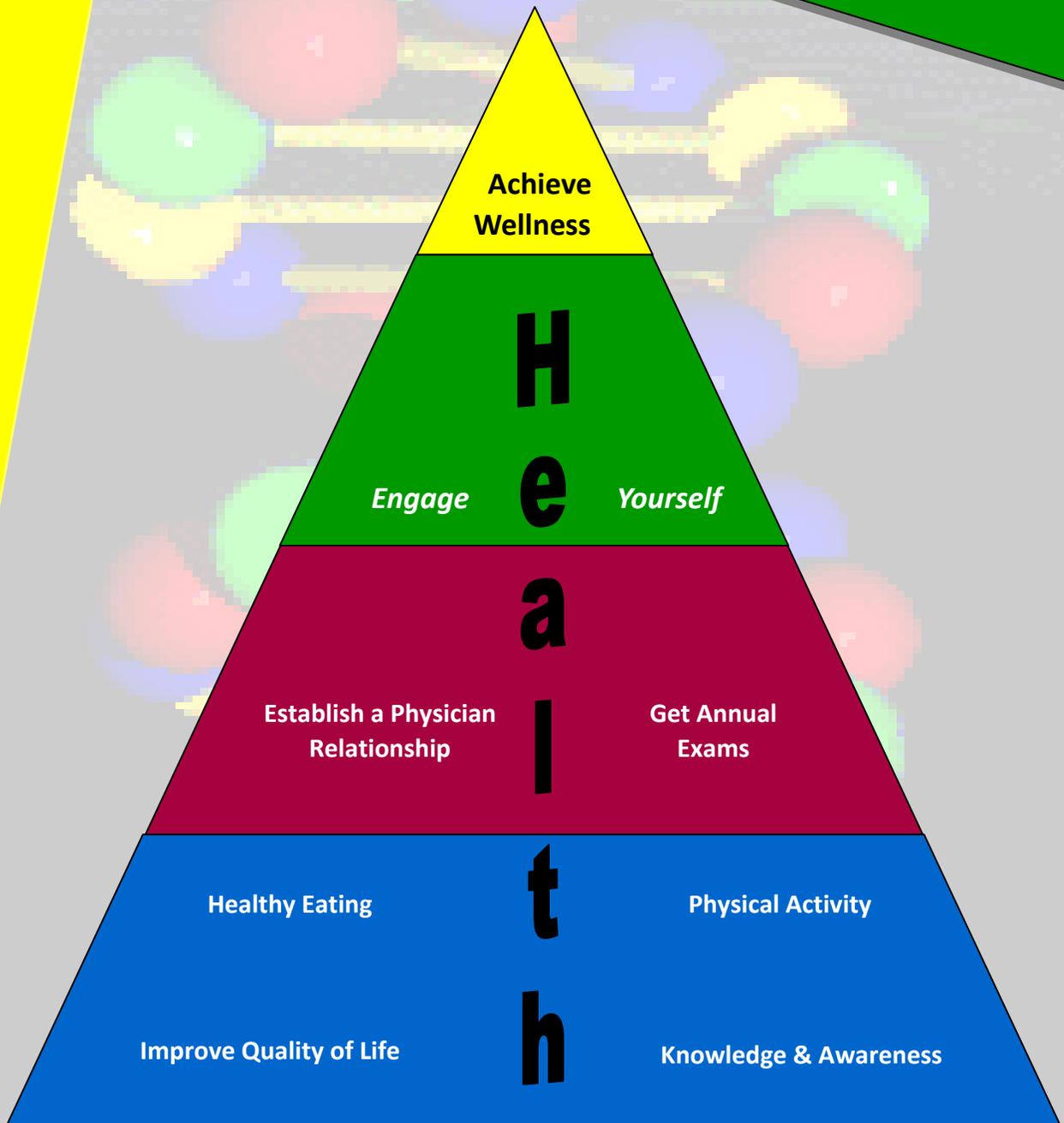


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**HARRIS COUNTY**

**2011- 2012  
RESOURCE GUIDE**



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 at <http://www.hctx/hrrm/> under the Plan Documents tab.

**NOTE: 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.**

This guide is provided for you to have access to necessary information regarding your benefits. We encourage you to read it and keep it as a convenient resource document for use throughout the year!

This Resource Guide is available online at <http://www.co.harris.tx.us/hrrm/> under the 2011 Benefit Resource Guide tab.

**HUMAN RESOURCES & RISK MANAGEMENT**

**WEB ADDRESS**

Employee Benefits.....	(713) 755-5117	<a href="http://www.hctx.net/hrrm">www.hctx.net/hrrm</a>
Toll Free (out of area only).....	(866) 474-7475	

**MEDICAL COVERAGE**

Aetna Member Services.....	(800) 279-2401	<a href="http://www.aetna.com">www.aetna.com</a>
Aetna Rx – Mail Order Delivery.....	(866) 612-3862	
On-site Representative.....	(713) 755-5604	

**FLEX SPENDING ACCOUNT (FSA) QUESTIONS**

Aetna.....	(888) 238-6226	<a href="http://www.aetna.com">www.aetna.com</a>
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**EMPLOYEE ASSISTANCE PROGRAM (EAP)**

Aetna EAP.....	(866) 849-8229	<a href="http://www.AetnaEAP.com">www.AetnaEAP.com</a>
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**DENTAL HEALTH MAINTENANCE ORGANIZATION (DHMO) & PPO**

UnitedHealthcare DHMO and PPO Plan.....	(866) 528-6072	<a href="http://www.yourdentalplan.com/harriscounty">www.yourdentalplan.com/harriscounty</a>
On-site Representative.....	(713) 755-4157	

**VISION COVERAGE**

Block Vision.....	(866) 265-0517	<a href="http://www.blockvision.com">www.blockvision.com</a>
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**LONG-TERM DISABILITY PLAN**

Cigna.....	(800) 362-4462	<a href="http://www.cigna.com">www.cigna.com</a>
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**LIFE INSURANCE**

Prudential Insurance Company.....	(800) 524-0542	
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**DEFERRED COMPENSATION / 457 PLANS**

VALIC Retirement.....	(800) 448-2542	
<a href="http://www.valic.com">www.valic.com</a> ING/Aetna Financial Services.....	(800) 525-4225	<a href="http://www.ingretirementplans.com">www.ingretirementplans.com</a>
Nationwide (PEBSCO).....	(877) 677-3678	<a href="http://www.nrsforu.com">www.nrsforu.com</a>

**RETIREMENT**

Texas County & District Retirement System (TCDRS).....	(800) 823-7782	<a href="http://www.tcdrs.org">www.tcdrs.org</a>
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**REMEMBER, we are here to help and encourage you to contact us should you need assistance. It's important to have the correct information to enable you to make educated decisions regarding your benefits.**

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Harris County determines benefits, eligibility and contributions for employees and their dependents subject to amendment and discontinuance at any time.

## OPEN ENROLLMENT OPTIONS

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 coverage that best suit their needs for the forthcoming plan year. **Choices made during open enrollment will remain in place until the following enrollment period.**

Open enrollment for the 2011/2012 plan year will be conducted from **January 1 through January 31, 2011**. Please contact your department's Benefit Coordinator for your department's deadline. Changes become effective **March 1, 2011**. **You should carefully consider the insurance plans available to you and your dependents.**

## REQUIRED DOCUMENTATION FOR DEPENDENTS

No benefit election changes may be made after open enrollment; however, you may still be able to add or drop dependents to your HCFlex plan following a qualified change in family status provided the request is on account of, and consistent with, the qualified change in family status. Open enrollment forms, as well as insurance enrollment forms for new employees that enroll dependents, must be accompanied by the appropriate documentation for 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 child. Coverage is available up to age 26.

**Stepchildren:** A birth certificate or other court document listing the employee's spouse as parent of the child as well as the marriage license of employee and parent. Coverage is available up to age 26.

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

**Adopted Children:** Documents from the adoption agency, court or State identifying date of possession/placement.

**Foster Children:** Documents from the State of Texas indicating date of possession/placement by the State.

## MEDICAL/DENTAL/VISION

All employees are automatically enrolled in the Base medical, DHMO dental and vision plans. Medical and dental plans each offer two options. Select your plan then choose whether to enroll your eligible dependents. Reference pages 15-18 for medical plan details and pages 19 & 20 for dental. Everyone in your family must choose the same plan.

## LIFE & AD&D/LONG-TERM DISABILITY (LTD)

All full time employees are automatically enrolled for basic Life and LTD coverage.

Employees may purchase optional Life up to 2X your annual salary subject to medical underwriting and may also purchase optional LTD coverage. Reference pages 23-25 for plan details.

## QUALIFIED STATUS CHANGE

Employees may experience life changes during the benefit year. "Qualifying Events" include:

- ◆ Birth of your child
- ◆ Adoption or placement of a foster child
- ◆ Marriage, divorce or death
- ◆ Spouse gains or loses coverage through employment
- ◆ Significant change in the financial terms of health benefits provided through a spouse's employer or another carrier
- ◆ Unpaid leave of absence taken by employee or spouse
- ◆ Changing a dependent care provider or having a significant increase or decrease in provider payment
- ◆ Gain or loss of eligibility for Medicare or Medicaid
- ◆ Loss of State Children's Health Insurance Program (SCHIP), but not gain of SCHIP

**Failure to drop dependents when required will result in the employee reimbursing the County for claims activity.**

Employees who fail to return their completed form will be defaulted to their benefit selections made for the 2010-2011 plan year.



### 2011-2012 CHANGES

**NEW** Vendors for dental, vision and LTD. See details on pages 19-22 and 24-25.

**Eligibility:**

Coverage of adult children to age 26 if they are not offered employer-based medical coverage.

**FSA:**

- Health FSA: Requirement for a doctor's prescription to purchase certain over-the counter (OTC) medicines. Other non-medicine related OTC items are still covered without a prescription.
- Dependent Care FSA: Changing a provider or having a significant increase or decrease in provider payment allow a modification to the amount designated toward your FSA and is considered a qualified status change.

**Medical plan modifications:**

**Bariatric surgery in-network benefit only**

- Bariatric surgery is a covered benefit in-network only and members are required to utilize the Aetna Bariatric Institute of Quality (IOQ) physician and facility network . This procedure is only a covered benefit when utilizing this Bariatric IOQ network—no benefits are available out-of-network. For a complete listing of approved providers go to [www.aetna.com](http://www.aetna.com) and search "Doc Find".

**Pharmacy:**

- Pharmacy claim update on page 13.
- Smoking cessation prescription drugs are now covered for up to 180 days.

**Other:**

A smoking cessation program is now available. For more information contact 713.755.5117.

## CHOOSING A PLAN



Making the right plan choice can be a difficult decision. This decision should be based on several things such as your personal medical condition and usage of services, financial situation, and your level of comfort with coinsurance vs. copayments. The following definitions may assist you in the decision-making process. Co-payments do not apply to coinsurance, out-of-pocket maximums or annual deductible.

**Co-payment:** the predetermined dollar amount you will pay for a service (Examples: physician office visits, urgent care, emergency room, physical therapy, counseling).

**Coinsurance:** percentage employee is responsible for paying up to a specific dollar amount per calendar year (Covered services paid from 50-100% depending on the plan selected and service rendered).

**Deductible:** initial out-of-pocket costs that must be paid before the plan begins to pay benefits (Base Plan In-Network \$250; Plus Plan In-Network \$0).

The **Base** plan has set copayments for some services, but requires coinsurance for inpatient hospitalization, physician hospital services and outpatient surgery. The Base plan also has a \$250 per individual deductible with an individual maximum out-of-pocket coinsurance limit of \$1,750 per calendar year. The deductible and coinsurance only apply where services are not indicated as set copayments.

The **Plus** plan has set copayments for almost all in-network services; however, this plan has a higher monthly premium contribution.

Your Aetna Choice POS II Plans do not require you to select a network primary care physician (PCP), although selecting a PCP is encouraged. These plans also allow you to self-refer to a specialist. Your choice of provider dictates the amount you will pay in copayments, coinsurance and/or deductibles.

*It's the law...*

## CHILD SUPPORT ORDERS

Upon receipt of a Medical Child Support Order from the **Texas Attorney General or presiding court**, or upon receipt of any similar such legal mandate by a court or agency having jurisdiction over the County, the County must comply with any such directive, subject to the terms of our plans. Such directives may not be overturned except through revised documentation received from the applicable agency overturning any prior directives.



