

Harris County

**Resource Guide
2006-2007**

HC Flex Benefits Program



Commissioners Court

Robert Eckels—County Judge

El Franco Lee—Commissioner, Precinct 1

Sylvia R. Garcia—Commissioner, Precinct 2

Steve Radack—Commissioner, Precinct 3

Jerry Eversole—Commissioner, Precinct 4

CALL FOR ASSISTANCE

For more information or to get answers to your questions, please contact your Benefits Coordinator or the Office of Human Resources & Risk Management. Listed below are telephone numbers and websites that may be of help to you.

HUMAN RESOURCES & RISK MANAGEMENT

Employee Benefits.....(713) 755-5117
Toll Free (out of area only).....(866) 474-7475
www.co.harris.tx.us\hrrm

FLEX ACCOUNT QUESTIONS

1Point Solutions.....(866) 602-1900
www.1pointsolutions.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Magellan Behavioral Health.....(800) 588-8417
www.magellanassist.com

MEDICAL COVERAGE

Aetna Member Services.....(800) 279-2401
Aetna Rx – Mail Order Delivery.....(866) 612-3862
www.aetna.com

VISION COVERAGE

Spectera Inc.(800) 638-3120
www.spectera.com

DENTAL HEALTH MAINTENANCE ORGANIZATION (DHMO) and DENTAL INDEMNITY

Safeguard.....(800) 880-1800
On-site Representative.....(713) 755-4157
www.safeguard.net

LONG-TERM DISABILITY PLAN

Unum Provident.....(800) 858-6843

LIFE INSURANCE

Prudential Insurance Company.....(713) 840-4005

DEFERRED COMPENSATION / 457 PLANS

AIG.....(800) 448-2542
ING/Aetna Financial Services.....(800) 525-4225
Nationwide (PEBSCO).....(877) 677-3678

RETIREMENT

Texas County & District Retirement System (TCDRS).....(800) 823-7782
www.tcdrs.org

This guide briefly describes, in non-technical language, the benefits offered to you and your family. It is not intended to modify the Group Policies and/or contracts between the carriers and the County. You may obtain a detailed description of coverage provisions from HRRM Employee Benefits or from the HRRM web page. If there is any variation between the information provided in this Guide, the Plan Document or the Group contracts, the Plan Document and Group contracts will prevail.

TABLE OF CONTENTS

Open Enrollment Information	1
Changes for 2006–2007	2
Health & Related Benefit Plans	3
Aetna Medical Plan Information	4

BASIC BENEFITS

Base Plan Summary of Benefits	5 & 7
Rx Coverage Review & Durable Medical Equipment (DME)	9
Aetna Rx Home Delivery—Clarifications	10
Harris County Dental Plans	11-13
Harris County Vision Plan	14
Life Insurance — Basic & TCDRS	18
Basic Long Term Disability	19–21
Harris County Wellness	22
Employee Assistance Program	22
COBRA Notification Obligations	23
Medicare Information	23

OPTIONAL BENEFITS

Base Plus Plan Summary of Benefits	6 & 8
HCFlex Benefits Program	15–17
Premium Redirection Overview	
Flexible Spending Accounts	
Qualified Transportation Accounts	
Optional Term Life Insurance	18-19
Optional Long-Term Disability Coverage	19-21
MONTHLY RATES	24

OPEN ENROLLMENT

Harris County is committed to providing you with a comprehensive benefits program. Our program, HCFlex, allows you to customize your benefits package to best suit your needs and the needs of your family.

Open enrollment is your opportunity to make allowable changes in your benefits. This Resource Guide is designed to help you through the enrollment process. During this time, employees may make changes in their benefit elections, dependent coverage(s), and optional coverages that best suit their needs for the coming plan year.

Open enrollment for the 2006/2007 plan year will be conducted from **January 1 through January 31, 2006**. Please contact your department's Benefit Coordinator for your department's deadline. Changes become effective **March 1, 2006**. You should carefully consider the insurance plans available to you and your dependents. **No changes may be made after open enrollment**; however, you may still be able to add dependents to your HCFlex plan following a qualified change in family status provided the request to add is on account of, and consistent with, the qualified change in family status.

HCFlex is your benefits program – please take the time to read this material and familiarize yourself with the options available to you. Your department Benefit Coordinator and the Office of Human Resources & Risk Management are ready to assist you if you have any questions.

Employees who fail to return their completed open enrollment paperwork with the appropriate documentation (if any) by the deadline, will be defaulted to the benefit selections chosen for the 2005-2006 plan year.

New employees will use this guide in making their benefit decisions and must make benefit selections prior to the effective date of their insurance.

Required Documentation for Dependents

Open enrollment forms, as well as insurance enrollment forms for new employees that enroll dependents, must be accompanied by the appropriate documentation proving dependent eligibility. Any enrollment forms received without the appropriate documentation will be rejected. Appropriate documentation is:

Spouse.....A filed copy of your Formal Marriage License or Certificate of Informal Marriage from the County Clerk's office.

Children..... A birth certificate or other court document listing employee as parent of the unmarried child. If the child is age 19-24, employee must provide proof of full-time student status.

Stepchildren.....A birth certificate or other court document listing the employee's spouse as parent of the unmarried child as well as the marriage license of employee and parent. Stepchildren must reside with the employee.

Grandchildren.....Certification of Financial Dependency form (obtain from HRRM), birth certificate on the child, and a birth certificate on the grandchild's mother or father indicating that the employee is the biological or adoptive parent of the unmarried child. The grandchild must be claimed on the employee's Federal Tax return every year to remain on the plan.

Foster Children.....Documents from the State of Texas indicating date of placement by the State.

Harris County determines eligibility for employees and dependents subject to amendment or discontinuance at any time.

CHANGES



DENTAL—SafeGuard will begin providing the DHMO and Dental Indemnity coverage. Great News – The new dental plans have lower monthly premiums, while the Dental HMO has reduced copayments for many services. Routine cleanings and exams are available at no cost to you! Carefully review the Schedule of Benefits for new procedures that are now covered!

The provider network is statewide (also California and Florida) which will better service those dependents living outside the metro Houston area. **SafeGuard** will continue to increase their provider network and welcomes your suggestions for provider additions. You can download a provider nomination form from the website and either fax or mail your nomination directly to **SafeGuard**. Visit their website @ www.safeguard.net, then click on the Harris County logo. The website provides great information on participating providers statewide, your benefits, health topics, frequently asked questions, and much more! This website is updated once per week. See pages 11–13 for detailed information.

