# HARRIS HEALTH SYSTEM


**DANNY JACKSON HEALTH CENTER**

# 2016 RETIREE BENEFITS RESOURCES GUIDEBOOK

*including Annual Enrollment Materials*

Annual Enrollment: November 18, 2015 - December 9, 2015

Retain this document as a resource tool for the upcoming year.

# HARRIS HEALTH SYSTEM EMPLOYEE BENEFITS DEPARTMENT PERSONNEL

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

## EMPLOYEE BENEFITS DEPARTMENT CONTACT INFORMATION

| | |
|---|---|
| **Main Customer Service Line** | *phone:* 713-566-6451<br>*email:* **Benefitsdepartment@harrishealth.org** |
| **Main Fax Line** | 713-440-5575 |
| **Fax Line** | 713-566-6445 |

## EMPLOYEE BENEFITS REPRESENTATIVES

| | | |
|---|---|---|
| **Monica Albarran** | *Employee Benefits Representative- Healthcare* | 713-566-6051 |
| **Lisa Burrell** | *Employee Benefits Representative - Healthcare* | 713-566-6262 |
| **Norma Campos** | *Employee Benefits Representative- Healthcare* | 713-566-6422 |
| **Stacey Holland** | *Employee Benefits Representative– Healthcare* | 713-566-6438 |
| **Vanessa Ontiveros** | *Employee Benefits Representative– Healthcare* | 713-566-6861 |
| **Ernestina Vergara** | *Employee Benefits Representative - Healthcare* | 713-566-6496 |
| **Morgan Simmons** | *Cigna Healthcare Advocate—Claims* | 713-566-4391 or 1-888-244-6293; Ext. 2612828 |
| **Louise Garcia** | *Employee Benefits Representative - 401K/457b* | 713-566-6453 |
| **Mark Smith** | *Employee Benefits Representative - Pension* | 713-566-6231 |
| **Pat Rye** | *Employee Retirement Plans- Supervisor* | 713-566-6443 |
| **Diana Loera** | *Employee Benefits Manager* | 713-566-6068 |
| **Carla Golemon** | *Employee Benefits Director* | 713-566-6450 |

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November 18, 2015

Dear Harris Health System Retiree:

Welcome to the 2016 Benefits Resources Guidebook! This booklet was developed to be a resource for you as you make benefit selections for you and your eligible dependents during Annual Enrollment. More importantly, the Guidebook is especially helpful as you encounter benefit questions throughout the Plan Year, so we encourage you to keep this book handy as a quick reference. For a quick review of changes for FY17, please refer to page 8 of this booklet. Your 2016 Annual Enrollment elections are scheduled to take effect March 1, 2016.

As you may know, our health plan is self-insured, which means Harris Health covers the full cost of claims instead of the insurance carrier. Under the Self-Insured arrangement we set our premium rates primarily based on our claims experience and administrative costs. Further, we are able to better control costs under a Self-Insured arrangement, as we avoid profit margins set by insurance companies that would be charged back to our Retiree's in premiums.

We are pleased to provide three Medical plan options to our benefit eligible participants; a KelseyCare Plan, a Low Deductible Plan and a High Deductible Plan, 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 this guidebook.

As a Retiree, you may add eligible dependent children to your coverage during Annual Enrollment. Please pay special attention to the documentation requirements for adding dependent children that can be found on pages 10-11 of this booklet. Documentation for new dependent children must be received by the Benefits Office by **December 9, 2015**; otherwise, they will not be covered under any Harris Health Benefit Plan. Please be sure that your name, social security number and telephone number is submitted with the dependent documentation.

Most importantly, please be sure that your Retiree Annual Enrollment Form is either Faxed, emailed, hand-delivered or mailed to our office by **December 9, 2015**, (mailed forms must be postmarked by December 9, 2015). 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,

Diane Poirot
Sr. Vice President, Human Resources

Benefits Main Line Number: 713-566-6451
Benefits FAX Number: 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 Location (appointments encouraged): 2525 Holly Hall, Houston, TX 77054

# ANNUAL ENROLLMENT 2016

**NOW IS THE TIME TO SELECT YOUR RETIREE BENEFIT PLANS**
**FOR MARCH 1, 2016 - FEBRUARY 28, 2017**

At Harris Health System we are committed to offering a competitive retiree benefits package that meets the diverse needs of our retirees. 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 retiree 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 Retiree 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: November 18, 2015—December 9, 2015
- The deadline for submitting the Retiree Benefit Enrollment/Change Form and Documentation is December 9, 2015
- Documentation submission deadline for new dependent children is December 9, 2015

## IMPORTANT INFORMATION ABOUT PLAN BENEFIT ELECTIONS

If you do not make an active election change for the 2016 enrollment period, your benefits will remain the same as noted on your enclosed enrollment statement.

# 2016 - 2017 PREMIUM RATE SCHEDULES

## EFFECTIVE MARCH 1, 2016

### CURRENT RETIREE *(RETIRED PRIOR TO 6/1/2012 OR RETIRED AFTER 6/1/2012 WITH GRANDFATHERED STATUS)*

| MEDICAL PLANS | RETIREE ONLY | RETIREE *and* SPOUSE | RETIREE *and* CHILDREN | RETIREE *and* FAMILY |
|---|---|---|---|---|
| **KelseyCare Plan** | $37.68 | $400.31 | $174.06 | $521.18 |
| **Low Deductible Plan** | $115.29 | $598.20 | $353.34 | $778.84 |
| **High Deductible Plan** | $37.68 | $400.31 | $174.06 | $521.18 |
| **DENTAL PLANS** | | | | |
| **HMO** | $0.88 | $9.28 | $9.28 | $13.13 |
| **PPO** | $28.64 | $46.15 | $47.30 | $86.76 |
| **VISION PLAN** | $0.54 | $4.17 | $4.17 | $7.44 |

### Rule of 80 Retiree *(Retired AFTER 6/1/2012 WITHOUT GRANDFATHERED STATUS)*

| | RETIREE ONLY | *RETIREE and SPOUSE* | *RETIREE and CHILDREN* | *RETIREE and FAMILY* |
|---|---|---|---|---|
| **Low Deductible Medical Plan** | | | | |
| Age 55 | $578.17 | $1,474.29 | $1,335.53 | $1,919.47 |
| Age 56 | $546.32 | $1,393.07 | $1,261.97 | $1,813.74 |
| Age 57 | $514.47 | $1,311.86 | $1,188.40 | $1,708.00 |
| Age 58 | $482.62 | $1,230.65 | $1,114.83 | $1,602.27 |
| Age 59 | $450.77 | $1,149.44 | $1,041.27 | $1,496.54 |
| Age 60 | $418.93 | $1,068.23 | $967.70 | $1,390.80 |
| Age 61 | $387.08 | $987.02 | $894.13 | $1,285.07 |
| Age 62 | $355.23 | $905.81 | $820.56 | $1,179.34 |
| Age 63 | $323.38 | $824.60 | $747.00 | $1,073.60 |
| Age 64 | $291.54 | $743.39 | $673.43 | $967.87 |
| **KelseyCare & High Deductible Medical Plans** | | | | |
| Age 55 | $509.57 | $1,299.38 | $1,177.07 | $1,691.73 |
| Age 56 | $477.72 | $1,218.16 | $1,103.51 | $1,586.00 |
| Age 57 | $445.87 | $1,136.95 | $1,029.94 | $1,480.26 |
| Age 58 | $414.02 | $1,055.74 | $956.37 | $1,374.53 |
| Age 59 | $382.17 | $974.53 | $882.81 | $1,268.80 |
| Age 60 | $350.33 | $893.32 | $809.24 | $1,163.06 |
| Age 61 | $318.48 | $812.11 | $735.67 | $1,057.33 |
| Age 62 | $286.63 | $730.90 | $662.10 | $951.60 |
| Age 63 | $254.78 | $649.69 | $588.54 | $845.86 |
| Age 64 | $222.94 | $568.48 | $514.97 | $740.13 |
| **Dental HMO** | $0.88 | $9.28 | $9.28 | $13.13 |
| **Dental PPO** | $28.64 | $46.15 | $47.30 | $86.76 |
| **Vision Plan** | $0.54 | $4.17 | $4.17 | $7.44 |

