HARRIS COUNTY

2012—2013 Resource Guide

Cafeteria of Benefits

...making the right choices...

...and $aving dollar$ on the road to...HEALTH

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 Human Resources & Risk Management (HRRM) Employee Benefits or from the HRRM web page at http://www.hctx.net/hrrm under the Plan Documents tab. This Resource Guide is also available electronically at http://www.hctx.net/hrrm under the 2012 Active Resource Guide tab. All plan documents are available electronically or hard copy upon request.

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.

		WEB ADDRESS
HUMAN RESOURCES & RISK MANAGEMENT		
Employee Benefits	(713) 755-5117	www.hctx.net/hrrm
Toll Free (out of area only)	(866) 474-7475	
MEDICAL COVERAGE		
Aetna Member Services	(800) 279-2401	www.aetna.com
Aetna Rx – Mail Order Delivery	(866) 612-3862	
On-site Representative	(713) 755-5604	
FLEX SPENDING ACCOUNT (FSA) QUESTIONS		
Aetna	(888) 238-6226	www.aetna.com
EMPLOYEE ASSISTANCE PROGRAM (EAP)		
Aetna EAP	(866) 849-8229	www.AetnaEAP.com
DENTAL HEALTH MAINTENANCE ORGANIZATION (DHMO) & PPO		
UnitedHealthcare DHMO and PPO Plan	(866) 528-6072	www.yourdentalplan.com/harriscounty
On-site Representative	(713) 755-4157	
VISION COVERAGE		
Block Vision	(866) 265-0517	www.blockvision.com
LONG-TERM DISABILITY PLAN		
CIGNA	(800) 362-4462	www.cigna.com
LIFE INSURANCE		
Prudential Insurance Company	(800) 524-0542	
DEFERRED COMPENSATION / 457 PLANS		
VALIC Retirement	(800) 448-2542	www.valic.com
ING Financial Services	(800) 525-4225	www.ingretirementplans.com
Nationwide (PEBSCO)	(877) 677-3678	www.nrsforu.com
RETIREMENT		
Texas County & District Retirement System (TCDRS)	(800) 823-7782	www.tcdrs.org

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

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OPEN ENROLLMENT OPTIONS & PLAN CHANGES

OPEN ENROLLMENT OPTIONS

The impact of provisions of the Affordable Care Act (ACA) (formerly known as Health Care Reform) will affect Harris County's group health plan for the upcoming year and in future years. The county takes great pride in providing our employees and their dependents a comprehensive benefits package. In order to maintain these comprehensive benefits while controlling the rising cost of healthcare, the county has instituted plan design and contribution changes this year. The requirements set forth by the ACA have been included as part of the county's plan design provisions. See page 3 for additional information.

Our program, 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 for the forthcoming year.

Your Options...

- ☑ Change your medical and/or dental plan
- ☑ Add and/or drop dependents
- ☑ Purchase or discontinue Optional Life insurance or LTD
- ☑ Flexible Spending Account enrollment/disenrollment

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 three times their annual salary. Optional LTD is also available for purchase. Reference pages 23—25 for plan details.

Employees who fail to return their completed form will be defaulted to their benefit selections made for the 2011-2012 plan year.

Open enrollment for the 2012/2013 plan year will be conducted from **January 1 through January 31, 2012.** Please contact your department's Benefit Coordinator for your department's deadline. Changes become effective **March 1, 2012**. **You should carefully consider the insurance plans available to you and your dependents.**

Choices made during open enrollment will remain in place until the following enrollment period.

2012-2013 CHANGES OVERVIEW

Health Care Flexible Spending Account (FSA): Contributions are limited to $2,500/year per federal law.

Qualified Transportation Account (QTA): Due to the burdensome administrative requirements and low participation, the QTA has been discontinued.

Medical plan: Modifications to the plan design are referenced on pages 15-18. Both plans experienced modifications to copayments, deductibles and coinsurance. **Preventive care will now be covered at 100%.**

Contribution changes: The county has changed its premium cost structure and added a fourth tier. The tier that was formerly employee + one has now been split into two tiers; employee + spouse and employee + child. The majority of employees will not experience a premium increase for the health plan. Reference page 32 for monthly rates.

Prescription Drug Plan: Pages 11-13 identify changes to the pharmacy benefit that include cost share percentage and copayment increases. The pharmacy benefit continues to be the same whether you enroll in the Base or Plus Plan.

Save-A-Copay: Eight new drug classifications have been added to the program. Reference page 13 for a potential savings opportunity.

Life insurance:

- You may purchase up to three times your salary up to a maximum of $375,000 coverage. Rates per $1,000 of coverage remain the same. Reference page 23 for details and rates.
- **The Texas County and District Retirement System (TCDRS) optional group term life insurance has been discontinued due to the increasing financial burden to the County.**

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.

Required documentation:

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 of the unmarried grandchild,
⇒ birth certificate of the grandchild's mother or father

NOTE: 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.

QUALIFIED STATUS CHANGE

Employees may experience life changes during the calendar year and a change form is required. "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

Changes are initiated either the 1st or 16th day of the month. All paperwork is due to HRRM by 12:00 on Friday of the preceding pay period.

Failure to drop dependents when required is insurance fraud and will result in the employee reimbursing the County for claims activity and possible referral to the District Attorney's office for investigation. Any questions concerning effective dates can be directed to your department's Benefit Coordinator/ Payroll Clerk.

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.

CONTRIBUTION POLICY

New tier structures effective March 1, 2012:

- Employee/Retiree Only
- Employee/Retiree + Spouse
- Employee/Retiree + Child
- Employee/Retiree + Two or More Dependents

Active Employees: The county continues to pay 100% of the total **Base** plan premium and 90% of the total **Plus** plan premium. Employees pay 50% of the incremental cost of dependent coverage.