VISION –Spectera will continue to provide the vision plan. Plan changes include a \$10 copayment for a vision exam, a \$25 copayment for hardware and increased coverage for contact lenses. See page 14 for additional information.

MEDICAL—The Aetna medical plan has been modified to allow one routine physical exam every calendar year. Previously, enrollees were able to obtain one routine physical every twelve months *and not 1 day sooner!*

LONG-TERM DISABILITY—UnumProvident will begin administering the County’s Basic and Optional Long-Term Disability Plans. Good news– substantially lower rates for you! Reference pages 19-21.

FLEXIBLE SPENDING—1Point Solutions will begin administering the County’s Health Care, Dependent Care, and Qualified Transportation accounts effective March 1, 2006. For detailed information see page 15-17.

STUDENT AUDIT— Effective March 1, 2006, dependent children age 19–24 must be enrolled as a full-time student in an accredited college, university or trade school.

GRANDCHILD AUDIT— Dependent grandchildren must be claimed as a dependent on employees’ Federal income tax return every year. Failure to do so will result in retroactive termination of the dependent coverage. Employee must obtain a “Certificate of Financial Dependency” form from HRRM, complete and return with other required documentation.

This guide briefly describes, in non-technical language, the benefits offered to you and your family. It is not intended to modify the Group Policies and/or contracts between the carriers and the County. You may obtain a detailed description of coverage provisions from HRRM Employee Benefits or from the HRRM web page. If there is any variation between the information provided in this Guide, the Plan Document or the Group contracts, the Plan Document and Group contracts will prevail.

HEALTH & RELATED BENEFIT PLANS

MEDICAL PLAN

(AETNA)

Coverage through Aetna Choice POS II

Enroll yourself and the eligible dependents you elect to cover.

Choice of two Plans:
Base Plan or Base *Plus* Plan

Choose one of the two plans for yourself and your covered dependents.

VISION PLAN

(Spectera)

Coverage through a PPO network provider or out of network option at a higher cost

Coverage is available for yourself and your covered dependents.

DENTAL PLANS

(SafeGuard)

Choice of two plan types:

- Dental Health Maintenance Organization (DHMO); OR
- Dental Indemnity Plan

Choose one of the two plans for yourself and your covered dependents. Everyone must choose the same plan.

LIFE & AD&D INSURANCE

(Prudential)

Basic coverage for you and your covered dependents paid by the County

Decide whether to purchase optional employee life coverage up to 2X your annual salary (subject to medical underwriting).

Optional coverage with enhanced benefits available at low rates

LONG-TERM DISABILITY INSURANCE

(UnumProvident)

Basic coverage paid by the County

Decide whether to purchase optional coverage.

Optional coverage available at new lower rates

HC FLEX PROGRAM

Health Care, Dependent Care, and Qualified Transportation Reimbursement Accounts

(1Point Solutions)

Premium Redirection—Use tax free dollars to pay for qualified expenses

Decide whether to participate with a monthly contribution to one or all reimbursement accounts.

Health Care: for eligible non-reimbursed expenses **(NOT TO BE USED FOR MONTHLY PREMIUM REIMBURSEMENT)**.

Health Care: \$30 min/\$250 max Per month

Dependent Care: for eligible childcare or qualified dependent care

Dependent Care: \$30 min/\$416 max per month

Qualified Transportation: for eligible parking and/or mass transit

Qualified transportation: \$30 min/\$105 max for mass transit/\$205 for parking per month





HOW YOUR AETNA CHOICE POS II PLAN WORKS

Your Aetna Choice POS II Plans do not require you to select a network primary care physician (PCP) although selecting a PCP is encouraged. By choosing a PCP, you have an opportunity to work with a physician who can develop a deeper understanding of your health needs, to better manage your care. And, you could lower your costs for covered expenses! To choose a PCP, log on to DocFind®; an online provider directory, at www.aetna.com or refer to your Aetna provider directory. You can also change your selected PCP anytime by logging on to Aetna Navigator, the self-service customer website, or by calling the Member Services number on your member ID card 800-279-2401.

THE FREEDOM TO SEEK CARE IN ONE OF FOUR WAYS, WITHOUT REFERRALS

Choice #1: Visit your Preferred PCP

Choice #2: Go Directly to Another Preferred PCP or Health Care Provider

Choice #3: Go Directly to a Participating or Non-Participating Aexcel Specialist

Choice #4: Go Directly to a Non-Preferred Physician or Health Care Provider

Your Base and Base Plus plans give you the freedom to choose any recognized physician or hospital, whenever you need medical treatment. No referrals are necessary, ever. The choice is always yours.

If you require specialty care in any of the 12 Aexcel specialty categories and you visit any Aexcel designated specialist, you will pay a \$30 copay on the Base Plan or a \$20 copay on the Base Plus Plan. If you choose to see an Aetna preferred-provider who is **not** an Aexcel designated specialist, you will pay a \$45 copay on the Base Plan or a \$30 copay on the Base Plus Plan.

Your choice of provider dictates the amount you will pay in copayment, coinsurance, and/or deductibles. Please refer to the summary of benefits included in this guide for applicable copayment, deductible and coinsurance amounts.



Important Aetna telephone numbers:

Informed HealthLine (24/7)	800-556-1555
Disease Management (24/7)	866-269-4500
Moms to Babies	800-272-3531

