2016/17 REMIF Health Plan Open Enrollment

Adopted by REMIF Board

Benefits Effective 7/1/16 through 6/30/17

REMIF
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BACKGROUND ON REMIF HEALTH PLAN

July 1, 2016 marks the first anniversary of the REMIF Self-Funded health plan. In July 2015 the REMIF Board implemented a new health plan for all participating agencies. Planning for the new program started in 2013 and in March of 2015 the REMIF Board voted to move from the fully insured Anthem Blue Cross plan to a Self-Funded plan. Last year all Anthem members who stayed on the REMIF Plan were transitioned to the new plan. We thought it would be helpful to review the basics of what a Self-Funded plan is, how it works, and why REMIF chose to adopt this program.

What is a Self-Funded health plan?

A Self-Funded health plan is one in which the employer assumes the financial responsibility of providing benefits and paying claims for the employees. Under a fully insured plan, the employer buys insurance directly from an insurance carrier. The insurance carrier provides the network, processes claims, and handles all administrative aspects of the plan. With a Self-Funded plan the employer contracts with various entities to administer the health plan. These include a network of doctors and hospitals; a Third Party Administrator to pay claims, process enrollment, administer COBRA and process billing; an insurance carrier to protect the plan against very high cost, catastrophic claims; and a Pharmacy Benefit Manager to administer the prescription drug benefits.

How do Self-Funded plans work?

To the member, a Self-Funded plan can look and feel like any other health plan. Members have an ID card that they present to providers and pharmacies; they receive Explanation of Benefits (EOBs) for all their claims, and generally use the plan in the same way that they always have. However, behind the ID card there are several different companies that administer the plan, instead of just one big insurance company.

As mentioned above, most Self-Funded plans contract with networks, administrators and insurers to “run” the plan. It’s useful to understand how the pieces fit together.

REMIF contracts with Anthem Blue Cross to allow members to use the Prudent Buyer PPO network. Maintaining the same network of providers meant less disruption for employees when the new plan was adopted. Members still have access to the same Anthem Blue Cross providers that they did under the prior plan.

The Plan contracted with HealthComp, a Third Party Administrator (TPA), to process enrollments and claims, provide ID cards, administer COBRA, and provide case management services. HealthComp processes all enrollments, issues ID cards, sends Explanation of Benefits forms on all claims, provides a member services center to assist with questions, and provides case management services.

EnvisionRx is the Plan’s Pharmacy Benefits Manager. Envision maintains a network of pharmacies, negotiates drug prices, handles prior authorization services and maintains the drug formulary for the Plan.

Since the employer is responsible for paying ALL eligible claims in a Self-Funded plan, it is extremely important for the plan to purchase insurance to protect the agencies against the risk of very high cost claims. This insurance is referred to as “Stop Loss” insurance. REMIF pays all claims up to a certain large deductible limit, and the Stop Loss carrier pays eligible claims beyond that deductible.

What are the advantages and disadvantages of being Self-Funded?

There are definite advantages to Self-Funded plans, but there is also risk to consider. The REMIF Board studied the idea of Self-Funding for two years prior to making the decision to implement the new plan. The Board’s consultants studied the financial data on the prior plans over several years and concluded that REMIF would be financially better off with a

Self-Funded plan that they would if they remained fully insured. In addition, there are other advantages to Self-Funding that were attractive to the Board.

Advantages

REMIF benefits from Self-Funding in the following ways:

Cost Savings and Financial Incentives

Self-Funded plans are exempted from having to pay certain taxes under the Affordable Care Act. In 2015/16 this saved the REMIF Plan approximately $650,000. In addition, unbundling contracts for products and services reduces administrative costs and increases accountability which ensures that each product or service is competitively priced.

A reduction in administrative costs is also expected by eliminating the insurance carrier's profit margin, and the need to comply with all state mandates. A Self-Funded plan does not have to comply with the Affordable Care Act (ACA) Medical Loss Ratio requirement, which means that in good years, funds can be kept on reserve or used for other purposes as directed by the board.

REMIF has control over the health Plan reserves that are built over time. This enables the group to maximize investments which otherwise would be held by the insurance company.