Retirees: The county pays no more than the premium it pays for active employees for each rate tier structure (retiree pays the difference).

HEALTH CARE REFORM AND HOW IT AFFECTS YOU

On March 23, 2010, the Patient Protection & Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA) were signed into law and is now referred to as the "Affordable Care Act" or ACA. The following benefit modifications are implemented to comply with the Affordable Care Act.

- If you participate in the **Flexible Spending Account (FSA) - Health care account**, effective January 1, 2013, the Act imposes a limit of $2,500 per taxable year on employee salary reductions. Since the county's plan year is 3/1/12-2/28/13 we are required to implement this new law effective March 1, 2012.

- **Employees now may provide coverage for their dependents up to the age of 26 regardless of whether they are offered employer-based coverage**. 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, 2012.

- The Affordable Care Act (ACA) has a number of new external review requirements. These rules set new timelines for appeals, require health plans to offer external review in more circumstances, and specify the use of at least three external review organizations. The new external review program allows enrollees to experience shorter timelines when awaiting an appeals decision, the ability to appeal a decision to an external review organization and the assurance the assignment of the appeal to these external organizations is unbiased. Additional information regarding these new rights are included in the Summary Plan Document (SPD) available on the Human Resources and Risk Management web page at http://www.hctx.net/hrrm under the medical plan documents tab.

Due to benefit plan changes effective March 1, 2012, Harris County does not qualify as a "grandfathered health plan". As a result, we will be complying with recent Federal mandates to provide 100% coverage for preventive care. This includes age appropriate or risk status screenings and standard immunizations recommended by the American Committee on Immunization Practices and all United States Preventive Services Task Force A and B recommendations. Well-child immunizations and exams, well-man and woman exams, and screenings are included in this coverage as adopted by the Department of Health and Human Services guidelines.

THIS IS AN EXCELLENT BENEFIT FOR EMPLOYEES AND THEIR DEPENDENTS AND WE ENCOURAGE ROUTINE PHYSICAL EXAMS AND TESTING TO IDENTIFY POTENTIAL HEALTH PROBLEMS IN EARLY STAGES!

OUT-OF-NETWORK COVERAGE

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. This will result in savings for both you and the county.

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.

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.

NOTE: No out-of-network benefits for health care services provided by North Cypress Medical Center. The only exceptions are: emergency care in its emergency department and emergency in-patient admissions.

CHOOSING THE BEST PLAN FOR YOU AND YOUR DEPENDENTS

Both the Base and Plus plans have experienced many benefit changes for the upcoming year so 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. Copayments do not apply to coinsurance, out-of-pocket maximums or annual deductible.

Copayment: the predetermined dollar amount you will pay for a service (Examples: physician office visits, walk-in clinics, 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 are paid from 50%-100% depending on the plan selected, service rendered and place of service.

Deductible: initial out-of-pocket costs that must be paid before the plan begins to pay benefits (Base Plan In-Network $500; Plus Plan In-Network $0).

The **Base** plan has set copayments for some in-network services, but requires coinsurance for ambulance, durable medical equipment, hearing aids, high-tech radiology, home health care, hospice, inpatient hospitalization, outpatient surgery, physician hospital services, private duty nursing and skilled nursing facility. The Base plan also has a $500 per individual in-network deductible with an individual maximum out-of-pocket coinsurance limit of $2,500 per calendar year. The deductible and coinsurance only apply where services are not indicated as set copayments.

The **Plus** plan has set copayments for most 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.

WE HAVE AN "APP" FOR THAT!

The Aetna Mobile app is now available for Android™smartphones, iPhone®, iPod touch®, iPad™, and BlackBerry® Curve™ models . The Aetna application or "app" enhances the capabilities of Aetna Mobile Web by leveraging key Android smartphone functions. Similar to the Aetna app for iPhone and Blackberry users, the Aetna apps are free and allow members to:

- ☑ Search for a doctor or facility based on their current location and get turn-by-turn directions with the built-in Global Positioning System (GPS)
- ☑ View their Aetna ID card information
- ☑ Check the status of recent claims
- ☑ Access their Personal Health Record to view items like "Alerts & Reminders, Emergency Information, Medications and Tests & Procedures" while on the go
- ☑ Get a drug cost estimate before a prescription is filled
- ☑ View their coverage and benefits, including account balances

To download the app...

⇒ **Android™** users go to the Marketplace and search for "Aetna" to download the app.
⇒ **iPhone®, iPod touch® and iPad™** users can simply tap the App Store logo, then type "Aetna Mobile" in the search box.
⇒ **BlackBerry® Curve™** users go the BlackBerry App World™ storefront and download the Aetna mobile "app".

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 physician's 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 $10 per visit on copays. To find an Aexcel specialist login to www.aetna.com and select "Find a doctor, pharmacy or facility". **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 who is not in one of the categories you will pay the lower specialist office visit copay of $40. In the PLUS PLAN, only the providers in the twelve specialties that are Aexcel designated are subject to the lower copay of $30.

Aetna Health Connections℠ Disease Management Programs

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 programs, login to **www.aetna.com**, select "Health Programs", then "Disease Management Program". **No computer…no problem! Just call (866) 269-4500 to get started in disease management.**

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.**

- **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℠ Maternity Program

Every mother expects to have a healthy baby. It doesn't matter if you've been through this before—every pregnancy is different. Enrolling in the Beginning Right℠ maternity program provided by Aetna ensures you will have access to vital prenatal and postnatal information! This benefit is available 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.
- To help prevent/ decrease the risk of your baby's stay in a Neo-natal Intensive Care Unit (NICU), take the pregnancy risk survey and find out if you have any issues or risk factors that could affect your pregnancy and/or your baby's health. 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 will provide you personal case management and find ways to lower your risks.

