

FOCUS ON WELL-BEING



2018 – 2019 Benefits Retiree Enrollment Guide

HARRISHEALTH
SYSTEM



YOUR HARRIS HEALTH BENEFITS

This brochure includes a brief overview of your retiree benefit options, as well as the important information you need during enrollment. We encourage you to read through it carefully so you can make educated choices when you are electing benefits.

The benefits in this brochure are effective March 1, 2018 through February 28, 2019.

Where to Find More Information

For more information about these benefits and other programs:

- Review our Retiree/COBRA Resources site for more information, including official plan documents, policies, and certificates: <https://www.harrishealth.org/en/pages/retiree-resource.aspx>

Benefits Annual Enrollment is November 15 - November 29, 2017!

- If you want to make changes, you must submit the Retiree Benefit/Change Form by November 29, 2017.
- Adding new children to your coverage? You must submit documentation for new dependent children by November 29, 2017.

WHAT'S NEW FOR 2018 – 2019?

Medical Plan

- The Deductible on the Low Deductible Option will increase to \$750 individual / \$2,250 family in-network.
- The Out-of-Pocket Maximum on the Low Deductible Option will increase to \$3,000 individual / \$9,000 family in-network.
- The Out-of-Pocket Maximum on the High Deductible Option will increase to \$3,750 individual / \$10,500 family.
- Telehealth copays will be \$10.
- Autism - Speech, Physical/Occupational Therapy & Applied Behavioral Analysis are no longer subject to annual limits.
- Premium Rates for all three plan options will increase.

Prescription Drugs

- \$100 Deductible, per member per year, will now apply to brand name drugs only.
- Generic Retail copay will be a flat \$10.*
- Generic Mail Order copay will be a flat \$25.*
- Specialty Drug copays will be \$120.
- Compound Drug copay will be \$50.
- Brand name formulary copay will increase to a maximum of \$60 at retail and \$150 through mail order.
- Brand name non formulary copay will increase to a maximum of \$120 at retail and \$300 through mail order.
- The Mandatory Generic Program will be revised to the following: When there is a generic available and you fill with a brand name, you will be responsible for the brand copay plus the difference in cost between the generic and brand name drug.

- Pre-65 Retirees and covered Spouses with Harris Health primary coverage engaged in the Livongo program through Harris Health will receive their diabetic medications at no cost as long as they remain engaged in the program.
- Refills on Opioids will not be allowed until 90% of the medication has been used.
- Harvoni® Hepatitis C program has been discontinued.
- Referenced Based Pricing Program will be eliminated.
- Lovastatin will be covered at zero copay if you are aged 40-75, have one or more cardiovascular risk factors, have a calculated 10-year risk of a cardiovascular event of 10 percent or greater and if it is being used for prevention of Cardio Vascular Disease.

Dental PPO Plan

- Composite fillings will be covered on back teeth.
- Missing tooth no longer excluded.
- Periodontal maintenance covered at four per year from two per year.
- Implants now covered at the same frequency as crowns.
- Surgical Extractions and General Anesthesia moved to Major Services.
- Out-of-Network reimbursement will be paid at the 80th percentile.
- Full Mouth X-Rays changed to 1 in 60 months.
- Crowns/Inlays/Onlays/Bridges/Dentures/Implants covered at 1 in 84 months.

* If the cost of your prescription is less than the copay amount, you will pay the lesser amount.

BENEFITS AT A GLANCE

Benefit	Who Pays for Coverage	Carrier	Description	Link to More Information
Medical	Harris Health and Employee	Cigna	Three plan options: KelseyCare (Kelsey-Seybold network only), High Deductible and Low Deductible	More medical information
Prescription Drugs	(Included with medical)	OptumRx	Prescription drug benefits included with your medical plan election	More Rx information
Dental	Harris Health and Employee	MetLife	Two plan options: DHMO and DPPO	More dental information
Vision	Harris Health and Employee	Davis Vision	One plan that helps you save money on vision exams, glasses, contacts and more	More vision information



GETTING STARTED

Eligibility

Effective June 1, 2012 the Harris Health System moved to a retiree healthcare eligibility point system. Retirees now need 80 points to be eligible for retiree healthcare benefits (i.e. medical, dental or vision).

The point system, also known as a “rule of 80,” is based on age and creditable years of full-time regular employment as of your date of retirement. Minimum retirement age is age 55.

Point System Examples:

- Age 55 + 25 Years = 80
- Age 60 + 20 Years = 80 Points
- Age 62 + 18 Years = 80 Points
- Age 65 + 15 Years = 80 Points

The percent of the total monthly retiree medical premium rate that you will pay will be based on your age at the time of your retirement.

