

Employee Resource Guide 2016-2017

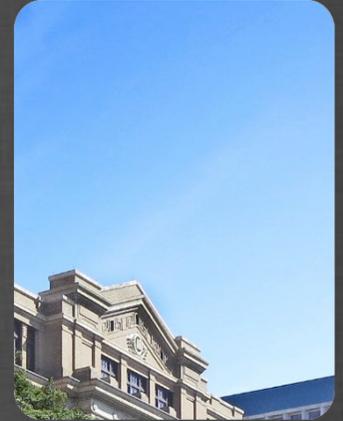


Photo courtesy of Harris County resident, Jim Adams

THESE BENEFITS ARE EFFECTIVE MARCH 1, 2016 THROUGH FEBRUARY 28, 2017. If there is any variation between the information provided in this Guide, the Plan Document, or the Group Contracts, the Plan Document and Group Contracts will prevail. This guide 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 including the Summary of Benefits Coverage (SBC) and the Glossary of Terms—both of which are available in English and Spanish versions— and/or Summary Plan Document (SPD) from Human Resources & Risk Management (HRRM) Employee Benefits. They are also available on the HRRM website at harriscountytexas.gov/hrrm.

All documents are available electronically and you may obtain a printed copy upon request, at no charge. Reference Page 1 for additional information about the SBC.

HUMAN RESOURCES & RISK MANAGEMENT

Employee Benefits.....(713) 274-5500
Out of Area Toll Free.....(866) 474-7475
Web: harriscountytexas.gov/hrrm, wellathctx.com

MEDICAL COVERAGE

Aetna Member Services.....(800) 279-2401
Aetna Rx—Mail Order.....(866) 612-3862
Onsite Representative.....(713) 274-5500
Flexible Spending Account..... (888) 238-6226
Resources for Living (EAP).....(866) 849-8229
Web: aetna.com, aetnafsa.com & mylifevalues.com

DENTAL COVERAGE

UnitedHealthcare DHMO & PPO.....(866) 528-6072
Onsite Representative.....(713) 274-5500
Web: yourdentalplan.com/harriscounty

VISION COVERAGE

Superior Vision.....(800) 507-3800
Web: www.superiorvision.com

LONG-TERM DISABILITY PLAN

CIGNA.....(800) 362-4462
Web: cigna.com

LIFE INSURANCE

Dearborn National Insurance Company.....(800) 348-4512
Web: dearbornnational.com

DEFERRED COMPENSATION/457 PLANS

VALIC Retirement.....(800) 448-2542
Web: valic.com

VOYA Financial Services.....(800) 525-4225
Web: voyaretirement.voya.com

Nationwide (PEBSCO).....(877) 677-3678
Web: nrsforu.com

RETIREMENT

Texas County & District Retirement System (TCDRS)..(800) 823-7782
Web: tcds.org

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IMPORTANT INFORMATION REGARDING PLAN CHANGES, RELATED DOCUMENTS, & PRIVACY

The Summary of Benefits Coverage (SBC), provided separately from the Resource Guide, summarizes the key features of our medical plans including: covered benefits, cost-sharing, coverage limitations, and exceptions.

The Glossary of Health Coverage and Medical Terms will help you understand some of the most common language used in health insurance documents.

Both the Summary of Benefits Coverage (SBC) for the Base, HAMP, & Plus Plans, and the Glossary of Health Coverage and Medical Terms are available in English and Spanish versions on the Harris County website at harriscountytexas.gov/hrrm, or you may obtain a printed copy upon request. To obtain a printed copy of the SBC or the Glossary of Health Coverage and Medical Terms at no charge, contact the Benefits Division at 713.274.5500 or toll free at 866.474.7475 and it will be sent to you within seven days.

2016 - 2017 PLAN CHANGES

In compliance with the Affordable Care Act, the Maximum Out-of-Pocket for in-network services for Individual/Family are now: Base Plan \$6,850/\$13,700; Healthy Actions Medical Plan (HAMP) \$6,350/\$12,700; and Plus Plan \$5,850/\$11,700. The deductible, coinsurance, medical and prescription drug copays will be applied to the maximum out-of-pocket.

Life insurance is now provided through Dearborn National. The Basic Life Insurance coverage for active employees will increase to \$30,000 effective March 1, 2016. Employees may increase their Optional Life Insurance coverage by 1x without having to complete Evidence of Insurability paperwork.

The maximum copays for prescription drugs have increased—see page 22 for details.

Please review the Medical Benefits Comparison on pages 19-21 for other plan changes.

Important Message Regarding Your 2015 Federal Income Tax Return

The Affordable Care Act requires Harris County to send an annual statement to all employees eligible for health insurance coverage describing the insurance available to them. The Internal Revenue Service (IRS) created Form 1095-C to serve as that statement. This form will be mailed directly to your home address in January 2016.

What do you need to do?

1. Provide Required Information: We need specific information on people enrolled in the health plan in order to provide you a complete 1095-C. If we do not have accurate Social Security Numbers on every dependent, the IRS may impose a penalty for non-compliance.
3. Ensure that your mailing address is correct in the County's payroll system. It's important because you will need information on the form to prepare your 2015 taxes.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN REQUEST ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR "NOTICE OF PRIVACY PRACTICES"

This Notice is for participants and beneficiaries in the Plan. As a participant or beneficiary of the Plan, you are entitled to receive this Notice of the Plan's privacy procedures with respect to your health information that the Plan creates or receives (your "Protected Health Information" or "PHI"). Our "Notice of Privacy Practices" was updated to comply with new changes to the Health Information Portability and Accountability Act ("HIPAA") effective as of March 26, 2013.

This Notice is intended to inform you about how we will use or disclose your PHI, your privacy rights with respect to PHI, our duties with respect to your PHI, your right to file a complaint with us or with the Secretary of the United States Health and Human Services ("HHS"), and how to contact our office for further information about our privacy practices. This Notice and the most updated "Notice of Privacy Practices" will be posted at harriscountytexas.gov/hrrm or you may request a copy by calling 713.274.5500.



OPEN ENROLLMENT FACTS FOR MEDICAL, DENTAL , VISION, FSA, LIFE, & LTD

Open enrollment for the 2016/2017 plan year will be conducted from January 1 through January 31, 2016. Please contact your department's Benefit Coordinator for your department's deadline. Changes become effective March 1, 2016. You should carefully consider the insurance plans available to you and your dependents.

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 19-21 for medical plan details and pages 27-30 for dental plan details. Everyone in your family must be in the same plan.

We recommend you consider purchasing Optional LTD and Life insurance to enhance financial security in the event of an unexpected life change.

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 Optional LTD
- Flexible Spending Account enrollment/disenrollment

To complete the process, sign your confirmation form and return it to your Benefit Coordinator/Payroll Clerk with the necessary documentation.

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

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

Employees who fail to return their completed form will be defaulted to their benefit selections made for the 2015-2016 plan year.

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 salaries. Optional LTD is also available for purchase. Reference pages 32-34 for plan details.

FAILURE TO DROP DEPENDENTS when required under this health plan may be considered **INSURANCE FRAUD** and may result in a referral to the District Attorney's office for investigation. Any employee committing insurance fraud will be liable to reimburse the County for any claims activity.

Any questions concerning effective dates can be directed to your department's Benefits Coordinator/Payroll Clerk.

QUALIFIED STATUS CHANGE/ DEPENDENT ELIGIBILITY

Employees may experience life changes during the calendar year that would allow them to add or drop a dependent. Employees must submit a Health & Related Benefits Change form to make changes. Qualified Status Changes include:

- ◆ Birth of your child
- ◆ Adoption or placement of a foster child
- ◆ Marriage, divorce, or death
- ◆ Spouse and/or dependent 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 benefits



Submitting required documentation is key to adding or dropping dependents to or from your coverage.

Spouse: A filed copy of a Formal Marriage License or Certificate of Informal Marriage. **Any documents written in a foreign language must be accompanied by a certified English translation.**

Children: A birth certificate listing the employee as the parent. A certificate of birth facts may be submitted up to age of five; however, a birth certificate is required for age five and up. Coverage is available up to age 26.

Legal Custody or Guardianship: Court documents, signed by a judge, granting permanent legal custody or permanent legal guardianship to employee. Coverage is available up to age 18.

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

Grandchildren:

- ⇒ Certification of Financial Dependency form (obtain from department Benefit Coordinator),
- ⇒ Birth certificate of the grandchild, and
- ⇒ Birth certificate of the grandchild's mother or father.
- ⇒ Coverage is available up to age 26.
- ⇒ The grandchild must be related to the employee by birth or adoption and cannot be your spouse's grandchild.

NOTE: Grandchild must be claimed as a dependent on the employee's Federal Tax return every year to remain on the plan. A Grandchild Audit occurs in June of each year.