# RETIREE HEALTHCARE ELIGIBILITY

**ABOUT YOUR RETIREMENT**

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 62 + 18 Years = 80 Points

Age 60 + 20 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 Retiree's 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 HCHD 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.

# ENROLLMENT HIGHLIGHTS

**MEDICAL & PRESCRIPTION INSURANCE CARD**

You will receive a new medical ID card after enrollment. You can also print a medical card anytime at **myCigna.com**. Your Cigna Medical card will also serve as your prescription card and will include the OptumRx coverage information on the back of the card.

**DENTAL & VISION INSURANCE CARDS**

Harris Health is partnering with a new dental carrier (MetLife) effective March 1, 2016.

DHMO enrollees: will receive a new ID card and it will be mailed after enrollment.

DPPO enrollees: a card is not required to receive services; therefore you will not automatically receive a card. If you would like an ID card you may print one online at metlife.com/mybenefits.

**VISION INSURANCE CARDS:**

You will not receive a new vision card unless you make changes to your current coverage during this Annual Enrollment Period. If you need a new vision card, you can request it by calling 800-999-5431.

# 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.

# CHANGES—PLAN DESIGN


Harris Health will continue to implement plan design changes effective in 2016 as part of a long term strategy aimed to comply with Healthcare Reform and align our benefits with the Texas Medical Center and national norm for healthcare systems in the U.S. These changes are necessary to avoid a potential Cadillac Tax initially estimated for Harris Health at $5.5 million dollars per year beginning in 2018. Based on plan design changes, our current Cadillac Tax estimate is now $2.5 million.

Below is a high level description of the major changes effective March 1, 2016. We encourage you to review the benefit details in each section of the Retiree Benefits Resources Guidebook for more specific information on each of these changes as well as the Healthcare Reform section which will give you a better understanding as to why these changes are necessary.

- Social Security numbers are now a mandated requirement for federal healthcare reporting purposes for all dependents enrolled in our medical plans. You need to ensure that Harris Health has the correct social security number on file for each eligible dependent so that healthcare coverage is properly reported and to avoid penalties imposed by the Internal Revenue Service (IRS). For additional details, refer to page 9.
- For the Low Deductible Medical Option the individual in-network deductible is increasing from $300 to $500. The family in-network deductible is increasing from $900 to $1,500.
- OptumRx and CatamaranRx have merged as one company. Your prescription drug benefits are a part of your medical plan benefits and are now administered by OptumRx.
- The PCP/Specialist copays on the High Deductible Medical Option are decreasing to $25/$35/$55.
- The Dispense as Written penalty regarding prescription drugs will not apply to the Out-of-Pocket Maximum.
- Amounts over the Reference Based Price will not apply to the Out-of-Pocket Maximum.
- The Specialty Drug copay will change from $60 to $90.
- A new voluntary Hepatitis C Outcomes Program is being implemented for members prescribed Harvoni who are diagnosed with Genotype 1 Hepatitis C Virus infection.
- **Optum** SECURE Compound Medication Management Program is being added
- Harris Health will be partnering with MetLife as the replacement to United Healthcare for dental benefits effective March 1, 2016. There is a deadline for electing your DHMO provider. For additional details refer to page 35.

# NATIONAL HEALTHCARE REFORM IMPACT ON THE HARRIS HEALTH SELF-INSURED MEDICAL PLAN

**2016:**

**Reporting Social Security Numbers to Your Health Insurance Company– Questions and Answers**

**Q1. My health insurance company has requested that I provide them with my social security number and the social security numbers of my spouse and children. Is there some new reason why they need our social security numbers?**

**A1.** Your health insurance company will be required to provide Form 1095-B to you and to the Internal Revenue Service. You will use the form to prepare your individual income tax return. Dependent SSNs will be reported on Form 1095-B.

**Q2: Why is my health insurance company asking for this information now?**

**A2:** The new reporting requirement will begin for the 2015 tax year and health insurance companies need advance time to program and test systems to make certain that this new reporting is done correctly and efficiently.

**Q3: Is there a specific Internal Revenue Service form that will be mailed to me to provide the information to my health insurance company?**

**A3:** No. Your health insurance company may mail you a written request which discusses these new rules.

**Q4: How will I use this new Form 1095-B to prepare my return?**

**A4:** Form 1095-B provides information needed to report on your income tax return that you, your spouse, and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who do not have minimum essential coverage and do not qualify for an exemption may be liable for the individual shared responsibility payment. You do not have to attach Form 1095-B to your tax return.

**Q5: What if I refuse to provide this information to my health insurance company?**

**A5:** The information received by the Internal Revenue Service will be used to verify information on your individual income tax return. If the information you provide on your tax return cannot be verified, you may receive an inquiry from the Internal Revenue Service. You also may receive a notice from the Internal Revenue Service indicating that you are liable for a shared responsibility payment.

**2018:**

All aspects of Healthcare Reform will be required and the Cadillac Tax impact will take place. The Cadillac Tax is an excise tax that will be charged to employers offering plans that are too rich in benefits. In 2013, the Cadillac Tax had been estimated to be $5.5 million. With the changes that Harris Health implemented in 2014, the tax has now been reduced to $2.5 million.

For a full list of Healthcare Reform impacts and changes please visit **whitehouse.gov/healthreform**.

# RETIREE GENERAL RULES

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.

4. 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.

5. 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.

6. Failure to timely pay premiums for coverage provided to the Benefit Eligible Retiree will result in loss of the coverage. After coverage is lost for failure to timely pay premiums, the coverage cannot be reinstated.

Adding or Re-Enrolling a Dependent

1. If you are adding or re-enrolling a dependent, 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. Dependent Definitions and Requirements for Coverage are contained on Page 12 of this guidebook.
4. 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**

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 shall 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.

# 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:** Is the Retiree's Spouse

**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 Retiree or the spouse of the Benefit Eligible Retiree.

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 Retiree or the spouse of the Benefit Eligible Retiree 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 a Child of your Child and/or a Child of your Spouse's Child.