POS II Summary of Benefits - BASE

Plan Features	Base Plan Preferred Benefits (In-Network)	Base Plan Non-Preferred Benefits (Out-of-Network)
Plan Deductible (per calendar year)	\$200 Individual \$600 Family	\$500 Individual \$1,500 Family
Deductible Carryover	None	None
Coinsurance Limit (excludes deductible; once Family Coinsurance Limit is met, all family members will be considered as having met their coinsurance for the remainder of the calendar year.)	\$1,500 Individual \$4,500 Family	\$3,000 Individual \$9,000 Family
Lifetime Maximum	Unlimited except where otherwise indicated	Unlimited except where otherwise indicated
Physician Services (except Mental Health/Alc/Drug)		
Office Visits to PCP	100% after \$20 copay	70% after deductible
Specialists (office visits)		
Participating Aexcel providers	100% after \$30 copay	70% after deductible
Non-Aexcel participating providers	100% after \$45 copay	70% after deductible
Routine Physicals/Immunizations		
Children: 7 exams in first 12 months of life, 2 exams in the 13th-24th months of life, 1 exam every 12 months of life thereafter up to age 18. Adults: 1 exam every calendar year. Includes coverage for immunizations for children and adults.	100% after \$20 copay. Copay waived for immunizations when an office visit charge is not made	70% after deductible
Routine Gynecological Care Exam Coverage is limited to 1 routine Ob/Gyn exam per year, including charges for 1 pap smear and related fees.	100% after \$30 copay (participating Aexcel providers) 100% after \$45 copay (non-Aexcel participating providers)	70% after deductible
Routine Mammography Ages 35-40 1 baseline, Ages 40+ 1 every calendar year	100%	70% after deductible
Routine Annual Digital Rectal Exam (DRE) & Prostate Antigen Test (PSA) for covered males age 40 and over	100% after \$20 copay	70% after deductible
Routine Hearing Exam (1 exam per 24 months)	100% after \$30 copay	70% after deductible
Hearing Aids One pair every 36 months with a maximum benefit of \$1,000 every 3 years	80% after deductible	80% after deductible
Outpatient surgery (facility) Except in physician's office when office visit copay applies	90% after deductible	70% after deductible
Physician Hospital Services	90% after deductible	70% after deductible

Plan Features	Base PLUS Plan Preferred Benefits (In-Network)	Base PLUS Plan Non-Preferred Benefits (Out-of-Network)
Plan Deductible (per calendar year)	None	\$500 Individual \$1,500 Family
Deductible Carryover	None	None
Coinsurance Limit (excludes deductible; once Family Coinsurance Limit is met, all family members will be considered as having met their coinsurance for the remainder of the calendar year.)	None	\$2,000 Individual \$6,000 Family
Lifetime Maximum	Unlimited except where otherwise indicated	Unlimited except where otherwise indicated
Physician Services (except Mental Health/Alc/Drug)		
Office Visits to PCP	100% after \$20 copay	80% after deductible
Specialists (office visits)		
Participating Aexcel providers	100% after \$20 copay	80% after deductible
Non-Aexcel participating providers	100% after \$30 copay	80% after deductible
Routine Physicals/Immunizations		
Children: 7 exams in first 12 months of life, 2 exams in the 13th-24th months of life, 1 exam every 12 months of life thereafter up to age 18. Adults: 1 exam every calendar year. Includes coverage for immunizations for children and adults.	100% after \$20 copay. Copay waived for immunizations when an office visit charge is not made.	80% after deductible
Routine Gynecological Care Exam Coverage is limited to 1 routine Ob/Gyn exam per year, including charges for 1 pap smear and related fees.	100% after \$20 copay (participating Aexcel providers) 100% after \$30 copay (non-Aexcel participating providers)	80% after deductible
Routine Mammography Ages 35-40 1 baseline, Ages 40+ 1 every calendar year	100%	80% after deductible
Routine Annual Digital Rectal Exam (DRE) & Prostate Antigen Test (PSA) for covered males age 40 and over	100% after \$20 copay	80% after deductible
Routine Hearing Exam (1 exam per 24 months)	100% after \$30 copay	80% after deductible
Hearing Aids One pair every 36 months with a maximum benefit of \$1,000 every 3 years	80%	80% after deductible
Outpatient surgery (facility) Except in physician's office when office visit copay applies	100% after \$200 copay	80% after deductible
Physician Hospital Services	100%	80% after deductible

Limits are combined for both preferred and non-preferred benefits. Please reference your Plan Document for a complete listing of covered services, reimbursement amounts, limitations and exclusions.

POS II Summary of Benefits - BASE

Plan Features	Base Plan Preferred Benefits (In-Network)	Base Plan Non-Preferred Benefits (Out-of-Network)
Allergy Testing (Allergy serum, injections and injectable drugs.)	100% after \$30 copay (waived for injections when an office visit charge is not made)	70% after deductible
Diagnostic X-ray & Laboratory	100% regardless of where services are performed	70% after deductible
Hospital Services - Inpatient Coverage	90% after deductible	70% after deductible
Hospital Services - Outpatient Coverage	90% after deductible	70% after deductible
Emergency Room	100% after \$125 Emergency Room copay; waived if confined; 90% after deductible if admitted	100% after \$125 copay; waived if confined; 90% after deductible if admitted
Non-Emergency Use of the Emergency Room	Not covered	Not covered
Urgent Care Provider	100% after \$40 Urgent Care copay	70% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Skilled Nursing Facility	90% after deductible w/limits	70% after deductible w/limits
Home Health Care	90% after deductible w/limits	50% after deductible w/limits
Private Duty Nursing - Outpatient	90% after deductible w/limits	70% after deductible w/limits
Hospice Care - Inpatient & Outpatient Coverage	Reference Plan Document	Reference Plan Document
Short-Term Rehabilitation - (Coverage for physical, speech and occupational therapy)	100% after \$30 copay up to 60 visits per calendar year	70% after \$30 copay up to 60 visits per calendar year
Chiropractic Care	100% after \$30 copay; up to \$500 per calendar year	70% after deductible; up to \$500 per calendar year
Ambulance	90% after deductible	90% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Contraceptive Drugs & Devices not obtainable at a pharmacy. Also includes coverage for contraceptive associated office visits.	Payable as any other covered expense	Payable as any other covered expense
Maternity (Coverage includes voluntary sterilization)	Payable as any other covered expense	Payable as any other covered expense
Basic Infertility Services Diagnosis & treatment of the underlying medical condition Artificial insemination	Payable as any other covered expenses 50% after deductible	Payable as any other covered expenses 50% after deductible
Alcohol and Drug Abuse Services		
Inpatient Coverage	90% after deductible; up to 60 days per calendar year	70% after deductible; up to 60 visits per calendar year
Outpatient Coverage	100% after \$30 copay; up to 60 visits per calendar year	70% after deductible; up to 60 visits per calendar year
Mental Health - Inpatient Coverage	90% after deductible	70% after deductible
Mental Health - Outpatient Coverage	100% after \$30 copay	70% after deductible