Adopted Children: Certified copy of court order or paperwork placing child in your home.

Foster Children: Foster care placement agreement between the employee and the Texas Department of Family & Protective Services or its subcontractor.

MEDICAL SUPPORT NOTICES



Upon receipt of a Medical Support Notice 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.

CHOOSING THE BEST PLAN FOR YOU AND YOUR

DEPENDENTS 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. **Copayments do not apply to the annual deductible.** The following definitions may assist you in the decision-making process.

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 \$600; HAMP In-Network \$300; and Plus Plan In-Network \$0).

The **Base and HAMP** plans have set copayments for some in-network services, but require coinsurance for ambulance, durable medical equipment, hearing aids, complex imaging, home health care, hospice, inpatient hospitalization, outpatient surgery, physician hospital services, private-duty nursing, and skilled nursing facility. The **Base** plan also has a \$600 per individual in-network deductible with an individual maximum out-of-pocket limit of \$6,850 per calendar year. The **HAMP** has a \$300 per individual in-network deductible with an individual maximum out-of-pocket of \$6,350 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. The individual maximum out-of-pocket limit is \$5,850 per calendar year.

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.

OUT-OF-NETWORK COVERAGE

Harris County has limits on authorized costs associated with Out-of-Network facilities/providers. In an effort to maximize the highest level of benefit coverage, advise your participating physician to refer you only to in-network facilities and providers with Aetna. This will result in savings for both you and the county.

To help curb excessive out-of-network facility/provider costs, the county has established a Limited Out-of-Network reimbursement that limits the Plan's exposure to unreasonable costs 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 and the amount the facility charges. Non-covered expenses will not apply to your out-of-pocket 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. For information on participating providers, log on to www.aetna.com and select "Find a Doctor, Dentist or Facility."

NOTE THE FOLLOWING:

- ◆ **There are no out-of-network benefits for health care services provided by North Cypress Medical Center. The only exceptions are for true emergency care provided in the emergency department and emergency in-patient admissions.**
- ◆ **If you are currently on dialysis, coverage is provided in-network ONLY.**

In need of LAB SERVICES?

You must obtain your lab services through an Aetna approved lab such as Quest Diagnostics. If you fail to do so, the services will be paid as an out-of-network benefit subject to deductibles and coinsurance.



Your Health and
Wellness Resource

all is well at Harris County

Begin your journey to better health and wellness! Harris County Employee Wellness provides both onsite and web-based services that will help you improve your overall health.

GET ACTIVE

Participate in community events, onsite exercise classes, Live Healthy Harris County challenges, and the HC Employee 5K. Take advantage of gym membership discounts with the YMCA and GlobalFit.

STAY WELL

Enroll in programs such as Naturally Slim that can help you stay well and better manage your condition.

KNOW YOUR RISK

Take your online health assessment to learn your overall risk, or visit the Wellness Clinic at 1310 Prairie Street to have a routine mammogram and/or your annual physical.

BE INFORMED

Take a hands-on cooking class to learn a new, healthy recipe or watch a wellness class online! Get one-on-one health coaching services with the RD on the Go program.

CELEBRATE SUCCESS

Harris County has been recognized annually for its efforts in improving employee wellness. Share your own health accomplishments to help inspire and motivate others.

Find out more about all programs and services offered by Harris County Employee Wellness!

Visit wellathctx.com

Want a program or class offered at your facility?

Contact your Department Wellness Champion!

Find your department champion at wellathctx.com

>About Employee Wellness



Questions?

Call: 713.274.5500

Email: wellness@bmd.hctx.net

Social Media: [f](https://www.facebook.com/wellhctx) /wellhctx

HEALTHY ACTIONS MEDICAL PLAN (HAMP)



3 Simple Steps to wellness & savings

1

Take the online Health Assessment. Go to aetna.com and login to Aetna Navigator. Not registered? Use the "Register" link to get started. Look for the "I want to" menu on the left side of your home page. Click "Take a Health Assessment."

2

Get an annual routine physical, well woman exam, OR County-coordinated wellness screening. You may either visit your own primary care physician or go to "Know Your Risk" to find information on upcoming onsite physical events (County-hosted) and the 2016 Wellness Screening program.

3

Complete THREE different actions from the following:

- Have one **routine dental cleaning**. If you are on the DHMO plan, please submit the HAMP Form and supporting documentation for credit.
- Have one **routine vision exam**.
- Participate in one **Live Healthy Harris County challenge** (must complete the challenge to receive credit).
- Take 2 hours of **County-coordinated wellness training classes** (online or onsite).
- Complete 2 hours of **health/nutrition coaching sessions** in the RD on the Go program (2, 1-hour sessions).
- Flu Shot
- Routine mammogram
- Routine colonoscopy
- Participation in Check.Change.Control. Program
- Aetna Health Connections Condition Management Program
- Aetna's Beginning Right Program (must register by 16 weeks gestation)
- Harris County Employee 5K (must complete)

To be eligible for the 2017-2018 Healthy Actions Medical Plan, you must complete these 3 Steps between October 1, 2015 and September 30, 2016.

The Healthy Actions Medical Plan (HAMP) will give you a higher level of insurance benefits with lower out-of-pocket costs—all for the same rate as the Base Plan. You get better coverage for the same monthly cost, simply by taking a few actions to benefit your health!

Find information and a quick overview video online at wellathctx.com

- Steps to Wellness are tracked by the Benefits Office (within Human Resources & Risk Management).
- To submit proof you completed your routine dental cleaning, routine vision exam, or annual physical/well woman exam, please use the 2017-18 HAMP Form that can be downloaded at wellathctx.com. This form is ONLY necessary if you do not see your steps posted within 90 days of the date you completed them.
- If you are on the DHMO plan and would like your routine dental cleaning to be applied, you must submit the 2017-18 HAMP Form with supporting documentation.

FITNESS DISCOUNTS

Aetna Fitness Discount Program

Get preferred rates at your choice of over 10,000 gyms in the GlobalFit network.

You also get:

- ⇒ FREE guest pass at most gyms
- ⇒ Flexible membership options
- ⇒ Easy billing through your bank account or credit card

Choose from GlobalFit's national network of gyms. To find a participating gym in your area, visit globalfit.com/fitness.

You can view details about any gym, including rates and amenities, and register for membership online or by calling GlobalFit toll free at 800.298.7800. A GlobalFit representative can answer your questions, send you a free guest pass, and help you join the gym of your choice.

Examples of some of the gyms in the metro Houston area include 24-Hour Fitness, Jazzercise, Curves, Anytime Fitness and many other independent local gyms.

Save on home exercise equipment

Build your home gym with discounts on elliptical trainers and treadmills. Also available are resistance bands, mats, yoga accessories, and more.

Join the YMCA for a discounted rate!

Harris County is now a Corporate Member of the YMCA of Greater Houston, which entitles you to some **GREAT BENEFITS** at any YMCA in Greater Houston!

Benefits of Corporate Membership

- Your joining fee will be waived! That's a savings of up to \$100.
- Membership rates can be based on household income for those who qualify.
- City-wide membership so you can access the YMCA close to work as well as close to home.
- **10% off all programs!** From Personal Training to Massage Therapy to Sports Leagues, Summer Camp, and Swim Lessons, you'll get an additional 10% off the Corporate City-wide Facility Member Program Rate as a Citywide Corporate Member.

Visit wellathctx.com and select "Get Active" for more information on free services.

Harris County Employee Wellness Clinic

Convenient Medical Care

(for Harris County Medical Plan members 18+ only)

Clinic Hours: Monday, Tuesday & Friday
7 a.m. - 1 p.m.

1310 Prairie, 9th Floor (Anderson Clayton Bldg/Annex 44)

A SAMPLING OF OUR SERVICES

RESPIRATORY CONDITIONS

- Allergies
- Cold and coughs
- Flu
- Sinus infection
- Strep throat and sore throat

HEAD, EAR, EYE AND SKIN CONDITIONS

- Earaches and infections
- Eye irritation and redness
- Pink eye
- Styes
- Insect bites and stings
- Minor skin rashes and infections
- Minor headaches and migraines

DIGESTIVE AND URINARY CONDITIONS

- Minor abdominal pain
- Diarrhea
- Vomiting
- Nausea
- Constipation
- Urinary tract and bladder infections

MUSCULOSKELETAL CONDITIONS

- Muscle strains
- Bursitis and tendonitis
- Joint sprains and strains

Appointments: 713-394-6747 *Walk-Ins Welcome*
Walk-in clinic copay applies

Please note that this clinic **DOES NOT** provide services for occupational accidents or injuries.