## HEALTH CARE REFORM AND HOW IT AFFECTS YOU



### FUTURE RETIREE BENEFITS

Employees eligible to retire by February 28, 2011 would be “grandfathered” under the current contribution rule they are entitled to as of that date. All other employees eligible to retire March 1, 2011 or after will have to attain a combination of age plus a minimum of 10 years non-forfeited Harris County/TCDRS service equal to 80 or be at least 65 (or Medicare eligible) with a minimum of 10 years of non-forfeited Harris County/TCDRS service to receive 100%\* of the county contribution for “retiree only” coverage and 50% for dependent coverage. Non-grandfathered retirees under age 65 will be required to pay a contribution for retiree healthcare as determined by Commissioners Court each plan year. Employees hired after February 28, 2007 would have to attain a combination of age plus a minimum of 20 years non-forfeited Harris County/TCDRS service equal to 80 or be at least age 65 (or Medicare eligible), with at least 15 years of non-forfeited Harris County/TCDRS service to receive any contribution for retiree healthcare.

*\*as determined by Commissioners Court*

**On March 23, 2010, the Patient Protection & Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA) was signed into law. The following benefit modifications are implemented to comply with the Act.**

- ◆ If you participate in the **Flexible Spending Account (FSA) - Health care account**, effective January 1, 2011, certain over the counter medicines without a prescription may no longer be reimbursed from your FSA. For a complete list of eligible reimbursements reference page 9.
- ◆ **Employees now may provide coverage for their dependents up to the age of 26.** Individuals whose coverage ended, or who were denied coverage, (or were not eligible for coverage) because the availability of dependent coverage of children ended before the attainment of age 26 are now eligible to enroll in Harris County’s benefit plans. Enrollment will be effective beginning March 1, 2011 or thereafter depending on when coverage is lost. If this dependent has another offer of employer-based coverage aside from coverage through the parent, you may not add the dependent at this time. An affidavit (declaration of eligibility) signed by the employee and this dependent will be required.
- ◆ Aetna generally allows, but does not require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you and/or your family members. For children, you may select a pediatrician as the primary care provider.

Harris County believes the medical plan coverage on the Base and Base Plus plans qualify as “**grandfathered health plans**” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that our plans may not include certain consumer protections in the Affordable Care Act, for example no lifetime limits on in-network benefits.

- ◆ 100% coverage for preventative care. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 713.755.5117.

### NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM (ERRP)

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

**ERRP INFORMATION CONTINUED...**

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

**OUT OF NETWORK SERVICE COSTS**

Harris County has a **Limited Out-of-Network benefit payment schedule**. When you need medical care, your Aetna health benefits plan gives you and your participating physician a choice. Advise your participating physician that it is important to you that the highest level of benefit coverage is desired by ensuring that they refer you to only in network facilities and providers with Aetna.

There are limits on authorized costs associated with Out-of-Network facilities/providers. To help curb excessive out-of-network facility/provider costs, the County has established a Limited Out-of-Network fee schedule that limits the Plan's exposure to the unreasonable cost for non-emergency services and procedures. If you use an out-of-network facility or provider, you will be responsible for paying the difference between the covered amount (which is based on established rates for our geographic area) and the amount the facility charges. If you incur non-covered expenses, they will not apply to your coinsurance maximum.

When you use a Network provider, you are protected from charges that are greater than the "allowed" amount. However, when you use an out-of-network provider, you may have to pay for any of the charges that are greater than the "allowed" amount in addition to your coinsurance and deductible.

All out-of-network provider and facility types will be included in the Limited Out-of Network benefit reimbursement. Examples include, but are not limited to: hospitals, ambulatory surgery centers, physicians, pathology laboratories, radiology centers, psychologists, master social workers, physical therapists, certified nurse anesthetists, outpatient dialysis, radiology, laboratory, sleep lab, MRI/CT etc.

**For example, if you are enrolled in the Base Plan, assume you have surgery and have already met your deductible or paid any co-payment required:**

	<u>Network Hospital</u>	<u>Out-of-Network Hospital</u>
Charges	\$8,000	\$8,000
Allowed	\$4,200*	\$4,500**
Plan Pays	80% or \$3,360	60% or \$2,700
You Pay	20% or \$840	40% or \$1,800
Hospital Write Off	\$3,800	\$0
Not Covered	\$0	\$3,500***
Your net cost	\$840	\$5,300



\* Example of a contracted rate of \$1,400/day  
 \*\* Out-of-Network payment example \$1,500/day  
 \*\*\* This is part of your total obligation but will not apply to your maximum coinsurance limit.

**NOTE: It is YOUR responsibility to make sure your physician, facility or hospital is in-network or you will pay out-of-network costs. You can help keep costs down by using in-network providers.**



## What is Aexcel®?

Aexcel is a designation for specialists in Aetna’s performance network that have met certain standards for clinical performance and efficiency. These standards include managing Aetna patient volume, adhering to clinical guidelines, external recognition and board certification information specific to the physicians’ Aexcel specialty and demonstrating overall effectiveness in the delivery of care.

Aexcel specialists are available in the following categories of care:

- |                        |                       |
|------------------------|-----------------------|
| Cardiology             | Obstetrics/Gynecology |
| Cardiothoracic Surgery | Orthopedic Surgery    |
| Gastroenterology       | Otolaryngology (ENT)  |
| Neurology              | Urology               |
| Neurosurgery           | Vascular Surgery      |
| General Surgery        | Plastic Surgery       |

Using Aexcel-designated providers will save you money on co-payments. To find an Aexcel specialist login to [www.aetna.com](http://www.aetna.com) and select “Find Healthcare in DocFind”. Aexcel specialists are indicated with a blue star.

Since Aexcel only applies to twelve specialties, if you are enrolled in the BASE PLAN and you see a specialist that is not in one of the categories you will pay the lower specialist office visit copay. In the PLUS PLAN, only the providers in the twelve specialties that are Aexcel designated are subject to the lower copay.

## Aetna Health Connections<sup>SM</sup> Disease Management

This program is designed to help you or your eligible family member(s) learn more about your condition and work closely with your doctor to improve your health and quality of life. Educational information is provided and for high risk members, access to a registered nurse “Health Coach” is offered. The adjacent list includes a few of the 35 conditions managed by this program. To learn more about Disease Management, login to [www.aetna.com](http://www.aetna.com).

If you receive a call or letter from Aetna please return their call or contact them as requested. **All information is confidential with Aetna and is not shared with Harris County.**

**No computer...no problem! Just call (713) 755-5604 to learn about any Aetna health programs.**

- Asthma
- Back pain
- Cancer
- Cerebrovascular Disease
- Chronic Heart Failure
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Cystic Fibrosis
- Depression
- Diabetes
- Digestive
- HIV
- Hepatitis
- Hypertension
- Inflammatory Bowel Disease
- Kidney Failure
- Peripheral Artery Disease
- Rheumatoid Arthritis
- Sickle Cell Anemia
- Weight Management

## Beginning Right<sup>SM</sup> Maternity Program

Having a baby? Or planning to? Beginning Right<sup>SM</sup> is our maternity program provided by Aetna for you and your covered dependents. Use it throughout your pregnancy and after your baby is born.

### Learn what’s best for a healthy pregnancy

- Receive materials on prenatal care, labor and delivery, newborn care, and more.
- Get information for Dad or partner.
- Take the pregnancy risk survey and find out if you have any issues or risk factors that could affect your pregnancy. Also, you’ll receive a small gift if you take the survey by your 16th week of pregnancy.

### Get special attention when you need it most

If you have issues or risk factors that need special attention, Aetna nurses can give you personal case management to find ways to lower your risks.



**If you or a covered member of your family is pregnant contact Aetna to precertify the pregnancy at  
1-800-CRADLE-1  
(1-800-272-3531)**

### Simple Steps To A Healthier Life® Program

When you feel good, it's easier to enjoy the people and things you love most. 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.

- You start by taking an online Health Assessment that will help identify some of your health needs. Questions focus on health habits and family health history and all answers are kept secure and confidential. You will need your current lab and biometric results to input into the assessment (Blood pressure, BM, cardiac CRP, total cholesterol, LDL and HDL cholesterol, triglycerides, and fasting glucose, and even if you don't have all of these results you can still complete your health assessment and fill these results in at a later date).
- Once your health needs are identified, you'll receive easy-to-understand Health Reports and a personal invite to join the program most likely to help meet your needs and an Action Plan that's just for you, suggesting a combination of Healthy Living Programs.
  - ⇒ *Balance (weight management & physical activity), Nourish (nutrition and diet), Relax (stress management), Breathe (smoking cessation), Overcoming Insomnia (sleep deprivation), Overcoming Depression (depression management).*
- Choose the programs, tools and information that are right for you. Each program includes interactive tools to help you reach your health goals in a fun and interesting way. You can use an online Fitness Planner, a Healthy Shopping List and more.

Take the first step to healthier living. Visit [www.simplestepslife.com](http://www.simplestepslife.com). **Be sure to complete or update your health assessment at [www.aetna.com](http://www.aetna.com)!** ALL information is confidential!



#### STEP 1

Assess your health by completing the health assessment at [www.aetna.com](http://www.aetna.com)

#### STEP 2

Take action using a personalized Healthy Living Program.

#### STEP 3

Learn to make informed health decisions.

### Join the Harris County wellness community and start the journey to a healthier, happier you.

**Get active** with walking and wellness challenges and community events.

**Stay well** with programs that help you manage diabetes, have a healthier pregnancy, quit smoking and more.

**Know your health risks** by getting a yearly no-cost health screening or free onsite mammogram and taking an online health assessment.

**Be informed** on healthy eating, fitness, pregnancy and other important topics. While you're there, get your monthly health tip and check the Wellness Calendar.

**Celebrate success!** Celebrate with others. Read success stories to get inspired.

**Be a part of the Harris County wellness community.**

Visit [www.wellathctx](http://www.wellathctx)

For the Active and Retiree site, simply enter the password: **WELL4HCTX**



#### TIP...

Aetna Informed Health Line nurses can discuss more than 5,000 health and wellness topics. Call them at (800) 556-1555 anytime you have a health question.

**DO YOU KNOW THAT ROUTINE COLONOSCOPY** is covered at 100% when using an in-network provider? If additional diagnostic procedures are needed you will be responsible for applicable copayment, coinsurance and/or deductible.

**Using Aetna Navigator® has never been easier!**

County employees using a County computer can log on to the employee information page for the Aetna Navigator Tutorial.

1. Type [www.hcintranet.net](http://www.hcintranet.net)
2. Select "Employee Information"
3. Select "Helpful Employee Links"
4. Select the "Aetna Navigator Tutorial" and become the expert!

Interested in obtaining a complete listing of Aetna participating providers? Log on to [www.aetna.com](http://www.aetna.com) and select "Find Health Care in DocFind®", then select your provider category. You can search by city, state, zip, specialty, hospital affiliation, provider name, gender, language and education.



**Make History<sup>SM</sup> - Personal Health Record**

You can make history by putting the Aetna® Personal Health Record to work for you. This secure, private, online resource makes it easy for you to view, access and manage your health information—and share it with your doctors.

- Keep your health information in one place—it's always available for you to access in an emergency.
- Share your history with your doctor.
- **Maintain or even improve your health.** Based on your health profile provided by insurance claims and information you enter yourself, the Personal Health Record generates personalized health-related alerts and reminders that can help you address your health needs in a timely manner.
- With your user name and password, you control who sees your information. You may add information to the record at any time.
- It's easy to get started! Just create a user name and password on the secure Aetna Navigator member website at [www.aetna.com](http://www.aetna.com).

**Aetna IntelliHealth®**



Aetna IntelliHealth® is an exclusive resource that can be accessed online to find up-to-date health information and resources including:

To access, login to [www.aetna.com](http://www.aetna.com)

- Information on diseases & conditions
- Articles on lifestyle improvement
- Gender and age specific health issues
- Medication information
- Health assessments
- Quizzes
- Medical dictionary
- Health calculators (BMI, etc.)
- Current health research news
- "How-to" slide shows
- Email health updates

**Informed Health® Line**

Aetna's Informed Health® Line gives you easy access to credible health information. All Informed Health Line services are available 24 hours a day, 365 days a year on demand from your touch-tone phone.

If you prefer to view health information online, simply login to [www.aetna.com](http://www.aetna.com) and click on the link for the *Healthwise® Knowledgebase*.

<b>24-Hour Nurse Line</b>	Speak with a registered nurse who has experience in a variety of health topics at any time of the day*.
<b>Audio Health Library</b>	Phone in to choose from thousands of common health topics to listen to. Easily transfer to the Nurse Line for questions.
<b>Healthwise® Knowledgebase</b>	Search for detailed information about health conditions, medical tests and procedures, medications and treatment options.