The chart (right) provides you with the schedule of monthly premium percentage rates that early retirees can expect to pay when retiring on or after June 1, 2012. The same percentage rate will be paid until the early retiree reaches age 65. Retiree premium rates may change each year, subject to Board approval.

Early Retiree Medical Plan Rate Schedule Effective June 1, 2012	
If your age at your date of retirement is:	The percent of the Harris Health System monthly premium you will pay until age 65 will be:
55	80%
56	75%
57	70%
58	65%
59	60%
60	55%
61	50%
62	45%
63	40%
64	35%

PLEASE NOTE:

If you retired prior to June 1, 2012 you are considered in Grandfather status. Should you rehire into a benefit-bearing position with Harris Health after June 1, 2012 you will be subject to the rule of 80 upon your subsequent termination.

Healthcare and Dependent Information

A benefit eligible retiree may continue to carry medical, dental, or vision coverage into retirement if he or she was enrolled in that type of coverage on the day immediately preceding his or her date of termination from Harris Health.

1. A benefit eligible retiree cannot add any new plan type of coverage. However, if more than one plan type of coverage is offered, the benefit eligible retiree may switch coverage types (e.g., Medical PPO to HMO or Dental PPO to HMO and vice versa) within 31 days of the effective date of retirement.
2. A benefit eligible retiree may continue to cover his or her spouse and other dependents that he or she covered as a benefit eligible employee, but cannot add a spouse to any coverage at the time of or following his or her termination.
3. A benefit eligible retiree may enroll a qualifying child in medical, dental, or vision coverage at the time of and following his or her termination, during annual enrollment, and in other situations described in the applicable group health plan.
4. A benefit eligible retiree may drop coverage during annual enrollment and in other situations described in the applicable group health plan. Once coverage is dropped, coverage cannot be reinstated at a later date. When coverage is dropped, the medical coverage will terminate as of midnight on the dropped date. The dental and vision coverage will end as of the last day of the month in which the coverage was dropped.

GETTING STARTED

5. Failure to pay premiums on time for coverage provided to the benefit eligible retiree will result in loss of the coverage. After coverage is lost for failure to pay premiums on time, the coverage cannot be reinstated.

Adding a Dependent

1. If you are adding a dependent during this enrollment period, you must complete a **Retiree Benefit Enrollment / Change Form** and provide proof of eligible dependent status at the time of the enrollment, but no later than the deadline. All proof of eligible dependent documents must be received and approved by the Employee Benefits department.
2. If you fail to timely submit the required proof of eligible dependent documents by the deadline, your dependent will not be added and you will have to wait until your next qualifying event or annual enrollment period, whichever occurs first.
3. See page 7 in this brochure for dependent definitions and requirements for coverage.
4. Contact the Employee Benefits office for eligibility questions or assistance with enrolling your dependents. Call 713-566-6451 or send an email to benefitsdepartment@harrishealth.org.

Termination of Dependent Coverage

Coverage provided to a benefit eligible dependent will terminate upon the first of the following events to occur:

- The date the dependent no longer satisfies the requirements for a benefit eligible dependent, or
- The date benefits coverage ends for the enrollee.

Note: If coverage is terminated, COBRA coverage will typically be offered retroactive back to the date of loss of coverage. Applicable COBRA premiums would apply.

Ineligible Dependent

If the benefit eligible retiree misses the qualifying event window to drop a dependent that is not a benefit eligible dependent (ineligible dependent), the ineligible dependent will be dropped from medical, dental and vision plan benefits by the Employee Benefits department as allowed by the terms of the applicable plan(s) to ensure that no benefits are payable under the plan(s) for the benefit of the ineligible dependent. If termination of coverage for the ineligible dependent results in a level of coverage change for the benefit eligible retiree, the level of coverage change will be initiated by the Employee Benefits department with applicable premium changes, if allowed by the terms of the plan(s), as determined by the new level of coverage; however, the benefit eligible retiree will not be allowed to voluntarily make any other benefit changes at that time. No refund of any applicable back premiums will be made unless the ineligible dependent status was due to an administrative error on the part of Harris Health System. Applicable COBRA provisions will apply.

Note: Cigna will NOT verify coverage or process any medical claims for dependents until a **Coverage Questionnaire** has been completed. Log into the Cigna website, 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 you need any medical services.

DEPENDENT DEFINITIONS AND REQUIREMENT 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.

Your eligible dependents include:

- Spouse
- Children up to age 26 (includes your biological child, adopted child, stepchild, a child to whom you are a permanent legal guardian)
- A child of any age who is medically certified as disabled and dependent on you for support and maintenance
- Grandchild

You will need to provide proof of your dependents’ eligibility before they can be enrolled.