HOUSTON
Methodist[®]
PRIMARY CARE GROUP

Aetna Health ConnectionsSM Condition Management Programs

This program is designed to help you or your eligible family member(s) learn more about your conditions 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. To learn more about Disease Management programs, login to aetna.com, select "Health Programs," then "Health 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

Aetna Compassionate CareSM

This is 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. Respite care provides short-term services to seriously ill individuals and relieves primary care givers of some of the burden.

For more information visit:
aetnacompassionatecareprogram.com

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'll get free online wellness coaching programs through HealthMedia[®] and learn strategies to fit healthy living into your busy life, at your own pace.

Online programs to help YOU reach YOUR goals

Manage your weight: Reach your goal weight, and boost how active you are with Balance [™] .	Sleep better: Beat sleepless nights with strategies from Overcoming [™] Insomnia.
Deal with stress: Find out where your tension comes from, and get proven strategies to stay calm under pressure with Relax [™] .	Quit Smoking: Get a quit plan that uses your strengths to help you get past old roadblocks with Breathe [™] .
Eat healthier: Get counseling one-on-one to learn better eating habits for life with Nourish [™] .	Be happier: Whether you have the blues or it's something more serious, you can get confidential help that gets results with Overcoming [™] Depression.

WHAT IS CASE MANAGEMENT AND DO I REALLY NEED IT?

SOMETIMES A PHONE CALL MAKES ALL THE DIFFERENCE IN THE WORLD and personalized help makes it easier for you to be healthy and well. That's why your Aetna program offers phone support from a caring registered nurse. Help is available when you need that support the most or when you just need a little advice.

For special situations, we know the health care system can be complicated. Just think of all the times you spoke with someone knowledgeable in health care issues, and how it put your mind at ease. Times when you are:

- ⇒ Planning for or coming home from a hospital stay
- ⇒ Managing a medical condition, like asthma or diabetes
- ⇒ Coordinating complex medical treatment among different doctors, hospitals, labs and other health care providers



The results are an improved relationship with your entire health care team

QUIT TOBACCO WITH THE AETNA HEALTHY LIFESTYLE COACHING PROGRAM

Break the habit of using tobacco for good! The Healthy Lifestyle Coaching Tobacco Free program is at no cost to you or your covered members. The program includes:

- Telephonic coaching sessions with an experienced wellness coach
- Access to online peer support available 24/7 (monitored by a wellness coach)
- Educational materials
- Extra support to address personal concerns, like maintaining your weight and managing stress
- Free 8-week supply of nicotine replacement therapy.



Get started today! Call **866.213.0153** or log in to aetna.com and complete your health assessment.



YOUR CONVERSATION IS PRIVATE

- ◆ It's in your best interest to talk openly with your program nurse.
- ◆ Rest assured that everything you discuss is confidential.
- ◆ Aetna never shares your information with anyone, including your employer.
- ◆ Be sure to answer the phone when Aetna calls.
- ◆ It's a phone call that can make a big difference.



DiabetesAmerica®

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

NO OFFICE VISIT
COPAYS

DiabetesAmerica is your "one-stop-shop" for diabetes care.

It provides comprehensive diabetes care, management, and education services at a single location with no office visit copay.

DiabetesAmerica 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
- Onsite labs
- Annual retinal exam
- Free glucose monitor

For locations, information, and appointments, call **866.693.4223** or visit diabetesamerica.com.

Beginning RightSM Maternity Program—Do it for yourself and your baby!

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 RightSM 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 the 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.

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



A COMPREHENSIVE LIST OF PARTICIPATING PROVIDERS is available at [aetna.com](https://www.aetna.com).

Contracted providers may have more than one office and it is possible that one or more offices are not considered "in-network." To avoid additional costs, please make sure that the provider you are seeing is "in-network" at the location of your visit.

If a provider orders a test or procedure for you, be sure to ask if it is experimental or investigational. If so, contact Aetna customer service before proceeding as it may not be covered.

Some procedures must be pre-certified!

aetnaSM 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, 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	Plastic Surgery
Neurosurgery	Urology
General Surgery	Vascular Surgery

For example, if you obtain specialty services from a Cardiologist or Neurologist, etc., or any other Aexcel specialty, you will have a **\$40 copay on the Base Plan, a \$35 copay on the HAMP, and a \$30 copay on the Plus Plan.** However, if you seek specialty services through an Aexcel specialty category such as cardiology and do not see an Aexcel designated cardiologist, **your copay on the Base Plan is \$50, on the HAMP is \$45, and on the Plus Plan is \$40.**

Since Aexcel only applies to twelve specialties, if you are enrolled in the BASE PLAN or HAMP and you see a specialist who is not in one of the twelve categories, you will pay the lower specialist office visit copay of \$40 (Base) or \$35 (HAMP). In the PLUS PLAN, only the providers in the twelve specialties that are Aexcel designated are subject to the lower copay of \$30.



Using Aexcel-designated providers will save you \$10 per visit on copays. To find an Aexcel specialist, login to [aetna.com](https://www.aetna.com) and select "Find a doctor, dentist or facility." Aexcel specialists are indicated with a blue star.

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 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 and choose from thousands of common health topics. 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 800.556.1555.



Aetna IntelliHealth® 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
- Emailed health updates

To access, login to aetna.com and begin learning everything you ever wanted to know about health and medical conditions.

Professional Care Management Aetna Resources for LivingSM

Do you have an adult loved one who might need a little more care? Now you can get expert help.

Professional Care Management: A valuable benefit to have at no cost.

Professional Care Management costs can range from \$85-\$200 an hour and are often not covered by insurance or Medicare.

We can help put your mind at ease

Each year, you can get up to six hours of free guidance from highly-trained Professional Care Managers (PCMs) to help a care recipient you are responsible for. Here’s what the PCM can do for you:

Home Assessment. After a visit with you and your loved one, the PCM will give you a written plan tailored for your loved one’s present and future needs. This will cover:

- Physical and mental condition
- Housing and support needs
- Support systems (friends, neighbors, emergency services, and more)
- Legal, financial, and insurance needs

Your care plan will include steps you can take to make things better. It’ll also give you resources to help along the way.

Facility Review. The PCM will tour selected care facilities to give you an idea of the level of quality you can expect from them.

Hospital visits and aftercare assessments. The PCM will visit your loved ones while still in the hospital to perform a needs assessment. Often the PCM will also look into the home or facility where your loved one will be going for aftercare.

Ongoing care coordination. To support your loved one’s needs, the PCM can make appointments, call for medical services, pay bills, set up community services, and more.

Easy to get started

One confidential call is all it takes to get started. A specialist will work with you to schedule an appointment with a PCM that’s convenient for you and your family members.

Call 866.849.8229 or visit mylifevalues.com (username & password: EAP4HCTX)



Aetna Resources For LivingSM

Confidential assistance is available 24 hours a day, 7 days a week when using Aetna **Resources For Living** (formerly Employee Assistance Plan, a.k.a. EAP).

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

Aetna Resources For Living understands that some days it can be tough to manage the competing priorities in our lives and keep them running smoothly. Sometimes life can become work and work can become your life. Either way, they are there to help you balance the two. Maybe you just need someone to talk to about a recent transition or conflict at work, or maybe you're looking for some guidance with your personal relationships...



Benefits of Resources For Living:

- ⇒ 8 FREE face-to-face counseling sessions *per issue*, per year
- ⇒ Free initial legal consultation and discounts on continuing legal consultation services
- ⇒ Free initial financial consultation
- ⇒ Online discounts and access to a full range of web-based tools and resources
- ⇒ Most importantly, all information is confidential between Aetna Resources for Living and you!

WHAT ARE YOU WAITING FOR?

Visit mylifevalues.com
and enter
Username: EAP4HCTX
Password: EAP4HCTX

or call 866.849.8229

**ASSISTANCE IS JUST A PHONE CALL
OR CLICK AWAY FOR
FREE SERVICES!**

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 and continues to provide that same level of support while adding assistance with all of the following:

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

WELLNESS & TECHNOLOGY

Make HistorySM - 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 by printing your record and taking it to your next visit.
- 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 aetna.com.

Are you computer shy?

Using Aetna Navigator[®] has never been easier!

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

1. Type hctx.net
2. Select "Employee Information"
3. Select "Helpful Employee Links"
4. Select the "Aetna Navigator Tutorial" and become the expert!

Interested in obtaining a complete listing of Aetna participating providers? Log on to 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.

aetnaSM WE HAVE AN "APP" FOR THAT!

The Aetna Mobile app is 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.



RECOMMENDED PREVENTIVE HEALTH/SCREENING/VACCINE

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 and 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. Influenza 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 and 15 months of age; and 1 dose between 4 and 6 years 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 and 12 years; 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 age 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

NOTE: Preventive health, screening and vaccines are a covered benefit on our plans based on frequency and age-specific guidelines indicated.