Do it for yourself….and your baby!

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)

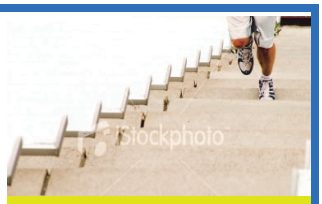
Simple Steps To A Healthier Life® Program

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 all answers are kept secure and confidential. You will need your current lab and biometric results to input into the assessment including blood pressure, cardiac CRP, BMI, 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**. ***Be sure to complete or update your health assessment at www.aetna.com!*** **ALL information is confidential!**



Step 1
Assess your health by completing the health assessment at www.aetna.com

Step 2
Take action using a personalized Healthy Living Program.

Step 3
Learn to make informed health decisions.

all is well at Harris County

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 on-site 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.com
Enter the password: **WELL4HCTX**

DO YOU KNOW THAT A 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.

Aetna Compassionate Care℠

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 twelve (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

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.

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.

Type www.hcintranet.net
Select "Employee Information"
Select "Helpful Employee Links"
Select the "Aetna Navigator (Medical)" and become the expert!

Interested in obtaining a complete listing of Aetna participating providers? Log on to www.aetna.com and select "Find a doctor", then select your provider category. You can search by city, state, zip, specialty, hospital affiliation, provider name, gender, language and education.

Make History℠ - 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.

Aetna InteliHealth®

To access, login to **www.aetna.com**

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

- 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, select "Health Programs", then** click on the link for the *Healthwise® Knowledgebase.*

24-Hour Nurse Line	Speak with a registered nurse who has experience in a variety of health topics at any time of the day.*
Audio Health Library	Phone in to choose from thousands of common health topics to listen to. Easily transfer to the Nurse Line for questions.
Healthwise® Knowledgebase	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.

NO OFFICE VISIT COPAYS

For locations, information and appointments, call **1-888-877-8427** or visit **www.diabetesamerica.com**.

Are You Diabetic? If so, it's important for you to have the best possible care and monitoring available to control your condition.

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
- Annual retinal exam
- Free glucose monitor

Aetna Resources For Living *(formerly EAP)*

Most people think of an EAP as a place to call when they have a crisis or an urgent need for emotional or mental health support. ***Resources For Living*** removes the stigma that often comes with the term EAP.

The focus of this program includes:

⇒ Work/life balance
⇒ Improved lifestyle
⇒ Better physical and mental health
⇒ Total well-being

Confidential assistance is available 24 hours a day, 7 days a week when using the Aetna ***Resources For Living*** (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 ***Resources for Living*** *(EAP)* for help with anything that interferes with your job or personal life such as:

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

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

Benefits of the Resources For Living:

⇒ **5 counseling sessions *per issue*, per year**

⇒ **Free initial legal consultation**

⇒ **Discounts on continuing legal consultation services**

⇒ **Free initial financial consultation**

Visit www.AetnaEAP.com (Company ID: EAP4HCTX) or call 1-866-849-8229

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA) is a special **non-taxed** account designed to save you money on health care and dependent care expenses. 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.

You elect an annual amount to contribute to your accounts, and these funds are transferred automatically from your paycheck into your FSA before taxes are calculated. Because this money is deducted pre-tax, you automatically save an average of 20-35% depending on your tax bracket.

The Affordable Care Act limits the amount you can contribute $208 per month **($2,500 per year)** in your Health Care FSA for the **March 1, 2012 to February 28, 2013** plan year. The minimum amount you can contribute is $25 per month. You then use the **tax-free** dollars you set aside to pay for eligible expenses incurred from 3/1/12—5/15/13 to pay for out-of-pocket health, dental, and vision expenses for you, your spouse, and your dependents.

How Does It Work?
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 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.

How Do I Begin?

- Estimate your annual out-of-pocket health care and/or dependent care expenses.
- Based on this amount, decide how much to contribute for the plan year (March 1, 2012 – February 28, 2013) 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.

⇒ **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

TIPS... FOR ESTIMATING YOUR MONTHLY DEDUCTION

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

Drug expenses — Including prescription drug copayments and PRESCRIBED over-the-counter drugs (OTC).

Dental care — Including a filling, extraction, root canal, crown, bridge, dentures and/or orthodontia.

Behavioral health care expenses — Including therapy copayments and medication management copayments.

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

To get more information on expenses eligible for your pre-tax dollars, go to www.aetnafsa.com .

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 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 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, 2013.

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 eligible prescribed over-the-counter (OTC) medications and non-medical expenses such as dental and vision claims.

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!

WHAT IS A DEPENDENT CARE ACCOUNT?

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 while you are at work.

Eligible expenses include:

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

For a list of eligible Dependent Care expenses go to www.aetnafsa.com.

The Dependent Care FSA works a little differently than Health Care FSAs in that it is not "pre-funded" and is similar to a checking account. 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 your child will not be in school or day care.

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

Example:

	WITH FSA	WITHOUT
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**
Your savings with the FSA	**$513**	

What is medication adherence?

When you learn that you have a long-term health problem, one of the most important ways you can manage your condition is by taking your medicine as directed by your doctor, pharmacist, or other health care professional. This is also known as medication adherence.

Reasons why people don't take their medication:

- **Side effects**
- **Forgetfulness**
- **Cost**
- **Don't believe they need it**

If you have questions about your condition such as how your medicine works, why you need to take medicine, side effects or other concerns– talk about it. Your doctor, pharmacist, nurse or other health care professional can help you understand your health problem and all of the things you can do to manage it – starting with taking your medicine as directed.

Prescription Drug Facts—

More than 1 in 3 medicine-related hospitalizations are because that person did not take their medication correctly. This can lead to additional health problems.

When you don't take your medicine as directed, you are putting your health and future at risk.