*\*Informed Health Line Nurses cannot diagnose, prescribe or give any medical advice. Contact your physician with any questions or concerns regarding your health care needs.*

**To reach the 24-Hour Nurse Line or Audio Health Library call 1-800-556-1555.**

**Aetna Compassionate Care<sup>SM</sup>**

A comprehensive program to provide expanded benefits, nurse support and information to employees and their families who are facing end-of-life and palliative care issues. Case management and bereavement services are covered up to 12 months.

Palliative care aims to relieve physical symptoms of disease and provides emotional and spiritual support to patients and family members while respite care provides short-term services to seriously ill individuals and relieves primary care givers of some of the burden.

For more information visit :  
[www.aetnacompassionatecareprogram.com](http://www.aetnacompassionatecareprogram.com)



**Newly arrived for 2011!**

**EosHealth**

With the touch of a button send your blood glucose/steps securely from your Global wireless glucometer/health coach to your personal health record and/or doctor.

- 24/7 On Call Nurse support where and when you need it.
- Full access to your personalized program from your cell or our website.

To learn more about any aspect of this new program go to [www.EosHealth.com/partners/HarrisCounty](http://www.EosHealth.com/partners/HarrisCounty) or simply call 1-800-945-4355.



DiabetesAmerica is your “one-stop-shop” for diabetes care. It provides comprehensive diabetes care, management and education services at a single location. **Diabetes America services include:**

- Physician care
- Certified diabetes education
- Certified diabetes nutritional counseling
- Exercise and lifestyle counseling and support
- Case management and monitoring
- Telephonic support/website access
- Eye, foot and cardiovascular screenings
- On-site labs
- Free glucose monitor



**Harris County Benefits**

**No office visit co-pays  
 Annual retinal exam**

For locations, information and appointments, call 1-888-877-8427 or visit [www.diabetesamerica.com](http://www.diabetesamerica.com).

**Employee Assistance Program**

**Confidential assistance** is available 24 hours a day, 7 days week when using the Aetna EAP program. This is a service provided as part of your benefits to you or any member of your household at no additional cost. You can turn to the EAP for help with anything that interferes with your job or personal life. Among other things, your EAP can help you with:

- |                        |                               |
|------------------------|-------------------------------|
| Stress management      | Family or parenting issues    |
| Substance abuse/misuse | Work/life balance             |
| Burnout                | Marital/relationship problems |
| Child and elder care   | Anxiety                       |
| Depression             | Anger management              |
| Legal concerns         | Financial issues              |
| Coping with change     | Self-esteem                   |

(ALL INFORMATION IS CONFIDENTIAL BETWEEN AETNA EAP AND YOU.)

Visit [www.AetnaEAP.com](http://www.AetnaEAP.com)

(Company ID: EAP4HCTX) or call

**1-866-849-8229**

**Benefits of the EAP:**

- ⇒ **5 counseling sessions per issue, per year**
- ⇒ **Free initial legal consultation**
- ⇒ **Discounts on continuing legal consultation services**
- ⇒ **Free initial financial consultation**

## HOW does the Health Care FSA work?

A Flexible Spending Account (FSA) and Qualified Transportation Account (QTA) are special **non-taxed** accounts designed to save you money on health care, dependent care, and transportation expenses. You elect an annual amount to contribute to your accounts, and these funds are transferred automatically from your paycheck into your FSA or QTA before taxes are calculated. Because this money is deducted pre-tax, you automatically save an average of 20-35% depending on your tax bracket.

You can contribute from \$25 to \$300 per month (**\$3,600 per year**) in your Health Care FSA for the **March 1, 2011 to February 29, 2012** plan year dollars to pay for out-of-pocket health, dental, and vision expenses for you, your spouse, and your dependents. You then use the **tax-free** dollars you set aside to pay for eligible expenses incurred from 3/1/11–5/15/12.

When you pay physician copayments on the Aetna plan, Aetna reimburses your copayment after the claim is processed. When you have a prescription filled at a local pharmacy or through AetnaRx Home Delivery, your copayment is automatically deducted from your Health Care FSA and paid directly to the provider if you have the full amount of funds available. If you prefer, you may elect to file all claims manually by contacting Aetna directly. You can choose to receive a check or make arrangements for direct deposit.

**Estimating your deduction...**when you enroll, it is important to carefully estimate your eligible expenses for the upcoming year. Review how much you spent for physician, prescription, dental, hospital, etc. copayments over the past year. If you haven't kept good records, you can go to [www.aetna.com](http://www.aetna.com), then proceed to Aetna Navigator® and review your claims history to provide you the necessary information. This will help you estimate how much should be deducted from each paycheck. Remember, even if you don't cover your dependents on your insurance, you may still file their claims on your Health Care FSA as long as you claim them on your federal income tax return as dependents.

The Health Care FSA is for eligible non-reimbursed expenses and is NOT to be used for monthly premium reimbursement.



To get more information on expenses eligible for your pre-tax dollars, go to [www.aetnafsa.com](http://www.aetnafsa.com).

## CHANGES DUE TO HEALTH CARE REFORM

As a result of Health Care Reform effective January 1, 2011 you will need a doctor's prescription when you use your health flexible spending account (FSA) to pay for certain over-the-counter (OTC) medications. This change only affects the drug categories listed below:

Acid controller	Anti-gas	Laxatives
Allergy & sinus	Baby rash ointments/creams	Motion sickness
Antibiotic products	Cold sore remedies	Pain relief
Antidiarrheals	Cough, cold & flu	Respiratory treatments
Anti-gas	Digestive aids	Sleep aids & sedatives
Anti-itch & insect bite	Feminine antifungal/anti-itch	Stomach remedies
Antiparasitic treatments	Hemorrhoidal preparations	

You do not need a prescription for other eligible OTC items since this change only affects the categories listed above. You can still buy other products with your FSA dollars without a prescription. An example is contact lens solution or bandages.

## TIPS... FOR ESTIMATING YOUR MONTHLY DEDUCTION

Hospital and medical deductibles and coinsurance — Including medical office visits, high-tech radiology, chiropractic, physical therapy, other medical services

Drug expenses — Including prescription drug copayments and PRESCRIBED over-the-counter drugs (go to [www.aetnafsa.com](http://www.aetnafsa.com) for a complete list of approved OTC

Dental care — Including fillings, extractions, root canal, crowns, bridges, dentures, orthodontia

Behavioral health care expenses — Including therapy copayments, medication management copayments

Vision care expenses — Including prescription eyeglass frames, prescription sunglasses, corrective vision surgery, contact lens solution or cleaner

⇒ When filing a health care and/or dependent care claim form, you need to use control # 0620329.

⇒ Questions? Call Aetna FSA customer service at (888) 238-6226

**Things to remember about the Health Care FSA**

**What if I don't want my claims automatically reimbursed for physician and prescription copayments?**  
 If you do not wish to have automatic reimbursement and wish to accumulate your claims for one submission, you may submit the "Streamline Option Cancellation Form" available at [www.aetna.com](http://www.aetna.com) to turn off the automatic reimbursement function in your personal Aetna FSA account and submit claims at your convenience (or opt out via the Navigator).

**Can I save time by having my claim reimbursements direct deposited into my bank account?**  
 Absolutely. You may enroll by going to [www.aetna.com](http://www.aetna.com) and complete the direct deposit form.

**What if I terminate my employment or retire?**  
 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! All claims incurred while actively at work must be filed by August 15, 2012.

**Will there be a debit card issued?**  
**NO.** Physician and prescription claims will be automatically filed on the Health Care FSA if you have an available balance. You will have to manually file claims for over-the-counter (OTC) medications, non-medical expenses such as dental and vision claims.

**Take a Big Bite Out of Your Taxes! (Pre-Tax)**

Section 125 of the Internal Revenue Code allows you to pay for your portion of the cost of certain employee benefits before federal income and social security taxes are withheld from your pay. That means you will pay less in taxes and have more spendable income; however, there are certain limitations. Generally, after you make your health insurance coverage decisions, you may not change your mind in the middle of the year unless there is a qualifying change in your family circumstances.

Your FSA may help you save on medical expenses. And, since you're paying out-of-pocket expenses with money that hasn't been subject to federal or Social Security taxes, you'll cut your annual tax bill and have more disposable income! For example: Here's a rough estimate of how a typical non-married tax filer with an annual income of \$35,000 can increase his/her take-home pay by \$513!  
**Keep in mind, each individual situation will vary.**

-  Estimate your annual out-of-pocket health care and/or dependent care expenses. See "TIPS" on [Page 9](#) for guidance.
-  Based on this amount, decide how much to contribute for the plan year (March 1, 2011 – February 29, 2012) 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 monthly elections and return to your department Benefit Coordinator by the deadline.



**DEDUCTION MINIMUMS & MAXIMUMS PER MONTH**

ACCOUNT	MIN	MAX
Health Care	\$ 25	\$300
Dependent Care	\$ 25	\$416
Mass Transit	\$ 25	\$230
Parking	\$ 25	\$230

**Example:**

	WITH FSA	WITHOUT FSA
Annual income:	\$35,000	\$35,000
Estimated health care pre-tax contributions:	\$2,000	\$0
Form W-2 wages:	\$33,000	\$35,000
Estimated Federal income tax:	\$2,587	\$2,947
Estimated FICA:	\$2,525	2,678
Health care expenses:	\$0	\$2,000
Net after-tax income	\$27,888	\$27,375
<b>Your savings with the FSA</b>	<b>\$513</b>	

## How does the dependent care FSA work?

The Dependent Care (DC) FSA lets you use tax-free dollars to pay for the care of your child (under age 13, or physically/mentally handicapped older dependents) and elder dependents. Eligible expenses:

- ⇒ Day care
- ⇒ Before and after school care
- ⇒ Pre-school tuition
- ⇒ Babysitting
- ⇒ Day camp



For a list of covered DC expenses go to [www.aetnafsa.com](http://www.aetnafsa.com).

## REMEMBER: This is not a pre-funded account!

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. Each time you pay your day care (or other approved provider) you can file a claim for reimbursement of funds available. 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.

When estimating consider things such as vacation and holidays when you child will not be in school or day care.

Dependent Care Benefits are manual claims submission either via mail or fax to Aetna FSA department.

DEPENDENT CARE

*DEDUCTIONS PER MONTH:*  
Minimum—\$25; Maximum—\$416

*DEDUCTIONS PER YEAR:*  
Minimum—\$300; Maximum—\$4,992

## Don't over-estimate!



IRS regulations state that any money left in the FSA at the end of the plan year plus a 2-1/2 month grace period 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. If you find yourself toward the end of the benefit year with dollars left in your account, you can always go to your local pharmacy and purchase needed over-the-counter medications and/or first aid supplies. REMEMBER, some OTC medications may need a doctor's prescription!

## How does the qualified transportation account work?

Your **Qualified Transportation Benefits: Mass Transit and Parking QTA** allows you to use tax-free dollars on the regular travel expenses you might incur traveling to and from work. These types of expenses include Mass Transit Expenses and Parking Expenses. You can contribute up to **\$230 for mass transit expenses** and **\$230 for parking expenses** per month. These are two separate accounts so the contributions cannot be commingled. Unlike your other FSAs, your Transportation funds will roll-over from year to year as long as you continue your participation in the Qualified Transportation Account (QTA). **You cannot submit claims for expenses incurred after your participation ends.**

Qualified Transportation Benefits are manual claims submission either via mail or fax to Aetna FSA department at:

PO Box 4000, Richmond, KY 40476; fax 1-888-238-3539

To enroll in the QTA update your employee voluntary deduction page to complete online or return the County Auditor's Form 777 to your Payroll Representative

Qualified transportation reimbursements must be claimed within a twelve (12) month period.

When filing a mass transit and/or parking claim form, you need to use control # 0620330.

**MEDICATION—THE IMPORTANCE OF USING IT CORRECTLY...**

If you do not take your medicines as prescribed, your medicines will not work the way they should. Your condition could get worse. You might feel worse instead of better. Talk to your doctor about problems you are having taking your medicines. Use these tips to help you get and stay on track.

**UNDERSTAND WHY YOU ARE TAKING A DRUG.** For example, say you go to the doctor with a painful ear infection. The doctor prescribes an antibiotic. You take it for a few days and feel better. So, you stop taking the antibiotic. Bad idea. You need to take all the antibiotic your doctor gave you. When you stop taking it too soon, you give the infection a chance to "come back to life." Only now the infection may be stronger, and you'll need a new antibiotic. Now you paid for one or two doctor visits and two prescription drugs. (And the pain in your ear came back.) Not taking your medicine can be dangerous

and costly.