Plan Features	Base PLUS Plan Preferred Benefits (In-Network)	Base PLUS Plan Non-Preferred Benefits (Out-of-Network)
Allergy Testing (Allergy serum, injections and injectable drugs.)	100% after \$30 copay (waived for injections when an office visit charge is not made)	80% after deductible
Diagnostic X-ray & Laboratory	100% regardless of where services are performed	80% after deductible
Hospital Services - Inpatient Coverage	100% after \$300 per confinement copay	80% after deductible
Hospital Services - Outpatient Coverage	100% after \$200 copay	80% after deductible
Emergency Room	100% after \$125 copay; waived if confined; \$300 copay applicable if admitted	100% after \$125 copay; waived if confined; \$300 copay applicable if admitted
Non-Emergency Use of the Emergency Room	Not covered	Not covered
Urgent Care Provider	100% after \$40 Urgent Care copay	80% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Skilled Nursing Facility	100% up to 60 days per calendar year w/limits	80% after deductible up to 60 days per calendar yr w/limits
Home Health Care	100% up to 100 visits per calendar year w/limits	80% after deductible; up to 100 visits per calendar yr w/limits
Private Duty Nursing - Outpatient	100% w/limits	50% after deductible w/limits
Hospice Care - Inpatient & Outpatient Coverage	Reference Plan Document	Reference Plan Document
Short-Term Rehabilitation - (Coverage for physical, speech and occupational therapy)	100% after \$30 copay up to 60 visits per calendar year	80% after \$30 copay up to 60 visits per calendar year
Chiropractic Care	100% after \$30 copay; up to \$500 per calendar year	80% after deductible; up to \$500 per calendar year
Ambulance	100%	100%; deductible waived
Durable Medical Equipment	100%	80% after deductible
Contraceptive Drugs & Devices not obtainable at a pharmacy. Also includes coverage for contraceptive associated office visits.	Payable as any other covered expense	Payable as any other covered expense
Maternity (Coverage includes voluntary sterilization)	Payable as any other covered expense	Payable as any other covered expense
Basic Infertility Services Diagnosis & treatment of the underlying medical condition	Payable as any other covered expense	Payable as any other covered expense
Artificial insemination	50%	50% after deductible
Alcohol and Drug Abuse Services		
Inpatient Coverage	100% after \$300 per confinement copay; up to 60 days per calendar year	80% after deductible; up to 60 days per calendar year
Outpatient Coverage	100% after \$30 copay; up to 60 visits per calendar year	80% after deductible; up to 60 visits per calendar year
Mental Health - Inpatient Coverage	100% after \$300 confinement copay	80% after deductible
Mental Health - Outpatient Coverage	100% after \$30 copay	80% after deductible

Prescription Drug Coverage for Both Plans—Two Tier Standard Generic/Brand Name Plan

	Percentage You Pay	Minimum/Maximum Copay
Retail (30 day supply)	25% Generic 25% Brand	\$5 min/\$15 max \$20 min /\$60 max
Mail Order (31-90 day supply)	25% Generic 25% Brand	\$10 min/\$30 max \$40 min/\$120 max

REMINDER: This is a mandatory generic prescription drug plan. If the member or physician request brand name when a generic is available, the member pays the brand copay plus the difference between the generic price and the brand price.

Generic Drug - An alternative version of a brand name drug that no longer is under the exclusive patent of the original manufacturer. All generic drugs must have the same active ingredients of the brand version and be “bioequivalent” which means that it delivers the same amount of active ingredient to the site in the body that it is meant to treat. Generic drugs are equally effective as brand drugs, but they are typically less expensive.

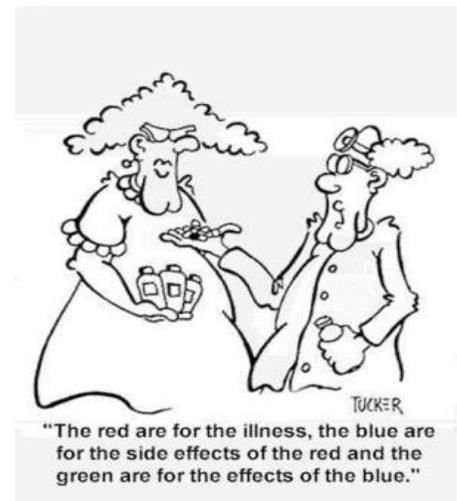
DURABLE MEDICAL EQUIPMENT (DME) INFORMATION

Recently diagnosed diabetics, did you know that Aetna will provide one (1) free blood glucose monitor? Call Aetna customer service for details and ordering assistance (800) 279-2401.

The accessories needed to operate your Durable Medical Equipment are covered under your DME benefit at 90% after deductible for Base Plan members and at 100% for Plus Plan members. You can order your diabetic supplies via the following Aetna DME providers: Sterling Medical Services (800) 216-5500 and Medical Plus Supplies (713) 440-6700.

DEFINITION of Durable Medical and Surgical Equipment (DME)

- ➔ No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:
 - made to withstand prolonged use;
 - made for and mainly used in the treatment of a disease or injury;
 - suited for use in the home;
 - not normally of use to person who does not have a disease or injury;
 - not for exercise or training.





CLARIFICATIONS

- ✓ Drug pricing information should be obtained from the Aetna Customer Service number listed on your Aetna ID Card. ARxHD does not have pricing and/or benefit information.
- ✓ Physicians can fax prescriptions for mail order processing. The prescription must be submitted on the physician's office letterhead and must include the member's name and Aetna identification number. Prior to processing faxed prescription(s), the member must have completed and submitted an ARxHD registration form. Members cannot fax prescriptions for filling via mail order.
- ✓ Prescriptions written for a brand medication will be dispensed as a generic if a generic is available (or becomes available while the Rx is active) and is formulary in the state. If a brand medication is necessary, the doctor must write/sign DAW (dispense as written) or brand necessary on the prescription. If this is not on the script and a formulary generic is available, the member will receive the generic medication. If the member or doctor wants the Rx filled with a generic that is not formulary in Kansas (KS), the Rx must be written specifically for that medication (not the brand name.)
- ✓ You may contact your Aetna Customer Service department to obtain information regarding the availability of generics for brand prescriptions and present this information to your doctor.
- ✓ If you recently filled a maintenance prescription, and your physician changes/increases your dosage, or if you are just reordering the maintenance medication and you are sending in a new prescription, you must have depleted the amount based on your individual plan's utilization percentage (mail order is usually 60%) prior to mailing in your new prescription .
- ✓ If you submit new prescriptions all on one script, and not all are available at one time, the order could be delayed by 24-48hrs. If the remaining prescription(s) are not available within the 7-10 day processing period, the order will then be split into 2 separate orders in an effort to avoid further delay.
- ✓ Level II drugs (narcotics) can be filled via mail order (ARxHD). They must be mailed in on the prescribing physician's letterhead and must include the **member's name, Aetna identification number, and the medical diagnosis.**
- ✓ **WHEN TRAVELING:** If you know you will run out of your prescription medication, and it is too soon to refill prior to your departure, call Aetna Pharmacy Management (APM) for a "vacation override" at (800)-238-6279. You will need to provide your departure date and your return date to the representative. Medication can be picked up as early as 3 days prior to your vacation departure date.