Plan Flexibility

Self-Funded plans allow maximum flexibility to customize plan designs to fit the group's needs. Through a Self-funded plan the group has access to cost and utilization data that can be used to design more cost effective plans.

Cost Control

A fully insured plan typically has very little customization and limited reporting. With a Self-Funded program the plan can access a wide variety of reports that help identify key cost drivers. These key cost drivers were analyzed to determine what changes needed to be made to decrease overall Plan costs in the coming plan year.

As mentioned above, contracting with different Self-funded plan components increases accountability and ensures competitive pricing. Each component – network access, administration, Stop Loss insurance, and pharmacy benefit management – is negotiated separately by the Plan. While this requires additional management and oversight, it also helps control costs.

Availability of Additional Products/Services

Often Third Party Administrators can leverage their relationships with vendors and provide additional administrative services at a lower cost. With HealthComp this includes COBRA administration, outside plan administration (Kaiser, Delta, VSP) and online enrollment and administration. These services can reduce costs and increase efficiency for all agencies.

Disadvantages

Adopting a Self-Funded plan does create some disadvantages:

Financial Responsibility for claims

Ultimately, in a Self-Funded plan, the employer group is responsible for all claims. While the plan contracts with a Stop Loss carrier to insure against catastrophic claims, the majority of claims must be paid by the Plan through premiums collected from each agency. The plan consultants estimate expected claims costs for the coming year, but there is never a guarantee that the risk won't be higher than expected in any given year.

Cash Flow Fluctuations

Cash flow fluctuations can occur if claims spike during any period. This can create cash flow issues which require the plan to dip in to reserves to pay claims.

Long Term Commitment

A Self-Funded plan is intended to be a longer term commitment than a fully insured plan. To realize true gains from a Self-Funded plan, the program has to be in place long enough to be able to provide credible data on the plan and any changes that the program makes.

Additional Administrative Oversight

A Self-Funded plan requires more management than a fully insured plan. The REMIF Board and its Committees are responsible for managing the Plan and all their contracted vendors. And, REMIF itself is required to establish and maintain policies and procedures, and Plan documents necessary for the Plan. Under a fully insured plan the carrier would handle the oversight of any vendors and the development of Plan documents.

SUMMARY OF THE FIRST PLAN YEAR

While no implementation is completed without some bumps in the road, the transition to a Self-Funded plan for REMIF members was relatively smooth. There were individuals that needed assistance with ID cards and pharmacy benefits, among other things. However the majority of members transitioned without any significant issues.

The program is producing reporting that REMIF will use during the coming years to identify significant cost drivers and address methods to reduce the Plan's overall costs. These cost reductions will hopefully keep premiums lower in the future.

If REMIF had remained fully insured in 2015/16 the plans would have increased 8% in 2015/16. And while it's difficult to project what the cost increase would have been for 2016/17 on a fully insured plan, most groups of similar size were seeing increases between 8% and 10%. **Rates for the REMIF plans did not increase in 2015/16 as the Self-Funded plan allowed REMIF to keep the rates stable for that year. For 2016/17 rates are increasing an average of 9.49% which is consistent with most group plans of similar size. In addition, because the Self-Funded plan is relatively new, the Board is adopting a prudent approach to rates with the goal of developing and maintaining adequate reserves.**

OPEN ENROLLMENT

This is an official Open Enrollment period for the REMIF Group Insurance Program for medical, dental and vision coverage. The REMIF Group Insurance Program is available to eligible employees and dependents.

During this period you have the opportunity to add or drop your eligible dependents; change plans or add coverage. All changes and additions will be effective July 1, 2016. If you do not add or change coverage during this Open Enrollment period, you will not be able to do so until the next Open Enrollment period unless you experience a qualifying event. Members who experience a qualifying event must enroll within 31 days of the event.

