered by your health plan. All drugs on a formulary are chosen by medical experts for their effectiveness and value.

Here are some other important facts.

- **Different drugs have different costs.** You'll pay less for generic medications than you will for brand-name versions. Some brand-name drugs cost more than others.
- **Everything on the formulary is safe and effective.** All drugs on the list have been approved by the Food and Drug Administration (FDA). Drugs that have not been approved by the FDA will not be covered.
- **It covers most conditions.** The formulary is wide enough to include drugs that treat most medical conditions. However, it does not include all drugs for all conditions – some drugs may be excluded if they're overly expensive, not effective or not approved by the FDA. Most formularies do not include cosmetic, weight loss or lifestyle drugs.
- **Formularies can change.** Our formulary is evaluated and updated regularly as the prescription drug market evolves. New drugs are added, some drugs are removed and new generics replace other generics from time to time.

Please Note the Following Important Items:

- The Dispense as Written penalty for the cost difference between brand and generic will not apply to the Out-of-Pocket Maximum.
- Any amount over Reference Based Pricing allowable will not apply to the Out-of-Pocket Maximum.
- A voluntary Hepatitis C Outcomes Program has been implemented for members prescribed Harvoni as initial therapy when diagnosed with Genotype 1 Hepatitis C Virus infection. As a member enrolled in this program you will be monitored during the entire treatment regimen. Your prescription fills under this program must go through Briova Rx Specialty Drugs, the first fill at retail does not apply to this program. Harvoni is FDC approved, has a cure rate of 94% to 99% and it is a single pill taken daily.
- **Optum** SECURE Compound Medication Management Program.

  1) Required prior authorization on compounds greater than $300. If denied, the member can file an appeal through OptumRx.

  2) Exclusions on all bulk chemicals and all compound kits.

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STOP PAYING TOO MUCH FOR YOUR PRESCRIPTIONS

Compare prices, print free coupons & save up to 80%.

HOW GOODRx WORKS

Drug prices vary wildly between pharmacies. Good Rx finds the lowest prices and discounts. How?

1. **Collect and compare prices** for every FDA approved prescription drug at more than 70,000 US pharmacies.
2. **Find free coupons** to use at the pharmacy.
3. **Show the lowest price** at each pharmacy near you.

SOUNDS GREAT. SO WHAT'S THE CATCH?

GoodRx is free to consumers, and does not require no personal information to search drugs and receive discounts. GoodRx does not sell your personal health information to anyone. They make money from advertisements on their site and referral fees. This revenue enables them to continue to make the best, free product to help Americans afford the prescriptions they need.

THE #1 REASON AMERICANS DON'T TAKE THEIR MEDICATIONS AS PRESCRIBED: COST

- 45% of Americans have trouble paying for the prescriptions they need
- 26% of Americans have not filled a prescription because they cannot afford it.
- Even if you can afford your prescriptions, you're probably paying too much. It costs as little as one cent to manufacture a pill, so why do our prescriptions cost $10, $100 or even $1,000?

WHY WE PAY TOO MUCH FOR OUR PRESCRIPTIONS

Prices for prescription drugs vary widely between pharmacies. U.S. drug prices are neither fixed nor regulated. The cost of a prescription may differ by more than $100 between two pharmacies across the street from each other!

HOW GOODRx CAN HELP

Every week GoodRx collect millions of prices and discounts from pharmacies, drug manufacturers and other sources. Here's how you can use it to save:

- Use GoodRx's drug price search to compare price (just like you do for travel or electronics on other sites) for your prescription at pharmacies near you. We don't sell the medications, we tell you where you can get the best deal on them.
- GoodRx will show you prices, coupons, discounts and savings tips for your prescription at pharmacies near you.
- **Download GoodRx's iPhone or Android app (mobile) to get drug prices and coupons on the go.**
- If you prefer, GoodRx can send you a discount savings card which you keep in your wallet or purse.
- Visit www.GoodRX.com to sign up.

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HIGH AND LOW DEDUCTIBLE OPTIONS—NETWORK BENEFITS & CLAIMS FILING

IN-NETWORK OR OUT-OF-NETWORK BENEFITS

When you are enrolled in our Self-Insured Medical Deductible Options, you may receive In-Network or Out-of-Network Medical benefits. The level of coverage depends on the provider you choose. Cigna has a nationwide network of health care providers and is solely responsible for determining which providers participate in its network. You may select an In-Network provider by contacting the Cigna customer service line at **1-800-244-6224** or visiting **myCigna.com.** If you already have a provider, you may check with Cigna or your provider to see if your provider is part of the Cigna Care Network (CCN).

THE ADVANTAGES OF CHOOSING AN IN-NETWORK PROVIDER		THE HAZARDS OF CHOOSING AN OUT-OF-NETWORK PROVIDER
When a procedure or service requires preauthorization, your **Cigna** provider will handle the preauthorization.	→	**You** are required to obtain preauthorization from Cigna on certain services and procedures.
Cigna providers file your claims and Cigna will reimburse the provider - little to no upfront money comes out of your pocket.	→	**You** may be required to pay the provider's bill in full at time of service. **You** must then file a claim with Cigna for reimbursement.
Cigna will provide you with an Explanation of Benefits (EOB) that explains your financial responsibility including deductibles, copays and coinsurance. You will also see your **savings** due to negotiated, In-Network allowances.	→	Your Explanation of Benefits (EOB) explains your financial responsibility, including deductibles, copays and coinsurance. **You will not receive a discount** off billed charges and your claim will be processed according to Reasonable and Customary charges.
Cigna network providers will not bill you for amounts higher than indicated on your EOB.	→	Out-of-Network providers **may bill you** for amounts over Reasonable and Customary charges as indicated on your EOB.

PLAN		DEADLINE
Medical claims with Cigna	→	In-Network providers have 90 days after the date of service to submit their claims. Out-of-Network claims must be filed within 180 days of date incurred.
FSA claims with Flexible Benefit Administrators - Claims incurred from 3/1/17—5/15/18	→	105 days after the last day of active service
Dental PPO claims with MetLife	→	File Out-of-Network claims within 365 days of date incurred.
Vision claims with Davis Vision	→	File Out-of-Network 20 days after incurred date.

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DIABETES AMERICA

Harris Health System and Diabetes America have created a comprehensive diabetes program to help you manage your diabetes and live well. Diabetes America Locations provide comprehensive best-in-class, one-stop care facilities built expressly to fulfill the unique needs of adult diabetic patients, all under one roof. Highly trained Medical professionals and Certified Diabetes Educators will work closely with you to help control blood sugar levels, treat complications and promote wellness through individualized care programs and education in a setting devoted entirely to diabetes care.

Diabetes America also saves you money, as there is **NO COPAY** for clinics or lab work**.** You can also get your lab work done right on-site. Diabetes America is not in the KelseyCare network. To find a Diabetes America location call **1-866-693-4223** or visit the website **diabetesamerica.com**.