- Understand why and when you should take your medicines.
- Take your medicines at the same time each day. Make it part of your daily routine.
- **Set a watch or cell phone alarm to remind you when to take your medicines.**

*Prevent forgetting to take your meds*



- Keep your medicines in a place where you will see them. For example, next to or inside your favorite tea or coffee mug.
- Use pill boxes marked with the days of the week. This will help you remember when you have taken

them last and will help to make sure you are not missing doses or taking too many doses.

- Remember to refill your prescription. Make a note on your calendar. Order and pick up the next refill before you are finished with your current supply.
- Get your medicines by mail order if you take a maintenance medication.
- Tell your doctor if cost is a concern. There may be other medicines that cost less and work the same.
- Tell your doctor if you think your medicines are making you feel bad. You may be having side effects your doctor should know about. There may be other medicines you can try that do the same thing but do not make you feel bad.
- Tell your doctor if you have trouble taking medicines several times a day. Your doctor may be able to order medicines you have to take less often.

<b>Harris County Prescription Drug Benefits</b>		
	<b>Percentage You Pay</b>	<b>Minimum/Maximum Copay</b>
<b>Retail (30 day supply)</b>	<b>25% Generic 25% Brand</b>	<b>\$5 min/\$20 max \$20 min/\$75 max</b>
<b>Specialty Drugs/Self-Injectables - through Aetna Specialty Pharmacy (30 day supply, only)</b>	<b>25% Generic 25% Brand</b>	<b>\$25 min/\$100 max \$25 min/\$100 max</b>
<b>Mail Order - 31-90 day supply (not available for specialty drugs /self-injectables)</b>	<b>25% Generic 25% Brand</b>	<b>\$10 min/\$40 max \$40 min/\$150 max</b>

**Mandatory Generic Plan continues...**

Prescriptions written for a brand medication will be dispensed as a generic, if available (or becomes available while the Rx is active). 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 generic is available, the member will receive the generic medication.

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.

**TAKING A TRIP?** 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 return date to the representative. Medication can be picked up as early as 3 days prior to your vacation departure date.

**Diabetic supplies are provided at no co-payment at retail and mail order pharmacies and through Aetna's durable medical equipment providers listed on page 13.**

**PRESCRIPTION FACTS**

- ◆ Drug pricing information should be obtained from the Aetna Customer Service number listed on your Aetna ID Card. Aetna Rx Home Delivery (ARxHD) does not have pricing and/or benefit information - check **Price-A-Drug** at [www.aetna.com](http://www.aetna.com).
- ◆ 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.
- ◆ 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 24-48 hours. 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.
- ◆ Some 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**.

**REMINDERS:**

- ◆ **Specialty medications/self-injectable drugs (30 day supply) are available only through the Aetna Specialty Pharmacy OR an Aetna designated and approved provider after the third refill at a retail pharmacy.**
- ◆ **PRICE-A-DRUG® - Use this online feature to obtain information about drug costs and less expensive bioequivalent or therapeutic alternatives.**
- ◆ **Employees without Internet access may contact Aetna member services at 1-800-279-2401 for pricing information to determine whether local or mail order pharmacy is the most cost efficient method for filling your prescription.**
- ◆ **Are you filing prescription drug paper claims? Talk to your pharmacist about calling Aetna Pharmacy Management for assistance in submitting your claim electronically, especially if you have two insurance carriers.**



Smart consumers go online to [www.aetna.com](http://www.aetna.com) and use Price-A-Drug to check prescription drug pricing and therapeutic alternatives before filling a prescription.

**DURABLE MEDICAL EQUIPMENT**

The accessories needed to operate your **Durable Medical Equipment (DME)** are covered under your DME benefit at 90% after deductible for Base Plan members and at 100% for Plus Plan members when using in-network providers. You can order your diabetic supplies at no cost 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.

<b>Vision Screening</b>	Periodically
<b>Hepatitis B (HepB)</b>	3-4 doses—1 dose at birth; 1 dose 1-2 months later; 1 dose at 4 months of age; and 1 dose between 16-18 months
<b>Hepatitis A (HepA)</b>	2 doses—1 dose between 12 and 23 months of age; and 1 dose at least 6 months later
<b>Rotavirus</b>	2-3 doses—1 dose each at 2, 4 and 6 months of age
<b>Diphtheria-Tetanus-Pertussis (DTaP)</b>	5 doses—1 dose each at 2, 4 and 6 months of age; 1 dose between 15 and 18 months of age; and 1 dose between 4 and 6 years of age
<b>Inactivated Polio (IPV)</b>	4 doses—1 dose each at 2 and 4 months of age; 1 dose between 6 and 18 months of age; and 1 dose between 4 and 6 years of age
<b>H. Influenzae Type B (Hib) (may be combined with DTaP) &amp; Pneumococcal Conjugate (PCV)</b>	4 doses—1 dose each at 2, 4 and 6 months of age; and 1 dose between 12 and 15 months of age
<b>Measles-Mumps-Rubella (MMR) &amp; Chicken Pox (Varicella)</b>	2 doses—1 dose between 12 and 15 months of age; and 1 dose between 4 and 6 years of age
<b>Influenza</b>	Every flu season—beginning at 6 months of age
<b>Meningococcal</b>	1 dose between 11 and 12 years of age
<b>Tetanus-Diphtheria-Pertussis (Tdap)</b>	1 dose between 11 and 12 if the childhood DTP/DTap series is complete and has not received Td booster
<b>Human Papillomavirus (HPV)</b>	3 doses (females ) between 11 & 12 yrs; second dose 2 months later, third dose 6 months after 1st dose
<b>Blood Pressure</b>	Every 2 years—18 years of age and older
<b>Body Mass Index (BMI)</b>	Periodically—18 years of age and older
<b>Cholesterol</b>	Government guidelines state that healthy adults who are aged 20 years or older should have a cholesterol test done once every 5 years.
<b>Glucose (diabetes blood sugar test)</b>	Beginning at age 45, then every 3 years unless you have other risk factors, then testing should occur every year
<b>Mammogram</b>	Every 1-2 years—women 40 years of age and older
<b>Cervical Cancer</b>	Every 1-2 years—Beginning at 21 years of age or earlier if sexually active; if 30 years of age and older, either a Pap Smear every 2-3 years after 3 consecutive normal results or HPV DNA test plus a Pap smear every 3 years if results of both tests are negative. Women 70 years of age and older may stop screening.
<b>Chlamydia</b>	Routinely—women 24 years of age and younger if sexually active
<b>Osteoporosis (Bone Density Test)</b>	Routinely—women 65 years of age and older
<b>Prostate Cancer</b>	Between 50-75 years of age—yearly screening with high-sensitivity fecal occult blood testing, OR sigmoidoscopy every 5 years with high-sensitivity fecal occult blood testing every 3 years
<b>Colonoscopy</b>	Men and women beginning at age 50, once every 10 years
<b>Depression/Alcohol Misuse/Tobacco Use</b>	Routinely—18 years of age and older
<b>Tetanus-Diphtheria-Pertussis (Td/Tdap)</b>	1 dose Td booster every 10 years
<b>Pneumococcal</b>	1 dose—65 years of age and older
<b>Zoster (shingles)</b>	1 dose—60 years of age and older

PLAN FEATURES/SERVICES	BASE PLAN PREFERRED BENEFITS (In-Network)	BASE PLAN NON-PREFERRED BENEFITS (Based on Out-of-Network fee schedule)
Plan Deductible (per calendar year)	\$250 Individual, \$750 Family	\$600 Individual, \$1,800 Family
Deductible Carryover	None	None
Coinsurance Limit (excludes deductible; once family coinsurance is met, all family members will be considered having met the deductible)	\$1,750 Individual, \$5,250 Family	\$6,000 Individual, \$18,000 Family
Lifetime Maximum	Unlimited except where otherwise indicated	\$1,000,000
Acupuncture	Up to \$500 per calendar year (no deductible or coinsurance applies)	Up to \$500 per calendar year (no deductible or coinsurance applies)
Alcohol & Drug Abuse Services—Inpatient	80% after deductible	60% after deductible
Alcohol & Drug Abuse Services—Outpatient	100% after \$30 copay	60% after deductible
Allergy Testing—serum, injections and injectable drugs (Allergy Specialist only)	100% after \$30 office visit copay (waived for injection if no office visit charge)	60% after deductible
Ambulance	90% after deductible	90% after deductible
Basic Infertility Services—Diagnosis & Treatment	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded
Chiropractic	\$30 copay, up to \$600 per calendar year (no deductible or coinsurance applies)	60% after deductible; up to \$600 per calendar year
Diagnostic X-ray and Laboratory	100% coverage	60% after deductible
Durable Medical Equipment	90% after deductible	60% after deductible
Emergency Room	\$150 copay, waived if admitted	\$150 copay, waived if admitted
Hearing Aids—one pair every 36 months with a maximum benefit of \$1,500	80% coverage, no deductible	80% after deductible
High Tech Radiology— Complex imaging, MRI, PET, CT scan, etc. (precertification required)	90% after deductible	60% after deductible
Home Health Care	90% after deductible (limit 100 visits per calendar year)	60% after deductible (limit 100 visits per calendar year)
Hospice Care—Inpatient & Outpatient	90% after deductible	60% after deductible
Hospital Services—Inpatient & Outpatient	80% after deductible	60% after deductible

**NOTE: Limits for the Base and Base Plus Plans 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.**

# MEDICAL BENEFITS SUMMARY—BASE PLUS PLAN

PLAN FEATURES/SERVICES	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Based on Out-of-Network fee schedule)
Plan Deductible (per calendar year)	None	\$600 Individual, \$1,800 Family
Deductible Carryover	None	None
Coinsurance Limit (excludes deductible; once family coinsurance is met, all family members will be considered having met the deductible)	None	\$6,000 Individual, \$18,000 Family
Lifetime Maximum	Unlimited except where otherwise indicated	\$1,000,000
Acupuncture	Up to \$500 per calendar year (no deductible or coinsurance applies)	Up to \$500 per calendar year (no deductible or coinsurance applies)
Alcohol & Drug Abuse Services—Inpatient	\$400 per confinement copay	70% after deductible
Alcohol & Drug Abuse Services—Outpatient	100% after \$30 copay,	70% after deductible
Allergy Testing—serum, injections and injectable drugs (Allergy Specialist only)	100% after \$30 office visit copay (waived for injection if no office visit charge)	70% after deductible
Ambulance	100% coverage	100% coverage
Basic Infertility Services—Diagnosis & Treatment	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded
Chiropractic	\$30 copay, up to \$600 per calendar year (no deductible or coinsurance applies)	70% after deductible; up to \$600 per calendar year
Diagnostic X-ray and Laboratory	100% coverage	70% after deductible
Durable Medical Equipment	100% coverage	70% after deductible
Emergency Room	\$150 copay, waived if admitted	\$150 copay, waived if admitted
Hearing Aids—one pair every 36 months with a maximum benefit of \$1,500	80% coverage, no deductible	80% after deductible
High Tech Radiology— Complex imaging, MRI, PET, CT scan, etc. (precertification required)	100% coverage	70% after deductible
Home Health Care	100% coverage (limit 100 visits per calendar year)	70% after deductible (limit 100 visits per calendar year)
Hospice Care—Inpatient & Outpatient	90% after deductible	60% after deductible
Hospital Services—Inpatient	\$400 per confinement copay	70% after deductible
Hospital Services—Outpatient	100% after \$250 copay for surgical procedures, 100% coverage for non-surgical	70% after deductible

# MEDICAL BENEFITS SUMMARY—BASE PLAN

PLAN FEATURES/SERVICES	BASE PLAN PREFERRED BENEFITS (In-Network)	BASE PLAN NON-PREFERRED BENEFITS (Based on Out-of-Network fee schedule)
Maternity (coverage includes voluntary sterilization)	Payable as any other covered expense	Payable as any other covered expense
Mental Health—Inpatient coverage	80% after deductible	60% after deductible
Mental Health—Outpatient coverage	100% after \$30 copay	60% after deductible
Non-Emergency Use of the Emergency Room	Not covered	Not covered
Outpatient surgery (facility) - (Except in physician's office when office visit copay applies)	80% after deductible	60% after deductible
Physician Hospital Services	80% after deductible	60% after deductible
Physician Services (excl. Mental Health/Alc/Drug) Office Visits to Primary Care Physician	100% after \$20 copay	60% after deductible
Specialist Office Visits Participating Aexcel providers Non-Aexcel participating providers	100% after \$30 copay 100% after \$50 copay	60% after deductible
Private Duty Nursing—Outpatient	90% after deductible (70 shifts per calendar yr)	50% after deductible (70 shifts per calendar year)
Routine Gynecological Care Exam Coverage is limited to one routine OB/Gyn exam per calendar year including charges for one pap smear and related fees.	100% after \$30 copay (participating Aexcel provider) 100% after \$50 copay (non-Aexcel participating provider)	60% after deductible
Routine Physicals/Immunizations Children: 7 exams in the 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 & adults.	100% after \$20 copay Copay waived for immunizations when an office visit charge is not made	60% after deductible
Routine Mammography—Ages 35-40 one baseline; age 40+, one every calendar year	100% coverage	60% after deductible
Short-Term Rehabilitation—coverage for physical, speech and occupational therapy	100% after \$25 copay, up to 60 visits per year	60% after deductible up to 60 visits per year
Skilled Nursing Facility	90% after deductible, 100 days per calendar year	60% after deductible, 100 days per calendar year
Urgent Care Provider	100% after \$40 copay	60% after deductible
Walk-in Clinics	100% after \$20 copay	60% after deductible