CHANGES FOR 2016/17

Eligibility Changes

The following eligibility changes are effective as of 7/1/16:

Dual Coverage between Spouses

It has come to the attention of the Plan that current eligibility provisions allow two employees with eligible spouses working for the same agency to cover themselves and their spouses under two REMIF employee policies. It was never the intention of the REMIF plan to allow dual coverage between spouses working for the same agency. **The eligibility guidelines have been changed effective 7/1/16 to eliminate the dual coverage policy for spouses. Starting 7/1/16, for spouses working for the same agency, both can be covered as employees, or one can waive and become a dependent of the other.**

Retiree Eligibility at age 65

The Plan has determined that it can no longer offer coverage to an Early Retiree (and/or spouse) once he/she attains age 65. Under the current plan provisions, a retiree (and/or spouse) who attains age 65 is required to enroll in Medicare and transition to the REMIF Hartford Medicare Supplement plan in order to continue retiree coverage. A retiree (and/or spouse) who is not eligible for premium free Medicare could remain on the REMIF plan at a higher "Non-Medicare" rate. However, as a Self-Funded plan REMIF is not able to offer Stop Loss coverage to these individuals. Without the availability of Stop Loss coverage, the risk to the plan is too significant to continue to allow the "Non-Medicare" retirees to remain on the plan. **Effective 7/1/16, the plan provisions will no longer allow Early Retirees (and/or spouses) who attain age 65 to continue on the REMIF Self-Funded Plan. Early Retirees (and/or spouses) who attain age 65 and lose Plan eligibility will be able to:**

- **Elect COBRA Continuation Coverage - as long as they have not applied for Medicare A or B, or**
- **Purchase Medicare A and B and enroll in the REMIF Hartford Medicare Supplement plan**

CalCOBRA

CalCOBRA is a California program that is similar to federal COBRA. Both provide certain former employees, retirees, and eligible dependents the right to continue employer provided coverage when they would otherwise lose coverage due to specific qualifying events. CalCOBRA is a state law that does not apply to Self-Funded plans. As a result, the REMIF Plan provisions have been changed to eliminate CalCOBRA continuation coverage.

Benefit Changes

The following benefit comparisons illustrate changes that will be made to each plan for 2016/17. The side by side comparisons show the current benefits, and what the new benefits will be beginning 7/1/16.

Changes were adopted by the REMIF Board in April. The Board considered the recommended premium increases and evaluated options for benefit changes that would reduce the premium increases needed for the next plan year. The goal was to keep the premium increases as low as possible while balancing Plan costs and member benefits.

The changes adopted by the Board require more cost sharing by members for certain services. The most significant changes are increases in copays required for some medications. The cost of prescriptions is rising faster than costs for other medical services, with prescription drug increases projected at 11% for this year.

The most significant change is the increase in the copay for Specialty Medication. While this won't affect the majority of members, it is a significant change for those who use Specialty Medication. Specialty drugs alone are projected to

increase in cost by almost 19% in 2016. Typically, these are very high cost, highly regulated medications. For the REMIF Plan the average cost of Specialty Medications per prescription is $4,444. Most members currently pay a $25 copay for a Specialty Medication. Because of the extremely high cost of these medications, and the projected increases in cost for the next year, the copay for Specialty Medication was increased to $150 per prescription.

Another significant change was made to the hearing aid benefit. The current plans have no limitation on hearing aids, either in the allowed amount or the frequency with which members can replace hearing aids. The Plan has changed this benefit for 2016/17 to allow a maximum of $2,500 benefit per ear; and replacement of hearing aids every three years. The Board recognized that it was important to allow members to maximize the $2,500 benefit, so as of 7/1/16, member will be able to obtain hearing aids from any provider or retailer. This would include discount retailers such as Costco, Sam's Club, etc.

Other changes include an increase in office visit copays for specialists, and added copays for lab and X-ray, and imaging services (for example MRI, CT, PET scans.)

Please review the comparisons below. If you have any questions regarding the benefits or plan changes, please contact your Human Resources Department or call RealCare at (800) 939-8088, Option 2.