SERVICES INCLUDE

- Care from a Diabetes Specialist
- On-Site Mail Order Pharmacy
- Case Management and Monitoring
- Eye, Foot and Cardiovascular Screenings
- Certified Diabetes Education
- Exercise and Lifestyle Counseling and Support
- Telephonic Support/Website Access
- On-Site Lab

OUTPATIENT REHAB SERVICES AT HARRIS HEALTH FACILITY

QUENTIN MEASE, BEN TAUB & LYNDON B. JOHNSON GENERAL HOSPITAL

Exceptional Rehabilitation Close to You!

The Outpatient Rehabilitation Centers at Quentin Mease Community Hospital, Ben Taub and Lyndon B. Johnson General Hospitals are a part of the Cigna network, but are not in the KelseyCare network. No copay is required for rehabilitation services provided at one of our facilities for members of the Deductible Plans, subject to plan limits.

Making an appointment at one of our Outpatient Rehabilitation Centers is simple and convenient.

To schedule an appointment call the Scheduling Line at **713-218-8250.**

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YOUR HEALTH FIRST - ***Free Health Advocate Coach***

Your Health First is a program offered through Cigna at no cost to you to help you or your family members cope with a chronic condition. Cigna's solution weaves through all the health issues affecting an individual with a chronic health condition into one ongoing conversation through personalized support from a dedicated health advocate.

The advocacy program works with the individual to create a plan to help them successfully reach their health goals. The dedicated health advocate coach focuses on members with a one-on-one relationship approach to establish trust and drive higher engagement. Whether assistance is needed in managing a condition, knowing what to expect or understanding medications, the advocate team is there to help. Contact a Cigna health advocate coach today by calling **1-855-246-1873** or visit **myCigna.com.**

NURSELINE - ***Free Health Guidance***

Have a health question? Cigna's Health Information Line gives you 24-hour, toll-free access to a team of registered nurses experienced in providing information on a variety of health topics. This valuable service can help you learn about health conditions and Medical procedures, or to improve the way you communicate with your doctor.

The Health Information Line also includes access to hundreds of Cigna's latest podcasts on a variety of health topics which are available to you to listen to in English or Spanish.

Call the Health Information line at 1-800-244-6224.

HEALTHY BABIES - ***Free Pregnancy Educational Tools***

Healthy Babies is a collection of Cigna educational mailings available to members as part of your Medical benefit plan. In addition to the educational mailings, you have access to other services to assist with pregnancy such as a 24/7 Health Information Line, High Risk Maternity Case Management, and Neonatal Intensive Care.

You also have access on **myCigna.com** to tools that help you create a plan for a healthy pregnancy, monitor your pregnancy week by week, prepare for labor and delivery, and care for your baby. For more information call Cigna at **1-800-244-6224** or visit **myCigna.com**.

CIGNA NUTRITIONAL COUNSELING

Cigna covers routine Nutritional Counseling at 100% with no deductible or copay. Eligible plan participants can receive up to a maximum of 3 visits per calendar year. Call Cigna today at **1-800-244-6224** to confirm if you are eligible to participate in Nutritional Counseling.

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CIGNA—PRECERTIFICATION REQUIREMENTS & NURSE CASE MANAGEMENT

Cigna care management is designed to help you access the services that are most appropriate for you. Through precertification (finding out in advance if a service is covered) and nurse case managers, Cigna can help you lower costs, avoid unnecessary procedures and support you as you recover after a procedure.

WHAT IS PRECERTIFICATION?

Precertification is the process of determining in advance whether a procedure, treatment or service will be covered under your medical plan. It also helps ensure you get the right care in the right setting – potentially saving you from costly and unnecessary services.

WHO IS RESPONSIBLE FOR GETTING THE PRECERTIFICATION?

- **In-Network services:** Your doctor is responsible.
- **Out-of-Network services:** You're responsible if you choose to see an Out-of-Network doctor and your plan covers Out-of-Network services. To get precertification, call the toll-free number on your Cigna ID card, **1-800-244-6224**. You'll need the name of the doctor or facility, the procedure or procedure code and the date of service when you call. Remember, when you go out-of-network, your out-of-pocket costs will be higher, your coverage may be reduced or denied and you may be subject to a $500 penalty if you fail to precertify.

WHAT SERVICES NEED TO BE PRECERTIFIED?

Your doctor will help you decide which procedures require a hospital stay and which can be handled on an outpatient basis. Inpatient services include procedures, treatments and services that you receive in a hospital or related facility that require you to stay overnight. Outpatient services don't require an overnight stay. Here are some services requiring precertification*.

INPATIENT SERVICES

- All inpatient admissions and non-obstetric observation stays such as:
  - Acute hospitals
  - Skilled nursing facilities
  - Rehabilitation facilities
  - Long-term acute care facilities
  - Hospice care
  - Transfers between inpatient facilities
- Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (Cesarean section)

OUTPATIENT SERVICES

- Certain outpatient surgical procedures
- High-tech radiology (MRI, CAT scans, PET scans)
- Injectable drugs (other than self-injectable)
- Durable medical equipment (insulin pumps, specialty wheelchairs, etc.)
- Home health care/home infusion therapy
- Dialysis (to direct to a participating facility)
- External prosthetic appliances
- Speech therapy
- Reconstructive procedures in conjunction with underlying medical condition or accident
- Infertility treatment
- Nuclear cardiology
- Radiation therapy

**** Note:** This list does not include all services requiring precertification.*

WHAT OTHER SERVICES ARE AVAILABLE TO ME?

If you or a covered family member needs care beyond a traditional hospital stay, our experienced nurse case managers work closely with you and your doctor to help you sort out your options, arrange care, or access helpful community resources and programs. Whether your need is for home care, explaining your medications or finding additional services, your case manager helps you find the care you need to help you get better.

WHAT IF I HAVE QUESTIONS ABOUT MY COVERAGE?

Visit **myCigna.com** or call the toll-free number **1-800-244-6224** which is on your Cigna ID card.

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CIGNA—CONVENIENCE CARE & URGENT CARE CLINICS

There is a new and improved reason not to wait at an emergency room for the treatment of a sudden illness or an unexpected injury. You have the option of visiting Convenience Care or Urgent Care Clinics for minor health needs. If it is critical then neither of these clinics should be used and the patient should be directed to the emergency room.

One of our highest cost factors continues to be the use of Emergency Room visits. We continue to steer Medical plan participants towards Convenience Care and Urgent Care Clinics when possible. Deductible Plan members should visit **mycigna.com** to find Convenience Care and Urgent Clinics and KelseyCare members should visit **mycigna.com** to find an Urgent Care Clinic and **myKelseyCare.com** to schedule a Saturday ILL—Care appointment.