- **12% percent of Americans don't fill their prescriptions**
- **12% don't take the medication after they fill the prescription**
- **29% stop taking their medication before it runs out**
- **22% take less of the medication than is prescribed**

The discontinuation of medication therapy including beta blockers, statins, and aspirin post myocardial infarction is common and can be directly linked to a higher mortality rate.

A word about Bulk Chemicals and Compound Drugs...

- The County's prescription drug benefit excludes bulk chemicals.
- All compound drugs made with bulk chemicals included on Aetna's Bulk Chemical Exclusion List as amended and administered for Harris County will be excluded from coverage.
- Covered compound drugs will require a brand level member copay responsibility.

HARRIS COUNTY PRESCRIPTION DRUG BENEFITS

	Percentage You Pay	Minimum Copay	Maximum Copay
RETAIL			
Generic	25%	$5	$35
Brand	30%	$25	$100
Specialty	30%	$50	$200
MAIL ORDER			
Generic	25%	$10	$70
Brand	30%	$50	$200

Mandatory Generic Plan continues...

This is a mandatory generic prescription drug plan. 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.

If the member or physician requests brand name when a generic is available, the member pays the brand copay plus the difference between the generic price and the brand price.

Price-A-Drug

BEFORE YOU GO TO THE PHARMACY OR MAIL YOUR PRESCRIPTION TO AETNA RX HOME DELIVERY, CHECK PRICE-A-DRUG AT www.aetna.com.

Price-A-Drug provides cost information for prescriptions at both retail and mail order so you can determine the least expensive method prior to having the prescription filled.

You can also use this online feature to obtain information about less expensive bioequivalent or therapeutic alternatives or contact Aetna Customer Service at (713) 755-5604 or toll free (800) 279-2401.

- **Maintenance Prescriptions:** 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.

- **Multiple Prescriptions:** 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.

- **Prescription Narcotics:** 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.***

- **Faxing prescriptions:** 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.

- **Specialty medications/self-injectable drugs available only for a 30-day supply through the Aetna Specialty Pharmacy OR an Aetna designated and approved provider after the third refill at a retail pharmacy.**

- **Filing paper claims for your prescriptions? Talk to your pharmacist about calling Aetna Pharmacy Management for assistance in submitting your claim electronically, especially if you have two insurance carriers.**

DURABLE MEDICAL AND SURGICAL EQUIPMENT (DME) IS A COVERED BENEFIT ON BOTH PLANS BASED ON THE FOLLOWING CONDITIONS:

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 a person who does not have a disease or injury;**
- **not for exercise or training.**

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.

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.

Would you like to save money on your prescriptions?

The **Save-A-Copay Program** is a consumer focused, VOLUNTARY program that offers employees and/or their dependents a prescription drug copayment savings opportunity. The program currently offers savings options to people using cholesterol-lowering (Statins) and anti-depressants (SSRIs) medication. However, if you currently are utilizing one of the following brand name drugs and are willing to switch to a lower cost preferred generic drug, you will have no copayments for six months!

- **Sleep Disorders (Hypnotics):** Ambien, Lunesta, Sonata, Rozerem, Edluar
- **Seizure Disorders (Anti-epileptics):** Lamictal, Trileptal, Topamax, Lamictal XR
- **Attention Deficit Disorders (Stimulants):** Concerta, Focalin XR, Strattera
- **Hypertension (ARBs-ACEs):** Atacand, Avapro, Benicar, Teveten
- **Non-Sedating Antihistamines (NSAs):** Clarinex, Clarinex D, Xyzal
- **Nasal Steroids:** Beconase AQ, Flonase, Nasacort AQ, Rhinocort
- **Overactive Bladder (OAB):** Detrol, Detrol LA, Ditropan XL, Sanctura, Sanctura XR, Toviaz
- **Benign Prostatic Hypertrophy (BPH):** Flomax

This program is available for prescriptions filled at participating retail and mail order pharmacies. When using mail order you will not pay any copayments on two 90-day fills.

Each person's treatment is unique. Talk to your doctor first to find out if a preferred generic drug may be right for you.

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.