EPO 250 Plan Changes Effective 7/1/16

July 1, 2016 changes to Plan benefits are highlighted in **bold print.**

Medical Benefits	CURRENT BENEFITS		BENEFITS EFFECTIVE 7/1/16	
	In Network	Out of Network	In Network	Out of Network
Office Visits Primary Care Physician (PCP) Specialist	(Deductible Waived) $25 Copay PCP $25 Copay Specialist	Not Covered	(Deductible Waived) $25 Copay PCP **$35 Copay Specialist**	Not Covered
ER Visit	0% after $100 Copay and deductible (Copay waived if admitted)		0% after **$150 Copay** and deductible (Copay waived if admitted)	
Lab & X-Ray	0% after deductible	Not Covered	**$10 Copay** after deductible	Not Covered
Advanced Imaging (Includes MRI, CT, PET)	0% after deductible	Not Covered	**$50 Copay** after deductible	Not Covered
Hearing Aids	0% after deductible	Not Covered	0% after deductible **Plan pays maximum benefit of $2,500 per ear every three years. Members can obtain hearing aids from any provider or retailer.**	
Retail Rx Copays (30 day supply)				
Tier 1 (Generic)	$10	$10 + excess	$10	$10 + excess
Tier 2 (Preferred Brand)	$25	$25 + excess	$25	$25 + excess
Tier 3 (Non-Preferred Brand)	$25	$25 + excess (Member pays copay + 100% of charges in excess of pharmacy Maximum Allowable Charge)	**$50**	**$50 + excess** (Member pays copay + 100% of charges in excess of pharmacy Maximum Allowable Charge)
Tier 4 (Specialty)	Specialty Medications are only available through Specialty Mail Order Pharmacy. (See Below)	Not Covered	Specialty Medications are only available through Specialty Mail Order Pharmacy. (See Below)	Not Covered
Mail Order Rx Copays (90 day supply except Specialty)				
Tier 1 (Generic)	$15	Not Covered	$15	Not Covered
Tier 2 (Preferred Brand)	$38		$38	
Tier 3 (Non-Preferred Brand)	$38		**$75**	
Tier 4 (Specialty)	$25		**$150**	
DAW (Dispense as Written)	Allows physician to specify Brand drugs even if generic is available		**Will require authorization based on medical necessity for brand drugs if generic is available**	

BlueCard Plan Changes Effective 7/1/16

July 1, 2016 changes to Plan benefits are highlighted in **bold print.**

Medical Benefits	CURRENT BENEFITS		BENEFITS EFFECTIVE 7/1/16	
	In Network	Out of Network	In Network	Out of Network
Office Visits Primary Care Physician (PCP) Specialist	(Deductible Waived) $25 Copay PCP $25 Copay Specialist	30% after deductible	(Deductible Waived) $25 Copay PCP **$35 Copay Specialist**	30% after deductible
ER Visit	0% after $100 Copay and deductible (Copay waived if admitted)		0% after **$150 Copay** and deductible (Copay waived if admitted)	
Lab & X-Ray	0 % after deductible	30% after deductible	**$10 Copay** after deductible	30% After deductible
Advanced Imaging (Includes MRI, CT, PET)	0% after deductible	30% after deductible (Plan pays maximum $800 per procedure)	**$50 Copay** after deductible	30% after deductible (Plan pays maximum $800 per procedure)
Hearing Aids	0% after deductible	30% after deductible	0% after deductible • **Plan pays maximum benefit of $2,500 per ear every three years. Members can obtain hearing aids from any provider or retailer.**	
Retail Rx Copays (30 day supply)				
Tier 1 (Generic)	$10	$10 + excess	$10	$10 + excess
Tier 2 (Preferred Brand)	$25	$25 + excess	$25	$25 + excess
Tier 3 (Non-Preferred Brand)	$25	$25 + excess (Member pays copay + 100% of charges in excess of pharmacy Maximum Allowable Charge)	**$50**	**$50** + excess (Member pays copay + 100% of charges in excess of pharmacy Maximum Allowable Charge)
Tier 4 (Specialty)	Specialty Medications are only available through Specialty Mail Order Pharmacy. (See Below)	Not Covered	Specialty Medications are only available through Specialty Mail Order Pharmacy. (See Below)	Not Covered
Mail Order Rx Copays (90 day supply except Specialty)				
Tier 1 (Generic)	$15	Not Covered	$15	Not Covered
Tier 2 (Preferred Brand)	$38		$38	
Tier 3 (Non-Preferred Brand)	$38		**$75**	
Tier 4 (Specialty)	$25		**$150**	
DAW (Dispense as Written)	Allows physician to specify Brand drugs even if generic is available		**Will require authorization based on medical necessity for brand drugs if generic is available**	