**Eligibility:** Unmarried grandchild who up to the end of the month in which the grandchild turns age 26 and who is a dependent of the Benefit Eligible Retiree 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 Retiree's child that is the birth parent of the grandchild.

A copy of the Benefit Eligible Retiree'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.

## KELSEYCARE

| | IN-NETWORK BENEFITS |
|---|---|
| **ANNUAL DEDUCTIBLE** - *per calendar year, applies to most covered services* | |
| Individual | None |
| Family | None |
| **ANNUAL OUT-OF-POCKET LIMIT** | |
| Individual | $750 |
| Family | $1,500 |
| **LIFETIME MAXIMUM** | None |
| **PHYSICIAN VISIT COPAY** | $15 |
| **SPECIALIST VISIT COPAY** | $30 |
| **ROUTINE PHYSICALS/IMMUNIZATIONS** | 100% |
| **ROUTINE GYNECOLOGICAL EXAM & PAP SMEAR** | 100% |
| **ROUTINE MAMMOGRAPHY** | 100% |
| **ROUTINE DIGITAL RECTAL EXAM (DRE) AND PROSTATE ANTIGEN TEST (PSA)** | 100% |
| **COLONOSCOPIES AND SIGMOIDOSCOPIES** | 100% |
| **ANNUAL ROUTINE HEARING EXAM** | 100% |
| **HEARING AID*** - *1 pair per 36 months* | 100% |
| **OUTPATIENT SERVICES** | 100% |
| **OUTPATIENT FACILITY** | $100 copay/visit and then 100% |
| **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 |
| **ROUTINE CHOLESTEROL TEST** | 100% |
| **DIAGNOSTIC X-RAY AND LABORATORY** | |
| PCP | 100% After Office Visit copay |
| Outpatient Facility/Independent Lab | 100% |
| **HIGH TECH RADIOLOGY** *CT/CTAs, MRI/MRA, PET scans, Nuclear Tests* | |
| Physician's Office | 100% |
| Outpatient Facility | 100% |
| Emergency Room | 100% |
| **HOSPITAL SERVICES** | |
| Inpatient Coverage | $100 per day copay up to 5 days, then 100% |
| Emergency Room | $200 per visit copay then 100% (copay waived if admitted) |
| **URGENT CARE PROVIDER** | $30 per visit then 100% (copay waived if admitted) |
| **CONVENIENCE CARE**** | Not Covered |

***Members will need to obtain hearing aids from a Cigna contracted provider that will dispense the device.**

****Kelsey-Seybold offers Saturday ILL-Care in lieu of Convenience Care. See page 15 for details.**

## KELSEYCARE CONTINUED

| | IN-NETWORK BENEFITS |
|---|---|
| **SKILLED NURSING FACILITY**<br>*up to 60 days per calendar year* | 100% |
| **HOME HEALTH CARE**<br>*up to 100 days per calendar year, 16 hour max per day* | 100% |
| **HOSPICE CARE**<br>Inpatient Coverage<br>Outpatient Coverage | <br>100%<br>100% |
| **SHORT-TERM REHAB**<br>*includes physical therapy, occupational therapy, speech therapy*<br>*up to 60 days per calendar year* | $15/$30 PCP or Specialist copay, then 100% |
| **REHAB PERFORMED AT QUENTIN MEASE, BEN TAUB, LBJ HOSPITALS** | Not Covered |
| **CHIROPRACTIC OUTPATIENT CARE**<br>*up to 20 days per calendar year* | $15/$30 PCP or Specialist copay, then 100% |
| **CARDIAC REHAB**<br>*unlimited days per year* | $15/$30 PCP or Specialist copay, then 100% |
| **ACUPUNCTURE COVERAGE** | Not Covered |
| **AMBULANCE** | 100% |
| **DIALYSIS** | 100% |
| **DURABLE MEDICAL EQUIPMENT**<br>*unlimited max per calendar year* | 100% |
| **MOUTH, JAWS AND TEETH** | $15/$30 PCP or Specialist copay, then 100% |
| **MATERNITY** | Payable as any other covered expense/costs vary based on facility in which it is performed |
| **INFERTILITY TREATMENT**-*excludes in-Vitro, GIFT, ZIFT, etc.* | $15/$30 PCP or Specialist copay |
| **ALCOHOL & SUBSTANCE ABUSE SERVICES**<br>*unlimited visits per calendar year*<br>Inpatient Coverage<br>Outpatient Coverage<br>Office Visit | <br><br>$100 copay per day up to 5 days, then 100%<br>100%<br>$15 copay |
| **MENTAL HEALTH SERVICES**<br>*unlimited visits per calendar year*<br>Inpatient Coverage<br>Outpatient Coverage<br>Office Visit | <br><br>$100 copay per day up to 5 days, then 100%<br>100%<br>$15 copay |

KelseyCare powered by Cigna

Pages 15-16 outline some of the KelseyCare services and how the network is tailored to fit your needs.

KelseyCare members may visit **myKelseyOnline.com** to schedule appointments and review most test results. For general KelseyCare information please visit **kelsey-seybold.com.**

KelseyCare® powered by Cigna

# Harris Health's Plan for quality, convenience and value!

## Your Health

- See the doctor you want from more than 400 Kelsey-Seybold physicians at 19 Houston- area locations – **with no referral required**.
- Kelsey-Seybold physicians partner with over 4,000 medical specialists and premier hospitals including **Texas Children's Hospital**, **CHI St. Luke's Health**, the **Texas Heart Institute**, select **Houston Methodist** facilities, **HCA The Woman's Hospital of Texas** and **HCA Clear Lake Regional**.
- State-of-the-art clinics offering advanced diagnostics, electronic medical records and on site pharmacies.

## Your Benefits

- No Deductible!
- Experience savings with the **lowest copays** for physician office visits compared to any other plan.
  - $15 for Primary Care
  - $30 for Specialist
- No extra out-of-pocket expenses for routine laboratory tests and X-rays.
- Lowest cost for hospital admissions.
- No copay for advanced imaging.
- Out-of-area network available for covered dependents through the Cigna Guest Privileges Program.
- Urgent Care network access available through Cigna.

## Complete Access to Care 24/7

- You can trust Kelsey-Seybold Clinic for quality care and medical excellence. We offer **19 convenient locations** all over the Greater Houston area.
- Same day and next day appointments available.
- See any Kelsey-Seybold doctor – including specialists – **NO REFERRAL NEEDED.**
- **We're here for you** – 24 hours a day, seven days a week. Call **713-442-0000** to reach our **After-Hours Nurse Hotline** or to make an appointment.
- **Exclusive Concierge Service**
  KelseyCare Concierge is here to assist you with your health related questions or billing concerns. Call **713-442-0006**.
- **Saturday hours for ill-care appointments** available from 9 a.m. to 2 p.m. at four locations – Clear Lake, Fort Bend, Spring/1960 and Tanglewood/Galleria.
- **Email your doctor's office**, receive most test results and directly schedule appointments with primary care physicians and an expanding list of specialists through our secure patient portal, **MyKelseyOnline.com**.
- **Secure Electronic Medical Record (EMR)**
  See any Kelsey-Seybold doctor at any location. Your secure, confidential EMR follows you wherever you go.
- Refill prescriptions online with your **MyKelseyOnline** account or at **kelsey-seybold.com/refills**. Get free mail-order delivery to your home or office.