This year the County will continue to provide two options for dental benefits: a Dental Health Maintenance Organization plan (DHMO) and a dental indemnity insurance plan. These benefits are provided at no cost to you. However, if you choose to enroll your eligible dependents, you will be responsible for their portion of the monthly fees. To enroll your dependents in the dental plan, they must also be enrolled in the medical plan. During open enrollment, you will have the opportunity to choose the plan that best meets your needs and pocketbook.

What are the differences between the two plans?

Dental HMO - SGC1011-TX	Dental Indemnity – SHCN420
No calendar year maximums; no yearly deductibles	\$1,750 calendar year maximum; \$50 yearly individual deductible (\$150 for family)
Basic care provided by contracted general dentists selected at enrollment. Members may change their designated provider by contacting SafeGuard customer service. Requested changes will be effective the 1 st of the following month.	You may receive care from any licensed dentist; contracted dentists have agreed to accept negotiated fees as payment in full.
Each family member may select a different general dentist (remember to include the facility number when enrolling).	Non-contracted dentists could “balance bill” which may result in higher out-of-pocket costs (see the Summary of Benefits for more information).
Covered procedures and co-payments are listed on the Schedule of Benefits.	Claims are paid based on the percentages listed on the Summary of Benefits.
When specialty care is required, your selected general dentist can refer with no need to contact SafeGuard for approval.	If you require specialty care, you may see any specialty care dentist you choose. Or receive care from a contracted dentist, which may save you on your expenses.
No waiting periods.	6 month wait on endodontic procedures & all Major services (Additional waiting period of 6 months for endodontia and major services for new employees and newly added dependents of current employees).
Adult & child orthodontics included.	Orthodontia is not a covered benefit.
No claim forms required.	Claim forms may be required.

More specific information, along with plan benefits, exclusions and limitations, is included in your SafeGuard enrollment kits.



Customer Service Options

SafeGuard has two sources for assistance 24 hours a day, 7 days a week. You can print an ID card, change providers, print or request a copy of your plan...all online or through advanced telephone technology. Register for the interactive website at www.safeguard.net (logon from the button in the lower left hand corner of the home page) or call 800.880.1800 and follow the prompts for IVR (Interactive Voice Recognition) assistance.

If, after reviewing the plan documents, you have any questions, our Member Services Representatives will be happy to help you.

800.880.1800.
8am – 8pm, CST, Monday–Friday

A dedicated representative from SafeGuard will also be available onsite in the Harris County Human Resources Benefits office after the March 1, 2006 effective date.

Open Enrollment Action - Required

DURING OPEN ENROLLMENT, CHOOSE ONE OF THE FOLLOWING PLANS FOR YOUR DENTAL BENEFIT COVERAGE:

SAFEGUARD DHMO PLAN – SGC1011-TX

If you choose to enroll in the dental HMO plan, remember to select a dentist from the **SafeGuard** Directory for you and each of your enrolled dependents. Write the Facility Number in the space allotted on your enrollment form for each person enrolled.

A full Schedule of Benefits with co-payments and Exclusions & Limitations is included in your enrollment kit. There is also an Evidence of Coverage document that provides great information on how to get the most from your **SafeGuard** dental HMO plan. Take the time to review this information before making your dental benefit decisions.



SAFEGUARD INDEMNITY PLAN – SHCN420

If you decide the indemnity plan is right for you, there is no need to “pre-register” with a dental care provider - you can receive treatment from any dentist. When choosing a dentist, remember that if you choose to receive care from a contracted **SafeGuard** dentist, you could save on your out-of-pocket costs. Contracted dentists have agreed to accept the negotiated fee as payment in full with no balance billing.

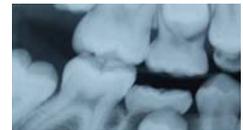
Your Costs

Payment of claims is based on a Maximum Allowable Charge (MAC). The Maximum Allowable Charge is set by **SafeGuard** and based on negotiated rates with contracted dentists. This MAC is the most that **SafeGuard** will pay for a particular dental procedure under the plan.

A Summary of Benefits includes the information on how payment is calculated for your plan and is included in your enrollment kit along with the plan Exclusions & Limitations. If, after reviewing the plan documents, you have any questions, Member Services Representatives will be happy to help you.

800.880.1800.

8am– 8pm, CST, Monday–Friday



Online Services

SafeGuard has created a website specifically for County employees. Logon at www.safeguard.net and select “**Group Specific Sites**” from the homepage. Benefit summaries, plan documents and answers to frequently asked questions are included along with much more. You can also learn more about **SafeGuard**, review educational information for adults and children, and access the online directory to find the most current provider listings.

The customized Harris County website was designed to help you get the most from your dental benefits program. You have instant access to...

- ▶ Find a new provider
- ▶ Print your plan
- ▶ Email Member Services
- ▶ Change providers (Dental HMO)
- ▶ Print an ID card

The Harris County Vision Care Program is offered through **Spectera Inc.** In accordance with the vision care schedule of benefits, you have the choice of using the PPO Plan or receiving the Indemnity Plan reimbursement allowance. Remember, vision coverage is provided automatically for you and each dependent you enroll in the medical plan.

With the PPO Plan, you use participating providers, pay lower out-of-pocket expenses and receive a higher level of benefit. The Indemnity Plan allows you to visit the providers of your choice in exchange for higher out-of-pocket costs.

HOW THE VISION CARE PROGRAM WORKS

Each Time You Need Vision Care, You May Seek Care Through the PPO Plan: Select a **Spectera** participating provider by calling the provider locator at (800) 839-3242, or from www.spectera.com.

- When you make your appointment, identify yourself as a Harris County **Spectera** Vision Plan member.
- Examination: \$10 copay; once every 12 months. A vision examination is provided by a network optometrist or ophthalmologist.
- Standard frames and lenses are covered at 100% after \$25 copay.
- Non-selection frames are available for wholesale cost plus a \$10 handling fee.
- Standard contact lenses are covered at 100% after \$25 copay in lieu of glasses.

Covered Services

Highlights of your vision care benefits are shown below. For the complete schedule of benefits reference the Vision Plan Benefit Certificate of Coverage.