Convenience Care Clinics are designed to treat common ailments such as sinus infections, flu or strep throat. They provide basic healthcare and are authorized to write prescriptions in order to treat you and your dependents' symptoms. The Convenience Care Clinics are designed to be convenient and low-cost.

KelseyCare members will not have access to the same Convenience Care Facilities as our other Harris Health sponsored plans. However, Kelsey-Seybold offers Saturday ILL-Care appointments for adults and children at select locations throughout the greater Houston area. Call the Kelsey-Seybold Contact Center at **713-442-0000** after 5pm on Friday or Saturday morning for a Saturday appointment.

Urgent Care Clinics are similar to Convenience Care Clinics but serve the patients who are suffering from acute illnesses and injuries, which are beyond the capacities of a Convenience Care Clinic. Urgent Care Clinics are open for extended hours and are open for patients with non-life threatening injuries and illnesses.

CONVENIENCE CARE CLINICS—HIGH & LOW DEDUCTIBLE OPTIONS

Helping you and your doctor better manage your health

When you need treatment for common ailments and injuries, you have more choices. Now you can get high-quality, affordable services for a wide variety of routine Medical conditions through Convenience Care Clinics located throughout the country.

Because we believe that your doctor has primary responsibility for your care and treatment, the results of your diagnosis and treatment are sent to your doctor with your permission. If you have a more severe condition, or require treatment in a different setting, the Convenience Care clinician will refer you to your doctor or an Emergency Room.

The Medical care you receive at a Convenience Care Clinic is covered by your health plan just like any other service you receive from a health care professional.

Find a Convenience Care Clinic in or near your favorite retail store, with hours that fit into your busy schedule.

Receive high-quality Medical care in a facility overseen by doctors and staffed by certified nurse practitioners and physician assistants.

CONVENIENCE CARE CLINICS MAY HELP WITH THE FOLLOWING CONDITIONS:

- Allergies
- Bladder
- Cold sores
- Ear infections
- Impetigo
- Infections
- Influenza
- Laryngitis
- Minor burns
- Mononucleosis
- Pink eye and sties
- Poison ivy
- Pregnancy testing
- Rashes
- Ringworm
- Sinus infections
- Strep throat
- Swimmer's ear

CLINICS ALSO PROVIDE VACCINATIONS FOR:

- DTaP (Diphtheria, Tetanus, Pertussis)
- Influenza
- Hepatitis A & B
- Polio
- Meningitis

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CIGNA—TELEHEALTH CONNECTION

Cigna Telehealth Connection lets you get the care you need - including most prescriptions - for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat or phone, without leaving your home or office. When, where and how it works best for you.

Choose When: Day or night, weekdays, weekends and holidays.

Choose Where: Home, work or on the go.

Choose How: Phone or video chat.

Televisits can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. **Costs are the same or less than a visit with a primary care provider**. Giving employees an easy-to-use and cost effective alternative to care can help reduce costs and non-urgent ER visits.

USE CIGNA TELEHEALTH CONNECTION TO CONNECT WITH A DOCTOR ABOUT:

- Acne
- Allergies
- Colds and flu
- Fevers
- Headaches
- Rashes
- Sore throats
- Stomachaches
- Urinary tract infections and more

Visit the Website or call to register:

MDLIVE
888-726-3171
MDLIVEforCigna.com

Amwell
855-667-9722
AmwellforCigna.com
*Amwell is not available in Texas at this time, but offered in other states around the country.

CIGNA CARE NETWORK (CCN) - HIGH PERFORMANCE NETWORK—HIGH & LOW DEDUCTIBLE OPTIONS

The Cigna Care Network is an innovative high performance network strategy that steers specialty care to physicians who meet volume and medical cost efficiency standards. Under the Harris Health System plan you will pay lower out -of-pocket costs when you choose a Cigna Care Designated Specialist for covered services. This means your cost will be lower with a Cigna Care Specialist than with a specialist in the Cigna network who does not have this designation. To find a Cigna Care Specialist go to **myCigna.com**. The Cigna Care Network doctors are easily identified with a C symbol and will appear at the top of the list.

CIGNA CARE NETWORK (CCN) SPECIALTY TYPES

- Allergy/Immunization
- Colon and Rectal Surgery
- Endocrinology
- Hematology/Oncology
- Neurosurgery
- Orthopedics and Surgery
- Urology
- Cardiology
- Dermatology
- Gastroenterology
- Nephrology
- Obstetrics/Gynecology
- Pulmonology
- Cardio-Thoracic Surgery
- Ear, Nose and Throat
- General Surgery
- Neurology
- Ophthalmology
- Rheumatology

SPECIALIST TYPE	LOW & HIGH DEDUCTIBLE OPTIONS
In-Network CCN Specialist	$35 copay
In-Network non-CCN Specialist whose specialty **falls** within the CCN Network	$55 copay
In-Network non-CCN Specialist whose specialty **does not fall** within the CCN Network	$35 copay
Out-of-Network Specialist	60 % after deductible

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CIGNA—FREE PREVENTIVE CARE

Cigna's preventive care coverage complies with Healthcare Reform. Services designated as preventive care include periodic well visits, routine immunizations and certain designated screenings for symptom-free or disease-free individuals.

Healthcare Reform requires that non-grandfathered health plans cover preventive care services with no cost sharing. Most plans cover the full cost of preventive care services for individuals with Cigna coverage, including copay and coinsurance. Typically, these services must be provided by In-Network healthcare professionals. There are some exceptions.

For more information regarding the preventive recommendations of these resources, please see the federal government website: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**.

CODING FOR PREVENTIVE SERVICES

Correctly coding preventive care services is key to receiving accurate payment for those services.

- Preventive care services must be submitted with an ICD-9 code that represents encounters with health services that are not for the treatment of illness or injury. The ICD-9 code must be placed in the first diagnosis position of the claim form. A positive result on a preventive screening exam does not alter the classification of that service as a preventive service.

- If claims for preventive care services are submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim, the service will not be identified as preventive care and your claims will be paid using your normal medical benefits rather than preventive care coverage.

- Use CPT coding designated as "Preventive Medicine Evaluation and Management Services" to differentiate preventive services from problem-oriented evaluation and management office visits. Non-preventive care services incorrectly coded as "Preventive Medicine Evaluation and Management Services" will not be covered as preventive care.

Payment of preventive services by Cigna is dependent on claim submission using diagnosis and procedure codes which identify the services as preventive. Additional information about preventive care guidelines is available in the health care professionals section of Cigna's Informed on Reform website: **InformedonReform.com.**

This information does not supersede the specific terms of an individual's health coverage plan, or replace the clinical

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CIGNA—FREE WELLNESS PROGRAMS & ON-LINE TOOLS

Cigna Wellness is a free program available to all of our Medical plan participants. This program is designed to support healthy behavior at home and in the workplace. This program promotes a healthy lifestyle through various activities, workshops and health fairs. Harris Health System has partnered with Cigna to find fun and active ways to educate our Medical plan participants on how to live a healthy life. The wellness categories that follow contain more information about the Cigna program, tips and wellness resources.