Hepatitis B (HepB)	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
Hepatitis A (HepA)	2 doses—1 dose between 12 and 23 months of age & 1 dose at least 6 months later
Rotavirus	2-3 doses—1 dose each at 2, 4 and 6 months of age
Diphtheria-Tetanus-Pertussis (DTaP)	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
Inactivated Polio (IPV)	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
H. Influenzae Type B (Hib) (may be combined with DTaP) & Pneumococcal Conjugate (PCV)	4 doses—1 dose each at 2, 4 and 6 months of age; and 1 dose between 12 and 15 months of age
Measles-Mumps-Rubella (MMR) & Chicken Pox (Varicella)	2 doses—1 dose between 12 &15 months of age; and 1 dose between 4 & 6 yrs of age
Influenza	Every flu season—beginning at 6 months of age
Meningococcal	1 dose between 11 and 12 years of age
Tetanus-Diphtheria-Pertussis (Tdap)	1 dose between 11 and 12 if the childhood DTP/DTap series is complete and has not received Td booster
Human Papillomavirus (HPV)	3 doses (females) between 11 & 12 yrs; second dose 2 months later, third dose 6 months after 1st dose
Blood Pressure	Every 2 years—18 years of age and older
Body Mass Index (BMI)	Periodically—18 years of age and older
Cholesterol	Government guidelines state that healthy adults who are aged 20 years or older should have a cholesterol test done once every 5 years.
Glucose (diabetes blood sugar test)	Beginning at age 45, then every 3 years unless you have other risk factors, then testing should occur every year
Mammogram	Every 1-2 years—women 40 years of age and older
Cervical Cancer	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.
Chlamydia	Routinely—women 24 years of age and younger if sexually active
Osteoporosis (Bone Density Test)	Routinely—women 65 years of age and older
Prostate Cancer	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
Colonoscopy	Men and women beginning at age 50, once every 10 years
Depression/Alcohol Misuse/Tobacco Use	Routinely—18 years of age and older
Tetanus-Diphtheria-Pertussis (Td/Tdap)	1 dose Td booster every 10 years
Pneumococcal	1 dose—65 years of age and older
Zoster (shingles)	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)	$500 Individual, $1,500 Family	$1,000 Individual, $3,000 Family
Deductible Carryover	None	None
Coinsurance Limit (excludes deductible; once family coinsurance is met, all family members will be considered having met the deductible)	$2,500 Individual, $7,500 Family	$8,000 Individual, $24,000 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	50% after deductible
Alcohol & Drug Abuse Services—Outpatient	100% after $40 or $50 copay	50% after deductible
Allergy Testing—includes serum, injections and injectable drugs (Allergy Specialist only)	100% after $40 office visit copay (waived for injection if no office visit charge)	50% 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	$40 copay, up to $600 per calendar year (no deductible or coinsurance applies)	50% after deductible; up to $600 per calendar year
Diagnostic X-ray and Laboratory	100% coverage	50% after deductible
Durable Medical Equipment	90% after deductible	50% after deductible
Emergency Room	$300 copay, waived if admitted	$300 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	50% after deductible
Home Health Care (100 visits per calendar year)	90% after deductible	50% after deductible
Hospice Care—Inpatient & Outpatient	90% after deductible	50% after deductible
Hospital Services—Inpatient	80% after deductible	50% after deductible
Hospital Services—Outpatient	80% after deductible	50% 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.

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	$1,000 Individual, $3,000 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	$8,000 Individual, $24,000 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	$500 per confinement copay	60% after deductible
Alcohol & Drug Abuse Services—Outpatient	100% after $30 or $40 copay	60% after deductible
Allergy Testing—includes serum, injections and injectable drugs (Allergy Specialist only)	100% after $40 office visit copay (waived for injection if no office visit charge)	60% 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)	60% after deductible; up to $600 per calendar year
Diagnostic X-ray and Laboratory	100% coverage	60% after deductible
Durable Medical Equipment	100% coverage	60% after deductible
Emergency Room	$300 copay, waived if admitted	$300 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	60% after deductible
Home Health Care (100 visits per calendar year)	100% coverage	60% after deductible
Hospice Care—Inpatient & Outpatient	90% after $250 deductible	60% after deductible
Hospital Services—Inpatient	$500 per confinement copay*	60% after deductible
Hospital Services—Outpatient	100% after $300 copay for surgical procedures, 100% coverage for non-surgical	60% after deductible

For inpatient maternity, copayment applies to mother and each child delivered.

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	50% after deductible
Mental Health—Outpatient coverage	100% after $30 copay	50% 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	50% after deductible
Physician Hospital Services	80% after deductible	50% after deductible
Preventive Care* (Routine physicals, immunizations and tests)	100% coverage	50% after deductible
Primary Care Physician Visits (excludes Mental/Health/Alcohol/Drug)	100% after $25 copay	50% after deductible
Specialist Office Visits Participating Aexcel providers Non-Aexcel participating providers	 100% after $40 copay 100% after $50 copay	50% after deductible
Private Duty Nursing—Outpatient (70 shifts per calendar year)	90% after deductible	50% after deductible
Residential Treatment Facility	80% after deductible	50% after deductible
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% coverage	50% after deductible
Routine Mammography—Ages 35-40 one baseline; age 40+, one every calendar year	100% coverage	50% after deductible
Short-Term Rehabilitation—physical, speech & occupational therapy (60 visits per calendar year)	100% after $25 copay	50% after deductible
Skilled Nursing Facility (100 days per calendar year)	90% after deductible	50% after deductible
Urgent Care Provider	100% after $50 copay	50% after deductible
Walk-in Clinics	100% after $25 copay	50% after deductible

***PREVENTIVE CARE—In accordance with the Affordable Care Act (ACA), preventive care services include age appropriate or risk status screenings, standard immunizations recommended by the American Committee on Immunization Practices and all United States Preventive Services Task Force A and B recommendations.**

Examples of these services include well-child immunizations and exams, well-man and woman exams, and screenings as adopted by HHS guidelines.

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 $500 per confinement copay	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)	100% after $300 copay	60% after deductible
Physician Hospital Services	100% coverage	60% after deductible
Preventive Care* (Routine physicals, immunizations and tests)	100% coverage	60% after deductible
Primary Care Physician Visits (excludes Mental/Health/Alcohol/Drug)	100% after $20 copay	60% after deductible
Specialist Office Visits Participating Aexcel providers Non-Aexcel participating providers	 100% after $30 copay 100% after $40 copay	60% after deductible
Private Duty Nursing—Outpatient (70 shifts per calendar year)	100% coverage	50% after deductible
Residential Treatment Facility	$500 copay	60% after deductible
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% coverage	60% after deductible
Routine Mammography—Ages 35-40 one baseline; age 40+, one every calendar year	100% coverage	60% after deductible
Short-Term Rehabilitation— physical, speech & occupational therapy (60 visits per calendar year)	100% after $20 copay	60% after deductible
Skilled Nursing Facility (100 days per calendar year)	100% coverage	60% after deductible
Urgent Care Provider	100% after $50 copay	60% after deductible
Walk-in Clinics	100% after $20 copay	60% after deductible

***PREVENTIVE CARE—In accordance with the Affordable Care Act (ACA), preventive care services include age appropriate or risk status screenings, standard immunizations recommended by the American Committee on Immunization Practices and all United States Preventive Services Task Force A and B recommendations. Examples of these services include well-child immunizations and exams, well-man and woman exams, and screenings as adopted by HHS guidelines. 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.**

UnitedHealthcare Dental®
A UnitedHealth Group Company

Harris County offers your dental benefits through United Healthcare 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.
- If you choose to enroll your dependents, you will be responsible for their portion of the monthly premium.