- **Spouse requirements:** A certified copy of a fully executed and valid marriage license 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.
- **Child requirements:** Birth certificate issued by a state, county or vital records office (or substantially equivalent document issued outside the United States and approved by the Employee Benefits Department). 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 employee or the spouse of the benefit-eligible employee 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.
- **Grandchild requirements:**
 - A certified 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 employee’s child who is the birth parent of the grandchild.
 - A copy of the benefit-eligible employee’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.

Please submit copies of your dependents social security cards to the Benefits Department for ACA reporting.

2018 – 2019 PREMIUM RATES

Current Retiree (retired prior to June 1, 2012, or retired after June 1, 2012 with grandfathered status)				
	Retiree Only	Retiree and Spouse	Retiree and Children	Retiree and Family
Medical Plans				
KelseyCare	\$38.09	\$404.71	\$175.68	\$526.91
High Deductible	\$38.09	\$404.71	\$175.68	\$526.91
Low Deductible	\$146.28	\$753.73	\$445.21	\$856.72
Dental and Vision Plans				
DHMO	\$0.88	\$9.28	\$9.28	\$13.13
Dental PPO	\$31.22	\$50.30	\$51.56	\$94.57
Vision	\$0.54	\$4.17	\$4.17	\$7.44

Rule of 80 Retiree (retired after June 1, 2012 without grandfathered status)				
	Retiree Only	Retiree and Spouse	Retiree and Children	Retiree and Family
Low Deductible				
Age 55	\$586.35	\$1,495.15	\$1,354.43	\$1,946.64
Age 56	\$554.61	\$1,414.21	\$1,281.11	\$1,841.25
Age 57	\$522.87	\$1,333.27	\$1,207.79	\$1,735.87
Age 58	\$491.12	\$1,252.32	\$1,134.46	\$1,630.49
Age 59	\$459.38	\$1,171.38	\$1,061.14	\$1,525.10
Age 60	\$427.64	\$1,090.44	\$987.81	\$1,419.72
Age 61	\$395.90	\$1,009.50	\$914.49	\$1,314.34
Age 62	\$364.15	\$928.55	\$841.17	\$1,208.95
Age 63	\$332.41	\$847.61	\$767.84	\$1,103.57
Age 64	\$300.67	\$766.67	\$694.52	\$998.18
KelseyCare and High Deductible				
Age 55	\$507.88	\$1,295.08	\$1,173.18	\$1,686.14
Age 56	\$476.14	\$1,214.14	\$1,099.86	\$1,580.75
Age 57	\$444.40	\$1,133.20	\$1,026.54	\$1,475.37
Age 58	\$412.65	\$1,052.25	\$953.21	\$1,369.99
Age 59	\$380.91	\$971.31	\$879.89	\$1,264.60
Age 60	\$349.17	\$890.37	\$806.56	\$1,159.22
Age 61	\$317.43	\$809.43	\$733.24	\$1,053.84
Age 62	\$285.68	\$728.48	\$659.92	\$948.45
Age 63	\$253.94	\$647.54	\$586.59	\$843.07
Age 64	\$222.20	\$566.60	\$513.27	\$737.68
Dental and Vision Plans				
Dental HMO	\$0.88	\$9.28	\$9.28	\$13.13
Dental PPO	\$31.22	\$50.30	\$51.56	\$94.57
Vision Plan	\$0.54	\$4.17	\$4.17	\$7.44

HEALTH PLAN NOTICES

You can find the following healthcare notices on our web page:

- **Women's Health and Cancer Rights Act**
Describes benefits available to those that will or have undergone a mastectomy.
- **Newborns' and Mothers' Health Protection Act**
Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- **HIPAA Notice of Special Enrollment Rights**
Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- **Children's Health Insurance Program Reauthorization Act (CHIPRA)**
Describes availability of premium assistance for Medicaid eligible dependents.

Summary of Material Modification

This benefits guide constitutes a summary of material modification (SMM) to the Harris Health System 2018 - 2019 summary plan description (SPD). It is NOT meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

EMPLOYEE BENEFITS DEPARTMENT CONTACTS

CORE BUSINESS HOURS

Monday – Friday
8:00 a.m. – 4:30 p.m.

Main Customer Service - Holly Hall Administration Office

benefitsdepartment@harrishealth.org

Phone: 713-566-6451

Fax: 713-440-5575

Lyndon B Johnson Hospital – HR Suite, 1.PCR.100

Phone: 713-566-4830

Ben Taub – HR Suite, 11-08

Phone: 713-873-6435

Kirby Location – 9240 Kirby

Phone: 713-634-1029

This brochure summarizes the health care benefits that are available to Harris Health System retirees and their eligible dependents. Official plan documents, policies, and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Employee Benefits Department.

Information provided in this brochure is not a guarantee of benefits.