WE'LL HELP YOU GET WHAT YOU NEED IF YOU'RE SUFFERING FROM A CHRONIC HEALTH CONDITION

Connect with a dedicated health advocate to help you:

- Manage a chronic health condition.
- Create a personal care plan.
- Understand medications or your doctor's orders.
- Identify triggers that affect your condition.
- Make educated decisions on your treatment options.
- Know what to expect if you need to spend time in the hospital.
- Improve your lifestyle by coping with stress, quitting tobacco use, maintaining good eating habits, and managing or losing weight.

Take charge of your health using online tools

We can also help you with a variety of Self-Service resources to help you better understand your condition and overcome barriers to better health with:

- A tool to help you understand your condition and make more informed treatment decisions.
- Articles and podcasts on hundreds of health topics.
- Online programs with email campaigns to help you with lifestyle issues.

Cigna may be calling you in order to take steps toward a healthier life. You may be eligible for an incentive when you participate. We do our best to suggest programs you might be interested in. Be on the lookout for communications regarding the following topics:

- Immunizations
- Diabetes
- Women's Health Tips
- Cold and Flu Tips
- Breast Cancer Screenings
- Flu Shots
- Prostate Cancer
- Fitness and Exercise
- Cervical Cancer Screenings
- High Blood Pressure
- Skin Cancer
- Chronic Conditions
- Cholesterol Screening
- Men's Health Tips
- Back Care
- Stress Management

Call Cigna today!

1-855-246-1873 or visit **myCigna.com**

MEDICAL PLAN—DEFINITIONS

ANNUAL OUT-OF-POCKET MAXIMUM
The most you pay for covered expenses each year. Once reached, the Plan pays 100% for most covered expenses for the rest of the year. If you are also covering dependents, each member's covered expenses accumulate toward the Family Out-Of-Pocket Maximum.

COINSURANCE
After you've met your Annual Deductible for In-Network or Out-of-Network charges, you begin paying the coinsurance or a percentage of the allowed amount for most medical services and supplies until you reach the Annual Out-Of-Pocket Maximum.

COORDINATION OF BENEFITS (COB)
A group policy provision that helps determine the primary carrier in situations where a plan enrollee is covered by more than one policy. This provision prevents the individual from receiving claims overpayments.

COPAY
The dollar amount you are responsible for paying when you incur certain eligible medical expenses. Services are generally those provided by physicians/practitioners, surgical facilities, emergency rooms and prescription drugs.

DEDUCTIBLE
The dollar amount you must pay each year for In-Network services and/or Out-of-Network services before the Plan begins paying a benefit toward eligible expenses.

FAMILY DEDUCTIBLE
The maximum dollar amount any one family will pay out in individual deductibles in a year.

FULLY INSURED

Under this plan the employer purchases coverage from an insurance company. The insurance company assumes the risk to pay all health claims. Beyond the listed deductibles and co-pays, and subject to lifetime maximums, the insurance company assumes the risk if premiums do not cover the allowable claims.

FORMULARY
A list of preferred prescription drugs that are approved for coverage by OptumRx's pharmacy benefits service. It includes brand name and generic drugs approved by the U.S. Food and Drug Administration (FDA). Preferred drugs on the formulary usually have lower copays than non-formulary drugs.

GENERIC
A prescription drug that contains the same active ingredients in the same amount as its brand name counterpart. The U.S. Food and Drug Administration (FDA) considers generic drugs to be as effective as brand name drugs. A generic drug can usually be sold when the patent on a brand name drug expires.

MEDICALLY NECESSARY
Services or supplies that are appropriate for or consistent with a diagnosis according to accepted medical standards as described in the Covered Benefits section of the Plan.

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NETWORK
Doctors, hospitals and other health care providers who have a contract with a health insurance/health benefits company to provide services at a negotiated rate of payment.

NON-FORMULARY
A list of approved but non-preferred prescription drugs. It includes many brand name and generic drugs approved by the U.S. Food and Drug Administration (FDA). Non-preferred drugs on the formulary list usually have higher copays than preferred formulary drugs.

OPEN ACCESS PLAN
This means you can see a Specialist without having to get a referral from a Primary Care Physician first.

PLAN YEAR
The Plan Year for annual enrollment plan design changes, premium changes, deductibles, out-of-pocket maximums, etc., are based on the Harris Health recognized Plan Year (March 1st to the end of February).

PRECERTIFICATION
Precertification is the process of determining in advance whether a procedure, treatment or service will be covered under your medical plan. It also helps ensure you get the right care in the right setting – potentially saving you from costly and unnecessary services.

QUALIFYING EVENT
Events (such as marriage, divorce, childbirth or change in job status) that qualify you to change your level of coverage during the year without waiting until Annual Enrollment.

REASONABLE AND CUSTOMARY CHARGES
Allowable expenses that the Plan will pay for medical services provided by Out-of-Network providers. Reasonable and Customary charges are consistent with those normally charged for the same services or supplies that are within the same geographical area. When you use an In-Network provider, you pay only the applicable copay or coinsurance based on a negotiated allowance, not Reasonable and Customary, for that contracted provider. When you use an Out-of-Network provider, the Plan pays 200% of the Medicare allowable amount.

SELF-INSURED MEDICAL PLAN
A plan in which the employer assumes the financial risk for providing benefits to its participants. A self-Insured plan lets the employer provide tailored programs to meet the special needs of its participants better than a "one size fits all" insurance offering, and there are financial benefits that can reduce the overall cost of the program, resulting in lower payments for both the employer and its participants.

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DENTAL PLANS

Harris Health partners with MetLife to offer two options for Dental coverage: a **DPPO** and **DHMO**. Identification cards will be mailed out after enrollment for DHMO plan participants. Please note that if you are a DPPO plan participant, you are not required to show an ID card to your dentist as proof of coverage. Just call your selected participating dentist to schedule an appointment any time after your effective date (March 1, 2017). For those enrolled in the DPPO who would like to have an ID card after March 1, 2017; you can print one online when you register/log-in to your MyBenefits website at www.metlife.com/mybenefits. You can also access your ID card (and other features) through the MetLife mobile app, which can be downloaded via iTunes or Google Play by searching "MetLife". Please note you must register via the website prior to downloading the app.

MetLife PPO

The MetLife DPPO plan has a network of over 380,000 participating providers nationwide who have agreed to provide services for a negotiated fee. The DPPO plan gives you access to your choice of providers and provides benefits both in-and-out-of-network. By going to a MetLife In-Network dentist you will benefit from greater discounts and reduced out-of-pocket costs.

