



TML MultiState Intergovernmental Employee Benefits Pool Rerate Notice and Benefit Verification Form

El Lago

Original

Plan Year 2016-2017 (12 Months)

Rates are subject to change if there is any legislation passed during the plan year affecting benefits.
Supplemental benefits cannot be accessed without accessing the TML MultiState IEBP Medical Benefit Plan

Medical

Employer Group Medical Plan

Plan	Benefit Percent	In Net Ded	Out Net Ded	In Net OOP	Office Visit	XRay & Lab in OV	Rates	Current	New
P85-100-10-Mac A	80/50	\$1000	\$1250	\$1000	N/A	No	Employee:	\$336.52	\$397.10
							Family:	\$379.68	\$448.02

Dental III

	Current Rate	New Rate
Employee:	\$34.52	\$37.64
Family:	\$54.16	\$59.04

Vol Vision B

	Current Rate	New Rate
Employee:	\$12.50	\$12.50
Family:	\$25.00	\$25.00

Calendar Year Pre-65 Retiree Medical

Pre Sixty-five Pool Benefits

Calendar Year Pre-65 Retiree Dental

No Pre-65 Retiree Dental Coverage

Calendar Year Pre-65 Retiree Vision

No Pre-65 Retiree Vision Coverage

LTD

No LTD Coverage

STD

No STD Coverage

Basic Life and AD&D: Plan 22 (\$50,000)

	<u>Current Rate</u>	<u>New Rate</u>
Life:	\$0.190	\$0.190
AD&D:	\$0.035	\$0.035

Dependent Life

No Dependent Life Coverage

Voluntary AD&D

No Voluntary AD&D Coverage

Additional Employee Life and AD&D

No Additional Employee Life and AD&D Coverage

Basic & Additional Retiree Life

No Basic & Additional Retiree Life Coverage

Continuation of Coverage (COC)

Yes

Benefit Waiting Period

Medical: 30 days after date of hire

Life: 30 days after date of hire

Medical Network

Choice Plus

Flex, HRA, HSA & RRA

<u>Flex Admin</u>	<u>HRA Admin</u>	<u>HSA Admin</u>	<u>RRA Admin</u>
No	Yes	No	Yes

Select one of the following options for Flex:

- Debit Card Flex (\$3.70 per participant per month)
- Paper Flex (\$5 per participant per month)

Select one or all of the following options for HRA, HSA & RRA:

- HRA (\$3.70 per participant per month - debit card only)
- HSA (\$3.70 per participant per month - debit card only)
- RRA (\$3.70 per participant per month - debit card only)

If employer accesses Debit Card Flex and/or HRA, HSA or RRA, only one charge of \$3.70 per participant per month will be incurred.

Medication Therapy Management Program

MAC A Plan: If a brand name drug is dispensed and a generic alternate drug exists, the **Covered Individual pays the difference between the brand name and generic price** in addition to the appropriate copayment for the brand name. The **cost difference between the brand name and generic price does not apply to any individual deductibles or out of pocket amounts.** The MAC differential applies to all prescriptions purchased through this program when a generic alternate is available.

MAC C Plan: If a brand name drug is dispensed and a generic alternate drug exists, the Covered Individual pays the appropriate brand copay.

Lessor of Benefit: Through the OptumRx network contract, the covered individual's out of pocket expense is managed by the pharmacy network agreement that the covered individual will receive the most advantageous pricing. This would be determined by the lessor of pharmacy contracts, Usual & Customary cost (U&C), copayments or the discounted cost the covered individual would be charged. Due to the lessor of Benefit the OptumRx Reportal will be an important price transparency resource to ensure covered individual is purchasing the prescription from the most cost effective pharmacy.

The most effective way to control costs is through the use of generic drugs and a drug formulary.

\$	Drug Tier	Includes	Helpful Tips
 \$	Tier 1 Lowest Cost	Lower cost, commonly used generic drugs. Some low cost brands may be included.	Use Tier 1 drugs for the lowest out-of-pocket costs.
 \$\$	Tier 2 Mid-range Cost	Many common brand-name drugs, called preferred brands.	Use Tier 2 drugs, instead of Tier 3, to help reduce your out-of-pocket costs.
 \$\$\$	Tier 3 Highest Cost	Mostly higher cost brand drugs, also known as non-preferred brands.	Many Tier 3 drugs have lower cost options in Tier 1 or 2. Ask your doctor if they could work for you.

Covered Individual Out of Pocket (OOP)

Prescribed (Doctor Ordered) Over the Counter Alternates and Prescription Networks	Retail: (up to 34 day supply max unless noted otherwise)	Mail/Maintenance: (up to 90 day dispensement)	SpecialtyRx/Biotech/Biosimilar: (up to 34 day dispensement)
<ul style="list-style-type: none"> Smoking Cessation (Nicorette Gum), Quantity Limit - 3 months per plan year Aspirin, Folic Acid, Fluoride Chemoprevention Supplements, Iron Deficiency Supplements, and Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at an increased risk for falls; per prescription 	\$0.00	N/A	N/A
Network Retail: 34 day <u>Non-Cost Share most Generic</u> Dispensement	\$5.00 (up to 34 day supply)	N/A	N/A
Network Retail: 90 day <u>Non-Cost Share most Generic</u> Dispensement	\$14.00 (35 up to 90 day supply)	\$30.00	
OptumRx Network <u>Non-Cost Share</u> Best Brand/Formulary List	\$43.00	\$100.00	
OptumRx Network <u>Non-Cost Share</u> Non-Best Brand/Non-Formulary List	\$65.00	\$155.00	
OptumRx Network Cost Share	\$120.00	\$300.00	
OptumRx Specialty/Biotech Prescriptions	N/A	N/A	\$100.00 (up to 34 day supply)
OptumRx Biosimilar Generic Prescriptions	N/A	N/A	\$75.00 (up to 34 day supply)
Prescription Refill Control Standards	75%	70%	