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 members a choice of dentists in-network, and the option to go out of network for services at a higher cost share. 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.

*UnitedHealthcare Dental HMO**	*UnitedHealthcare Dental PPO***
No calendar year maximums; no yearly deductibles	*$1,750 calendar year maximum; $50 yearly individual deductible ($150 for family)*
Basic care provided by network general dentists selected at enrollment. Members may change their designated dentist by contacting UnitedHealthcare Dental customer service by the 20th of the month. Requested changes will be effective the first of the following month.	*You may receive care from any licensed dentist; network dentists have agreed to accept negotiated fees as payment in full with no "balance billing".*
Each family member may select a different UnitedHealthcare Dental network general dentist (remember to include the Practice ID number when enrolling).	*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).*
Covered procedures and copayments are listed on the Schedule of Benefits and may be found on: www.yourdentalplan.com/harriscounty	*All claims are paid based on the percentages of the Maximum Allowable Charge.*
When specialty care is required, your selected general dentist and UnitedHealthcare Dental Customer Service Representative will assist in managing your referral.	*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.*
No waiting periods.	*New enrollees: 6 month waiting period on endodontic procedures & all major services (new employees and newly added dependents of current employees).*
Adult & child orthodontics is included.	*Orthodontia is not a covered benefit in the PPO plan.*
No claim forms are required.	*Claim forms may be required when a non-network dentist is used.*

*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

UnitedHealthcare Dental®
A UnitedHealth Group Company

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

(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

UnitedHealthcare DHMO Plan— Remember to select a dentist from the *UnitedHealthcare* Dental Directory or Dentist Locator on 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 http://www.hctx.net/hrrm or www.yourdentalplan.com/harriscounty. You may also 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

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 an 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.
- As part of the wellness visit, attending dentists provide counseling and materials about the impact of tobacco use, obesity and oral piercings as well as information about oral disease and other medical conditions.

Proper Use and Benefits of the PPO

UnitedHealthcare 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 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. After reviewing the plan documents, if you have any questions, a customer service representative will be happy to help you. Or, you may download a copy of the Certificate of Coverage at http://www.hctx.net/hrrm .

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. Crowns are generally necessary 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 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 preventable** 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 mother's 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. 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. Copayments are not applicable when utilizing out-of-network providers. For the complete schedule of benefits, reference the Vision Plan Benefit Certificate of Coverage.

Service/Product	In-Network	Out-of-Network
Complete Visual Exam*	$10 copay	Up to $35
Materials (when purchasing eyeglasses, lenses, frames OR contacts in lieu of eyeglasses)	$25 copay	
Frames		
	$130 retail allowance after $25 materials copay	Up to $70
Lenses		
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
Contact Lenses		
Elective	$130 retail allowance after $25 Materials copay	Up to $80
Necessary***	100% after $25 Materials copay	Up to $150
Laser Correction		
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

OPTIONAL TERM LIFE INSURANCE: Employees have the option of purchasing additional Life Insurance equal to one, two or three times their annual salary up to a maximum of $375,000. If your salary or wage changes your insurance amount will change on the next plan year.

REMINDER: Any Pre-Tax Life Insurance provided under the County plans in excess of $50,000 is subject to annual taxation.

If you purchased optional coverage prior to this enrollment period, you may increase your level of coverage by one times your salary without having to complete Evidence of Insurability (EOI), for example:
- **One times salary may increase to two times salary**
- **Two times salary may increase to three times salary**

If you have not previously purchased Optional Life insurance or currently have purchased it and are electing to increase by more than one level, you will be required to complete an Evidence of Insurability (EOI) form.

√ Life insurance and Accidental Death and Dismemberment (AD&D) Insurance provides 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.

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 under 18 designated as beneficiaries?
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.

IMPORTANT INFORMATION: Harris County will no longer offer a supplemental death benefit through the Texas County and District Retirement System (TCDRS) due to increased financial burden. However, employees may now purchase up to three times their annual salary in Optional Life insurance subject to a $375,000 maximum.

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

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

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

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.

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 do 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 **www.cigna.com/our_plans/disability/calculator/income_needs_calc.html** .
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 (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 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 to get your claim information. Through this relationship, CIGNA will work together with you and Harris County 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.

Important reminders:

☑ Always seek appropriate medical attention immediately. Your health and safety come first.

☑ Contact your supervisor 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.

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 Optional 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.

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 (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 people 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 U.S. 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.

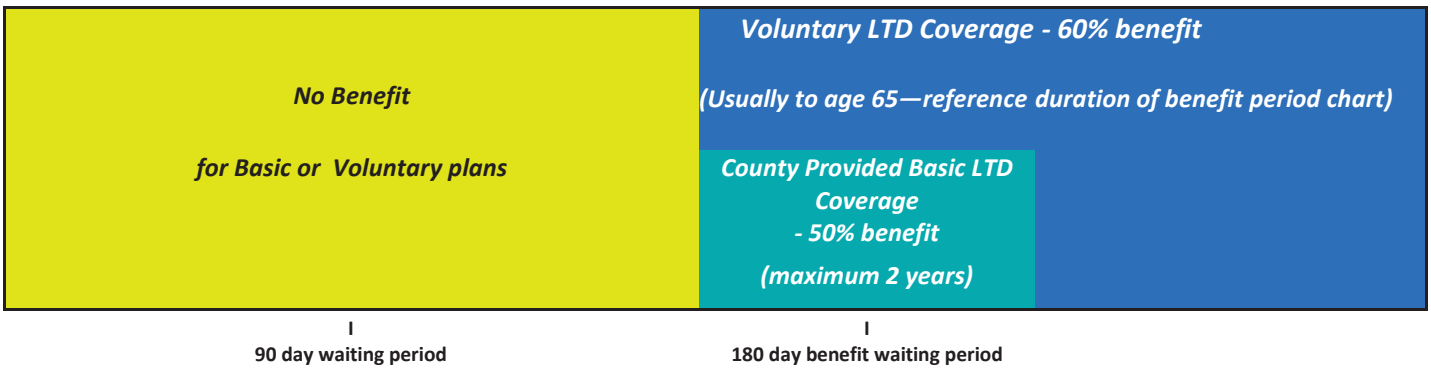
Long-Term Disability Comparison of Basic & Optional Plan