POA Only -
EPO 500 Plan Changes Effective 7/1/16

July 1, 2016 changes to Plan benefits are highlighted in **bold print.**

Medical Benefits	CURRENT BENEFITS		BENEFITS EFFECTIVE 7/1/16	
	In Network	Out of Network	In Network	Out of Network
Office Visits Primary Care Physician (PCP) Specialist	(Deductible Waived) $30 Copay PCP $30 Copay Specialist	Not Covered	(Deductible Waived) $30 Copay PCP **$40 Copay Specialist**	Not Covered
ER Visit	10% after $100 Copay and deductible (Copay waived if admitted)		10% after **$150 Copay** and deductible (Copay waived if admitted)	
Hearing Aids	10% after deductible	Not Covered	10% after deductible **Plan pays maximum benefit of $2,500 per ear every three years. Members can obtain hearing aids from any provider or retailer.**	
Retail Rx Copays (30 day supply)				
Tier 1 (Generic)	$15	$15 + excess	$15	$15 + excess
Tier 2 (Preferred Brand)	$30	$25 + excess	**$35**	**$35** + excess
Tier 3 (Non-Preferred Brand)	$30	$25 + excess	**$50**	**$50 + excess**
		(Member pays copay + 100% of charges in excess of pharmacy Maximum Allowable Charge)		(Member pays copay + 100% of charges in excess of pharmacy Maximum Allowable Charge)
Tier 4 (Specialty)	Specialty Medications are only available through Specialty Mail Order Pharmacy. (See Below)	Not Covered	Specialty Medications are only available through Specialty Mail Order Pharmacy. (See Below)	Not Covered
Mail Order Rx Copays (90 day supply except Specialty)				
Tier 1 (Generic)	$23	Not Covered	$23	Not Covered
Tier 2 (Preferred Brand)	$45		**$53**	
Tier 3 (Non-Preferred Brand)	$45		**$75**	
Tier 4 (Specialty)	$40		**$150**	

REMIF Health Plan Frequently Asked Questions

FAQ

Q1. Why are the plans changing?

A1. There will be no changes to deductibles, out of pocket maximums or Primary Care office visits. However, to minimize the premium increases necessary to cover Plan costs for 2016/17, the REMIF Board elected to adopt several changes to the existing plans. Additional copays will be charged for some services, and benefit limitations were placed on hearing aids.

Q2. Who is a Specialist and why do I have to pay more to see one?

A2. Specialists are doctors that have completed advanced education and undergone additional clinical training in a specific field of medicine. Examples of specialists include cardiologists, surgeons, dermatologists, gynecologists, gastroenterologists, and endocrinologists. Consequently, specialists' fees are substantially higher than those of a Primary Care doctor. A higher copay helps cover the additional cost.

Q3. Do I have to meet my deductible on lab and x-ray?

A3. Yes, you must meet your deductible for lab and x-ray services.

Q4. How can I keep my costs lower?

A4. Using only network providers is one way to keep your costs lower. Network providers agree to accept a discounted rate for services and will not bill you for additional charges. Other ways to keep costs down include:

- Using generic drugs whenever possible
- Utilizing urgent care facilities instead of emergency rooms where available
- "Shopping" for services by asking providers the cost for procedures, and utilizing resources such as the California Healthcare Compare website to compare quality and cost between providers.
- Talking with your doctor about the most cost effective treatment for your situation. One size does not fit all! What works best for one person may not work best for another. Be an active consumer of healthcare services.

Q5. What is Advanced Imaging?

A5. Advanced Imaging refers to a number of diagnostic technologies that use digital recordings of physical images to help providers with diagnosis and treatment of diseases and conditions. The term refers to the most "advanced" imaging technology available, and includes CT scans, MRI, PET scans and others. Advanced Imaging services do require prior authorization under the Plan.