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

Don't use an Emergency Room when a visit to a physician's office, walk-in clinic, or urgent care center is adequate! Use the lowest level of care appropriate for your immediate need.



\$20-\$25 for Walk-in Clinic

Some of the facilities listed on the following pages are considered "walk-in clinics" and they are marked with an asterisk (*) and shaded gray. These clinics generally offer services similar 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/HAMP Plans.

\$50 for Urgent Care

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 versus 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. 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.

Advantages: Lower copayment & shorter wait time!

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.

\$300 for EMERGENCY CARE

PURPOSE: Treatment for life-threatening emergencies, or emergency conditions that can permanently impair or endanger the life of an individual.



DISADVANTAGES:

- ⇒ Higher copayment of \$300 per visit
- ⇒ Higher cost to the health plan
- ⇒ Extended wait time based on severity of the issue

WHAT ARE STANDALONE ERs?

Many standalone emergency care centers are located near high-end shopping for easy consumer accessibility and convenience; however, they charge double or triple the amount of a physician's office or urgent care center and are NOT designed to treat life-threatening illness.

Your copayment will be \$300 and you may have to pay additional fees for transport and admission to a hospital. We urge our employees and their dependents to be responsible, educated health care consumers when determining the appropriate treatment facility.

HOSPITAL ADMISSION & EMERGENCY ROOM INFORMATION

If a member is admitted to an out-of-network hospital through the emergency room, clinicians from Aetna's Utilization Management area will confirm the admission was clinically necessary. If it is determined the admission is not a true emergency, it will be covered at the out-of-network benefit level. This means you will have to pay a larger portion of the bill at the out-of-network hospital.

Occasionally members brought to the emergency room are not always admitted, but placed under observation. Coverage for observation in a hospital emergency room is limited to 24 hours. At such time, the member must either be admitted or discharged, but cannot remain in holding in the emergency room or the balance may be billed by the provider.

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

North (Montgomery County)	Conroe, The Woodlands, Spring Montgomery, Porter, & Kingwood	
MinuteClinic* (CVS)	25110 Grogans Mill Rd., Spring	(866) 389-2727
Nextcare Urgent Care	15320 Hwy 105 W #120, Montgomery	(936) 582-5660
Nextcare Urgent Care	1331 Northpark Dr., Kingwood	(281) 359-5330
Oaks Urgent Care	25410 IH 45 North, Spring	(281) 363-5600
RediClinic* (H-E-B)	2108 North Frazier, Conroe 130 Sawdust Road, Spring 10777 Kuykendahl Road, Spring	(936) 494-4350 (281) 419-3162 (281) 907-4104
Take Care* (Walgreens)	24917 FM 1314 Road, Porter 8000 Research Forest, The Woodlands	(866) 825-3227
Urgent Care for Kids	1640 Lake Woodlands, The Woodlands	(281) 367-0010
E/NE (Liberty County)		
Quality Care Plus	2718A North Main Street, Liberty	(936) 336-3616
North/NW/NE (Harris County)	Cypress, Humble, Kingwood, Spring, Houston, Huffman, & Tomball	
Champions Urgent Care	4950 FM 1960 West, Suite A6	(281) 444-1711
Concentra Health Services, Inc.	401 Greens Road, Houston 6360 W Sam Houston Pkwy N, Suite 200 8799 N Loop East, Suite 110	(281) 873-0111 (713) 280-0400 (713) 674-1114
Convenient Urgent Care	411 W Parker Road, Houston	(713) 691-3300
Doctors Express Urgent Care	10850 Louetta Rd #1500, Houston	(281) 320-2338
CyFair Urgent Care	9110 Barker Cypress Rd., Cypress	(281) 517-9900
Excel Urgent Care	25801 U.S. Hwy. 290, Cypress	(281) 304-1100

North/NW/NE (Harris County)	Cypress, Humble, Kingwood, Spring, Houston, Huffman, & Tomball	
Kingwood Urgent Care & Special Clinic	2601 W Lake Houston Pkwy, Kingwood	(281) 360-7502
Medspring Urgent Care	1450 Kingwood Drive, Kingwood	(832) 548-4420
Minute Clinic* (CVS)	8000 N Sam Houston Pkwy E, Humble 24802 Aldine Westfield, Spring 8754 Spring Cypress Rd, Spring 26265 NW Frwy, Cypress 12550 Louetta Road, Cypress	(866) 389-2727 (866) 389-2727 (866) 389-2727 (866) 389-2727 (866) 389-2727
Next Level Urgent Care	15882 Champion Forest Drive, Spring 8100 Hwy 6 N, Suite E, Houston	(281) 809-6615 (832) 304-2314
Nextcare Urgent Care	10906 FM 1960 Road West	(281) 477-7490
Only Choice Urgent Care	11515 FM 1960 #C, Huffman	(281) 324-1550
Night Light Pediatric Urgent Care	19708 NW Frwy #500, Houston	(713) 957-2020
RediClinic* (H-E-B)	28520 Tomball Pkwy., Tomball 4303 Kingwood Drive, Houston 10919 Louetta, Houston 24224 Northwest Frwy, Cypress 7405 FM 1960 East, Humble	(281) 255-3085 (866) 607-7334 (281) 758-2282 (866) 607-7334 (866) 607-7334
Take Care* (Walgreens)	1215 W 43rd St, Houston 7440 FM 1960 Road East, Humble 19710 Holzwarth Road, Spring 16211 Spring Cypress Rd, Cypress 11970 Spring Cypress Rd. Cypress	(866) 825-3227 (866) 825-3227 (866) 825-3227 (866) 825-3227 (855) 925-4732
Westfield Urgent Care	2010 FM 1960 East, Houston	(281) 821-8200

IMPORTANT INFORMATION...

Walk-in clinics are marked with an asterisk (*) and shaded gray. Your copay at the walk-in clinics is only \$25 on the Base Plan and \$20 on the HAMP and Plus Plan.

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

East (Jefferson County)	Beaumont, Nederland, & Port Arthur	
Doctors Express of the Beaumont Area, P.A.	3195 Dowlen Rd #105, Beaumont	(409) 860-1888
Mid County Urgent Care	1908 Hwy 365, Nederland	(409) 729-1900
MinuteClinic* (CVS)	2712 Hwy 365, Nederland	(866) 389-2727
East/Southeast/South (Harris County)	E. Houston, Baytown, Pasadena, Deer Park, Clear Lake Area, & Central Houston	
Baytown Urgent Care Limited	2800 Garth Road, Baytown	(281) 425-3835
Beamer Urgent Care	12880 Beamer Rd., Suite D, Houston	(281) 481-9595
Concentra Health Services, Inc.	10909 I-10 East Frwy, Houston 8505 Gulf Frwy, Suite F, Houston 125 East 8th Street, Deer Park	(713) 973-7943 (713) 944-4442 (281) 930-8555
East Houston Urgent Care	11410 I-10 East #168, Houston	(713) 453-9800
Immediate Medical Care	1202 Nasa Parkway, Nassau Bay 525 Blossom St, Webster 6825 Spencer Hwy, Pasadena	(281) 335-0606 (281) 724-1885 (281) 741-0070
MinuteClinic* (CVS)	2469 Bay Area Blvd, Houston 3505 Center St, Deer Park 9828 Blackhawk Blvd, Houston	(866) 389-2727 (866) 389-2727 (866) 389-2727
Normandy Urgent Care	779 Normandy St. #114, Houston	(713) 453-8900
Primary Urgent Care	2802 Garth Rd #111, Baytown	(281) 838-8575
RediClinic* (H-E-B)	6210 Fairmont Pkwy, Pasadena	(832) 775-0165
Take Care* (Walgreens)	16185 Space Center Blvd, Houston 3300 Center Street, Deer Park	(866) 825-3227 (866) 825-3227

Southeast/South (Galveston County)	Friendswood, League City, & Galveston	
Calder Urgent Care	1100 Gulf Frwy #230, League City	(281) 557-4404
Immediate Medical Care	3354 FM 528, Friendswood 2640 E League City Pkwy #114, League City	(832) 569-5739 (281) 538-8000
RediClinic* (H-E-B)	701 W Parkwood Drive, Friendswood 2955 South Gulf Frwy., League City	(281) 947-0018 (281) 337-7351
Twin Oaks Urgent Care	1111 S. Friendswood Dr., Friendswood	(832) 385-3675
Urgent Clinics Medical Care	2560 State Hwy 96 #B, League City	(832) 982-7228
West Isle Urgent Care	2027 61st Street, Suite B, Galveston	(409) 744-9800
South/Southwest (Brazoria County)	Angleton, Lake Jackson, & Pearland	
Immediate Medical Care	2705 Broadway St.#101, Pearland	(281) 412-0508
Minute Clinic* (CVS)	2900 E Broadway St, Pearland 9522 Broadway St, Pearland	(866) 389-2727 (866) 389-2727
Options Urgent Care & Wellness Center	208 Oak Dr #502, Lake Jackson	(979) 285-2273
Prime Urgent Care	2510 Smith Ranch Rd #102, Pearland	(713) 340-3111
RediClinic* (H-E-B)	2805 Business Ctr. Dr., Pearland	(713) 436-5208
Take Care* (Walgreens)	8430 Broadway St., Pearland	(866) 825-3227

IMPORTANT INFORMATION...