For more info  
reference pg. 5

**NOTE: Limits for the Base and Base Plus Plans 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.**

PLAN FEATURES/SERVICES	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Based on Out-of-Network fee schedule)
Maternity (coverage includes voluntary sterilization)	Payable as any other covered expense	Payable as any other covered expense
Mental Health—Inpatient coverage	100% after \$400 per confinement copay	70% after deductible
Mental Health—Outpatient coverage	100% after \$30 copay	70% after deductible
Non-Emergency Use of the Emergency Room	Not covered	Not covered
Outpatient surgery (facility) - (Except in physician's office when office visit copay applies)	100% after \$250 copay	70% after deductible
Physician Hospital Services	100% covered	70% after deductible
Physician Services (excl. Mental Health/Alc/Drug) Office Visits to Primary Care Physician	100% after \$20 copay	70% after deductible
Specialist Office Visits Participating Aexcel providers Non-Aexcel participating providers	100% after \$20 copay 100% after \$40 copay	70% after deductible
Private Duty Nursing—Outpatient	100% covered (70 shifts per calendar year)	50% after deductible (70 shifts per calendar year)
Routine Gynecological Care Exam Coverage is limited to one routine OB/Gyn exam per calendar year including charges for one pap smear and related fees.	100% after \$20 copay (participating Aexcel provider) 100% after \$40 copay (non-Aexcel participating provider)	70% after deductible
Routine Physicals/Immunizations Children: 7 exams in the 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 & adults.	100% after \$20 copay Copay waived for immunizations when an office visit charge is not made	70% after deductible
Routine Mammography—Ages 35-40 one baseline; age 40+, one every calendar year	100% coverage	70% after deductible
Short-Term Rehabilitation—coverage for physical, speech and occupational therapy	100% after \$20 copay, up to 60 visits per year	70% after deductible up to 60 visits per year
Skilled Nursing Facility	100% covered, 100 days per calendar year	70% after deductible, 100 days per calendar year
Urgent Care Provider	100% after \$40 copay	70% after deductible
Walk-in Clinics	100% after \$20 copay	70% after deductible

For more info  
reference pg. 5



Harris County is now offering your dental benefits through UnitedHealthcare Specialty Benefits and continues to provide two dental options:

A Dental Health Maintenance Organization (DHMO) and a Dental Preferred Provider Organization (PPO) plan. Either plan is available to employees at no cost. However, if you choose to enroll your dependents, you will be responsible for their portion of the monthly fees.

The DHMO plan provides comprehensive dental care with defined copayments for each covered procedure. You select a participating DHMO dentist from a network of providers and follow the plan rules/guidelines for services provided.

The PPO plan offers a choice of dentists; network or non-network. The plan includes an annual deductible and a calendar year maximum. With this plan you pay a higher percentage of costs for services. **Choose the plan that best suits your needs for the upcoming benefit year.**



<b>UnitedHealthcare Dental HMO*</b>	<b>UnitedHealthcare Dental PPO**</b>
<b>No calendar year maximums; no yearly deductibles</b>	<b>\$1,750 calendar year maximum; \$50 yearly individual deductible (\$150 for family)</b>
<b>Basic care provided by network general dentists selected at enrollment. Members may change their designated dentist by contacting UnitedHealthcare Dental customer service by the 20<sup>th</sup> of the month. Requested changes will be effective the first of the following month.</b>	<b>You may receive care from any licensed dentist; network dentists have agreed to accept negotiated fees as payment in full with no "balanced billing".</b>
<b>Each family member may select a different UnitedHealthcare Dental network general dentist (remember to include the Practice ID number when enrolling).</b>	<b>Non-network dentists could "balance bill", which may result in higher out-of-pocket costs (see the Benefit Summary or determine out-of-pocket costs by using the online Treatment Cost Calculator for more information).</b>
<b>Covered procedures and copayments are listed on the Schedule of Benefits and may be found on <a href="http://www.yourdentalplan.com/harriscounty">www.yourdentalplan.com/harriscounty</a> by clicking 'Plan Information'.</b>	<b>Network claims are paid based on the percentages of the Maximum Allowable Charge. Non-network claims are paid based on UCR (Usual, Customary &amp; Reasonable charges).</b>
<b>When specialty care is required, your selected general dentist and UnitedHealthcare Dental Customer Service Representative will assist in managing your referral.</b>	<b>If you require specialty care, you may see any specialty care dentist you choose. When you receive care from a network dentist, you may save on your cost of care.</b>
<b>No waiting periods.</b>	<b>New enrollees: 6 month waiting period on endodontic procedures &amp; all major services (new employees and newly added dependents of current employees).</b>
<b>Adult &amp; child orthodontics is included.</b>	<b>Orthodontia is not a covered benefit in the PPO plan.</b>
<b>No claim forms are required.</b>	<b>Claim forms may be required when a non-network dentist is used.</b>

\*Benefits for the UnitedHealthcare Dental DHMO plans are provided by the following UnitedHealth Group company: National Pacific Dental, Inc.

\*\*Benefits for the UnitedHealthcare Dental PPO plans are provided by UnitedHealthcare Insurance Company, located in Hartford, Connecticut



**CUSTOMER SERVICE OPTIONS**

UnitedHealthcare Dental assistance is available 24 hours a day, 7 days a week. You can check eligibility, claims, determine out-of-pocket costs using the Treatment Cost Calculator and print or request your plan information... either online or through advanced telephone technology. Register for online access at :

[www.yourdentalplan.com/harriscounty](http://www.yourdentalplan.com/harriscounty)

(registration and login button at the bottom center of the home page) or call the toll-free number on your member ID card and follow the prompts for IVR (Interactive Voice Recognition) assistance.

**Proper Use and Benefits of the DHMO**

**United Healthcare DHMO Plan\***— Remember to select a dentist from the UnitedHealthcare Dental Directory (or Dentist Locator on [www.yourdentalplan.com/harriscounty](http://www.yourdentalplan.com/harriscounty)) for yourself and each of your enrolled dependents. Indicate the Practice ID Number in the space on your enrollment form for each person enrolled.

A complete Schedule of Benefits with covered procedures and copayments along with Exclusions & Limitations are available online at [www.yourdentalplan.com/harriscounty](http://www.yourdentalplan.com/harriscounty) or request a copy by calling customer service at the number located on your member ID card.

An Evidence of Coverage document may also be requested or viewed online and provides additional information about how to get the most from your UnitedHealthcare Dental HMO plan. Please take time to review this information before making dental benefit decisions.

DHMO members: check out the dental health and wellness link at [www.yourdentalplan.com/harriscounty](http://www.yourdentalplan.com/harriscounty).



**Included with your Dental HMO:**

The UnitedHealthcare Dental HMO Wellness plan, through its six (6) Centers of Excellence, created a program that makes wellness a priority by performing a variety of unique services. By simply visiting the dentist, individuals might find that they may save more than their teeth and gums, it may just lead to early diagnosis, referral for and treatment of a variety of diseases.

- The Centers of Excellence offer free, possibly life-saving, wellness screening services. Members set an appointment and complete a questionnaire. The dentist makes and assessment and provides appropriate screening(s) for any or all of four conditions.
- Screenings may help determine if a member is ‘at-risk’ for oral cancer, diabetes, or cardiovascular disease, and may lead to a referral for these conditions.
- Attending dentists include as part of the wellness visit, counseling and materials about the impact of tobacco use, obesity and oral piercings as well as information about oral disease and other medical conditions.

**Ortho Takeover** is available for UnitedHealthcare Dental HMO plan members. If you are currently in orthodontic treatment with Harris County’s plan, please obtain an Ortho Takeover Form from your benefit coordinator/payroll clerk or from [www.yourdentalplan.com/harriscounty](http://www.yourdentalplan.com/harriscounty). You will need to complete the upper portion of the form and bring it with you to your orthodontic appointment. The orthodontist will complete the balance of the form and submit it to UnitedHealthcare Dental.

**PPO**

**United Healthcare PPO Plan**—There is no need to pre-select a dentist - you can receive treatment from any dentist - network or non-network. If you opt for a network dentist, the Dental Directory (or Dentist Locator on [www.yourdentalplan.com/harriscounty](http://www.yourdentalplan.com/harriscounty)) can help you find a dentist. When choosing a dentist, if you choose to receive care from a UnitedHealthcare Dental network dentist, you could save on your out-of-pocket costs. Network dentists have agreed to negotiated fees as payment in full with no balance billing.



**Your PPO Costs**

Payment of claims is based on a Maximum Allowable Charge (MAC). The Maximum Allowable Charge is set by *UnitedHealthcare Dental* and uses negotiated rates with network dentists. This MAC is the most that *UnitedHealthcare Dental* pays for a plan’s covered dental procedure.

A Summary of Benefits includes the information about percentage of coverage by procedure category along with Exclusions & Limitations and is included in your enrollment kit. After reviewing the plan documents, if you have any questions, a customer service representative will be happy to help you.

**Included with your PPO dental plan:**

**Prenatal Dental Care Program:** Women in their second and third trimester are eligible for this program. When visiting your dentist you need to supply the name and contact number of your OB/GYN. You will then receive additional cleanings or periodontal maintenance, at little or no cost, if the need is determined by your dentist.



**Oral Cancer Screening:** Individuals who are determined at-risk by their dentist who are 30 years of age or older may be eligible for this once-yearly, light-contrast screening.

### “Quick Facts” About Some Dental Procedures

“**Routine Cleaning**” (prophylaxis) is the removal of normal tartar build-up and polishing teeth to remove stains. If you see your dentist regularly and have your teeth cleaned twice a year, a routine cleaning will likely be your dentist’s prescription.

“**Deep Cleaning**” is a term used to describe scaling and root planing, a procedure that removes plaque and tartar build-up on teeth below the gums. Usually, when you need a deep cleaning, it is a sign that your oral health has changed, typically due to gingival (gum) inflammation. There could be several reasons for the change...periodontal disease, stress, pregnancy, tobacco use, or a change of medication – even a simple change in brushing or flossing habits.

“**Fillings**” - Amalgam is the silver filling that dentists have been using for many years to fill cavities; resin-based composite fillings are white (tooth colored). You may have heard about the safety concern of using amalgams because mercury is part of the filling material. However, the American Dental Association, the National Institutes of Health, and the U.S. Public Health Service, among others, have stated that, when combined with other metals, as it is in amalgam, it is an acceptable standard of treatment. Because some dentists have a concern about using amalgam material, they choose to provide only composite fillings for their patients. We suggest you discuss with your dentist his or her practice policies.

“**Crowns**” - A crown is a metal cap that covers and strengthens a tooth. It is along with a root canal or when a standard filling is not enough support for the tooth structure. Crowns are made of different materials; metal only or a porcelain (“tooth-colored”). A crown is not just the cap that sits over the tooth...there can be other procedures and materials required, such as a gold post, a core build up or a pin...each one adds to the total cost. Crown costs vary depending on the materials used – your dentist can provide an itemized treatment plan. For the DHMO plan, each covered crown is listed on your Schedule of Benefits. Check the copayment and any additional fees that are indicated (i.e. porcelain on back teeth and additional lab fees for noble (low gold) and high noble (high gold) metals). Other procedures may be required during your treatment, such as a root canal - this adds to the cost of restoration. Under the PPO plan for your benefit allowance is 50%, whether your dentist is in- or out-of-network. The out-of-network dentist may balance bill for services above the maximum allowable charge fee schedule. You have greater savings when you choose a network dentist.



### When Visiting Your Dentist—Knowledge is Power!

It’s been said that people typically visit their dentist more often than they visit other doctors. It’s important to know that as health care becomes more integrated and dentists increasingly focus on more than just teeth, they are becoming indispensable members of the larger health care team.