KelseyCare® powered by Cigna

## Kelsey Pharmacy Locations

Clear Lake Clinic
**713-442-4360**

Cypress Clinic
**713-442-4059**

Downtown at The Shops at Houston Center 4
**713-442-6337**

Fort Bend Medical and Diagnostic Center
**713-442-9475**

Summer Creek (Humble)
**713-442-2079**

Katy Clinic
**713-442-4179**

Kingwood Clinic
**713-442-2179**

Main Campus
**713-442-0079**

Meyerland Plaza Clinic
**713-442-3200**

Pasadena Clinic
**713-442-7179**

Spring Medical and Diagnostic Center
**713-442-1779**

The Vintage
**713-442-1549**

The Woodlands Clinic
**713-442-1975**

Tanglewood Clinic (Galleria area)
**713-442-2450**

Pearland Clinic
**713-442-7200**


## KelseyCare Telephone Numbers

**TTY/TDD** - Text communication for individuals using a telecommunications device.

**713-442-5818**

**24-Hour Appointment Scheduling** - Our Customer Service Contact Center operates 24 hours a day,

7 days a week for your convenience.

**713-442-0000**

**KelseyCare Concierge** - Call your KelseyCare Concierge Monday-Friday, 8 a.m. to 5 p.m. for personalized assistance in scheduling appointments and selecting physicians.

**713-442-0006**

**After-Hours Nurse** - Speak with a Kelsey-Seybold nurse after regular business hours, on holidays and on weekends. Our After-Hours Nurse can assist you and refer you for care.

**713-442-0000**

**Nutrition Counseling** - Provides individual and group nutrition counseling by a Registered Dietitian.
**713-442-3277**

**Diabetes Services** - Provides individual and group classes by diabetes educators.

**713-442-3277**

**Release of Information** - Provides authorization for release of healthcare information.

**713-442-5700**

Kelsey-Seybold is nationally recognized for quality care.

DIABETES NCQA RECOGNITION
ACCOUNTABLE CARE ORGANIZATION NCQA ACCREDITATION LEVEL 2
HEART/STROKE NCQA RECOGNITION

## HIGH DEDUCTIBLE

| | IN-NETWORK BENEFITS | OUT-OF-NETWORK BENEFITS |
|---|---|---|
| **ANNUAL DEDUCTIBLE**- *per calendar year, applies to most covered services* | | |
| Individual | $1,500 | $3,000 |
| Family | $4,500 | $9,000 |
| **ANNUAL OUT-OF-POCKET LIMIT** | | |
| Individual | $3,000 | $6,600 |
| Family | $9,000 | $19,800 |
| **LIFETIME MAXIMUM** | None | None |
| **PHYSICIAN VISIT COPAY** | $25 | 60% after deductible |
| **SPECIALIST VISIT COPAY** | $35 CCN Specialist<br>$55 Non CCN Specialist | 60% after deductible |
| **ROUTINE PHYSICALS/IMMUNIZATIONS** | 100% | 60% after deductible |
| **ROUTINE GYNECOLOGICAL EXAM & PAP SMEAR** | 100% | 60% after deductible |
| **ROUTINE MAMMOGRAPHY** | 100% | 60% after deductible |
| **ROUTINE DIGITAL RECTAL EXAM (DRE) AND PROSTATE ANTIGEN TEST (PSA)** | 100% | 60% after deductible |
| **COLONOSCOPIES AND SIGMOIDOSCOPIES** | 100% | 60% after deductible |
| **ANNUAL ROUTINE HEARING EXAM** | 100% | 60% after deductible |
| **HEARING AID** - *1 pair per 36 months* | 80% after deductible | 60% after deductible |
| **OUTPATIENT SERVICES** *(facility) - except in physician's office when office visit copay applies* | 80% after deductible, $100 copay for surgical treatment | 60% after deductible |
| **ALLERGY TREATMENT** - *allergy serum, allergy injections and injectable drugs* | $25/$35/$55-PCP or Specialist copay Serum is paid at 100% if dispensed in PCP office | 60% after deductible |
| **ROUTINE CHOLESTEROL TEST** | 100% | 60% after deductible |
| **DIAGNOSTIC X-RAY AND LABORATORY** | | |
| PCP or Specialist | 100% after copay | 60% after deductible |
| Outpatient Facility/Independent Lab | 80% after deductible | |
| **HIGH TECH RADIOLOGY** -*Outpatient Facility & Emergency Room & Physicians Office*<br>*CT/CTAs, MRI/MRA, PET scans, Nuclear Tests* | 80% after deductible | 60% after deductible<br>ER—80% after deductible |
| **HOSPITAL SERVICES** | | |
| Inpatient Coverage | $100 per day copay up to 5 days, then 80% after deductible | $500 per confinement deductible then 60% after plan deductible |
| Emergency Room | 80% after deductible | 80% after deductible |
| **URGENT CARE PROVIDER** | $55 | 60% after deductible |
| **CONVENIENCE CARE** | $25 PCP Copay | 60% after deductible |
| **SKILLED NURSING FACILITY** - *up to 60 days per calendar year* | 80% after deductible | 60% after deductible |

## HIGH DEDUCTIBLE CONTINUED

| | IN-NETWORK BENEFITS | OUT-OF-NETWORK BENEFITS |
|---|---|---|
| **HOME HEALTH CARE** - *100 days per calendar year, 16 hour max per day* | 80% after deductible | 60% after deductible |
| **HOSPICE CARE**<br>Inpatient Coverage<br>Outpatient Coverage | <br>80% after deductible<br>80% after deductible | 60% after deductible<br>60% after deductible<br>60% after deductible |
| **SHORT-TERM REHAB** *includes physical therapy, occupational therapy, and speech therapy 60 days per calendar year* | $35 copay, then 100% | 60% after deductible |
| **REHAB PERFORMED AT QUENTIN MEASE, BEN TAUB, LBJ HOSPITALS** | 100% | N/A |
| **CHIROPRACTIC OUTPATIENT CARE** *up to 20 days per calendar year* | $35 copay, then 100% | 60% after deductible |
| **CARDIAC REHAB** - *unlimited days per year* | $35 copay, then 100% | 60% after deductible |
| **ACUPUNCTURE COVERAGE** *$500 maximum per calendar year* | $25/$35/$55 PCP or Specialist copay, then 100% | 60% after deductible |
| **AMBULANCE** | 80% after deductible | 60% after deductible |
| **DIALYSIS** | 80% after deductible | Not covered |
| **DURABLE MEDICAL EQUIPMENT** *unlimited max per calendar year* | 80% after deductible | 60% after deductible |
| **MOUTH, JAWS AND TEETH**<br>Physicians office<br>Inpatient coverage<br>Outpatient coverage | <br>$25/$35/$55 PCP or Specialist copay, applies to office visits<br>$100 per day copay up to 5 days, then 80% coinsurance after deductible<br>$100 per facility copay, then 80% coinsurance after deductible | 60% after deductible<br>$500 per confinement deductible then 60% after plan deductible<br>60% after deductible |
| **MATERNITY**<br>Physician Services<br>All subsequent Prenatal and Postnatal visits<br>*(Delivery is covered the same as plan's hospital benefit)* | <br>$25/$35/$55 PCP or Specialist copay, then 100%<br>80% after deductible | <br>60% after deductible<br>60% after deductible |
| **INFERTILITY TREATMENT** *excludes in-Vitro, GIFT, ZIFT, etc.*<br>Physician Services<br>Inpatient Coverage<br>Outpatient Coverage | <br>70% after deductible<br>$100 per day copay up to 5 days, then 70% coinsurance after deductible<br>$100 per facility copay, then 70% coinsurance after deductible | <br>50% after deductible<br>$500 per confinement deductible then 60% after plan deductible<br>50% after deductible |
| **ALCOHOL & SUBSTANCE ABUSE SERVICES** *unlimited visits per calendar year*<br>Inpatient Coverage<br>Outpatient Coverage<br>Office Visit | $100 copay per day up to 5 days, then 80% after deductible<br>80% after deductible<br>$25 copay | $500 per confinement deductible, then 60% after plan deductible<br>60% after deductible<br>60% after deductible |
| **MENTAL HEALTH SERVICES** *unlimited visits per calendar year*<br>Inpatient Coverage<br>Outpatient Coverage<br>Office Visit | $100 copay per day up to 5 days, then 80% after deductible<br>80% after deductible<br>$25 copay | $500 per confinement deductible, then 60% after plan deductible<br>60% after deductible<br>60% after deductible |