Walk-in clinics are marked with an asterisk (*) and shaded gray. Your copay at the walk-in clinics is only \$25 on the Base Plan and \$20 on the HAMP and Plus Plan.

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

Central /Southwest (Harris County)	Houston	
Concentra Health Services, Inc.	9321 Kirby, Houston 6545 SW Frwy, Houston 2004 Leeland, Houston	(713) 797-0991 (713) 995-6998 (713) 223-0838
Doctors Express Urgent Care	107 Yale St #200, Houston	(713) 861-6060
Houston Medical Care	5568 Wesleyan Street	(713) 666-7050
Medsprings Urgent Care	1917 W Gray St, Houston	(832) 260-0650
Memorial Urgent Care	14629 Memorial Dr, Houston	(281) 589-8500
Minute Clinic* (CVS)	5402 Westheimer Rd #K, Houston 3939 Bellaire Blvd, Houston 1003 Richmond Ave, Houston	(866) 389-2727 (866) 389-2727 (866) 389-2727
Optum Clinic—Urgent Care	3651 Wesleyan St., Houston	(713) 835-3791
RediClinic* (H-E-B)	2660 Fountainview, Houston	(713) 343-2699
Take Care* (Walgreens)	1919 W Gray Street, Houston 5200 Westheimer Road, Houston 2808 N Gessner Road, Houston	(713) 526-3621 (713) 623-0643 (713) 460-0535
West/Southwest (Fort Bend County)	Katy, Missouri City, Stafford, & Sugar Land	
Excel Urgent Care	6840 Hwy 6, Missouri City	(281) 403-3660
Medsprings Urgent Care	1403 Hwy 6 #100, Sugar Land 6501 S Fry Road, Katy	(832) 260-0640 (832) 260-0670
Next Level Urgent Care	16902 SW Frwy #108, Sugar Land 8720 Hwy 6 S #400, Missouri City	(832) 342-9205 (832) 342-9204
Night Light After Hours Pediatrics	15551 SW Frwy, Sugar Land	(281) 325-1010

West/Southwest (Fort Bend County)	Katy, Missouri City, Stafford, & Sugar Land	
RediClinic* (H-E-B)	6711 South Fry Road, Katy 8900 Hwy 6, Missouri City 19900 Hwy 59, Sugar Land 23675 Nelson Way, Katy	(281) 395-5080 (281) 778-0622 (281) 341-8330 (281) 347-7700
Southwest Urgent Care	19875 SW Frwy #100, Sugar Land	(281) 545-2323
Take Care* (Walgreens)	6768 Hwy 6 South, Houston	(281) 530-9768
Texas Children's Urgent Care	9727 Spring Green Blvd #900, Katy	(281) 789-6300
Urgent Care for Kids	23730 Westheimer Pkwy #N, Katy	(281) 392-3033
West (Harris County)	Katy & West Houston	
Concentra Health Services, Inc.	1000 N Post Oak Rd #G-100, Houston 12345 Katy Frwy, Houston	(713) 686-4868 (281) 679-5600
Entrust Immediate Care	9778 Katy Frwy #100, Houston	(713) 468-7845
Excel Urgent Care	19450 Katy Frwy, Houston	(281) 829-9900
Katy Urgent Care Partners	21700 Kingsland Blvd., Ste. 104, Katy	(281) 829-6570
Medsprings Urgent Care	14045 Memorial Drive, Houston	(832) 548-4410
Minute Clinic* (CVS)	3103 N. Fry Road, Katy 5603 FM 1960 W, Houston	(866) 389-2727 (866) 389-2727
Next Level Urgent Care	10705 Spring Green Blvd. #600, Katy	(281) 907-9646
RediClinic* (H-E-B)	9710 Katy Frwy, Houston	(713) 932-8800
Take Care* (Walgreens)	411 South Mason Rd., Katy	(281) 579-0910
Texas Children's Urgent Care	12850 Memorial Dr #210, Houston	(832) 827-4000
West Oaks Urgent Care	2150 South Hwy. 6, Suite 100	(281) 496-4948

The urgent care centers and walk-in clinics listed are current providers and may be subject to change. It is your responsibility to check the provider's status and hours of operation when you seek services.

MEDICAL BENEFITS COMPARISON—BASE PLAN/HAMP VS. PLUS PLAN

PLAN FEATURES/SERVICES	BASE PLAN/HAMP PREFERRED BENEFITS (In-Network)	BASE PLAN/HAMP NON-PREFERRED BENEFITS (Out-of-Network)	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Out-of-Network)
Plan Deductible per Individual /Family (Per Calendar Year)	BASE: \$600/\$1,800 HAMP: \$300/ \$900	\$1,000 Individual \$3,000 Family	None	\$1,000 Individual \$3,000 Family
Maximum Out-of-Pocket—includes deductible, coinsurance, medical and Rx copays (Per Individual/Family Per Calendar Year)	BASE: \$6,850/\$13,700 HAMP: \$6,350/\$12,700	\$10,000 Individual \$30,000 Family	\$5,850 Individual \$11,700 Family	\$10,000 Individual \$30,000 Family
Lifetime Maximum	Unlimited except where otherwise indicated	\$1,000,000	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)	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	\$500 per confinement copay	50% after deductible
Alcohol & Drug Abuse Services—Outpatient	100% after \$40 copay	50% after deductible	100% after \$40 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	100% after \$40 office visit copay (waived for injection if no office visit charge)	50% after deductible
Ambulance	90% after deductible	90% after deductible	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	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	\$30 copay, up to \$600 per calendar year (no deductible or coinsurance applies)	50% after deductible; up to \$600 per calendar year
Complex Imaging—MRI, PET, CT scan, etc. (pre-certification required)	90% after deductible	50% after deductible	\$100 copay	50% after deductible
Diagnostic X-ray and Laboratory	100% coverage	50% after deductible	100% coverage	50% after deductible
Durable Medical Equipment	90% after deductible	50% after deductible	100% coverage	50% after deductible

NOTE: Limits for the Base/HAMP and Base Plus Plans are combined for both preferred and non-preferred benefits. Please reference your Plan Document for a complete listing of covered services, reimbursement amounts, limitations, and exclusions.

MEDICAL BENEFITS COMPARISON—BASE PLAN/HAMP VS. PLUS PLAN

PLAN FEATURES/SERVICES	BASE PLAN/HAMP PREFERRED BENEFITS (In-Network)	BASE PLAN/HAMP NON-PREFERRED BENEFITS (Out-of-Network)	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Out-of-Network)
Emergency Room	\$300 copay, waived if admitted	\$300 copay, waived if admitted	\$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	80% coverage, no deductible	80% after deductible
Home Health Care (100 visits per calendar year)	90% after deductible	50% after deductible	100% coverage	50% after deductible
Hospice Care—Inpatient & Outpatient	90% after deductible	50% after deductible	90% after \$250 deductible	50% after deductible
Hospital Services—Inpatient	80% after deductible	50% after deductible	\$600 per confinement copay*	50% after deductible
Hospital Services—Outpatient	80% after deductible	50% after deductible	100% after \$400 copay for surgical procedures, 100% coverage for non-surgical	50% after deductible
Maternity* (coverage includes voluntary sterilization)	Payable as any other covered expense	Payable as any other covered expense	Payable as any other covered expense	Payable as any other covered expense
Mental Health—Inpatient coverage	80% after deductible	50% after deductible	100% after \$600 per confinement copay	50% after deductible
Mental Health—Outpatient coverage	100% after \$30 copay	50% after deductible	100% after \$30 copay	50% after deductible
Outpatient surgery (facility) (Except in physician's office when office visit copay applies)	80% after deductible	50% after deductible	100% after \$400 copay	50% after deductible
Physician Hospital Services	80% after deductible	50% after deductible	100% coverage	50% after deductible
Preventive Care** (Routine physicals, immunizations, and tests)	100% coverage	50% after deductible	100% coverage	50% after deductible

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

**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/HAMP and Base Plus Plans are combined for both preferred and non-preferred benefits. Please reference your Plan Document for a complete listing of covered services, reimbursement amounts, limitations, and exclusions.