Service/Product	PPO Plan	Indemnity Reimbursement Plan
Complete Visual Exam*	\$10 copay	Up to \$40
Materials— Entire purchase of eyeglasses, including lenses & frames OR contacts in lieu of eyeglasses	\$25 Materials Copay for eyeglasses or contact lenses	Up to \$45
Lenses		
Single Vision Lenses*	100% after \$25 Materials Copay	Up to \$40
Bifocal Vision Lenses*	100% after \$25 Materials Copay	Up to \$60
Lined Trifocal Vision Lenses*	100% after \$25 Materials Copay	Up to \$80
Contact Lenses		
Elective	100% after \$25 Materials Copay	Up to \$105
Necessary**	100% after \$25 Materials Copay	Up to \$210

*Limited to one exam and set of lenses or contacts every 12 months from the last date of service.

** Necessary contact lenses are determined at the provider’s discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact Spectera concerning the reimbursement that Spectera will make before you purchase such contacts.



Flexible Spending Account Program



What is an FSA?

A Flexible Spending Account is a special **non-taxed** account designed to save you money on healthcare, dependent care, and transportation expenses.

You elect an annual amount to contribute to your FSA, and these funds are transferred automatically from your paycheck into your FSA before taxes are calculated. You then use the **tax-free** dollars you set aside to pay for eligible expenses.

There are three kinds of Flexible Spending Accounts: the **Health Care FSA**, the **Dependent Care FSA**, and the **Transportation FSA**. You may choose to participate in one or all of these programs.



How Your Health Care FSA Works

The Health Care FSA lets you use your tax-free dollars to pay for out-of-pocket health, dental, and vision expenses for you, your spouse, and your dependents. You can contribute up to **\$3000** in your Healthcare FSA for the 2006-2007 plan year.

The IRS has defined a list of expenses which you can purchase with your tax-free dollars—items such as prescription co-pays, dental cleanings, doctors visits, eyeglasses and contacts, and even over-the-counter drugs. A general rule of thumb is that if a doctor deems an item medically necessary, it is considered an eligible expense. To see a complete list of eligible expenses, visit:

<http://www.1pointsolutions.com/forms/medexp.pdf>.

Another benefit of your Health Care FSA is that it is pre-funded, meaning that the amount you choose for your annual election is available to you from the first day of your plan year!

IRS regulation states that any money left in the FSA at the end of the plan year is forfeited, so it is important to look carefully at your annual medical expenses and select an election amount that is adequate for your needs.



1POINT SOLUTIONS

[How Your Dependent Care FSA Works](#)

The Dependent Care FSA lets you use tax-free dollars to pay for the care of your child and elder dependents. You can use your FSA to pay for those regular expenses such as day-care, pre-school tuition, babysitting, and even day camp. You can contribute up to **\$5000** in your Dependent Care FSA for the 2006-2007 plan year.

The Dependent Care FSA works a little differently than Health Care FSAs in that they are not “pre-funded.” This means that you can only be reimbursed for an amount up to the total you have deposited into your account at any given point in the year.

Keep in mind that any unused funds in your Dependent Care FSA do not roll-over from year to year and will be forfeited if not used.



[How Your Transportation FSA Works](#)

Your Transportation FSA allows you to use tax-free dollars on the regular travel expenses you or your spouse might incur traveling to and from work. These types of expenses include Mass Transit Expenses and Parking Expenses. You can contribute up to **\$105 for mass transit expenses** and **\$205 for parking expenses**. Unlike your other FSAs, your Transportation funds will roll-over from year to year.



Customer Service needs? Call 1-866-602-1900

Toll-free FAX: 1-866-254-1927

The 1Point Flexible Spending Card

Using your FSAs to save money should be as easy as possible. Our Flexible Spending Card improves your old FSA and makes it even easier to access your funds.

To pay for expenses with your FSA, just present the card anywhere MasterCard is accepted and the amount is automatically deducted from your FSA. No more submitting claim forms or waiting for reimbursement!



Using Your FSA at the Pharmacy

Your Flexible Spending Card recognizes certain vendor codes at the point of sale. This feature protects you from accidental misuse of the card at unauthorized vendors. However, your pharmacy is coded to sell both eligible and ineligible expenses.

In order to use your card at the pharmacy, follow these steps:

1. Ring up only your eligible expenses on the Flexible Spending Card.
2. Pay separately for any other expenses you might have.
3. Keep your receipt!
4. If requested, fax a copy of your itemized receipt to 1Point within two weeks.



Failure to submit receipts for pharmacy purchases within due time will subject your card to deactivation.

How To Enroll

To enroll in your benefits, follow these instructions:

Estimate your annual out-of-pocket health care, and/or dependent care, and/or transportation expenses.

Based on this amount, decide how much to contribute for the plan year (March 1, 2006 – February 28, 2007) up to the maximum limits. Be sure to plan carefully! You cannot change the amount you contribute during the year unless you have a qualifying change in family status.

Complete your enrollment form, indicating your annual elections and return to your department Benefit Coordinator by the deadline.

If you terminate employment or retire from Harris County before the end of the plan year, your participation in any FSA program will end. Any contributions made while you were an active employee must be spent before your plan participation ends!

Provided by *Prudential Insurance Company*

1. BASIC LIFE INSURANCE FOR EMPLOYEES AND DEPENDENTS

Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance provide protection for your family in the event of your death or accidental injury. The County currently provides a basic level of insurance to eligible employees and your covered dependents at no cost as shown below.

Provided by Prudential

a. Active Employees

Annual Rate of Basic Earnings is:	Life*	AD&D
\$20,000 or more	\$25,000	\$5,000
\$15,000 but less than \$20,000	\$20,000	\$5,000
\$10,000 but less than \$15,000	\$15,000	\$5,000
Less than \$10,000	\$10,000	\$5,000

b. Dependent Life Insurance¹

Classification	Life ¹
Spouse	\$5,000
Unmarried child(ren)	\$2,000

**Benefits reduce 35% at age 70 and 50% at age 75.*

¹Dependent Life Insurance coverage is only available for the dependents covered under your Medical Plan. All Dependent Life Insurance terminates when the employee retires.

If you die while insured for Life Insurance, or if you have an accident while insured for AD&D Insurance, and the accident results in loss, Prudential will pay benefits according to the terms of the Group Policy after receiving proof of loss.

For AD&D Insurance, loss means loss of life, hand, foot or sight which is caused solely and directly by an accident, occurs independently of all other causes, and occurs within 365 days after the accident.