	BASIC LTD COVERAGE	*VOLUNTARY LTD COVERAGE*
MONTHLY BENEFIT	**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.**
MONTHLY MAXIMUM	**$5,000**	**$6,000**
MONTHLY MINIMUM	**$100**	**The greater of $200 or 10% of your disability benefit, prior to any deductible sources of income.**
BENEFIT WAITING PERIOD	**180 days**	**90 days**
MAXIMUM BENEFIT PERIOD	**Two years**	**Your benefit period begins on the first day after you complete your elimination period. And, should you remain disabled, your benefits continue according to the following schedule, 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



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 $50 per visit vs. the hospital emergency room copayment of $300.**

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 $300 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 $25 on the Base Plan and $20 on the Plus Plan. 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**		
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, 8:30 am-7:30 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 am-8 pm; Sat., 9 am-5 pm; Sun 10 am-5 pm
RediClinic* (H-E-B)	130 Sawdust Road, Spring	(281) 419-3162	M-F, 8 am-8 pm; Sat., 9 am-5 pm; Sun 10 am-5 pm
RediClinic* (H-E-B)	10777 Kuykendahl Road, Spring The Woodlands	(281) 907-4104	M-F, 8 am-8 pm; Sat., 9 am-5 pm; 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 pm; Sun, 1 pm-6 pm
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

* Denotes medical walk-in clinic. Copayments are $25 for the Base Plan and $20 for the Plus Plan.

North/NW/NE (Harris Co.) - includes:	Cypress, Humble, Kingwood, N/NW Houston, Tomball		
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	9 am-9 pm/7 days a week
Kingwood Urgent Care & Special Clinic	2601 W. Lake Houston Pkwy. Kingwood	(281) 360-7502	7 am-7 pm/7 days a week
MinuteClinic* (CVS)	8000 N. Sam Houston Pkwy East Humble	(866) 389-2727	M-F, 8:30 am-7:30 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm
MinuteClinic* (CVS)	24802 Aldine Westfield Spring	(866) 389-2727	M-F, 8:30 am-7:30 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, 8:30 am-7:30 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm
Night Light Pediatric Urgent Care	19708 Northwest Freeway, Suite 500	(713) 957-2020	M-F, 5 pm-11 pm Sat-Sun, 12 pm-7 pm
RediClinic* (H-E-B)	28520 Tomball Pkwy. Tomball	(281) 255-3085	M-F, 8 am-8 pm; Sat, 9 am-5 pm; Sun, 10 am-5 pm
RediClinic* (H-E-B)	4303 Kingwood Drive, Houston	(866) 607-7334	M-F, 8 am-8 pm; Sat, 9 am-5 pm; Sun, 10 am-5 pm
RediClinic* (H-E-B)	10919 Louetta	(281) 758-2282	M-F, 8 am-8 pm; Sat, 9 am-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, 9 am-5 pm; Sun, 10 am-5 pm
RediClinic* (H-E-B)	7405 FM 1960 East, Humble	(866) 607-7334	M-F, 8 am-8 pm; Sat, 9 am-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

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

North/NW (Harris County) - includes:	Cypress, Humble , Kingwood, N/NW Houston, Tomball		
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 12 pm-5 pm
East (Jefferson County) - includes:	**Beaumont , Nederland**		
Doctors Express of the Beaumont Area, P.A.	3195 Dowlen Road, Suite 105 Beaumont	(409) 860-1888	M-Sat, 8 am-8 pm; Sun, 8 am-5 pm
MinuteClinic* (CVS)	2712 State Highway 365, Nederland	(866) 389-2727	M-F, 8:30 am-7:30 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm
East/SE/South (Harris County) - includes :	**E. Houston, Baytown, Pasadena, Deer Park, Clear Lake Area , Central Houston**		
Baytown Urgent Care Limited	2800 Garth Road, Baytown	(281) 425-3835	M-F, 5 pm-9:30 pm; Sat., 9 am-5:30 pm; Sun, 1 pm-5:30 pm
Beamer Urgent Care	10851 Scarsdale Blvd., Ste 130	(281) 481-9595	M-F, 9 am-8 pm; Sat & Sun, 10 am-4 pm
Concentra Health Services, Inc.	10909 I-10 East Frwy.	(713) 675-4777	M-F, 8 am-5 pm; Sat, 8 am- 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 1-10 East, Suite 168	(713) 973-7943	M-F, 9 am-7 pm; Sat, 9 am-2 pm
Immediate Medical Care	1202 Nasa Parkway, Nassau Bay	(281) 335-0606	9 am-9 pm/7 days a week
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 am-5 pm
Take Care* (Walgreens)	16185 Space Center Boulevard	(866) 825-3227	M-F, 8 am-7:30 pm; Sat & Sun, 9:30 am-5 pm
Take Care* (Walgreens)	3300 Center Street, Deer Park	(866) 825-3227	M-F, 8 am-7:30 pm; Sat & Sun, 9:30 am-5 pm
Urgent Care MDs	1658 W. Baker Road, Suite A Baytown	(281) 428-0000	M-F, 9 am-9 pm; Sat-Sun, 12 pm-6 pm
SE/South (Galveston County) - includes:	**Friendswood, League City & Galveston**		
Calder Urgent Care	1100 So. 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
RediClinic* (H-E-B)	701 West Parkwood, Friendswood	(281) 947-0018	M-F 8 am-8 pm; Sat 9 am-5 pm; Sun 10 am-5 pm

* Denotes medical walk-in clinic. Copayments are $25 for the Base Plan and $20 for the Plus Plan.