MEDICAL BENEFITS COMPARISON—BASE PLAN/HAMP VS. PLUS PLAN

PLAN FEATURES/SERVICES	BASE PLAN/HAMP PREFERRED BENEFITS (In-Network)	BASE PLAN/HAMP NON-PREFERRED BENEFITS (Out-of-Network)	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Out-of-Network)
Primary Care Physician Visits (excludes Mental Health/Alcohol/Drug)	BASE: \$25 copay HAMP: \$20 copay	50% after deductible	100% after \$20 copay	50% after deductible
Specialist Office Visits Participating Aexcel providers Non-Aexcel participating providers	BASE: \$40 copay HAMP: \$35 copay BASE: \$50 copay HAMP: \$45 copay	50% after deductible	100% after \$30 copay 100% after \$40 copay	50% after deductible
Private Duty Nursing—Outpatient (70 shifts per calendar year— requires precertification)*	90% after deductible	50% after deductible	100% coverage	50% after deductible
Residential Treatment Facility	80% after deductible	50% after deductible	\$600 copay	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	100% coverage	50% after deductible
Routine Mammography—Ages 35-40 one baseline; age 40+, one every calendar year	100% coverage	50% after deductible	100% coverage	50% after deductible
Short-Term Rehabilitation—physical, speech, & occupational therapy (60 visits per calendar year)	100% after \$25 copay	50% after deductible	100% after \$20 copay	50% after deductible
Skilled Nursing Facility (up to 100 days per calendar year and requires precertification)*	90% after deductible	50% after deductible	100% coverage	50% after deductible
Urgent Care Provider	100% after \$50 copay	50% after deductible	100% after \$50 copay	50% after deductible
Walk-in Clinics	BASE: \$25 copay HAMP: \$20 copay	50% after deductible	100% after \$20 copay	50% after deductible
Women’s Health—includes well woman exam, screening, testing , contraceptives, breast feeding supplies/support*	100% coverage	50% after deductible	100% coverage	50% after deductible

*Reference the Summary Plan Document available at www.harriscountytexas.gov/hrrm for details regarding coverage.

HARRIS COUNTY PRESCRIPTION DRUG BENEFITS

	Percentage You Pay	Minimum Copay	Maximum Copay
RETAIL			
Generic	25%	\$5	\$50
Brand	30%	\$25	\$150
Specialty	30%	\$50	\$300
MAIL ORDER			
Generic	25%	\$10	\$100
Brand	30%	\$50	\$300



Price-A-Drug

BEFORE YOU GO TO THE PHARMACY OR MAIL YOUR PRESCRIPTION TO AETNA RX HOME DELIVERY, CHECK PRICE-A-DRUG AT 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 Member Services at 713.274.5500 or toll free 800.279.2401.

THIS IS A MANDATORY GENERIC 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.

Aetna Rx Step Program

Precertification is required for angiotensin receptor blocker (ARB drugs), angiotensin converting enzyme inhibitor (ACE inhibitors), statin (cholesterol), and diabetic prescriptions.

With step-therapy, certain medications will be excluded from coverage unless one or more "prerequisite therapy" medications are tried first, or unless the prescriber obtains a medical exception.

The plan will not cover certain step-therapy drugs if your prescriber does not prescribe a prerequisite drug first or fails to obtain a medical exception unless the corresponding prerequisite therapy drug(s) are used first.

Prerequisite therapies and any medical exception prescriptions will be subject to dose and quantity recommendations outlined by the manufacturer.

SPECIALTY MEDICATIONS AND/OR SELF INJECTIBLE DRUGS

are available only for a 30-day supply through a network retail pharmacy, Aetna's Specialty Pharmacy, or an Aetna designated and approved provider.

MAINTENANCE PRESCRIPTIONS

If you recently filled a maintenance prescription, and your physician changed/increased your dosage, or if you are just reordering the maintenance medication and you are sending in a new prescription, you must have used 2/3 of your prescription prior to mailing in your new prescription.

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.

IMPORTANT PRESCRIPTION DRUG INFORMATION

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. If you are currently 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! If you qualify for this program, Aetna will send a letter to you encouraging your participation.

The below list of Drug Class and Targeted Drugs is subject to change without notice.

Drug class	Targeted drugs
Antidepressants (SSRIs)	Paxil CR, Lexapro, Cymbalta
Migraine	Imitrex, Maxalt, Maxalt MLT, Alsuma Injection, Amerge, Axert, Frova, Migranal, Relpax, Sumavel, Treximet, Zomig, Zomig ZMT, Cambia powder
Seizure Disorder (Anti-epileptics)	Topamax, Lamictal XR, Oxtellar XR
Attention Deficit Disorders (Stimulants)	Concerta, Focalin XR, Quillivant SUS XR, Adderall XR
Sleep Disorders (Hypnotics)	Ambien, Lunesta, Rozerem, Sonata, Edluar, Zolpimist Spray, Intermezzo sub
Nasal Steroids	Beconase AQ, Rhinocort, Flonase, Nasacort AQ
Non Sedation Antihistamines (NSAs)	Clarinet/D, Xyzal
Benign Prostatic Hypertrophy (BPH)	Flomax
Overactive Bladder (OAB)	Detrol, Detrol LA, Ditropan XL, Toviaz
Acne	Retin-A, Minocin, Dynacin, Duac, Benzefoam, Benzacilin, Acanya, Adoxa, Atralin, Benzamycin, Monodox

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.

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.

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.

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.

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. In most instances you will receive a maximum three-month supply of medication.

DURABLE MEDICAL AND SURGICAL EQUIPMENT (DME) IS A COVERED BENEFIT

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 HAMP/Base Plan members and at 100% for Plus Plan members when using in-network providers.



BREASTFEEDING SUPPLIES & LACTATION SUPPORT

To receive a complimentary breast pump, you must obtain a prescription from your OB/GYN and present it to a participating Durable Medical Equipment (DME) provider. For a list of providers, go to aetna.com.

The plan will pay for one electric breast pump in a 36-month period within 60 days of birth, 1 manual pump in a 36-month period within 12 months of birth, and one (1) set of breast pump supplies on alternate years from receipt of the pump.

Lactation Support and Counseling:

Six visits per year to a qualified lactation consultant for either individual or group classes. Any additional visits (7+) will be covered according to the plan's provisions.

FINANCIAL PLANNING FOR THE FUTURE IS NECESSARY FOR A COMFORTABLE RETIREMENT



What is a 457 plan and do I need it?

The 457 deferred compensation plan (deferred comp) is a voluntary 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.

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.

Roth 457 Accounts

Harris County employees also have the opportunity to participate in Roth 457 accounts through one of Harris County's deferred compensation vendors. When you contribute to a Roth 457, you pay taxes on the portion of your salary that goes into the plan; however, withdrawals of contributions and earnings can be tax free during retirement if certain conditions are met. If you wish, you can even split your contributions between traditional pre-tax contributions and Roth after-tax contributions.

How do you put money into your account?

Contact one of the Deferred Compensation vendors for guidance and additional information. If you decide to participate, complete the county Auditor's Form 777—Payroll Deduction Agreement for automatic deductions from your paycheck. The minimum deduction is \$25 per month.

FLEXIBLE SPENDING ACCOUNTS

SHOULD I ELECT TO PARTICIPATE IN 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 disposable 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.

You can contribute \$212 per month (**\$2,544 per year**) in your Health Care FSA for the **March 1, 2016 to February 28, 2017** 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 3/1/16—5/15/17 for out-of-pocket health, dental, and vision expenses for you, your spouse, and your dependents.

You will receive a PayFlex debit card to access your Health Care FSA funds at a pharmacy for prescription drug purchases only.

Once your account has been set up, you can order additional cards online for your spouse or dependents.

FSA Control # 620329.

Cards are good for 5 years.



Your PayFlex Card, an account debit card, will look similar to this.

TIPS

Estimating Your Monthly Deductions

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, vision, hospital, etc., copayments over the past year. If you haven't kept track of your expenses, you can log in to your Aetna Navigator at aetna.com and review your claims history to provide you with 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.



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. Contribution changes are only permitted in the event of a qualified status change.

Example:

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

When you pay physician copayments on the Aetna medical plan, Aetna reimburses your out-of-pocket expenses after the claim is processed. 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.

Things to remember about the Health Care FSA

What if I don't want my claims automatically reimbursed for physician and other medical copayments?

If you do not wish to have automatic reimbursement, you may go online via aetnavigators.com or via payflexdirect.com and turn off the automatic reimbursement function within your personal FSA account, which would allow you to submit claims at your convenience.

Can I save time by having my claim reimbursements direct deposited into my bank account?