Q6. What is DAW?

A6. "DAW" means "Dispense as Written." This term is used to describe a benefit that allows a doctor to authorize a pharmacy to dispense a Brand name drug even if a generic version is available. Effective 7/1/16, all REMIF plans will eliminate the DAW feature. This means that members who take Brand name drugs instead of generics will be required to obtain medical authorization from Envision to continue to use the Brand name drugs.

Q7. What if I have to take a specific Brand Name drug for my medical condition?

A7. If a generic version of your drug exists, then your doctor will need to submit a request for authorization for you to use the Brand name drug based on medical necessity.

Q8. What if I can't take generics?

A8. If your doctor can show that it is medically necessary for you to take the Brand name version of your drug then Envision will provide authorization for you to continue to take the Brand name drug. Authorizations must be obtained at least annually, and sometimes more often, depending on the situation.

Q9. I just got hearing aids. When will I be able to get them again?

A9. The hearing aid benefit limitations take effect on 7/1/16. You will be eligible for hearing aids in 2016/17, subject to the plan maximum of $2,500 benefit per ear. You will then be eligible for hearing aids again 3 years from the last date of service (following 7/1/16).

Q10. Where can I find the Preferred Drug List?

A10. Visit www.EnvisionRx.com. Click on "Resource Tools" and then choose "Formulary." From there, you can click on the 2016 Standard Formulary.

Q11. How do I look up contracted medical providers?

A11. Visit www.anthem.com/ca and click on "Find a doctor" on the right hand sidebar. Then, under "Search as a Member" enter the first three letters from your Member ID on your ID card. That three letter code brings up the correct provider directory for you to search. From there you can search for providers, hospitals and other facilities.

Q12. What do I pay at Urgent Care?

A12. Urgent care centers will cost you the same copay as a Primary Care office visit. (For those on the HSA plan, the deductible will apply.)

Q13. What if I don't have an Urgent Care available to me?

A12. If possible, we recommend you contact your personal physician to seek care. However, in an emergency, please use your local emergency room.

Q14. How do I know if I'm taking Specialty Medications?

A14. Specialty Medications must be obtained through the Specialty Pharmacy, a mail order program. If you are obtaining your prescriptions at a retail pharmacy, your prescription is not considered a Specialty Medication. If you have specific questions about your medication please call EnvisionRx Member Services at (800) 361-4542 or call RealCare at (800) 939-8088, Option 2.

Care Advocate Program

HealthComp's Care Advocate Program

This program is designed to provide an additional layer of assistance for those individuals and their families who may be experiencing a complex health condition. HealthComp's Case Managers can help you navigate through the often confusing and impersonal maze experienced in today's medical delivery system.

HealthComp will identify participants based on claims and referrals. If you're identified as a potential participant, you will be assigned a nurse who will contact you to discuss the program and answer your programs. This program is completely voluntary and confidential.

If you choose to participate, your Nurse Case Manager will work with you, your doctor(s) and care providers to develop a custom-made care plan, designed specifically for you. HealthComp will assist throughout the entire treatment plan to ensure your care is being provided timely, appropriately, and safely, while staying within the guidelines of your health plan. Care Advocate provides:

- Education around your medical condition
- Continuity of care within the healthcare delivery system
- Ongoing coordination of care with medical providers and facilities
- Assistance with available resources in your community
- Assistance with claim questions

The advice given is not meant to replace your medical provider, but rather to complement the care being provided. We encourage you to establish a relationship with a Primary Care Provider for care based on your age, gender and condition.

What does it cost?

Your participation in Care Advocate is voluntary, completely confidential, and costs you nothing! Should you decide Care Advocate isn't right for you, you may opt out of the program at any time, for any reason.

How do I reach the Care Advocate Program?

You can call HealthComp at (800) 755-7247. Their office hours are 6:00 AM to 4:30 PM.

Specialty Medications

Specialty Medications are unique and powerful medications used to treat chronic diseases and genetic disorders. These medical conditions are complex and require close management. Specialty drugs are often highly regulated and require special handling, administration and monitoring. Most are also very expensive, and the overall cost of Specialty Medications is increasing at a faster pace than other drugs or medical care.