SE/South (Galveston County) - includes:	Friendswood, League City & Galveston		
RediClinic * (H-E-B)	2955 South Gulf Frwy., League City	(281) 337-7351	M-F 8 am-8 pm; Sat 9 am-5 pm; Sun, 10 am-5 pm
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
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	9 am-10 pm/7 days a week
South/SW (Brazoria County) - includes:	**Angleton, Lake Jackson & Pearland**		
Angleton Urgent Care	2327 East Hwy. 35, Angleton	(979) 848-8070	Mon & Fri 9 am-7 pm, Tu/W/Th, 9 am-5 pm; Sat, 11 am-5 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, 8:30 am-7:30 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 am-5 pm; Sun 10 am-5 pm
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
Central /SW (Harris County) - Houston			
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
Houston Medical Care	5568 Weslayan Street	(713) 666-7050	M-Sat, 8 am-8 pm; Sun, 8 am-5 pm
Minute Clinic* (CVS)	5402 Westheimer Rd, Suite K	(866) 389-2727	M-F, 8:30 am-7:30 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 am-5 pm; Sun 10 am-5 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

West/SW (Ford Bend Co.) - includes: Katy, Missouri City, Stafford and Sugar Land			
Take Care* (Walgreens)	6768 Hwy. 6 South	(866) 825-3227	M-F, 8 am-7:30 pm Sat-Sun, 9:30 am-5 pm
Excel Immediate Medical Care	6840 Hwy. 6, Missouri City	(281) 403-3660	M-F, 9 am-9 pm; Sat/Sun, 10 am-8 pm
Night Light After Hours Pediatrics	15551 Southwest Frwy., Sugar Land	(281) 325-1010	M-F, 5 pm-11 pm; Sat-Sun, 12 pm—7pm
RediClinic* (H-E-B)	6711 South Fry Road, Katy	(281) 395-5080	M-F, 8 am-8 pm; Sat, 9 am-5 pm; Sun, 10 am-5 pm
RediClinic* (H-E-B)	8900 Highway 6, Missouri City	(866) 607-7334	M-F, 8 am-8 pm; Sat, 9 am-5 pm; Sun, 10 am-5 pm
RediClinic* (H-E-B)	19900 Hwy. 59, Sugar Land	(281) 341-8330	M-F, 8 am-8 pm; Sat, 9 am-5 pm; Sun 10 am-5 pm
RediClinic* (H-E-B)	23675 Nelson Way, Katy	(866) 607-7334	M-F, 8 am-8 pm; Sat, 9 am-5 pm; Sun, 10 am-5 pm
The Clinic at Walmart*	5660 Grand Parkway West Richmond	(281) 342-1624	M-Sat, 8 am-7 pm; Sun, 11 am-7 pm
West (Harris County) includes: Katy			
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-8:45 pm
Minute Clinic* (CVS)	3103 N. Fry Road, Katy	(866) 389-2727	M-F, 8:30 am-7:30 pm; Sat, 9 am-5:30 pm; Sun, 10 am-5:30 pm
RediClinic* (H-E-B)	9710 Katy Freeway	(866) 607-7334	M-F, 8 am-8 pm; Sat, 9 am-5 pm; Sun, 10 am-5 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

* Denotes medical walk-in clinic. Copayments are $25 for the Base Plan and $20 for the Plus Plan.

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 the 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 who 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 $25,260, if you are married and living with your spouse, or $12,640 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. 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 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, 2012

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 $67.13 for the Base Plus Plan.

BASE PLAN MONTHLY COST

PPO

	Employee Cost	County Cost	Total Cost
Employee Only	$0.00	$490.00	$490.00
Employee + Spouse	$248.55	$739.58	$988.13
Employee + Child	$223.18	$714.21	$937.39
Employee + Two or More	$393.05	$885.23	$1,278.28

DHMO

	Employee Cost	County Cost	Total Cost
Employee Only	$0.00	$476.37	$476.37
Employee + Spouse	$242.07	$719.43	$961.50
Employee + Child	$216.70	$694.06	$910.76
Employee + Two or More	$379.25	$857.71	$1,236.96

BASE PLUS PLAN MONTHLY COST

PPO

	Employee Cost	County Cost	Total Cost
Employee Only	$67.13	$632.02	$699.15
Employee + Spouse	$444.52	$1,010.45	$1,454.97
Employee + Child	$371.40	$937.32	$1,308.72
Employee + Two or More	$601.00	$1,168.07	$1,769.07

DHMO

	Employee Cost	County Cost	Total Cost
Employee Only	$67.13	$618.39	$685.52
Employee + Spouse	$438.04	$990.30	$1,428.34
Employee + Child	$364.92	$917.17	$1,282.09
Employee + Two or More	$587.20	$1,140.55	$1,727.75

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http://www.hctx.net/hrrm

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PLAN YEAR: March 1, 2012 – February 28, 2013

COMMISSIONERS COURT

Ed Emmett—County Judge

El Franco Lee—Precinct 1 Commissioner

Jack Morman—Precinct 2 Commissioner

Steve Radack—Precinct 3 Commissioner

R. Jack Cagle —Precinct 4 Commissioner