Absolutely. You may enroll by going to aetnafsa.com or by completing the direct deposit form. Reimbursement funds will appear in your bank account approximately five (5) business days from the day that Aetna processes your claim. The direct deposit will be reflected in the "check stub" portion of your Health Care FSA Explanation of Payment (EOP). The EOP will state the amount of the reimbursement, when the electronic funds transfer was made, and when the funds will be posted to your bank account.

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, 2017.

Can I use my PayFlex Debit Mastercard for expenses other than prescriptions?

No, the debit card will only work at pharmacies to purchase prescription drugs.



Flexible Spending Accounts for the 2016-2017 plan year will not be set up and available for your use until your first paycheck of the new plan year. For bi-weekly employees, the date will be March 11, 2016. Employees paid monthly will have their accounts available on March 31, 2016. You will not receive your PayFlex card until 10 business days after your account is set up.

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 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 require manual claims submission either via mail or fax to Aetna's FSA department.



UNITED HEALTHCARE DENTAL PLANS - DHMO & PPO PLAN OPTIONS

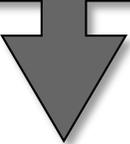
OPTIONS: Harris County offers your dental benefits through UnitedHealthcare Specialty Benefits and continues to provide two dental options:

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

QUESTIONS? UNITEDHEALTHCARE CUSTOMER SERVICE STAFF ARE AVAILABLE Monday-Friday, 7 a.m.-10 p.m. CST at 866.528.6072 and select "0" to speak to a representative.

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.

Call 866.528.6072



Register for online access at:
yourdentalplan.com/harriscounty (registration and login button located 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.

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 20 th 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. For more information, see the Benefit Summary or determine out-of-pocket costs by using the online Treatment Cost Calculator.
Covered procedures and copayments are listed on the Schedule of Benefits and may be found at: yourdentalplan.com/harriscounty	In-network claims are paid based on the percentages and network discounts. Out of network claims are paid based on percentages of Maximum Allowance Charge (MAC).
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 and all major services (new employees and newly-added dependents of current employees).
Adult & child orthodontics is included in the DHMO plan.	Orthodontia is <u>not</u> 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.

COMPARE THE DHMO AND PPO DENTAL PLANS TO MAKE THE RIGHT DECISION FOR YOU AND YOUR FAMILY

WHICH PLAN IS BEST FOR ME?

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 DHMO Plan

Remember to select a dentist from the *United Healthcare Dental Directory* or *Dentist Locator* on yourdentalplan.com/harriscounty for you and each of your enrolled dependents. Indicate the Practice ID Number in the space on your enrollment form for each person enrolled.

You can obtain a complete Schedule of Benefits with covered procedures and copayments along with Exclusions & Limitations, available online at harriscountytexas.gov/hrrm or 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 yourdentalplan.com/harriscounty.

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 decide to use a network dentist, you can log on to yourdentalplan.com/harriscounty to browse the *Dental Directory* or *Dentist Locator* to 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 negotiated discounts with network dentists. Payment of non-network claims is based on a Maximum Allowable Charge (MAC). The Maximum Allowable Charge is set by *UnitedHealthcare Dental*. This MAC is the most that *United Healthcare Dental* pays for a plan's covered dental procedure when a non-network dentist is used.

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 harriscountytexas.gov/hrrm.

Included with your PPO Dental Plan:

Prenatal Dental Care Program: Women in their second and third trimesters 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 and are 30 years of age or older may be eligible for this once-yearly, light-contrast screening.

DENTAL WELLNESS AND ESTIMATING THE COST OF TREATMENT

WELLNESS SCREENING Included with your Dental HMO and PPO:

- The UnitedHealthcare Dental Wellness plan, through its eight (8) 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.
- Contact the UnitedHealthcare Dental Onsite Representative at 713.274.5500 to locate a Center of Excellence near you.

What is the difference between Routine Cleaning and Deep Cleaning?

“**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.

How much your dental treatments will cost

UnitedHealthcare Dental is committed to helping make the most of your dental plan benefits, by getting actual prices for treatments based on your individual plan, comparing the rates charged by different providers, and seeing your out-of-pocket cost so you can plan ahead. We have created an easy-to-use tool: the Treatment Cost Calculator.

With the Treatment Cost Calculator, you can always make an informed choice about your dental treatments. It's easy to use and available to members 24 hours a day at yourdentalplan.com/harriscounty.

HERE'S HOW IT WORKS:

1. To get started, visit yourdentalplan.com/harriscounty and select Plan Info > Treatment Cost Calculator.
2. At the next screen, log in with your username and password. If you haven't previously registered at yourdentalplan.com/harriscounty, you can register now.
3. At the next screen, you'll enter information about the practitioner performing the procedure.
You'll need the following information:
 - ◆ The approximate date of the procedure
 - ◆ The Practitioner ID. To find the ID of a network practitioner, click the link to search for dentists who perform the procedure.
4. At the next screen, you'll enter information about your procedure. Select the procedure from the list of common treatments shown. You can also enter the procedure code, if you know it, or display a list of procedure codes.
5. Your treatment cost results will be displayed, including the cost of the service based on your specific plan, the amount you're responsible for (coinsurance), any limitations or waiting periods in your plan, and your annual deductible, which is the amount you must pay each year before your plan starts paying benefits.
6. From the treatment cost results page, you can display your dental benefits summary, which lists your plan features, including in and out-of-network coverage rates, your annual deductible, and your annual maximum.

IMPORTANT DENTAL INFORMATION

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.

UnitedHealthcare Dental DHMO Specialty Care Referrals and Emergency Dental Services Instructions:

Customer Service: 866.528.6072, Hours: 7 a.m. - 10 p.m. CST

Specialty Care Referrals - Certain dental procedures may require the expertise of a specialist and require a specialty care referral. Your assigned primary care dentist is responsible for completing the specialty referral form. With your form in hand, contact Customer Care for an authorization number and a specialist authorized to provide your care. Referrals are not needed for children up to age eight to see a pediatric dentist. Children aged eight and older need to get a referral from a primary care dentist. Children under age eight who need services of a specialist other than a pediatric dentist must still get a specialty referral.

Emergency Dental Services - If you are within seventy-five (75) miles of your Selected General Dentist, simply contact your selected dentist who will make reasonable arrangements for such emergency dental care. If you are more than seventy-five (75) miles from your Selected General Dentist, or you cannot reach your Selected General Dentist or Customer Service, you may obtain Emergency Dental Services for stabilization from any licensed dentist. Potential examples of emergencies are excessive bleeding, severe pain, or acute infection. Reference the Dental Plan Documents for specifics at harriscountytexas.gov/hrrm.

In a **non-emergency situation**, you will receive an explanation of benefits via the mail that will list the specialist contact information and your authorization number. **For emergency situations**, you will receive a call back from your approved participating specialist.

FILLING OPTIONS TO CONSIDER

"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 and 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.



SUPERIOR VISION

The Harris County Vision Care Program is offered through Superior Vision.

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 Superior Vision for reimbursement.

HOW THE VISION CARE PROGRAM WORKS

Each time you need vision care, you may seek care through the Superior Vision benefit plan. Select a *Superior Vision* participating provider by calling customer service at 800.507.3800, or visit superiorvision.com. When you make your appointment, identify yourself as a Harris County *Superior 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 Superior 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 in lieu of other benefits.

COVERED SERVICES

Highlights of your vision care benefits are shown in the chart. Copayments are not applicable when utilizing out-of-network providers.

For the complete schedule of benefits, reference the Vision Plan Benefit Certificate of Coverage at harriscountytexas.gov/hrmm.

Vision Benefit Coverage - Available In or Out-of-Network

All benefits are available once every 12 months from last date of service.

Service/Product	In-Network	Out-of-Network
Complete Visual Exam	\$10 copay	Up to \$35
CHOOSE GLASSES OR CONTACTS		
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
Single Vision* Lined Bifocal* Lined Trifocal* Lenticular Lenses*	Standard basic lens covered at 100% after \$25 Materials copay	Up to \$25 Up to \$40 Up to \$45 Up to \$80
Contact Lenses—Elective	\$130 retail allowance after \$25 Materials copay	Up to \$80
Contact Lenses—Necessary**	100% after \$25 Materials copay	Up to \$150
Lasik Vision Correction***	\$300 benefit	\$300 retail benefit

* 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 Superior Vision concerning the reimbursement that Superior Vision will make before you purchase such contacts.

***Lasik Vision Correction: Superior Vision provides each member a \$300 allowance available both in and out-of-network. Superior 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.