METLIFE HMO

The MetLife DHMO plan requires you to select a MetLife DHMO provider. You may select a different provider for each covered family member.

For Annual Enrollment 2017, the cut-off date for electing your DHMO provider is a hard stop date of February 25, 2017 (and the 25th of each month thereafter for non Annual Enrollment enrollees). To find your DHMO provider, go to www.metlife.com/dental, and select "Find a Dentist." Type in the zip code where you would like to find a dentist, and select "Dental HMO/Managed Care." Select the plan name "Met290," and then click the search button. A list of providers in your area will appear.

With this plan you do not have access to Out-of-Network coverage. The plan runs on a copayment fee schedule for all covered services. You may access the copayment fee schedule when you log-in to your MyBenefits page (www.metlife.com/mybenefits). For specialist services you must be referred for treatment by your designated MetLife general dentist. There are no claims to file; therefore, you will not receive any Explanations of Benefits (EOB).

MetLife Website: metlife.com

MetLife DHMO Phone Number: 1-800-880-1800

MetLife DPPO Phone Number: 1-800-942-0854

To register for metlife.com/mybenefits you will need your Social Security number to create a new log-in. Once registered, you may update your username and password. You will only need your Social Security number for the initial log-in.

Website Features! - Your MyBenefits page offers a variety of information and features including, your Explanation of Benefits, your dental ID card, finding and updating your DHMO dentist (complete with Google map directions)! You can access the site from your smart phone. If you have questions, Customer Care is ready to help! 1-800-880-1800 (DHMO) 1-800-942-0854 (DPPO)

BENEFIT SUMMARY

	METLIFE DHMO	METLIFE DPPO
Calendar Year Deductible *(does not apply to preventive services)*	$0	$50 per person / $150 per family
Annual Benefit Maximum *(for In-Network and Out-of-Network)*	No annual maximum	$1,750 per person
Preventive Services *(cleanings, exams and x-rays)*	Copay varies	100% no deductible
Basic Services *(fillings, root canals and extractions)*	Copay varies	80% after deductible
Major Services *(bridges, crowns and dentures)*	Copay varies	50% after deductible-6 month waiting period
Orthodontia	Copay varies Adult & children covered	50% up to a $1,000 lifetime max Only children up to age 19 covered 12 month waiting period for new enrollees.

Note: *Dental plan benefits are calculated on a calendar year basis. Annual deductibles and annual maximums start over each January. Some services have a waiting period associated before coinsurance is applied. See official plan documents for additional details.*

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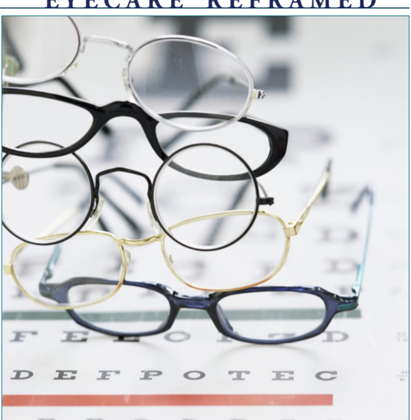
VISION PLAN

Davis Vision
EYECARE REFRAMED℠



Vision care is important to your overall health and can be a valuable part of your total benefits package. Davis Vision is our Vision care provider, providing benefits through a nationwide network that includes private practice and retail optical providers.

By selecting an In-Network provider you may receive a higher level of benefits and pay less out of your pocket. You will also enjoy the convenience of In-Network providers handling the claims process for you. To find an In-Network Provider visit davisvision.com or call **1-800-999-5431**.

When you use an Out-of-Network provider, you may pay more money out of your pocket at the time services are rendered and you are required to file the claim for reimbursement.

VISION EMPLOYEE BENEFIT SUMMARY

	COPAYS & ALLOWANCES	OUT-OF-NETWORK REIMBURSEMENTS*
Exams *(every 12 months)*	$10 copay	Up to $40 reimbursement
Lenses *(every 12 months)*		
Single Vision	$20 copay	Up to $40 reimbursement
Bifocal	$20 copay	Up to $60 reimbursement
Trifocal	$20 copay	Up to $80 reimbursement
Lenticular	$20 copay	Up to $80 reimbursement
Frames *(every 12 months)*		
Retail	Up to $130 allowance	Up to $45 reimbursement
The Exclusive Collection	Fashion Level - $0 copay	N/A
	Designer Level - $0 copay	N/A
	Premier Level - $25 copay	N/A
Contact Lenses *(every 12 months)*		
Non-collection, elective	Up to $105 allowance	Up to $105 reimbursement
Visually Required	$0 copay	Up to $210 reimbursement
Contact lens evaluation, fitting & follow up	$20 copay	N/A
The Exclusive Collection of Contact Lenses	$0 copay - Up to 4 boxes included	N/A

*Out-of-network reimbursement form must be submitted

VALUE-ADDED FEATURES

DAVISVISIONCONTACTS.COM

- Purchase replacement contact lenses at discounted prices (service is considered out-of-network)
- Convenient home delivery
- Partial reimbursement available of up to $105
- Free shipping on orders over $99

LASER VISION CORRECTION

- Special pricing available for Davis Vision members - 40% to 50% off national average price for traditional LASIK
- Over 900 locations nationwide
- Flexible financing available—12 months interest free.

FREE ONE-YEAR BREAKAGE WARRANTY

Available on all Exclusive Collection and in-network retail eyewear produced in a Davis Vision lab.

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MEDICARE REQUIREMENTS

WHEN ENROLLMENT IN MEDICARE IS REQUIRED TO CONTINUE RECEIVING HARRIS HEALTH MEDICAL PLAN BENEFITS AFTER RETIREMENT/DISABILITY

BENEFIT ELIGIBLE RETIREES AGE 65 OR OLDER AND THEIR DEPENDENTS AGE 65 OR OLDER MUST BE ENROLLED IN BOTH MEDICARE PART A AND B

For as long as you are a Benefit Eligible Employee enrolled in one of Harris Health's Medical Plan options, that Medical Plan option will have primary responsibility for paying your qualifying medical claims regardless of your age or health status. Consequently, when you reach age 65 and qualify to enroll in Medicare, you do not have to enroll in Medicare coverage in order to continue to receive benefits under the Harris Health Medical Plan option in which you are enrolled as a Benefit Eligible Employee.

When you retire from Harris Health and cease to be a Benefit Eligible Employee, the Medical Plan option coverage you received as a Benefit Eligible Employee will stop. If you qualify as a Benefit Eligible Retiree, you will be eligible to enroll in a Harris Health Medical Plan option. However, if you are age 65 or older when you retire you will have to be enrolled in both Medicare Part A and Part B in order to receive any benefits under the Medical Plan option in which you enroll. Similar rules apply to your qualifying dependents who are age 65 or older.