The bacteria that inhabit the mouth, causing tooth decay and gum disease, may be found elsewhere in the body. Though there may be no pain or noticeable symptoms, this bacteria can lead to far more serious conditions. We are continuing to learn that gum disease may heighten the risk for heart disease, diabetes, pregnancy complications and other conditions.

- Chronic diseases – such as **heart disease**, stroke, **cancer**, **diabetes**, and arthritis – are among the most common, **costly**, and **pre-ventable** of all health problems in the U.S.
- The presence of bacteria in active periodontal disease leads to inflammation, which can reduce **diabetic control**
- Experimental models have linked the bacteria found in the plaque of the **arterial walls** to those found in the **periodontal pockets**
- Bacteria contributes to inflammation that increases plaque build-up in the **small arteries of the heart**, restricting blood flow to the heart muscle, which can lead to a **heart attack**
- The bacteria present in **periodontal disease** has been found in **amniotic fluid** and the **mothers placenta**
- Mothers with **periodontal disease** have a **higher incidence of pregnancy complications**



The Harris County Vision Care Program is offered through **Block Vision**. Remember, vision coverage is provided automatically for you and each dependent you enroll in the medical plan. With the vision plan, when you use participating providers you will pay lower out-of-pocket expenses and receive a higher level of benefits. You may also use out of network benefits, however your benefit level is reduced, you will pay for the services and you must file a claim with Block Vision for reimbursement.

**HOW THE VISION CARE PROGRAM WORKS**

Each time you need vision care, you may seek care through the Block Vision benefit plan: Select a **Block Vision** participating provider by calling the provider locator at (866) 265-0517, or from [www.blockvision.com](http://www.blockvision.com). When you make your appointment, identify yourself as a Harris County **Block Vision** Plan member. A vision examination is provided by a network optometrist or ophthalmologist once every twelve months. At an in-network provider, members will receive a \$130 retail allowance towards the cost of the frame. The Block Vision benefit plan provides \$130 toward your contact lens /evaluation and fitting fee as well and the cost of contact lenses. A \$300 Lasik benefits reimbursement is also available either in or out of network.

**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.

<u>Service/Product</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Complete Visual Exam*	\$10 copay	Up to \$35
Materials (when purchasing eyeglasses, lenses, frames OR contacts in lieu of eyeglasses)	\$25 copay	
<b><u>Frames</u></b>		
	\$130 retail allowance after \$25 materials copay	Up to \$70
<b><u>Lenses</u></b>		
Single Vision Lenses**	Standard basic lens covered at 100% after \$25 Materials copay	Up to \$25
Lined Bifocal Vision Lenses**	Standard basic lens covered at 100% after \$25 Materials copay	Up to \$40
Lined Trifocal Vision Lenses**	Standard basic lens covered at 100% after \$25 Materials copay	Up to \$45
<b><u>Contact Lenses</u></b>		
Elective	\$130 retail allowance after \$25 Materials copay	Up to \$80
Necessary***	100% after \$25 Materials copay	Up to \$150
<b><u>Laser Correction</u></b>		
Lasik Vision Correction****	\$300 benefit	\$300 retail benefit

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

\*\* Standard basic lens coverage included in your \$25 copay for glasses lenses or frames and lenses. Lens cost that exceeds the basic coverage is the member's responsibility. Members may receive a discount of up to 20% from a participating provider's usual and customary fees for eyewear purchases which exceed the benefit coverage.

\*\*\* 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 Block Vision concerning the reimbursement that Block vision will make before you purchase such contacts.

\*\*\*\***Lasik Vision Correction:** Block Vision provides each member a \$300 allowance available both in and out of network. **Block Vision** has partnered with the LCA . In network providers may offer additional savings and financing. Call 877-557-7609 for assistance in coordinating your care.

**Life Insurance provided by:**  **Prudential Financial**  
Growing and Protecting Your Wealth®

- ✓ 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 at no cost as shown.
- ✓ Employees have a life insurance benefit of \$25,000 and an AD&D benefit of \$5,000.
- ✓ Dependent life is also provided at \$5,000 for a spouse and \$2,000 for unmarried children at no cost to you.

- 2 Free, 1 You Buy**
1. Basic Life
  2. TCDRS Life
  3. **Optional Life**

**Dependent 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.**

## **Do you have children designated as beneficiaries?**

Did you know if a **MINOR** is designated as the beneficiary and is not of legal age at the time the payment is to be disbursed, the insurance proceeds will be held by Prudential until the minor is of legal age (based on state law) to receive the payment. If the employee would like the minor beneficiary to receive the insurance proceeds, there must be a legally appointed guardian over the financial assets of the minor, who can legally receive the funds on behalf of the minor. The employee should check with state laws in regard to legal guardianship, or seek advice from their own legal counsel.

**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 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.**

**Rates may change as the Insured enters a higher age category. Also, rates may change if plan experience requires a change for all Insured.**

**OPTIONAL TERM LIFE INSURANCE:** Employees have the option of purchasing additional Life Insurance equal to one or two times their annual salary. If your salary or wage changes your insurance amount will change on the next plan year. **Any Pre-Tax Life Insurance provided under the County plans in excess of \$50,000 is subject to annual taxation.**

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

<b>OPTIONAL LIFE INSURANCE*</b>	<b>MONTHLY RATE/\$1,000 OF COVERAGE</b>
<b>Under 30</b>	<b>\$ .047</b>
<b>30-34</b>	<b>.063</b>
<b>35-39</b>	<b>.075</b>
<b>40-44</b>	<b>.098</b>
<b>45-49</b>	<b>.15</b>
<b>50-54</b>	<b>.23</b>
<b>55-59</b>	<b>.43</b>
<b>60-64</b>	<b>.60</b>
<b>65-69</b>	<b>1.10</b>
<b>70-74</b>	<b>1.90</b>
<b>75-79</b>	<b>2.06</b>
<b>80 and over</b>	<b>2.06</b>



**Why buy long term disability coverage?** 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.

## LONG TERM DISABILITY (LTD) FACTS

- ◆ Three out of every 10 workers will experience an accident or illness that keeps them out of work for three months or longer.
- ◆ Forty-three percent of all 40-year olds will suffer a disability for at least 90 days prior to age 65.
- ◆ More than half of all personal bankruptcies and mortgage foreclosures are due to disability.
- ◆ In just the past hour, almost 3,000 Americans became disabled. That's 49 every minute.
- ◆ Every :01 second another disabling injury occurs in the US. Every four minutes the injury is fatal.
- ◆ More than 1 in 5 adults believe that unemployment or Social Security will cover them if they become disabled
- ◆ Less than half - 39% - of the 2.1 million workers who applied for Social Security Disability Insurance (SSDI) benefits in 2005 were approved.
- ◆ The average monthly SSDI benefit is \$1,004.
- ◆ In 2007, the percentage of working-age people with disabilities receiving SSDI payments in the US was 17.1%.
- ◆ Over 85% of disabling accidents and illnesses are not work related, and therefore not covered by workers' compensation.
- ◆ Over 6.8 million workers are receiving SSDI benefits, almost half are under age 50. This represents only 13% of the over 51 million Americans classified as disabled.



## How would you provide for your family if you were unable to work due to illness or injury?



**Long-Term Disability Insurance from CIGNA** – affordable income protection if you are unable to work due to a covered injury or illness.

Disability insurance can help you pay your bills and maintain your standard of living if you were to become disabled due to a covered injury or illness. When you can't work – even for a short time – your financial situation can become difficult very quickly. Disability insurance helps protect the most important asset you have – your ability to earn a paycheck.

### How much disability insurance you need?

To get an idea of how much your family would need to continue its current lifestyle, check out our **Disability Income Needs Calculator**, on [cigna.com/diam](http://cigna.com/diam). It can help you estimate your insurance needs based on your unique personal situation.

### Valuable Programs and Services from CIGNA

You and your covered family members have access to the following CIGNA Programs and Services at no cost:

**CIGNA Healthy Rewards®** program provides you and your covered family members discounts on health and wellness programs and services like weight loss management, fitness, smoking cessation and more. Enjoy instant savings of up to 60% when you take advantage of this opportunity. Visit [www.cigna.com/rewards](http://www.cigna.com/rewards) (Password: savings) or call: 800.258.3312.

**CIGNA's Will Preparation Program** offers you and your covered spouse access to a website that helps you build state-specific customized wills and other legal documents. Visit [www.cignawillcenter.com](http://www.cignawillcenter.com) or call: 800.901.7534.

### Fast, hassle-free claim service

Prompt attention to claims actually improves results when it comes to getting people back to work. Experienced disability claim managers will work quickly and accurately get your claim information. Through this relationship, we will work together with you and your employer to devise the best strategy for your speedy, safe return to work.

### Claim Information

It's easy to file a claim. Simply call CIGNA's toll-free number at 1.800.36.CIGNA or 1.800.362.4462 and a representative will walk you through the process. You can also fill out the online claim form on [www.cigna.com](http://www.cigna.com). Click on Forms located in the Customer Care tab.



### Important reminders:

- Always seek appropriate medical attention immediately. Your health and safety come first.
- Contact your employer to let them know you will be absent.
- Call CIGNA as soon as possible.

### Please have this information ready before you report a claim:

- ⇒ Your name, address, phone number, birth date, date of hire, Social Security Number and employer's name, address and phone number.
- ⇒ The date and cause of your disability and when you plan to return to work. If you are pregnant, give your expected delivery date.
- ⇒ The name, address and phone number of each doctor you are seeing for this absence.

# LONG TERM DISABILITY COVERAGE

**OPEN ENROLLMENT ACTION REQUIRED BY YOU:** Once you receive your enrollment materials be sure to read them carefully.

Determine your disability insurance needs and consider adding additional protection to your paycheck through Voluntary Disability insurance coverage.

**Optional Long-Term Disability:** If you elect to enroll in this plan, premiums are automatically deducted from your paycheck on an after-tax basis.

***This year only...no evidence of insurability required!***

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 Comparison of Basic & Optional Plan

BASIC LTD COVERAGE		VOLUNTARY LTD COVERAGE
<b>MONTHLY BENEFIT</b>	Your employer pays a benefit amount for up to 50% of the first \$10,000 of your pre-disability covered monthly earnings.	The Voluntary LTD Coverage level allows you to change the percentage of your monthly benefit to 60% of your pre-disability covered monthly earnings.
<b>MONTHLY MAXIMUM</b>	<b>\$5,000</b>	<b>\$6,000</b>
<b>MONTHLY MINIMUM</b>	\$100	The greater of \$200 or 10% of your disability benefit, prior to any deductible sources of income.
<b>BENEFIT WAITING PERIOD</b>	<b>180 days</b>	<b>90 days</b>
<b>MAXIMUM BENEFIT PERIOD</b>	Two years	Your benefit period begins on the first day after your complete your elimination period. And, should you remain disabled, your <b>benefits continue according to the following schedule</b> , depending on your age at the time you become disabled.

**MONTHLY RATE OPTIONAL LONG-TERM DISABILITY IS \$.337/ \$100 OF YOUR PRE-DISABILITY MONTHLY EARNINGS**

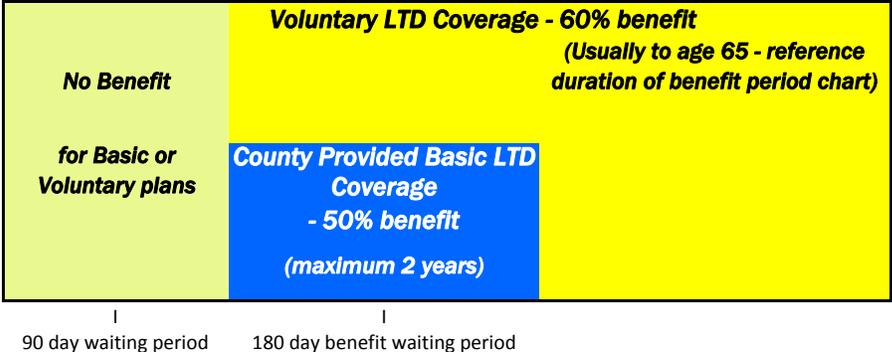
Covered earnings means your wages or salary, excluding earnings received from overtime pay, and other extra compensation.

Age at Commencement of Disability	Duration of Benefit Period
Less than age 62	To age 65, or 3 years and 6 months if longer.
62	3 years, 6 months
63	3 years
64	2 years and 6 months
65 or older	2 years

**Great News!** 

**THIS YEAR ONLY...**

Employees may purchase optional Long Term Disability without completing an evidence of insurability application.