BASIC LIFE & AD&D

- ⇒ Life insurance and Accidental Death and Dismemberment (AD&D) Insurance provide protection for your family in the event of your death or accidental injury.
- ⇒ The County currently provides a basic level of insurance to eligible employees at no cost. Employees have a life insurance benefit of \$30,000 and an AD&D benefit of \$5,000.
- ⇒ Dependent life is also provided at \$5,000 for a spouse and \$2,000 for children up to age 26 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, Dearborn National 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.

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 \$450,000. 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.

Employees who choose to increase their optional term life insurance by 1x this open enrollment are automatically approved. Employees electing to increase their optional life insurance by more than 1x are required to complete an Evidence of Insurability (EOI) form and be approved by Dearborn National before additional coverage will be effective.

OPTIONAL LIFE INSURANCE*	MONTHLY RATE/\$1,000 OF COVERAGE
Under 30	\$.046
30-34	.061
35-39	.073
40-44	.095
45-49	.146
50-54	.223
55-59	.417
60-64	.582
65-69	1.067
70-74	1.843
75 and over	1.998

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.

Converting Group Term Life Insurance to Individual Insurance

Under the terms of your group life policy, some or all of your insurance coverage may be converted to permanent insurance. The right to convert to a Dearborn Guaranteed Life Insurance policy is guaranteed, provided the terms as described in your Booklet-Certificate are met. A Dearborn representative can assist you, without cost or obligation, with the conversion process and answer any questions you may have (800-348-4512). If you are age 76+, your only conversion option is for a Single Pay Life Policy. Your application and first premium must be submitted within the 31-day period specified in your Book-Certificate.



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: 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**, at cigna.com/our_plans/disability/calculator/income_needs_calc.html, to 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 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 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 800.36.CIGNA or 800.362.4462 and a representative will walk you through the process. You can also fill out the online claim form on 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.

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

BASIC & VOLUNTARY LTD COMPARISON

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

This benefit applies to covered earnings such as wages or salary, and excludes earnings received from overtime pay and other extra compensation.

COVERAGE	WAITING PERIOD	MONTHLY BENEFIT	MONTHLY MINIMUM	MONTHLY MAXIMUM	MAXIMUM BENEFIT PERIOD	
BASIC LTD	180 days	Your employer pays a benefit amount for up to 50% of the first \$10,000 of your pre-disability covered monthly earnings.	\$100	\$5,000	2 years	
OPTIONAL LTD	90 days	The Voluntary LTD Coverage level allows you to change the percentage of your monthly benefit to 60% of your pre-disability covered monthly earnings.	The greater of \$200 or 10% of your disability benefit, prior to any deductible sources of income.	\$6,000	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					

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.

DISABILITY FACTS TO PONDER

- ◆ **3 out of every 10 workers** will experience an accident or illness that keeps them out of work for three months or longer.
- ◆ **43% 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 and that calculates to 49 people becoming disabled every minute.
- ◆ Every :01 second another disabling injury occurs in the US.
- ◆ More than **1 in 5** adults believe that unemployment or Social Security will cover them if they become disabled, but **the average monthly SSDI benefit is only \$1,004.**
- ◆ **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.**

IMPORTANT INFORMATION ABOUT MEDICARE & COBRA

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 before 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.

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.

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 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.

If you meet certain income and resource limits, Medicare's Extra Help Program may assist you by paying some of the costs of its prescription drug coverage. You may qualify if you have up to \$17,655 in yearly income (\$23,895 for a married couple living together) and up to \$13,640 in resources (\$27,250 for a married couple living together).

If you don't qualify for Extra Help, your state may have programs that can help pay your prescription drug costs. Contact your State Health Insurance Assistance Program (SHIP) for more information at 800-252-3439. Remember, you can reapply for Extra Help at any time if your income and resources change.

For more information about getting help with your prescription drug costs, call Social Security at 800.772.1213 or visit [socialsecurity.gov](https://www.socialsecurity.gov). If you or any of your covered dependents are eligible for additional coverage through **Medicaid**, you should contact 800-MEDICARE (800.633.4227) or visit [medicare.gov](https://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!

**MONTHLY RATES
EFFECTIVE
MARCH 1, 2016**

MEDICAL

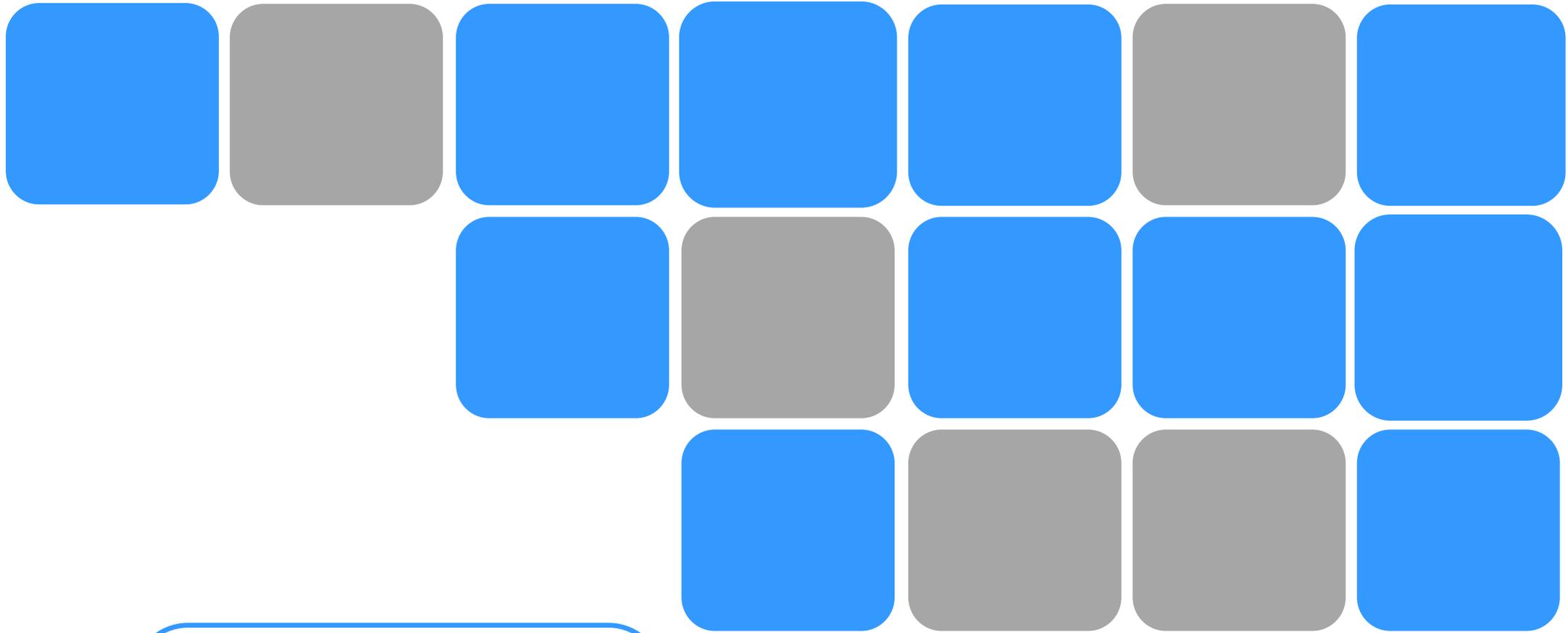
DENTAL

VISION

Harris County continues to pay 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/HAMP Medical Plan and \$67.13 for the Base Plus Plan.

	BASE/HAMP MEDICAL PLAN W/PPO DENTAL			BASE/HAMP MEDICAL PLAN W/DHMO DENTAL		
	Employee	County	Total	Employee	County	Total
Employee Only	\$0.00	\$561.95	\$561.95	\$0.00	\$547.12	\$547.12
Employee + Spouse	\$248.55	\$848.82	\$1,097.37	\$242.07	\$826.35	\$1,068.42
Employee + Child	\$223.18	\$819.59	\$1,042.77	\$216.70	\$797.12	\$1,013.82
Employee + Two or More	\$393.05	\$1,015.95	\$1,409.00	\$379.25	\$984.88	\$1,364.13

	PLUS MEDICAL PLAN W/PPO DENTAL			PLUS MEDICAL PLAN W/DHMO DENTAL		
	Employee	County	Total	Employee	County	Total
Employee Only	\$67.13	\$725.54	\$792.67	\$67.13	\$710.71	\$777.84
Employee + Spouse	\$444.52	\$1,160.84	\$1,605.36	\$438.04	\$1,138.37	\$1,576.41
Employee + Child	\$371.40	\$1,076.60	\$1,448.00	\$364.92	\$1,054.13	\$1,419.05
Employee + Two or More	\$601.00	\$1,341.76	\$1,942.76	\$587.20	\$1,310.69	\$1,897.89



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

Human Resources & Risk Management

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