# MEDICAL SUMMARY

## LOW DEDUCTIBLE

| | IN-NETWORK BENEFITS | OUT-OF-NETWORK BENEFITS |
|---|---|---|
| **ANNUAL DEDUCTIBLE**- *per calendar year, applies to most covered services* | | |
| Individual | $500 | $1,000 |
| Family | $1,500 | $3,000 |
| **ANNUAL OUT-OF-POCKET LIMIT** | | |
| Individual | $1,850 | $6,000 |
| Family | $3,700 | $18,000 |
| **LIFETIME MAXIMUM** | None | None |
| **PHYSICIAN VISIT COPAY** | $25 | 60% after deductible |
| **SPECIALIST VISIT COPAY** | $35 CCN Specialist<br>$55 Non CCN Specialist | 60% after deductible |
| **ROUTINE PHYSICALS/IMMUNIZATIONS** | 100% | 60% after deductible |
| **ROUTINE GYNECOLOGICAL EXAM & PAP SMEAR** | 100% | 60% after deductible |
| **ROUTINE MAMMOGRAPHY** | 100% | 60% after deductible |
| **ROUTINE DIGITAL RECTAL EXAM (DRE) AND PROSTATE ANTIGEN TEST (PSA)** | 100% | 60% after deductible |
| **COLONOSCOPIES AND SIGMOIDOSCOPIES** | 100% | 60% after deductible |
| **ANNUAL ROUTINE HEARING EXAM** | 100% | 60% after deductible |
| **HEARING AID** - *1 pair per 36 months* | 90% after deductible | 60% after deductible |
| **OUTPATIENT SERVICES** *(facility) - except in physician's office when office visit copay applies* | 90% after deductible, $100 copay for surgical treatment | 60% after deductible |
| **ALLERGY TREATMENT -** *allergy serum, allergy injections and injectable drugs* | $25/$35/$55-PCP or Specialist copay Serum is paid at 100% if dispensed in PCP office | 60% after deductible |
| **ROUTINE CHOLESTEROL TEST** | 100% | 60% after deductible |
| **DIAGNOSTIC X-RAY AND LABORATORY** | | |
| PCP or Specialist | 100% after copay | 60% after deductible |
| Outpatient Facility/Independent Lab | 90% after deductible | 60% after deductible |
| **HIGH TECH RADIOLOGY -***Outpatient Facility & Emergency Room & Physicians Office*<br>*CT/CTAs, MRI/MRA, PET scans, Nuclear Tests* | 90% after deductible | 60% after deductible<br>ER - 90% after deductible |
| **HOSPITAL SERVICES** | | |
| Inpatient Coverage | $100 per day copay up to 5 days, then 90% after deductible | $500 per confinement deductible then 60% after plan deductible |
| Emergency Room | 90% after deductible | 90% after deductible |
| **URGENT CARE PROVIDER** | $55 | 60% after deductible |
| **CONVENIENCE CARE** | $25 PCP copay | 60% after deductible |
| **SKILLED NURSING FACILITY -** *up to 60 days per calendar year* | 90% after deductible | 60% after deductible |

## LOW DEDUCTIBLE CONTINUED

| | IN-NETWORK BENEFITS | OUT-OF-NETWORK BENEFITS |
|---|---|---|
| **HOME HEALTH CARE** - *100 days per calendar year, 16 hour max per day* | 90% after deductible | 60% after deductible |
| **HOSPICE CARE** | | |
| Inpatient Coverage | 90% after deductible | 60% after deductible |
| Outpatient Coverage | 90% after deductible | 60% after deductible |
| **SHORT-TERM REHAB** *includes physical therapy, occupational therapy, and speech therapy 60 days per calendar year* | $35 copay, then 100% | 60% after deductible |
| **REHAB PERFORMED AT QUENTIN MEASE, BEN TAUB, LBJ HOSPITALS** | 100% | N/A |
| **CHIROPRACTIC OUTPATIENT CARE** *up to 20 days per calendar year* | $35 copay then 100% | 60% after deductible |
| **CARDIAC REHAB** - *unlimited days per year* | $35 copay then 100% | 60% after deductible |
| **ACUPUNCTURE COVERAGE** *$500 maximum per calendar year* | $25/$35/$55 PCP or Specialist copay, then 100% | 60% after deductible |
| **AMBULANCE** | 90% after deductible | 90% after deductible |
| **DIALYSIS** | 90% after deductible | Not Covered |
| **DURABLE MEDICAL EQUIPMENT** *unlimited max per calendar year* | 90% after deductible | 60% after deductible |
| **MOUTH, JAWS AND TEETH** | | |
| Physicians office | $25/$35/$55 PCP or Specialist copay, applies to office visits | 60% after deductible |
| Inpatient coverage | $100 per day copay up to 5 days, then 90% coinsurance after deductible | $500 per confinement deductible then 60% after plan deductible |
| Outpatient coverage | $100 per facility copay, then 90% coinsurance after deductible | 60% after deductible |
| **MATERNITY** | | |
| Physician Services | $25/$35/$55 PCP or Specialist copay, then 100% | 60% after deductible |
| All subsequent Prenatal and Postnatal visits | 90% after deductible | 60% after deductible |
| *(Delivery is covered the same as plan's hospital benefit)* | | |
| **INFERTILITY TREATMENT –** *excludes in-Vitro, GIFT, ZIFT, etc.* | | |
| Physician Services | 70% after deductible | 50% after deductible |
| Inpatient Coverage | $100 per day copay up to 5 days, then 70% coinsurance after deductible | $500 per confinement deductible then 60% after plan deductible |
| Outpatient Coverage | $100 per facility copay, then 70% coinsurance after deductible | 50% after deductible |
| **ALCOHOL & SUBSTANCE ABUSE SERVICES** *unlimited visits per calendar year* | | |
| Inpatient Coverage | $100 copay per day up to 5 days, then 90% after deductible | $500 per confinement deductible, then 60% after plan deductible |
| Outpatient Coverage | 90% after deductible | 60% after deductible |
| Office Visit | $25 copay | 60% after deductible |
| **MENTAL HEALTH SERVICES** *unlimited visits per calendar year* | | |
| Inpatient Coverage | $100 copay per day up to 5 days, then 90% after deductible | $500 per confinement deductible, then 60% after pan deductible |
| Outpatient Coverage | 90% after deductible | 60% after deductible |
| Office Visit | $25 copay | 60% after deductible |