2. BASIC SUPPLEMENTAL DEATH BENEFITS (TCDRS) FOR EMPLOYEES

Subject to the County's participation in the Texas County and District Retirement System (TCDRS) life insurance program, you are provided a supplemental death benefit policy through the Retirement System that is paid by Harris County. The value of this policy is equal to your most recent hourly rate or most current salary, converted to an annual amount.

Optional Term Life Insurance

You also have the opportunity to increase the level of your insurance at competitive group rates. You may purchase Optional Life Insurance for yourself equivalent to one or two times your basic annual salary or wage (at time of enrollment), up to \$250,000. If your salary or wage changes, your Optional Life Insurance amount will change on the next anniversary of the plan. Any Pre-Tax Life Insurance provided under the County plans in excess of \$50,000 is subject to taxation.

OPTIONAL LIFE & LONG-TERM DISABILITY

Employees have the option of purchasing additional Life Insurance equal to one or two times annual salary.

Employees who currently purchase the Optional Life Insurance and wish to increase their coverage amount and employees who are not currently participating will be required to complete a medical questionnaire and be approved by Prudential before deductions will begin.

*These amounts will be calculated on your enrollment form according to your age and/or salary at the time of enrollment.

OPTIONAL LIFE INSURANCE*	RATE/\$1,000 OF COVERAGE
Under 30	\$.06
30-34	.08
35-39	.10
40-44	.13
45-49	.20
50-54	.33
55-59	.60
60-64	.75
65-69	1.28
70-74	2.08
75-79	3.37
80 and over	7.14



Effective March 1, 2006, UnumProvident will begin providing Long-Term Disability (LTD) Insurance to Harris County employees. Long-Term Disability (LTD) Insurance is designed to provide peace of mind providing income protection in the event you become disabled and cannot work.

Long-Term Disability (LTD) is part of your Harris County Benefit Plan. The insurance has two (2) parts: Basic LTD and Optional LTD. You are eligible for the Basic LTD insurance on the first day of the month after three (3) months of continuous employment with Harris County. For Optional LTD, you are eligible for coverage the first day of the month following twelve (12) months of continuous employment with Harris County.

Long Term Disability Coverage

The Basic LTD coverage replaces 50% of the first \$10,000 of your pre-disability earnings, reduced by deductible sources of income. There is a benefit waiting period of 180 days. The maximum benefit duration is two (2) years.

The Optional LTD increases your monthly benefit to 60% of the first \$10,000 of your pre-disability earnings, reduced by any deductible sources of income. This also extends the length of disability benefits from two (2) years to age 65+, if you are still medically disabled. The minimum benefit you will receive is \$200 or 10% of your LTD benefit, whichever is greater. This Optional LTD coverage is fully contributory by the Harris County employees who elect this coverage.

Both the Basic LTD and Optional LTD insurance coverage are offered through contracts with Unum Life Insurance Company of America (UnumProvident). Premiums deducted for the Optional LTD will be on an after-tax basis, so any disability benefits you receive for the Optional LTD coverage will not be subject to taxation.

SOME THINGS YOU SHOULD KNOW ABOUT LTD INSURANCE:

[Why Buy Long Term Disability?](#)

Disability insurance provides income replacement if you should become disabled and cannot work. The National Safety Council's report on injuries in America indicates a disabling event occurs once every five (5) seconds. Most of us live from paycheck to paycheck and cannot afford to be without some income. This coverage can help provide income to pay for your financial obligations such as: a mortgage or rent, car loans, car insurance, food, utilities, medical and dental insurance, credit card payments and taxes. This benefit will help pay all the normal monthly expenses and bills that continue even when you cannot work and are not receiving a paycheck from Harris County.

[Important Things to Know About the Harris County Employees LTD Insurance Plan](#)

If you enroll in the Optional LTD Plan within the first 31 days after you are eligible to enroll, you just complete an enrollment form. If you wait and want to enroll after the first 31 days, you must complete and submit proof of good health or an evidence of insurability form to UnumProvident. UnumProvident will review and must approve your late application before any coverage is effective. Additional pre-existing conditions apply to current Harris County employees enrolling in the plan and new hires first choosing to enroll in the plan. This pre-existing limitation could possibly limit any disability benefit.

There are additional exclusions and limitation that apply to your LTD coverage. If you have any questions about the Harris County LTD Plan, please contact UnumProvident, your Harris County Benefits Coordinator, or the Harris County Office of Human Resources & Risk Management.

[Open Enrollment Action Required by You](#)

Decide if the Optional LTD insurance is something you wish to add to your benefit package.

Optional Long-Term Disability (LTD) Coverage

Both levels of coverage are offered through UnumProvident. Premiums deducted for Optional LTD will be on an after-tax basis, so that any benefits you receive attributable to your premium contribution will not be subject to taxation.

Why Buy Long-Term Disability Insurance?

Disability insurance provides income replacement when you experience a covered illness, injury or pregnancy. The coverage can help with financial obligations, such as mortgage or rent payments that continue even when you can't work – expenses that health insurance does not cover.

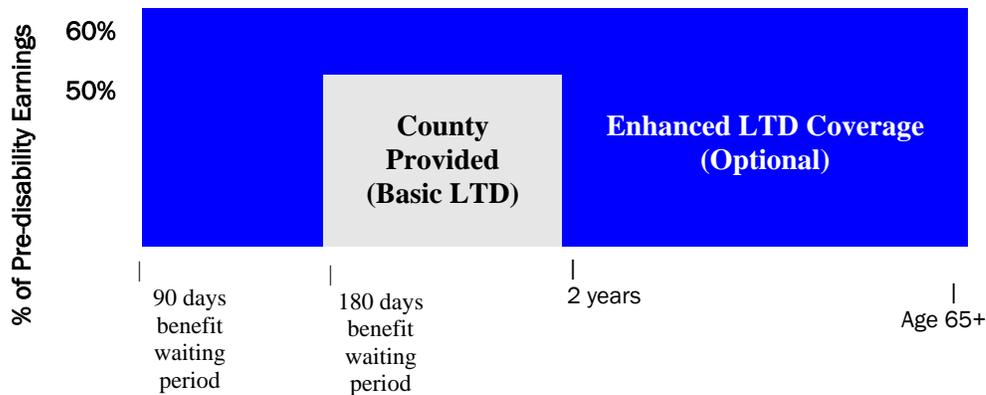
Note: Your LTD benefit may be reduced if you or your immediate family members receive or are eligible to receive deductible income as defined in the Group Policy. Examples of deductible income include sick pay, Social Security, Workers' Compensation and TCDRS benefits.