Urgent care facilities are traditionally used to treat the sudden onset of illness or unexpected injury. Overcrowding of our emergency rooms for non-emergent services is an epidemic and unnecessary expense in many cases for the patient, the employer and the health plan. Urgent care facilities generally result in shorter wait times, lower expenses and less out-of-pocket cost for our employees since the copayment is \$40 per visit vs. the hospital emergency room cost of \$150.

Urgent care facilities fill a critical need for patients when they are seeking immediate care that is not life threatening and their general practitioner is unavailable. For example, a patient with a sprain, fracture, minor burns, skin rashes, possible infection, illness with nausea, vomiting and/or diarrhea, sore throat, fever, earache or minor laceration(s) may go to an urgent care facility if their doctor's office has already closed. If a patient feels like their situation is life threatening, then they should seek help in the appropriate setting or call 9-1-1. Employees should continue to coordinate their care with the advice of their primary care physicians. Most urgent care centers are independent facilities. If they are connected to a hospital, the copayment is generally \$150 per visit.

Some of the facilities listed are considered "walk-in clinics" and they are marked with an asterisk (\*) and . These clinics generally offer similar services to urgent care centers and are staffed by nurse practitioners. Your copay at the walk-in clinics is only \$20!

This summary is intended for reference purposes only, and medical conditions vary by individual. Always use your best judgment when seeking treatment for you and your family.

The urgent care centers and walk-in clinics listed are current providers and may be subject to change. It is your responsibility to check their status at time of service.

## URGENT CARE CENTERS & WALK-IN CLINICS in the Greater Houston area

North (Montgomery Co.) - Includes :	Conroe, The Woodlands, Montgomery, Spring, Kingwood, Houston		
First Choice Emergency Room	10333 Kuykendahl Rd., Suite B The Woodlands	(832) 381-1999	Mon–Sun, 10 am –10 pm
Lake Area Urgent Care	15320 Hwy. 105 West, Suite 120 Montgomery	(936) 582-5660	M-F, 10 am-8 pm; Sat, 9 am-6 pm; Sun., 10 am-5 pm
MinuteClinic* (CVS) 	25110 Grogans Mill Rd., Spring	(866) 389-2727	M-F, 9 am–8 pm; Sat 9 am-5:30 pm; Sun, 10 am-5:30 pm
RediClinic* (H-E-B) 	2108 North Frazier, Conroe	(936) 494-4350	M-F, 8-8; Sat., 9-5; Sun 10-5
RediClinic* (H-E-B) 	130 Sawdust Road, Spring	(281) 419-3162	M-F, 8-8; Sat., 9-5; Sun 10-5
RediClinic* (H-E-B) 	10777 Kuykendahl Road, The Woodlands	(281) 907-4104	M-F, 8am-8 pm; Sat., 9 am-5pm, Sun. 10 am-5 pm
Take Care* (Walgreens) 	24917 FM 1314 Road, Porter	(866) 825-3227	M-F, 8 am-7:30 pm Sat & Sun, 9:30 am–5 pm
Take Care* (Walgreens) 	8000 Research Forest Drive, The Woodlands	(866) 825-3227	M-F, 8 am-7:30 pm; Sat & Sun, 9:30 am–5 pm
Texas Family Medical & Minor Emer. Ctr	1331 Northpark Drive, Kingwood	(281) 359-5330	M-Th, 8:30 am–6 pm; Fri, 8:30-am-5 pm; Sat, 9 am-3 pm
East/NE (Liberty County)			
Quality Care Plus	2718A North Main Street, Liberty	(936) 336-3616	Mon-Sat, 10 am-7:30 pm; Sun, 1 pm-7:30 pm

**NOTE:** Hours listed are current and subject to change at any time. Services available at each clinic may vary by location.

 \* denotes medical walk-in clinic—you pay a copayment of \$20

## URGENT CARE CENTERS & WALK-IN CLINICS

North/NW/NE (Harris Co.) - includes:	Cypress, Humble, Kingwood, N/NW Houston, Tomball		
Concentra Health Services, Inc.	401 Greens Road	(281) 873-0111	M-F, 8 am-5 pm
Concentra Health Services, Inc.	6360 W. Sam Houston Pkwy. North, Suite 200	(713) 280-0400	M-F, 8 am-5 pm
Concentra Health Services, Inc.	8799 North Loop East, Suite 110	(713) 674-1114	M-F, 8 am-5 pm
CyFair Urgent Care	9110 Barker Cypress Road, Cypress	(281) 517-9900	M-F, 12 pm–9pm Sat-Sun, 9 am-9pm
Excel Immediate Medical Care	25801 U.S. Hwy. 290, Cypress	(281) 304-1100	Mon-Sun, 9 am-9 pm
Family Health Associates	16125 Cairnway	(281) 855-1600	M-F, 9 am-5 pm
First Choice Emergency Room	21301 Kuykendahl Road, Suite A Spring	(281) 803-1000	Mon-Sun, 12 pm-10 pm
First Choice Emergency Room	10130 Louetta Road, Suite L	(281) 301-3130	Mon-Sun, 12 pm-10 pm
First Choice Emergency Room	15881A FM 529	(281) 220-3500	Mon-Sun, 12 pm–10 pm
First Choice Emergency Room	5324 Atascocita Rd., Suite T, Humble	(832) 644-3400	Mon-Sun, 8 am -12 am
Kingwood Urgent Care & Special Clinic	2601 W. Lake Houston Pkwy. Kingwood	(281) 360-7502	Mon-Sun, 7 am-7 pm
MinuteClinic* (CVS) 	8000 N. Sam Houston Pkwy East Humble	(866) 389-2727	M-F, 9 am-8 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm
MinuteClinic* (CVS) 	24802 Aldine Westfield Spring	(866) 389-2727	M-F, 9 am-8 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm
MinuteClinic* (CVS) 	8754 Spring Cypress Road Spring	(866) 389-2727	M-F, 9 am-8 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm
RediClinic* (H-E-B) 	28520 Tomball Pkwy. Tomball	(281) 255-3085	M-F, 8 am-8 pm; Sat, 9am-5 pm; Sun, 10 am-5 pm
Night Light Pediatric Urgent Care	19708 Northwest Freeway	(713) 957-2020	M-F, 5 pm-11 pm Sat-Sun, 12 pm-7 pm
RediClinic* (H-E-B) 	10919 Louetta	(281) 758-2282	M-F, 8 am-8 pm; Sat, 9am-5 pm; Sun, 10 am-5 pm
RediClinic* (H-E-B) 	24224 Northwest Freeway, Cypress	(866) 607-7334	M-F, 8 am-8 pm; Sat, 9am-5 pm; Sun, 10 am-5 pm
Take Care* (Walgreens) 	1215 West 43rd Street	(866) 825-3227	M-F, 8 am-7:30 pm Sat & Sun, 9:30 am–5 pm
Take Care* (Walgreens) 	7440 FM 1960 Road East Humble	(866) 825-3227	M-F, 8 am-7:30 pm Sat & Sun, 9:30 am–5 pm
Take Care* (Walgreens) 	19710 Holzwarth Road, Spring	(866) 825-3227	M-F, 8 am-7:30 pm Sat & Sun, 9:30 am–5 pm
Take Care* (Walgreens) 	16211 Spring Cypress Road, Cypress	(866) 825-3227	M-F, 8 am-7:30 pm Sat & Sun, 9:30 am–5 pm
Texas Urgent Care	10906 FM 1960 Road West @ Jones Road	(281) 477-7490	M-F, 9 am-9 pm; Sat, 9 am-5 pm; Sun, 11 am-5 pm
The Clinic at Walmart* 	3450 FM 1960 West, Houston	(281) 444-1738	M-Sat, 8 am-7 pm Sun, 11 am-7 pm

## URGENT CARE CENTERS & WALK-IN CLINICS

<b>North/NW (Harris County) - includes:</b>	<b>Cypress, Humble , Kingwood, N/NW</b>		
The Clinic at Walmart* 	155 Louetta Crossing, Spring	(281) 528-0278	M-Sat, 8 am-7 pm Sun, 11 am-7 pm
Westfield Urgent Care	2010 FM 1960 East	(281) 821-8200	M-F, 8 am-5 pm; Sat-Sun 11 am-5 pm
<b>East (Jefferson County) - includes:</b>	<b>Beaumont</b>		
Doctors Express of the Beaumont Area, P.A.	3195 Dowlen Road, Suite 105 Beaumont	(409) 860-1888	M-Sat, 8am-8 pm Sun, 8 am-5 pm
<b>East/SE/South (Harris County) - Includes :</b>	<b>E. Houston, Pasadena, Deer Park, Clear Lake Area &amp; Central Houston</b>		
Bay Side Clinic	4001 Preston Avenue, Suite 110 Pasadena	(281) 249-2203	M-F, 8 am-10 pm Sat-Sun, 9 am- 9 pm
Baytown Urgent Care Limited	2800 Garth Road, Baytown	(281) 425-3835	M-F, 5 pm-9:30 pm; Sat., 9 am-5 pm; Sun, 1 pm-6 pm
Beamer Urgent Care	10851 Scarsdale Blvd., Ste 130	(281) 481-9595	M-F, 9 am-8 pm Sat & Sun, 10 am-4pm
Concentra Health Services, Inc.	10909 I-10 East Frwy.	(713) 675-4777	M-F, 8 am-5 pm, Sat, 8-12 pm
Concentra Health Services, Inc.	8505 Gulf Freeway, Suite F	(713) 944-4442	M-F, 8 am-5 pm
Concentra Health Services, Inc.	125 East 8th Street, Deer Park	(281) 930-8555	M-F, 8 am-5 pm
East Houston Urgent Care	11410 I-10 East, Suite 168	(713) 453-9800	M-F, 9 am-6:30 pm Sat, 9 am-2 pm
Immediate Medical Care	1202 Nasa Parkway, Nassau Bay	(281) 335-0606	M-F, 9 am-9 pm; Sat & Sun, 9 am-5 pm
RediClinic* (H-E-B) 	6210 Fairmont Parkway, Pasadena	(832) 775-0165	M-F 8 am-8 pm; Sat 9-5; Sun 10-5
RediClinic* (H-E-B) 	9828 Blackhawk Blvd.	(713) 991-0497	M-F 8 am-8 pm; Sat 9-5; Sun 10-5
<b>SE/South (Galveston County) - includes:</b>	<b>Friendswood, League City &amp; Galveston</b>		
Calder Urgent Care	1100 Gulf Freeway, Suite 230 League City	(281) 557-4404	M-F, 9 am-7 pm; Sat, 9 am-3 pm; Sun, 10 am-2 pm
First Choice Emergency Room	3033 Marina Bay Dr., Suite 100 League City	(281) 549-9400	Mon-Sun, 12 pm-10 pm
RediClinic* (H-E-B) 	701 West Parkwood, Friendswood	(281) 947-0018	M-F 8 am-8 pm; Sat 9-5; Sun 10-5
RediClinic * (H-E-B) 	2955 South Gulf Frwy., League City	(281) 337-7351	M-F 8 am-8 pm; Sat 9-5; Sun 10-5
The Clinic at Walmart* 	150 W. El Dorado Blvd., Friendswood	(281) 280-0986	M-Sat, 8 am-7 pm Sun, 11 am-7 pm
The Clinic at WalMart* 	255 FM 518, Kemah	(281) 535-2439	M-Sat, 8 am-7 pm Sun, 11 am-7 pm