# PRESCRIPTION DRUG SUMMARY

OptumRx and CatamaranRx have merged as one company. Your prescription drug benefits are a part of your medical plan benefits and are now administered by OptumRx. If you are enrolled in one of our medical plans administered through Cigna you will automatically be enrolled in the prescription drug coverage through Optum. The ID card you receive from Cigna will serve as the medical and prescription ID card and will contain both carriers' information. The back of your medical ID card will have the prescription contact information. You may reach Optum at **1-800-880-1188** or via web at OptumRx.com/MyCatamaranRx.com. Please review the Optum benefit information below.

**Rx OUT OF POCKET MAXIMUM—**Annual amounts of $3,600 for individual and $4,200 for family , apply to all three plans.
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.

**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 is reference based priced, 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 Optum Customer Care Department at 1-800-880-1188.

## 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

**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 | | |

**HYDROCODONE**—All Hydrocodone combination drugs require a hard copy prescription every time you fill the medication due to new DEA guidelines.

**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 $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 for 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.

## 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.
- The Specialty Drug copay will be changing from $60 to $90.
- A new voluntary Hepatitis C Outcomes Program is being 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 though 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 is being added. This consists of

  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.

**STOP PAYING TOO MUCH FOR YOUR PRESCRIPTIONS**

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

**HOW GOOD RX 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 we require no personal information to search drugs and receive discounts. We do not sell your personal health information to anyone. We make money from advertisements on our site and referral fees. This revenue enables us 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 we 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.

# HIGH AND LOW DEDUCTIBLE OPTIONS—NETWORK BENEFITS & CLAIMS FILING

**IN-NETWORK OR OUT-OF-NETWORK EMPLOYEE BENEFITS**

When you are enrolled in our Self-Insured Medical Deductible Options Low Deductible or High Deductible, 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 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 discounts. | → | You will receive an Explanation of Benefits (EOB) that 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 - Claims incurred from 3/1/15 -Present | → | 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. |
| 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. |

## 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.

Harris Health System Medical plan participants, with a physicians referral, can receive therapy from our expert therapists. Many of our therapists are board certified and fellowship trained in areas such as orthopedics and neurology. Our rehabilitation department has three Certified Hand Therapists who rehabilitate patients who have suffered hand, elbow and shoulder injuries. We also offer outpatient pediatric occupational and physical therapy.

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.**

**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.

# 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 and your coverage may be reduced or denied if you don't get precertification.

**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

**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
- Experimental and investigational procedures
- Cosmetic procedures
- 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
- Biofeedback
- Speech therapy
- Cosmetic or reconstructive procedures
- 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.

# 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 options. 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
- Athlete's foot
- Bladder
- Chlamydia
- Cold sores
- Deer tick bites
- Ear infections
- Impetigo
- Infections
- Influenza
- Laryngitis
- Minor burns
- Minor sunburn
- Mononucleosis
- Pink eye and sties
- Poison ivy
- Pregnancy testing
- Rashes
- Ringworm
- Sinus infections
- Strep throat
- Swimmer's ear
- Swimmer's itch
- Wart removal

## CLINICS ALSO PROVIDE VACCINATIONS FOR:

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

# CIGNA–URGENT CARE CLINICS CONTINUED

**URGENT CARE CLINICS—HIGH, LOW DEDUCTIBLE & KELSEYCARE OPTIONS**

Urgent Care Clinics provide great care for non-life-threatening situations. Staffed by physicians, nurses and fully-trained assistants, these walk-in clinics can perform basic x-rays and lab work and dispense prescriptions. Waiting time at an Urgent Care Clinic can be shorter than in the Emergency Room (ER), where life-threatening conditions are treated first. Cost is also another factor to consider when weighing the use of an Urgent Care Clinic versus the ER. Visiting an In-Network Urgent Care Clinic will be less costly than a visit to an In-Network ER facility. Find an Urgent Care Clinic via **myCigna.com** (click on find a doctor or service, find a place by type and type in urgent care followed by address, city, state or zip code. You can also call the Cigna customer service line at **1-800-244-6224** for assistance).

**URGENT CARE** CLINICS MAY HELP WITH THE FOLLOWING CONDITIONS:

- Coughs, colds and sore throats
- Allergic reactions
- Rash or other skin irritations
- Animal bites
- Ear infections
- Fever or flu-like symptoms

YOU SHOULD GO TO THE **EMERGENCY ROOM** IF YOU HAVE . . .

- Chest pain
- Difficulty breathing
- Loss of consciousness
- Poisoning
- Signs of a stroke
- Severe bleeding or head trauma
- Sudden loss of vision or blurred vision
- Complicated fractures or broken bones

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

| 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 |

# 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 judgment of the treating physician with respect to appropriate and necessary care for a particular patient.

# 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**

# HARRIS HEALTH—FREE EMPLOYEE WELLNESS PROGRAMS

These programs are available to the Medical plan participants. They aim to promote a healthy work environment and healthy lifestyles through health education, health risk screenings, and risk factor reduction projects and services. Our programs are overseen by health professionals with expertise and training in health risk management, adult education, and behavior change. These wellness programs are offered at no cost to you. The programs are 100% employer paid and offer free activities for Medical plan participants to enjoy.

**THE MISSION OF HARRIS HEALTH SYSTEM EMPLOYEE WELLNESS INCLUDES:**

- **Assuring good health and maximum effectiveness of employees while on the job.**
- **Increasing awareness among employees about wellness and healthy lifestyles.**
- **Establishing health risk reduction programs.**
- **Developing and facilitating weight management programs with an emphasis on healthy eating, increased physical activity and self awareness**.


**HARRIS HEALTH SYSTEM IS DESIGNATED AS A MOTHER-FRIENDLY WORKSITE**

Employee Wellness maintains multiple rooms to provide a private space for lactating mothers to express and store milk during the workday. To find out where your lactation area is contact Employee Wellness.

**DISCOUNT HEALTH AND FITNESS OPTIONS**

Discounts at gyms, health clubs and activity classes are available Contact Employee Wellness for details at **713-634-1290**.