In recent years most drug plans have created a special tier of coverage for Specialty Medication. All Specialty Medications must be obtained through a mail order pharmacy where strict control of the drug's inventory and distribution can be maintained.

Often people who take Specialty Medications can get help from drug manufacturers to offset the cost of medication. Because of the high cost of many of these drugs, manufacturers often issue coupons and offer other financial assistance to members who need it.

EnvisionSpecialty is now the Specialty Pharmacy (formerly Orchard Specialty) that handles all Specialty Medication prescriptions. The EnvisionSpecialty pharmacy will assist you and your doctor in obtaining Specialty Medications and set up refills. Effective 5/1/16 Orchard Specialty moved to EnvisionSpecialty under the EnvisionRx Options family.

Important things for you to know:

- **EnvisionSpecialty will not change the Orchard phone and fax numbers**
- **Members will not require new prescription(s)**
- Members are being informed and the customer service team is prepared to answer questions
- New brochures and member enrollment forms reflecting the name change will be available shortly. Current forms will be honored.
- EnvisionPharmacies will update the website and create a new email address, but the Orchard ones still work.
    - orchardrx.com will change to envisionpharmacies.com
    - orchardspecialty.com will change to envisionspecialty.com

Here are some examples of Specialty Medications:

Specialty Medication List
Humira
Enbrel
Otezla
Oxlair
Harvoni
Pulmozyme
Tecfidera
Stelara

Important Contact Information

Medical Plan

Call HealthComp Member Services for:.....(800) 442-7247

- Information on medical claims
- Information on deductibles or out of pocket maximums
- Replacement medical plan ID Cards (also available at www.hconline.healthcomp.com)
- Eligibility information
- General medical benefit questions
- Prior Authorization questions
- Care Advocate Program: (800) 755-7247

Call Anthem for:.....(800) 274-7767

- Assistance with Utilization Review, Prior Authorizations

Call EnvisionRx for: .....(800) 361-4542

- Questions about prescription coverage
- Assistance with prior authorizations
- Help in finding a pharmacy
- Call EnvisionRx Pharmacy for:
  - Mail Order pharmacy questions: (866) 909-5170
  - Specialty Pharmacy questions: (877) 437-9013

Call RealCare Insurance Brokers for: .....(800) 939-8088

- Assistance with claims issues
- Help understanding benefits or eligibility

Dental Plan

Call Delta Dental for: .....(800) 765-6003

- Information on dental claims and benefits
- Help in finding a Delta Dental provider

Vision Plan

Call VSP for: .....(800) 877-7195

- Information on vision claims and benefits
- Help in finding a VSP provider

2016 Required Notices

HIPAA Notice of Special Enrollment Rights

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

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 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact your Human Resources Department or Benefit Administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance outlined in your benefit summary will apply.

If you would like more information on WHCRA benefits, contact your Human Resources Department or Benefits Administrator.

Notice to Employees Regarding Employer Contributions to HSAs

This notice explains how you may be eligible to receive contributions from your employer **if you are covered by a High Deductible Health Plan (HDHP), and your employer has agreed to contribute to the Health Savings Account (HSA) of each employee who is enrolled in the HSA qualified health plan.** If you are an eligible employee, you must do the following in order to receive an employer contribution:

(1) Establish an HSA with the vendor chosen by your employer and;

(2) Notify your Human Resources Department or Benefits Administrator that you have established your HSA account

If you establish your HSA on or before the last day of February in the year after the year for which the contribution is being made, and notify your Human Resources or Benefit Administration contact of your HSA account information, you will receive your HSA contributions, plus reasonable interest (if established late), for the HSA contribution by April 15 of the year after the year for which the contribution is being made.

If, however, you do not establish your HSA or you do not notify us of your HSA account information by the deadline, then the employer is not required to make any contributions to your HSA for the year of the HSA contribution. You may notify your employer that you have established an HSA by sending a written notice to your Human Resources contact person. If you have any questions about this notice, please connect with your Human Resources contact person.