Women's Preventive Health Services

Benefit	Retail Rx Medical Plan	Prescription Plan	Plan Ineligible
Oral Contraceptives Generic (no cost share)		X	
IUD Device (no cost share)	X	X	
Implant Device (no cost share)	X	X	
Permanent Implantable Contraceptive Coil (subject to the appropriate deductible and benefit percentages)	X		
Insertion and/or Removal of Devices (no cost share)	X		
Sonogram to Detect Placement of Device (no cost share)	X		
Injectable Contraceptives (no cost share)	X	X	
Injectable Administration Fee (no cost share)	X		
Diaphragm (cervical), Hormone Vaginal Ring, Hormone Patch, Cervical Cap, Spermicides, Sponges (no cost share)		X	
Diaphragm Instruction and Fitting Fee (no cost share)	X		
Emergency Birth Control			X
Over-The-Counter (OTC) Birth Control			X
Contraceptive Management/Urinalysis/Pregnancy Test (no cost share)	X		
Female Condoms (no cost share)		X	
Female Surgical Sterilization	X		
Medications for risk reduction of breast cancer in women who are at increased risk for breast cancer and at low risk for adverse medication effects: Tamoxifen or Raloxifene		X	

Women found to be at increased risk using a screening tool designed to identify a family history that may be associated with an increased risk of having a potentially harmful gene mutation must receive coverage w/o cost-sharing for genetic counseling, and, if indicated, testing for harmful BRCA mutations. This is true regardless of whether the woman has previously been diagnosed with cancer, as long as she is not currently symptomatic of a receiving active treatment for breast, ovarian, tubal, or peritoneal. Jan 1, 2016 genetic counseling for BRCA testing is covered 100% as a preventive benefit.

Mandate to provide a list of the lactation counseling providers available within the network under the plan or coverage. Grandfathered plans cannot apply cost-share expenses for OON lactation services. Services for lactation support services w/o cost-sharing must extend for the duration of breastfeeding.

Monthly Employer Subsidy or Defined Contribution Amounts

Due to the employer customization regarding defined contribution amount for employees, part-time employees that meet the definition of an active employee (an Employee who works at least twenty (20) hours per week or is accessing vacation, sick or paid/unpaid Family Medical Leave Act of 1993 (FMLA) and is receiving the same benefits as all other employees) and/or dependents, TML MultiState Intergovernmental Employee Benefits Pool requests the below information to ensure accurate information is maintained in the enrollment, eligibility and billing adjudication system.

	<u>Employer Funded Defined Contribution</u>		<u>Dependent Additional Employer Subsidy or Defined Contribution</u>					
	<u>Employee</u>		<u>Spouse</u>		<u>Child</u>		<u>Family</u>	
Active Employees	Amount	% of Rate	Amount	% of Rate	Amount	% of Rate	Amount	% of Rate
Employer Subsidy	\$ _____ or _____ %		\$ _____ or _____ %		\$ _____ or _____ %		\$ _____	1st Year 50 % 2nd Year 75 % 3rd Year 100 %
Employer Defined Contribution	\$ _____		\$ _____		\$ _____		\$ _____	
Retirees	\$ _____ or _____ %		\$ _____ or _____ %		\$ _____ or _____ %		\$ _____ or _____ %	

Additional Employer Funding for HRA, FSA or HSA (Example criteria: 100% participation in Employer Fair; Receipt of Healthy Initiative Payment)

HRA \$ 1,000 Criteria: To cover annual deductible

Employer Contribution to FSA \$ _____ Criteria: _____

Employer Contribution to HSA \$ _____ Criteria: _____

NOTE: If you have funding requirements that cannot be specified in the above form, please contact your Billing & Eligibility Representative.

Signature Section

The undersigned employer hereby acknowledges that for an employee to receive coverage, TML MultiState Intergovernmental Employee Benefits Pool (IEBP) must receive enrollment information within thirty-one (31) days of the commencement of employment regardless of whether the Employer has a waiting or a waiting and orientation period. If an employee is not enrolled within thirty-one (31) days of hire, the employee cannot be added to the Plan until the next Open Enrollment period or a qualifying event occurs.

_____	_____	_____
Employer	Authorized Signature	Date
	_____	_____
	Printed Name	Title

The entity named on this Rerate and Benefit Verification Form desires large claim information as specified in Article 21.49-15 of the Insurance Code in Section 2.(2), to be for individual claims that reach or exceed \$35,000 during the plan year. This information is considered confidential for purposes of Chapter 552 of the Local Government Code.

The rates are based on census information five months prior to plan year. If the census changes by more than 10%, TML MultiState IEBP reserves the right to revise rates due to census change and underwriting impact.

_____	_____	_____
Tax ID Number	Authorized Signature	Date