If you are not already receiving benefits from Medicare, you should contact the Social Security Administration (*SSA*) about three months before your 65th birthday to enroll in Medicare Part A and consider when you will need to enroll in Medicare Part B. You can sign up for Medicare even if you plan to continue working after you reach age 65. Many individuals can receive Medicare Part A at no cost, but there is a monthly premium charged for Medicare Part B coverage. While you are not required to have either Medicare Part A or Part B as long as you are a Benefit Eligible Employee (even if you are over 65), once you retire you *must* have both Part A and Part B to receive benefits under a Harris Health Medical Plan option as a Benefit Eligible Retiree. To avoid gaps in coverage, you should contact the SSA and ensure that Part A and Part B coverage is in place at the time of your retirement.

In addition, if you retire due to a disability that the SSA determines qualifies you to receive Social Security Disability Income, you will have to be enrolled in Medicare Part A and Part B as of the first day you are eligible for Medicare Part A and Part B coverage to continue to receive benefits under the Harris Health Medical Plan option in which you enroll as a Benefit Eligible Retiree. Similar rules apply to your qualifying disabled dependents.

For these reasons it is important for you and your dependents to have a basic understanding of Medicare coverage so that you and your dependents can enroll in Medicare *as soon as necessary to ensure you will continue to receive benefit under the Harris Health Medical Plan option in which you are enrolled*. Below, you will find a brief description of those parts of Medicare coverage that you need to consider, and the conditions under which you and your dependents will need Medicare coverage to remain eligible for plan benefits under a Harris Health Medical Plan option.

Medicare – Coverage Types

Medicare is our country's traditional health insurance program for people age 65 or older. It helps with the cost of healthcare, but it does not cover all medical expenses or the cost of most long-term care. Medicare benefits are managed by the Centers for Medicare & Medicaid Services (*CMS*), but you apply for Medicare through the SSA. Medicare is financed by a portion of payroll taxes paid by workers and their employers. It is also financed in part by monthly premiums deducted from SSA checks. Medicare has several parts to it.

Part A: Hospital insurance that helps pay for inpatient care in a hospital or skilled nursing facility and some home healthcare and hospice care.

Most individuals are required to enroll with the SSA to receive Medicare Part A.

Medicare Part A recipients who have worked for ten years or more (or whose spouses have worked for ten years or more) generally do not have to pay a monthly premium for Part A coverage. For everyone else, there is a monthly premium.

Part B: Medical insurance that helps pay for doctors' services, and other medical services and supplies not covered by the hospital insurance provided under Part A.

You must enroll with the SSA (and pay the monthly premium) to receive Medicare Part B coverage.

The 2017 regular Part B monthly premium is $134.00. Some people may pay a higher premium based on personal adjusted income.

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Part D: Prescription drug coverage that helps pay for medications doctors prescribe for treatment. Benefit Eligible Retirees and their dependents enrolled in and receiving benefits under a Harris Health Medical Plan option should not enroll in Medicare Part D because prescription drug coverage is included as a part of the Harris Health Medical Plan coverage.

You Must Be Enrolled in Medicare if you are a Benefit Eligible Retiree, or a Benefit Eligible Dependent of a Retiree, and Age 65 or Over

As a Benefit Eligible Retiree age 65 or over, you must be enrolled in both Medicare Part A and Part B in order to receive benefits under a Harris Health Medical Plan option. You DO NOT need to enroll in Medicare Part D coverage. Likewise, a Benefit Eligible Retiree's Benefit Eligible Dependent who is age 65 or over must be enrolled in both Medicare Part A and Part B in order to receive benefits under a Harris Health Medical Plan option. If you or your dependent who must be enrolled are not enrolled in Medicare Part A and Part B, your (or your dependent's) medical expenses will NOT be paid by the Harris Health Medical Plan option in which you are enrolled and the plan administrator of the Medical Plan will not be able to verify coverage or process medical expenses for that individual during the period he or she is not enrolled. Additionally, the failure to have both Medicare Part A and Part B coverage will result in your continuing to pay Harris Health Medical Plan premiums for the coverage in which you are enrolled even though you will NOT be entitled to payment of medical expenses until you (or your dependent) are enrolled in both Medicare Part A and Part B and the enrollment in both parts is effective.

It is important for you to understand how to obtain Medicare coverage since that coverage must be in place on the date you retire (or reach age 65 if you retire early). Likewise, it is important for you and your dependents to understand how your dependents obtain Medicare coverage since that coverage must be in place on the date you retire (if your dependent is age 65 or older) or the date your dependent reaches age 65 (if you retire before your dependent reaches age 65).

When you first become eligible for Medicare, you have a seven month period (your initial Medicare enrollment period) in which to enroll in Medicare. A delay in enrolling may cause a delay in Medicare coverage. If you become eligible for Medicare at age 65, your initial enrollment period begins three months before the month of your 65th birthday, includes the month you turn age 65, and ends three months after the month of that birthday (for a total of seven months). If you enroll in Medicare during the first three months of your initial Medicare enrollment period, your Medicare coverage will start the first day of the month you are first eligible. If you enroll during the last four months, your Medicare coverage will start from one to three months after you enroll. You should consider these dates when planning for retirement to ensure your and your dependents' Medicare Part A and Part B coverage will be in effect on the date you retire. Remember that as a Benefit Eligible Retiree age 65 or over, you cannot receive benefits under a Harris Health Medical Plan option unless you are also enrolled in Medicare Part A and Part B. For this reason, to avoid gaps in coverage, you should contact the SSA and ensure that Part A and Part B coverage is in place at the time of your retirement.

If you do not enroll in Medicare during your initial Medicare enrollment period described above, you will have another chance each year to sign up during a "General Enrollment Period" from January 1st to March 31st. Your Medicare coverage would then begin the following July 1st. However, the monthly Medicare Part B premium will increase for each month that you were eligible to enroll but did not timely enroll in Medicare (there is an exception for employees and spouses covered by an employer-provided group health plan – see next paragraph). For more information, go to the ssa.gov or medicare.org websites.

In addition to your initial Medicare enrollment period and the Medicare General Enrollment Period each year, you will have an opportunity to enroll in Medicare when you retire if you continue to work after reaching age 65.

A similar rule applies if you have coverage through your spouse's employer-provided group health plan after reaching age 65. While in these situations you do not need to be enrolled in Medicare Part A or Part B while you have employer-provided group medical plan coverage, if you will be covered under a Harris Health Medical Plan option when you retire, you need to ensure your enrollment in both Medicare Part A and Part B is effective beginning the day after you retire or lose your spouse's coverage. *Only in cases where your enrollment in Medicare was delayed due to your or your spouse's continuing employment and associated healthcare coverage* will delaying enrollment in Medicare not require you to wait for the Medicare General Enrollment Period or necessitate your paying a Medicare premium surcharge for late enrollment. There are limits to this exception, so we strongly advise you to contact the CMS for more information. However, to prevent delays in any future benefits coverage, you are encouraged (but not required) to enroll in Medicare Part A, which is free, immediately upon reaching age 65, and arrange for Medicare Part B coverage to begin no later than the month your active employment or your spouse's active employment ends if you will enroll in a Harris Health Medical Plan option when you retire.