***Join our FREE Employee Wellness Activities Today!***
***Spouses and dependents over 18 years old are welcome.***

Aqua Aerobics • Basketball • Boot Camps • Dance • Flag Football •
Zumba • Martial Arts • Pilates •Softball• Aerobics • Volleyball •Yoga

**FEED YOUR BODY, MIND AND SOUL WITH THESE CLASSES AND PROGRAMS:**

Cooking Classes• Stress Relief Series • Financial Freedom • Smoking Cessation

**COMMIT TO A HEALTHY LIFESTYLE CHANGE WITH:**

Health Coaching • Lifestyle Programs • Disease Management • Healthy Babies
Diet • Sleep • Diabetes • Maternity Coaching • Fitness • Counseling
Hypertension • Lactation Support • Prevention • Relaxation
Chronic Conditions • Health Education

**Contact us to get started today!**
**713-634-1290**
**employeewellness@harrishealth.org**

# 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 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.

**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 deductibles, out-of-pocket limits, annual limits, etc. is based on the calendar year. Annual enrollment and premium changes are based on the Harris Health System recognized Plan Year of 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.

# DENTAL PLANS

MetLife

Effective March 1, 2016 Harris Health will be partnering 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, 2016). For those enrolled in the DPPO who would like to have an ID card after March 1, 2016; you can print one online when you login at metlife.com/mybenefits.

**MetLife DPPO**

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.

Please note that the annual maximum is increasing this year from $1,750 to $2,000.

**METLIFE DHMO**

The MetLife DHMO plan requires you to select a MetLife DHMO provider. You may select a different provider for each covered family member. **Please note** that if you are a current participant enrolled in a MetLife DHMO dentist's office, you will not have coverage effective March 1, 2016 *if you do not re-enroll under MetLife's plan*.

The cut-off date for electing your DHMO provider is a hard stop date of February 25, 2016. 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 on the Employee Benefits website. 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: 1-888-466-8673**

To register for metlife.com/mybenefits you will need your member and group number from your dental ID card *or* your Social Security number to create a new login.

**Website Features!** - On the site, you can view and print Explanations of Benefits (EOB), print your ID card, find a dental cost calculator, or find a 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) 1-888-466-8673 (DPPO)

# DENTAL EMPLOYEE BENEFIT SUMMARY

| | TX DHMO | NATIONAL OPTION PPO 30 |
|---|---|---|
| **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 | $2,000 per person |
| **Preventive Services** *(cleanings, exams and x-rays)* | No copay | 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<br>Adult & children covered | 50% up to a $1,000 lifetime max<br>Only children up to age 19 covered<br>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.*

# 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

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Copays** | | |
| Exams | $10 copay | Up to $40 |
| Lenses | $20 copay | |
| Contact lens evaluation, fitting & follow up | $20 copay | |
| **Exams** *(every 12 months)* | 100% after copay | Up to $40 |
| **Lenses** *(every 12 months)* | | |
| Single Vision | 100% after copay | Up to $40 |
| Bifocal | 100% after copay | Up to $60 |
| Trifocal | 100% after copay | Up to $80 |
| Lenticular | 100% after copay | Up to $80 |
| **Frames** *(every 12 months)* | | |
| Retail | Up to $130 | Up to $45 |
| Davis Collection | Fashion Level-Included<br>Designer Level-Included<br>Premier Level-$25 copay | |
| **Contact Lenses** *(every 12 months)* | | |
| Non-collection, elective | Up to $105 | Up to $105 |
| Medically Necessary | Included | Up to $210 |
| Davis Collection | Up to 4 boxes included | N/A |

## VALUE-ADDED FEATURES

### LENS123

*Replacement Contact Lenses By Mail*

- A mail-order contact lens replacement program
- Purchase replacement contact lenses at significant savings
- Lowest prices guaranteed

### LASER VISION

- Nationwide credentialed network of renowned ophthalmologists and eye surgeons at pre-eminent Eye Centers of Excellence
- Up to 25% off the provider's Usual and Customary; or 5% off promotional price (whichever is lower)
- Usual and customary fees: $1,000-$2,400 per eye
- Davis Vision typical pricing: $895-$1,800 per eye

### FREE ONE-YEAR BREAKAGE WARRANTY

All plan eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses, for a period of one year from the date of delivery. The one year breakage warranty applies to all plan-covered eyeglasses. (i.e. spectacle lenses, Davis Vision exclusive collection frames and national retailer frames where our exclusive collection is not displayed).

# HARRIS COUNTY HOSPITAL DISTRICT FOUNDATION

**FOSTERING PROGRAM INNOVATION AND SUPPORTING HARRIS HEALTH STAFF**

The mission of the Harris County Hospital District Foundation is to enhance the broad healthcare mission of the Harris Health System by soliciting and raising funds for, and increasing the community's awareness of Harris Health System. The Foundation makes an impact by working hand-in-hand with the Harris Health Administration to fund projects and initiatives that have been identified as "the greatest need" in the community. It is of prime importance that the projects supported by the Foundation directly impact the improvement of quality and access to care for the uninsured and underinsured people of Harris County. Our work also aims to enhance the quality of the workplace found at Harris Health sites for all employees.

**Some of the initiatives are:**

- Employee Disaster Relief Fund: Funds are used to support employees in time of need.
- Employee Contribution Fund: Applications are received on a quarterly basis for projects that benefit employees.
- Nursing Leadership Fund: Funds raised each year to provide scholarships for books and fees for nursing staff
- Honorariums & Memorials: To honor a loved one or a colleague's contribution to our Harris Health community, a donation can be made in their name and used to support a specific program in Harris Health.
- Bricks, Benches, and Trees: Make a last tribute at Harris Health – Buy an engraved Brick, Tree, or Bench to be placed in one of three healing gardens (Ben Taub Hospital, Lyndon B. Johnson Hospital, and Smith Clinic).

For more information or to make a donation, please call the HCHD Foundation office at 713-566-6409 or send us an email to HCHDFoundation@harrishealth.org.

# MEDICARE REQUIREMENTS

**HARRIS HEALTH SYSTEM SPONSORED SELF-INSURED GROUP MEDICAL PLAN**

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

***What actions you need to take:***

1. **If you are a Medicare approved under Age 65 Disabled Retiree or an under Age 65 Disabled Dependent of a Retiree, you need to ensure that you or your Disabled Dependent are not only enrolled in the Medical Plan but that you or your Disabled Dependent are also enrolled in both Part A and Part B of Medicare.** The Medical Plan will be secondary to Medicare and will generally remain the secondary coverage as long as you or your Disabled Dependent continues to meet Medical Plan eligibility rules.

2. **If you are a Medicare approved under Age 65 Disabled Retiree or an under Age 65 Disabled Dependent of a Retiree but do not currently meet this Medical Plan eligibility rule, immediately contact Medicare about enrollment for both Medicare Part A and Part B.**

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

**Qualifying for Medicare –** Medicare is available to those individuals under Age 65 who have received Social Security Disability Income (SSDI) benefits for 24 months. However, 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.

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

- ✧ ALS or Lou Gehrig's Disease qualify for Medicare the first (1st) month SSDI benefits are received;
- ✧ End Stage Renal Disease or Kidney Failure qualify for Medicare after the third (3rd) 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.