 \* denotes medical walk-in clinic—you pay a copayment of \$20

## URGENT CARE CENTERS & WALK-IN CLINICS

<b>SE/South (Galveston County) - includes:</b>			
<b>Friendswood, League City &amp; Galveston</b>			
The Clinic at Walmart* 	1701 W. FM 646, League City	(281) 337-5430	M-Sat, 8 am-7 pm Sun, 11 am-7 pm
West Isle Urgent Care	2027 61st Street, Suite B Galveston	(409) 744-9800	M-Sun, 9 am-10 pm
<b>South/SW (Brazoria County) - Includes:</b>			
<b>Angleton, Lake Jackson &amp; Pearland</b>			
Angleton Urgent Care	2327 East Hwy. 35, Angleton	(979) 848-8070	M-F, 1 pm-5 pm Sat, 12 pm-7 pm
First Choice Emergency Room	1851 Pearland Pkwy, Suite Z Pearland	(713) 474-9800	Mon-Sun, 12 pm-10 pm
Pearland Healthcare Center	1801 Country Place Pkwy, Suite 109, Pearland	(713) 436-4333	M-Th, 9 am-6 pm; Fri, 9 am-5 pm; Sat, 9 am-3 pm
Minute Clinic* (CVS) 	2900 E. Broadway St., Pearland	(866) 389-2727	M-F, 9 am-8 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm
Options Urgent Care & Wellness Ctr.	208 Oak Dr., Ste. 502, Lake Jackson	(979) 285-2273	Mon-Sun, 11 am-8 pm
RediClinic* (H-E-B) 	2805 Business Ctr. Dr., Pearland	(713) 436-5208	M-F 8 am-8 pm; Sat 9-5; Sun 10-5
Take Care* (Walgreens) 	8430 Broadway St., Pearland	(866) 825-3227	M-F, 8 am-7:30 pm Sat-Sun, 9:30 am-5 pm
The Clinic at Walmart* 	1710 Broadway St., Pearland	(281) 648-1296	M-Sat, 8 am-7 pm Sun, 11 am-7 pm
<b>Central /SW (Harris County) - Houston</b>			
Concentra Health Services, Inc.	9321 Kirby	(713) 797-0991	M-F, 8 am-5 pm
Concentra Health Services, Inc.	6545 Southwest Frwy.	(713) 995-6998	M-F, 8 am-5 pm
Concentra Health Services, Inc.	2004 Leeland	(713) 223-0838	M-F, 8 am-5 pm
Minute Clinic* (CVS) 	5402 Westheimer Rd, Suite K	(866) 389-2727	M-F, 9 am-8 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm
RediClinic* (H-E-B) 	2660 Fountainview	(866) 607-7334	M-F 8 am-8 pm; Sat 9-5; Sun 10-5
Salazi Medical Center	1826 Wirt Road	(832)428-4546	M-F, 9 am-9 pm; Sat, 10 am-2:30 pm
Take Care* (Walgreens) 	1919 West Gray Street	(866) 825-3227	M-F 8 am-7:30 pm Sat-Sun, 9:30 am-5 pm
Take Care* (Walgreens) 	5200 Westheimer Road	(866) 825-3227	M-F 8 am-7:30 pm Sat-Sun, 9:30 am-5 pm
Take Care* (Walgreens) 	2808 N. Gessner Road	(866) 825-3227	M-F 8 am-7:30 pm Sat-Sun, 9:30 am-5 pm
Take Care* (Walgreens) 	6768 Hwy. 6 South	(866) 825-3227	M-F 8 am-7:30 pm Sat-Sun, 9:30 am-5 pm
<b>West/SW (Ford Bend Co.) - Includes:</b>			
<b>Katy, Missouri City, Stafford and Sugar Land</b>			
Excel Immediate Medical Care	6840 Hwy. 6, Missouri City	(281) 403-3660	9 am-9 pm/7 days a week
Minute Clinic* (CVS) 	6220 Sienna Pkwy., Missouri City	(866) 389-2727	M-F, 9 am-8 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm

<b>West/SW (Ford Bend Co.) - includes:</b>	<b>Katy, Missouri City, Stafford and Sugar</b>	<b>Land</b>	
Night Light After Hours Pediatrics	15551 Southwest Frwy., Sugar Land	(281) 325-1010	M-F, 5 pm-11 pm; Sat-Sun, 12 pm-7pm
Physicians at Sugar Creek	14023 Southwest Frwy., Sugar Land	(281) 276-2000	M-F, 7 am- 7pm
RediClinic* (H-E-B) 	6711 South Fry Road, Katy	(281) 395-5080	M-F 8 am-8 pm; Sat, 9-5; Sun 10-5
RediClinic* (H-E-B) 	8900 Highway 6, Missouri City	(866) 607-7334	M-F 8 am-8 pm; Sat, 9-5; Sun 10-5
RediClinic* (H-E-B) 	19900 Hwy. 59, Sugar Land	(281) 341-8330	M-F 8 am-8 pm; Sat, 9-5; Sun 10-5
Stafford Medical	3832 Greenbriar Dr., Stafford	(281) 980-1901	M-F, 8 am-5 pm; Sat, 9 am- 12 pm
The Clinic at Walmart* 	5660 Grand Parkway West Richmond	(281) 342-1624	M-Sat, 8 am-7 pm Sun, 11 am-7 pm
<b>West (Harris County) includes: Katy</b>			
Concentra Health Services, Inc.	1000 N. Post Oak Road, Bldg. G #100	(713) 686-4868	Mon-Fri, 8 am-5 pm
Concentra Health Services, Inc.	12345 Katy Freeway	(281) 679-5600	M-F, 7 am-9 pm; Sat-Sun, 8 am-6 pm
Katy Urgent Care Partners	21700 Kingsland Blvd., Ste. 104 Katy	(281)829-6570	Mon-Sun, 9 am-9 pm
Minute Clinic* (CVS) 	3103 N. Fry Road, Katy	(866) 389-2727	M-F, 9 am-8 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm
Take Care* (Walgreens) 	411 South Mason Rd., Katy	(866) 825-3227	M-F, 8 am-7:30 pm; Sat-Sun, 9:30 am-5 pm
West Oaks Urgent Care	2150 South Hwy. 6, Suite 100	(281) 496-4948	M-Sat, 10 am-9 pm; Sun, 1 pm-8 pm
<b>West (Austin County) - Sealy</b>			
Sealy Urgent Care	526 5th Street, Sealy	(979) 877-0022	M-F, 7 am-7:30 pm; Sat-Sun, 8 am-4 pm

**QUESTIONS & ANSWERS ABOUT THE 457 DEFERRED COMP PLAN**

**What is a 457 plan and do I need it?**

The 457 deferred compensation plan (deferred comp) is a tax-deferred retirement plan that your employer offers so you can put even more money toward retirement directly from your pay. It's designed to be a supplement to your pension and is an additional way to invest long term. Deferred comp can help you create a more financially secure future for you and your family. It can provide a simple approach for you to enjoy the benefits of long-term investing. You're always in control of how to use deferred comp to help achieve your goals.

**How much money do you need when you retire?**

The amount is different for everyone. But experts say you generally need 70 to 90 percent of your current income to maintain your current standard of living. It's important to know the difference between what you'll have (from your Social Security, pension and personal savings) versus what you'll need in retirement. Contributing to a deferred comp plan can help bridge that gap.



**Where does retirement income come from?**

Most people depend on Social Security and their pension. On average, a public pension will replace only 50% of current income after 25 years of service. Most people will look to Social Security as a secondary source of retirement income, with their own savings, pensions and continued work as primary sources.

**What are the benefits of a tax-deferred plan?**

Tax deferred means your money goes into your account before taxes come out of your check. For example, let's say you pay around 25% in income taxes. Because you contribute to your deferred comp plan pre-tax, putting \$100 in your account only costs you \$75 from your take-home pay. When you make withdrawals from the account in the future you will have to pay income taxes.

**How do you put money into your account?**

Complete the county Auditor's Form 777—Payroll Deduction Agreement for automatic deductions from your paycheck. The minimum deduction is \$25 per month.

**NOTE:** If you are actively at work upon attaining the age of 65 you do not need to purchase Medicare Part B. If your spouse's primary insurance is the Harris County plan, they do not have to purchase Medicare Part B until you retire.



**Medicare Parts A & 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.

The Harris County Medical Plan coordinates its benefits with Medicare parts A & B. Since Medicare is the primary insurance, it must pay benefits first then Harris County Medical Plan will pay benefits. The 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 as a retiree.

**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.

**Medicare Part D**

Harris County Medicare eligible employees and retirees should NOT enroll in Part D— Medicare Prescription Drug Plan. Enrollment in a Medicare Prescription Drug Plan is voluntary, but in most cases it is **unnecessary** because the Harris County medical plan administered through Aetna provides more comprehensive prescription drug coverage. In addition, there is **no** coordination of benefits between Harris County's medical plan and the Medicare Prescription Drug Plan; however, there will continue to be coordination with Medicare Parts A and B.

**Under certain circumstances, you may be eligible for financial assistance if you enroll in a Medicare Prescription Drug Plan.**

- ⇒ You have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance); and
- ⇒ You live in one of the 50 states or the District of Columbia; and
- ⇒ Your combined savings, investments, and real estate are not worth more than \$25,010, if you are married and living with your spouse, or \$12,510 if you are not currently married or not living with your spouse. (**DO NOT include** the home you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.)

For more information about getting help with your prescription drug costs, call Social Security at 1-800-772-1213 or visit [www.socialsecurity.gov](http://www.socialsecurity.gov). If you or any of your covered dependents are eligible for additional coverage through **Medicaid**, you should contact 1-800-MEDICARE (1-800-633-4227) or visit [www.medicare.gov](http://www.medicare.gov) to determine the best prescription drug option for you.

**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, 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!

**TOTAL MONTHLY COST FOR MEDICAL,  
DENTAL & VISION PLANS  
EFFECTIVE MARCH 1, 2011**

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 \$63.93 for the Base Plus Plan.

**BASE PLAN MONTHLY COST**

**PPO**

	Employee Cost	County Cost	Total
<i>Employee Only</i>	\$0	\$490.00	\$490.00
<i>Employee + One</i>	\$223.18	\$714.21	\$937.39
<i>Employee + Two or More</i>	\$393.05	\$885.23	\$1,278.28

**DHMO**

	Employee Cost	County Cost	Total
<i>Employee Only</i>	\$0	\$476.37	\$476.37
<i>Employee + One</i>	\$216.70	\$694.06	\$910.76
<i>Employee + Two or More</i>	\$379.25	\$857.71	\$1,236.96

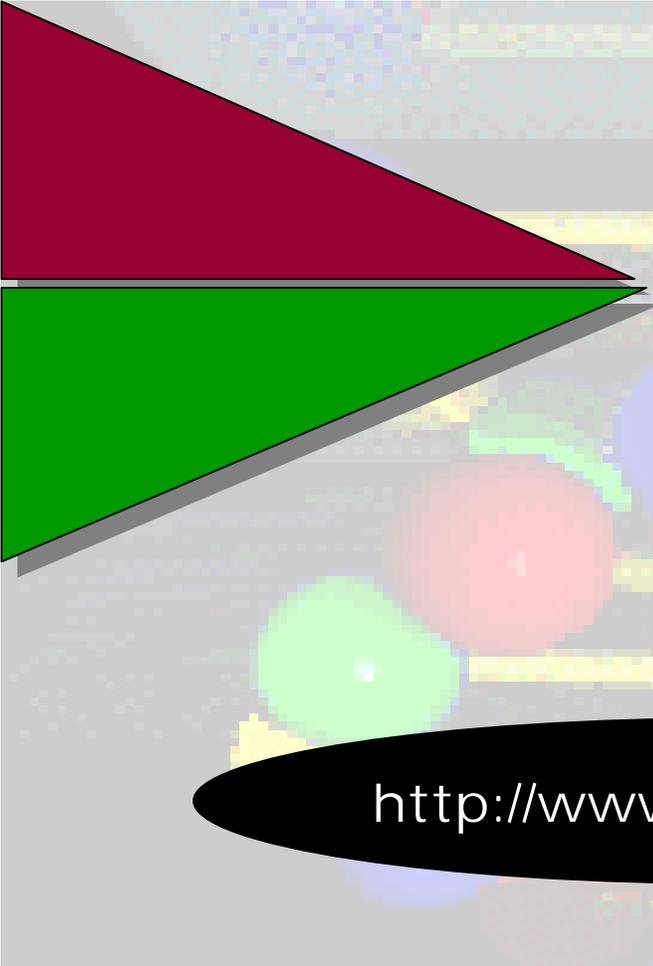
**BASE PLUS PLAN MONTHLY COST**

**PPO**

	Employee Cost	County Cost	Total
<i>Employee Only</i>	\$63.93	\$603.25	\$667.18
<i>Employee + One</i>	\$368.20	\$908.55	\$1,276.75
<i>Employee + Two or More</i>	\$597.80	\$1,139.30	\$1,737.10

**DHMO**

	Employee Cost	County Cost	Total
<i>Employee Only</i>	\$63.93	\$589.62	\$653.55
<i>Employee + One</i>	\$361.72	\$888.40	\$1,250.12
<i>Employee + Two or More</i>	\$584.00	\$1,111.78	\$1,695.78



HUMAN RESOURCES & RISK  
MANAGEMENT

Benefits Division

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Houston, TX 77002-2042

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PLAN YEAR: March 1, 2011—February 29, 2012

COMMISSIONERS COURT

Ed Emmett—County Judge

El Franco Lee- Precinct 1 Commissioner

Sylvia R. Garcia—Precinct 2 Commissioner

Steve Radack—Precinct 3 Commissioner

Jerry Eversole—Precinct 4 Commissioner