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If you retire from Harris Health before reaching age 65 and are a Benefit Eligible Retiree enrolled in one of Harris Health's Medical Plan options, that Medical Plan option will provide your primary medical coverage only until you reach age 65. When you reach age 65, the Medical Plan option in which you are enrolled will stop providing your primary medical coverage, and will not provide any coverage unless you are enrolled in both Medicare Part A and Part B. Consequently, your enrollment in both Medicare Part A and Part B must be effective by the date you reach age 65 or you will not receive medical benefits under the Harris Health Medical Plan option in which you are enrolled.

BENEFIT ELIGIBLE RETIREES AND BENEFIT ELIGIBLE DEPENDENTS WHO ARE DISABLED MUST BE ENROLLED IN BOTH MEDICARE PART A AND B

Effective January 1, 2011, a Social Security approved under age 65 Disabled Benefit Eligible Retiree or under age 65 Disabled Benefit Eligible Dependent of a retiree must be enrolled in both Medicare Part A and Part B to be eligible for Harris Health Medical Plan coverage. The retiree or dependent must be enrolled in both Medicare Part A and Part B as of the date the under age 65 Disabled Benefit Eligible Retiree or under age 65 Disabled Benefit Eligible Dependent becomes eligible for Medicare. There is no requirement to enroll in Medicare Part D.

Individuals under age 65 can enroll after they have received Social Security Disability Income (*SSDI*) benefits for 24 months. Due to the five month waiting period from the start of the disabling condition for individuals who qualify for SSDI benefits, Medicare coverage cannot start sooner than the beginning of the 30th month after the start of the qualifying disability. However, in order to receive Harris Health Medical Plan benefits, you should enroll in Medicare as soon as you are allowed by the SSA to do so.

SSDI beneficiaries with specific conditions may begin receiving Medicare benefits sooner than the traditional 30 month qualifying period. At present, individuals with:

ALS or Lou Gehrig's Disease qualify for Medicare the first month SSDI benefits are received;

End Stage Renal Disease or Kidney Failure qualify for Medicare after the third month of receiving SSDI benefits; and

Kidney problems in which the individual receives a kidney transplant qualify for Medicare in the month the individual receives the transplant.

If you are already receiving Social Security benefits for a Social Security approved disability, the SSA will send you information a few months before you become eligible for Medicare. In most cases, you will be automatically enrolled in Medicare Part A and Part B. However, because you must pay a premium for Part B coverage, you can choose to turn it down. If you accept automatic enrollment in Medicare Part B, or if you enroll during the first three months of your initial enrollment period, your coverage will start the month you are first eligible.

> Failure to retain both Medicare Part A and Part B coverage will result in Harris Health's Medical Plan claims administrator not being able to verify coverage or process otherwise eligible medical expenses. Failure to enroll in both Part A and Part B of Medicare will result in the Benefit Eligible Retiree continuing to pay the regular Medical Plan option premium, even though the under age 65 Disabled Benefit Eligible Retiree or under age 65 Disabled Benefit Eligible Dependent will not be entitled to benefits under the Harris Health Medical Plan option until he or she successfully enrolls in both Part A and Part B of Medicare. The Medical Plan option will be secondary to Medicare and will generally remain the secondary coverage as long as you remain eligible for a Harris Health Medical Plan option.

There is an exception to the general rule described above. An under age 65 Disabled Benefit Eligible Retiree or under 65 Disabled Benefit Eligible Dependent *who was awarded prior to September 30, 2010 Medicare eligibility as a result of a Social Security approved disability* is considered to be under grandfather status and therefore exempt from this Medicare enrollment requirement. For these individuals the Harris Health sponsored plan option will continue to provide coverage until such time as the grandfathered participant enrolls in Medicare Parts A and B or attains age 65, whichever occurs first.

As an offset to the cost to carry Medicare Part B coverage, *Harris Health's Medical Plan will waive the Benefit Eligible Retiree's cost share of the Medical Plan's monthly premium rate based on the Benefit Eligible Retiree only level of coverage until the under age 65 Disabled Benefit Eligible Retiree or under age 65 Disabled Benefit Eligible Dependent attains age 65*. This premium rate reduction assumes the under age 65 Disabled Benefit Eligible Retiree or dependent remains covered under the Medical Plan option and in Social Security disabled status until age 65. A limit of one premium rate reduction per month per eligible Benefit Eligible Retiree will apply.

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MEDICARE REQUIREMENTS CONTINUED

Questions or Benefits Assistance:

Medicare – Questions

If you have questions about eligibility for and enrolling in Medicare, Social Security retirement benefits, or disability benefits, call the Social Security Administration at 1-800-772-1213 or TTY 1-800-325-0778. You may also visit Medicare online at their website: SocialSecurity.gov. For general questions about Medicare call 1-800-MEDICARE, 1-800-633-4227 or TTY 1-877-486-2048.

Medical-Benefits Assistance

If you would like to discuss the Harris Health System Medical Plan options in more detail, you may contact the Employee Benefits Department of Harris Health at 713-566-6451, Monday-Friday, 8:00 a.m. – 4:30 p.m. or visit our offices at 2525 Holly Hall, Suite 100, Houston, TX 77054.

Note: In order to avoid coverage interruption, submit a copy of your Medicare card indicating enrollment in Part A and Part B to the Benefits Department as soon as possible upon enrollment.

COMMUNITY HEALTH CHOICE, INC. (COMMUNITY)

Community Health Choice, Inc. (Community) is a non-profit Health Maintenance Organization (HMO) licensed by the Texas Department of Insurance (TDI). Community is more than a health plan. We were founded to increase access to quality health care for those who need it most. Our mission is to improve the health of under-served residents of Southeast Texas by opening doors to coordinated, high-quality, affordable, health care and health-related services. Through our network of more than 10,000 doctors and 70 hospitals, Community serves over 360,000 Members with the following:

- **Medicaid State of Texas Access Reform (STAR):** Program for low-income children and pregnant women
- **Children's Health Insurance Program (CHIP):** Program for the children of low-income parents--includes perinatal benefits for the unborn in the form of free prenatal care for the unborn child, even if the mother does not qualify for Medicaid
- **Health Insurance Marketplace (Marketplace):** Plan that offers premium assistance and cost-sharing reductions for individual health coverage that includes preventive care, emergency services, prescription drugs, and hospitalization available to all, regardless of pre-existing conditions

Eligibility for STAR and CHIP benefits are income based. To learn if you are eligible, go to www.yourtexasbenefits.com.