***Age 65 or Over - Retiree and Retiree Dependent***

**As a Retiree Age 65 or over and as a Retiree Dependent Age 65 or over Medicare will be your primary coverage.** When you first become eligible for Medicare, you have a seven (7) month period (your initial enrollment period) in which to enroll in Medicare. A delay on your part will cause a delay in Medicare coverage. If you are eligible for Medicare at Age 65, your initial enrollment period begins three (3) 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. If you enroll in Medicare during the first three (3) months of your initial Medicare enrollment period, your Medicare coverage will start with the month you are first eligible. If you enroll during the last four (4) months, your Medicare coverage will start from one (1) to three (3) months after you enroll. If you do not enroll in Medicare during your initial Medicare enrollment period, 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 premium will increase for each month that you were eligible to enroll but did not timely enroll in Medicare. For more information go to **ssa.gov** or **medicare.org** web sites.

**IMPORTANT NOTICE -**

**HARRIS HEALTH SYSTEM SPONSORED SELF-INSURED GROUP MEDICAL PLAN**

***Medicare – Coverage Types***

Medicare is our country's traditional health insurance program for people Age 65 or older and 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 Social Security Administration (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 employees receive Part A coverage automatically at Age 65. They do not have to pay a monthly premium for Part A because they or a spouse paid certain employment taxes while they were working.

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

- ✧ The 2016 regular Part B monthly premium is $104.90. Some people may pay a higher premium based on personal adjusted income.

Part D - Prescription drug coverage helps pay for medications doctors prescribe for treatment. Participants in the Harris Health System Medical Plan should not enroll in Medicare Part D because prescription drug coverage is provided through the Medical Plan.

**COORDINATION OF BENEFITS**

**HARRIS HEALTH SYSTEM ELIGIBLITY RULES - ACTIVE EMPLOYEE AND ACTIVE EMPLOYEE DEPENDENT**

***At Any Age***

As long as you meet Harris Health System eligibility guidelines and you participate in the Medical Plan, the Medical Plan will be primary to Medicare regardless of your age or the age of your eligible Dependent.

***Age 65 or Over***

If you are Age 65 or older and covered by one of our Medical Plans or covered under a group Medical plan like our Medical Plans, either from your own or your spouse's current employment, you may delay enrolling in Medicare without having to wait for the Medicare General Enrollment Period and paying a Medicare premium surcharge for late enrollment. You are therefore encouraged to enroll in Medicare Part A and Part B no later than the month your active employment or your spouse's active employment ends if you are Age 65 or older.

**HARRIS HEALTH SYSTEM ELIGIBLITY RULES - SOCIAL SECURITY APPROVED DISABILITY**

***Under Age 65 – Disabled Retiree and Disabled Dependent of a Retiree***

Effective January 1, 2011 Medicare Part A and Part B are required for a Social Security approved under Age 65 Disabled Retiree and under Age 65 Disabled Dependent of a Retiree to be eligible for our Medical Plan coverage. Each under Age 65 Retiree and each under Age 65 Retiree Dependent who is: (1) covered under our Medical Plan and (2) eligible to participate in Medicare Part A and Part B because of a Social Security approved disability will be required to participate in both Medicare Part A and Part B as of the date the under Age 65 Disabled Retiree or under Age 65 Disabled Dependent of a Retiree becomes eligible for Medicare. There is no requirement to enroll in Medicare Part D.

Medicare will provide primary coverage and our Medical Plan will provide secondary coverage. Secondary benefits under our Medical Plan will be conditioned upon mandatory participation in both Medicare Part A and Part B. Failure to participate in both Medicare Part A and Part B will result in our Medical Plan claims administrator not being able to verify coverage or process otherwise eligible Medical Plan expenses. Failure to participate in both Part A and Part B of Medicare will result in the Harris Health System Retiree continuing to pay the regular Medical Plan premium even though the under Age 65 Disabled Retiree or the under Age 65 Disabled Dependent of a Retiree will not be entitled to benefits under our Medical Plan until he or she successfully enrolls in both Part A and Part B of Medicare.

**HARRIS HEALTH SYSTEM SPONSORED SELF-INSURED GROUP MEDICAL PLAN**

**If** you are an enrollee in the Harris Health System Medical Plan and **Medicare is your primary coverage, you must be enrolled in Part A and Part B of Medicare in order to receive benefits under our Medical Plan.** You DO NOT need to enroll in Medicare Part D coverage.

**If you fail to enroll in Medicare Part A and Part B your Medical expenses will NOT be covered by our Medical Plan and the plan administrator will not be able to verify coverage or process Medical expenses for you.** Additionally, your failure to enroll in Medicare Part A and Part B will result in the Retiree continuing to pay Medical Plan premiums even though you will NOT be entitled to our Medical Plan coverage until you successfully enroll in Medicare Part A and Part B.

Harris Health System sponsored Retiree Medical plan premiums are deducted from the monthly Pension check or by bank draft. Special arrangements must be made for self-pay premiums. Failure to timely pay the Retiree portion of the Medical Plan premium will result in loss of coverage after a 30-day grace period. If the Harris Health System Medical Plan coverage is lost, Retiree coverage cannot be reinstated and applicable COBRA provisions will apply.

**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 web site **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 in more detail you may contact the HR-Benefits department 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 **Part A** and **Part B** to the Benefits Department as soon as possible upon enrollment.

# COMMUNITY HEALTH CHOICE, INC. (CHC)

**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 providing access to coordinated, high-quality, affordable, health care services. Through our network of more than 10,000 doctors and 70 hospitals, Community serves nearly 300,000 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 900, 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.

# 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, 2015. Contact your State for more information on eligibility –**

To see if any other states have added a premium assistance program since July 31, 2015, 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)

**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

**ARIZONA – CHIP**
Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

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

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

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

**IDAHO – Medicaid and CHIP**
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov; CHIP Phone: 1-800-926-2588

**INDIANA – Medicaid**
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

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

**KANSAS – Medicaid**
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

**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: 1-800-977-6740
TTY: 1-800-977-6741

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

**MINNESOTA – Medicaid**
Website: http://www.mass.gov/MassHealth
Click on Health Care, then Medical Assistance
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://medicaid.mt.gov/member
Phone: 1-800-694-3084

**NEBRASKA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-800-632-7633

**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: 1-800-755-2604

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

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

**PENNSYLVANIA** – Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

**RHODE ISLAND** – Medicaid
Website: www.ohhs.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: 1-866-435-7414

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

**WISCONSIN – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
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.

# 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.**

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- 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

OPTUMRx®

**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!

# 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

**KELSEYCARE CONCIERGE SERVICE**
713-442-0006 or 866-609-1630

**MYKELSEYONLINE**
713-442-6565
myKelseyOnline.com

## DENTAL

**DENTAL HMO - METLIFE**
800-880-1800
metlife.com

**DENTAL PPO - METLIFE**
888-466-8673
metlife.com

## VISION

**DAVIS VISION**
800-999-5431
DavisVision.com

## PRESCRIPTION DRUGS

**OPTUMRx**
800-880-1188
myCatamaranRx.com

**OPTUMRx (MAIL ORDER)**
800-881-1966

## OTHER

**DIABETES AMERICA**
866-693-4223
DiabetesAmerica.com

**PHYSICAL THERAPY & REHAB - HARRIS HEALTH SYSTEM**
713-218-8250