LONG-TERM DISABILITY

Long-Term Disability Comparison of Basic & Optional Plan

	BASIC LTD COVERAGE	OPTIONAL LTD COVERAGE
MONTHLY BENEFIT	Up to 50% of the first \$10,000 of your pre-disability earnings reduced by any deductible sources of income	Up to 60% of the first \$10,000 of your pre-disability earnings reduced by any deductible sources of income
MONTHLY MAXIMUM	\$5,000	\$6,000
MONTHLY MINIMUM	\$100	The greater of \$200 or 10% of your disability benefit, prior to any deductible sources of income.
BENEFIT WAITING PERIOD	180 days	90 days
MAXIMUM BENEFIT PERIOD	Two years	Determined by your age when disability begins as follows:

AGE	MAXIMUM BENEFIT PERIOD
61 or younger	To age 65, or 3 years, 6 months if longer
62	3 years, 6 months
63	3 years
64	2 years, 6 months
65 or older	2 years



OPTIONAL LONG-TERM DISABILITY IS \$.337/ \$100 OF PAYROLL

Simple Steps To A Healthier Life®

Simple Steps To A Healthier Life is an interactive online health and wellness program that can help you improve or maintain your health in ways that fit your lifestyle. The program takes you step-by-step to help you achieve your health goals. You will be able to identify some of your health needs, receive a tailored Health Report and a personalized Action Plan as well as participate in recommended Healthy Living Programs. For easy-to-find information on diseases, treatments, drugs, tests and medical terms log in to www.simplestepslife.com to help you make informed health decisions.

Health And
Wellness
Made Simple.

One Step
At A Time.



Employee Assistance Program (EAP)

Everyone needs a little help now and then. Life is full of challenges and surprises, ups and downs, highs and lows. It's natural to feel like there is just too much to handle. You're not alone. **Confidential assistance** is available 24 hours a day, 7 days a week at Magellan Health Services. This service is offered as part of your benefits package to you or any member of your household. There is no additional cost. Get information, resources, referrals and self-help tools on a wide range of issues, including:

Stress ~ Grief
Marital or relationship issues
Child and elder care

Family or parenting issues
Adjusting to change
Pre and postnatal concerns

Alcohol or drug dependencies
Self-improvement
Work/life balance

On-line you can learn about health and wellness issues, personal development and more at the member site. In addition, complete self-assessments, screenings and behavioral tests and get valuable feedback. You can also request EAP referrals, find childcare and/or elder care providers, and access various topics of interest.



Visit MagellanHealth.com or
call 1-800-588-8417
For TTY Users – (800) 456-4006

IMPORTANT NOTICE FOR EMPLOYEES

COBRA NOTIFICATION OBLIGATIONS

The federal *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)* provides group health insurance continuation rights to employees, spouses, and dependent children if they lose group health insurance due to certain qualifying events. Two qualifying events under COBRA require you, your spouse, or dependent children to follow certain notification rules.

You are **required** to notify Harris County of a Divorce or if a Dependent Child ceases to be a Dependent Child Under the Terms of the Group Health Insurance Plan.

Each covered employee, or spouse, or dependent child is responsible for notifying Harris County within 60 days after the date of the divorce or the date the dependent child ceased to be a dependent, as defined under the terms of the group health insurance plan.

Failure to properly notify Harris County within the required 60 days will forfeit all COBRA rights that may have arisen from these two qualifying events!

MEDICARE PART B

Medicare becomes the primary insurer when a retiree, or a dependent of a retiree turns 65 or becomes eligible due to disability. Harris County medical benefits then become secondary to Medicare.

Harris County Medical Plan coordinates its benefits with Medicare parts A & B. If a retiree or a dependent of a retiree is eligible for Medicare, Medicare is the primary insurance, it must pay benefits first then Harris County Medical Plan will pay benefits. Harris County Medical Plan will pay benefits as if Medicare part B paid first even if you are not enrolled in Medicare part B. **This will cause a gap in your coverage if you do not enroll in Medicare part B.**

Active employees and their covered dependents that are eligible for Medicare may postpone enrolling in Medicare until the employee retires. Each employee and/or their dependent should make this decision based on their individual situation. Medicare will pay secondary to the Harris County Medical Plan for covered services if you do choose to enroll while actively employed.

You should contact the Social Security Administration at 1-800-772-1213 if you have any questions concerning coordination of benefits between the Harris County Medical Plan and Medicare.



PLAN COST

Harris County pays a significant portion of the cost for your health care coverage. For example, if you select coverage for yourself only, you pay no monthly premium for the Base Medical Plan and \$52.42 for the Base Plus Plan.

TOTAL MONTHLY COST FOR MEDICAL, DENTAL & VISION PLANS EFFECTIVE MARCH 1, 2006

BASE PLAN MONTHLY COST

DENTAL INDEMNITY PLAN

	Employee Cost	County Cost	Total
Employee Only	\$0.00	\$416.40	\$ 416.40
Employee + One	\$189.99	\$606.37	\$796.36
Employee + Two or More	\$335.14	\$751.54	\$1,086.68

DHMO

	Employee Cost	County Cost	Total
Employee Only	\$0.00	\$403.84	\$403.84
Employee + One	\$184.03	\$587.84	\$771.87
Employee + Two or More	\$322.44	\$726.28	\$1,048.72

BASE PLUS PLAN MONTHLY COST

DENTAL INDEMNITY PLAN

	Employee Cost	County Cost	Total
Employee Only	\$52.42	\$497.03	\$549.45
Employee + One	\$303.30	\$747.89	\$1,051.19
Employee + Two or More	\$493.30	\$937.91	\$1,431.21

DHMO

	Employee Cost	County Cost	Total
Employee Only	\$ 52.42	\$484.47	\$536.89
Employee + One	\$ 297.34	\$729.36	\$1,026.70
Employee + Two or More	\$480.60	\$912.65	\$1,393.25

Plan Year:

March 1, 2006—February 28, 2007



**Harris County Office of
Human Resources & Risk Management
Benefits Division
1310 Prairie, Fourth Floor
Houston, Texas 77002**

**Phone: (713) 755-5117 or
Toll free: (866) 474-7475**

Fax: (713) 755-8659

E-mail: www.co.harris.tx.us/hrrm