Community Health Choice is located at 2636 South Loop West, Suite 125, Houston, TX. 77054. Hours of operation are 8:00 a.m. – 5:00p.m. Contact us at 713-295-2222 or 1-877-635-6736.

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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.

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 July 31, 2016. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/ebsa	www.cms.hhs.gov
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

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ALABAMA – Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Phone : 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-877-438-4479
Website: http://www.indianamedicaid.com Phone: 1-800-403-0864

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/ma/
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov
http://hijosaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: htts://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
Chip Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid and CHIP
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

MANDATORY NOTICES

HIPAA - Special Enrollment Rights

Loss of Other Coverage If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if your or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your spouse or your dependents' other coverage). However, you must request enrollment within 31 days after your spouse or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

New Dependent by Marriage, Birth, Adoption or Placement for Adoption In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Certain Changes in Medicaid or CHIP Coverage If you or your eligible dependent are eligible to enroll in the Plan, but are not enrolled, you or your dependent will be entitled for coverage under the Plan if:

- You or your eligible dependent were covered under a Medicaid plan or under a State child health plan and that coverage was terminated because you or your eligible dependent lost eligibility for coverage; or
- You or your eligible dependent become eligible under a Medicaid plan or under a State child health plan for assistance with your premium payments under the Plan.

However, you must request enrollment in the Plan no later than 60 days after the date of termination of the Medicaid plan or State child health plan coverage or the date you or your eligible dependent is determined to be eligible for the assistance.

HIPAA - Notice of Privacy Practices

You May Obtain a Copy of the Notice of Privacy Practices The Notice of Privacy Practices for the Plans explains how the Harris Health System Plan use and disclose personal health information (PHI) of individual covered by the Plans. Harris Health System has previously provided you with a copy of that notice. The Plans are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to periodically advise you of the availability of the Notice of Privacy Practices adopted by the Plans and how to obtain a copy. The Notice of Privacy Practices for the Plans may be obtained by contacting Employee Benefits at 713-566-6451 or you may mail your request to: Harris Health System 2525 Holly Hall, Houston, TX 77054, Attn: Benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") generally prohibits group health plans such as the Harris Health System Plan from using genetic information of plan participants to discriminate in providing coverage or benefits. The Plan is administered by Harris Health System to comply with the applicable requirements of "GINA."

MENTAL HEALTH PARITY ACT

Per the Mental Healthy Parity Act, the Harris Health System Plan provide mental health benefits comparable to the Medical benefits offered to you. Deductibles, copays, out-of-pocket expenses, visits or frequency of treatments are no longer more restrictive than the requirements or limitations to your Medical benefits.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The Plans are in compliance with this law.

Under the Act, the Medical plan and the claim administrators that offer mastectomy coverage under the plans must, for any participant or beneficiary who elects breast reconstruction in connection with a mastectomy, cover:

Reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema.

The covered procedures will be performed in a manner determined in consultation with the attending physician and the patient and will be subject to the same annual deductibles and co-insurance provision consistent with those established for other benefits under the applicable plan.

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VENDOR PHONE APPS

Phone Apps have become increasingly popular due to their convenience; they allow consumers quick and easy access to various products.

MYCIGNA MOBILE APP

Introducing the simple, personalized myCigna Mobile App. You're busier than ever. At Cigna, we get that. While we can't wave a magic wand and make all the frustrating, time-consuming aspects of your life go away, we can give you a tool to help make your life easier and healthier.

The all-new myCigna Mobile App gives you a simple way to personalize, organize and access your important health information – on the go. It puts you in control of your health, so you can get more out of life.

LITTLE APP. BIG FEATURES.

HEALTH CARE PROFESSIONAL DIRECTORY

- Search for a doctor or health care facility from the Cigna national network and compare quality-of-care ratings
- Access maps for instant driving directions

ID CARDS

- Quickly view ID cards (front and back) for entire family
- Easily print, email or scan right from smartphone

CLAIMS

- View and search recent and past claims
- Bookmark and group claims for easy reference

ACCOUNT BALANCES

- Access and view health fund balances
- Review plan deductibles and coinsurance

HEALTH WALLET

- Store and organize all important contact information for doctors, hospitals and more
- Add health care professionals to contact list right from a claim or directory search

Get the myCigna Mobile app from the app StoreSM or Google Play.

OPTUM MOBILE APP

FIND THE OPTUM

MOBILE APP.

The mobile app provides easy, on-the-go access to your personalized health information. Once you receive your Member ID number, download the App to take advantage of the benefits your pharmacy plan offers.

EASY ACCESS ANYTIME, ANYWHERE

- Show your doctor exactly what drugs you are taking. Pull up your medication history anytime.
- Stay on top of medication refills. See when refills are due, get refill reminders and quickly contact your pharmacy.
- Find network pharmacies by ZIP code or location, then check and compare current prescription prices.

… And much more!

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VENDOR CONTACT INFORMATION

BENEFITS ENROLLMENT OR ELIGIBILITY
Employee Benefits Department
713-566-6451
benefitsdepartment@harrishealth.org

MEDICAL

CUSTOMER SERVICE - CIGNA 800-244-6224 **myCigna.com**	**DEDICATED ADVOCATE-CIGNA** 713-566-4391	**HEALTH FIRST COACHING PROGRAM - CIGNA** 855-246-1873 **myCigna.com**
CIGNA HEALTH AND NURSELINE INFORMATION 800-244-6224 **myCigna.com**	**HEALTHY BABIES - CIGNA** 800-564-9286 **myCigna.com**	**KELSEY-SEYBOLD 24-HOUR CONTACT CENTER** 713-442-0000 **Kelsey-Seybold.com**
TELEHEALTH CONNECTION - CIGNA 888-726-3171 **MDLIVEforCigna.com**	**KELSEY-SEYBOLD 24-HOUR CONTACT CENTER** 713-442-0000 **Kelsey-Seybold.com**	**KELSEYCARE CONCIERGE SERVICE** 713-442-0006 or 866-609-1630
MYKELSEYONLINE 713-442-6565 **myKelseyOnline.com**		

DENTAL

DENTAL PPO - METLIFE 800-942-0854 **metlife.com**	**DENTAL HMO - METLIFE** 800-880-1800 **metlife.com**	

VISION

DAVIS VISION
800-999-5431
DavisVision.com

PRESCRIPTION DRUGS

OPTUMRx 800-880-1188 **optumrx.com**	**OPTUMRx (MAIL ORDER)** 800-881-1966	

OTHER

COBRA-FLEXIBLE BENEFIT ADMINISTRATORS 800-437-3539 **Flex-admin.com**	**DIABETES AMERICA** 866-693-4223 **DiabetesAmerica.com**	**PHYSICAL THERAPY & REHAB - HARRIS HEALTH SYSTEM** 713-218-8250

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