

2017 EMPLOYEE BENEFITS RESOURCES GUIDEBOOK

Annual Enrollment: January 2, 2017 - January 23, 2017

Retain this document as a resource tool for the upcoming year

Important Disclaimer: Harris County Hospital District has made every effort to accurately report the information in this document. If any information contained in this document conflicts with the applicable official plan documents or the official policies and procedures of Harris County Hospital District, the official plan documents and official policies and procedures of Harris County Hospital District will govern.

HARRIS HEALTH SYSTEM EMPLOYEE BENEFITS/EMPLOYEE WELLNESS DEPARTMENT

Core Business Hours
Monday - Friday
8:00 a.m. - 4:30 p.m.

CONTACT INFORMATION

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Benefitsdepartment@harrishealth.org

Phone: 713-566-6451

Fax: 713-440-5575

Lyndon B. Johnson Hospital - HR Suite, UT Annex 214

Phone: 713-566-4830

Ben Taub - HR Suite, 1I-08

Phone: 713-873-6435

Kirby Location - 9240 Kirby

Phone: 713-634-1029

WELLNESS

Main Customer Service

EmployeeWellness@harrishealth.org

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January 2, 2017

Dear Harris Health System Employee:

Welcome to the 2017 Annual Enrollment! Annual Enrollment will run from January 2, 2017 to January 23, 2017. Our Benefits Resources Guidebook was developed to be a resource for you as you make benefit selections for yourself and your eligible dependents during Annual Enrollment. Harris Health has made the decision not to mail the Benefits Resources Guidebook out to participants this year, but instead will post the materials online for easier access. You can access the Benefits Resources Guidebook by going to the Benefits webpage on the Human Resources site from the Harris Health Intranet. **Your 2017 Annual Enrollment elections are scheduled to take effect March 1, 2017.**

As you may know, our health plan is self-insured, which means Harris Health covers the full cost of claims instead of the insurance carrier. Under the self-Insured arrangement, we set our premium rates primarily based on our claims experience and administrative costs. Further, we are able to better control costs under a self-Insured arrangement; as we avoid profit margins set by insurance companies that would be charged back to our Employee's in premiums. **This year we are very excited to announce that we will not be increasing the employee or retiree premium for any of the Harris Health System plans.**

We are pleased to continue to provide three Medical Plan options to our benefit eligible participants: a KelseyCare option, a Low Deductible option and a High Deductible option, all of which are administered through Cigna. More detailed information regarding the levels of coverage and premiums for these three medical options can be found in the guidebook on our website.

As an Employee, you may add eligible dependents to your coverage during Annual Enrollment. Please pay special attention to the documentation requirements for adding dependents and remember to submit the documentation to the Benefits Office by **January 23, 2017**; otherwise, they will not be covered under any Harris Health Benefit Plan. Make sure that your name, employee ID and telephone number are submitted with the dependent documentation.

Most importantly, please be sure that you have made your elections through PeopleSoft by January 23, 2017. We will not accept any changes after that date.

As always, our benefits representatives are here to answer your questions. Please reach out to us with any comments or concerns; we are here to serve you.

Sincerely,

Omar C. Reid
Sr. Vice President, Human Resources



Benefits Main Line Number: 713-566-6451

Benefits Fax Number: 713-440-5575/ 713-566-6445

Benefits Email Address: Benefitsdepartment@harrishealth.org

Benefits Mailing Address:

Harris Health System

HR Benefits Department

2525 Holly Hall, Suite 100, Houston, TX 77054

Walk-in Assistance Locations: **(Appointments Encouraged)**

Holly Hall - 2525 Holly Hall, Houston, TX 77054 ■ Kirby - 9240 Kirby, Houston, TX 77054

LBJ - 5656 Kelley St. UT Annex 214, Houston, Texas 77026 ■ Ben Taub - 1504 Ben Taub Loop, Houston, TX 77030

ANNUAL ENROLLMENT 2017

NOW IS THE TIME TO SELECT YOUR EMPLOYEE BENEFIT PLANS FOR MARCH 1, 2017 - FEBRUARY 28, 2018

At Harris Health System we are committed to offering a competitive employee benefits package that meets the diverse needs of our employees. We know the importance of healthcare and recognize the significant costs associated with healthcare expenses for you and your family. We have worked diligently on ways to contain the ever-increasing costs for these benefit programs. We are pleased to share with you the following comprehensive employee benefits package for the upcoming plan year, which continues to provide you and your family with quality healthcare benefits.

Please read the information provided in this Employee Benefits Resources Guidebook carefully and share it with your family. Then use this information to help make benefit elections that meet your personal healthcare needs.

IMPORTANT DATES

- Annual Enrollment Dates: January 2, 2017 - January 23, 2017
- Documentation submission deadline for new dependents is January 23, 2017.

IMPORTANT INFORMATION ABOUT PLAN BENEFIT ELECTIONS

If you do not make an active election change for the 2017 enrollment period, your benefits will remain the same as they currently are with the exception of flexible spending accounts which require an election each year.



ENROLLMENT HIGHLIGHTS

MEDICAL INSURANCE CARD

You will receive a new medical ID card upon enrollment. You can also print a medical card anytime at myCigna.com.

PRESCRIPTION CARD

You will receive a prescription insurance card from OptumRx upon enrollment.

DENTAL & VISION INSURANCE CARDS

- DHMO enrollees that are enrolling in the plan for the first time will be mailed a new ID card after enrollment. Current participants will not receive a card this plan year unless a change is made to their enrollment profile.
- A card is not required to receive services on the DPPO plan; therefore enrollees will not automatically receive a card. If you would like an ID card you may print one online at metlife.com/mybenefits.
- Current enrollees will not receive a new card, unless changes are made to your coverage. If you need a new vision card, you can request it by calling 800-999-5431 or by visiting davisvision.com/Member.

FSA VISA DEBIT CARD

You will receive a FSA Visa debit card from Flexible Benefit Administrators. If you need additional cards, FBA will ask you to submit a request in writing to confirm your identity.

NETWORK DIRECTORIES

You may visit each carrier's website to access a network directory. Website information and each carrier customer service number is identified on page 56 of this booklet.

EMPLOYEE BENEFIT PLANS ELIGIBILITY REQUIREMENTS

- Online employee benefits enrollment and supporting documentation must be completed within 31 days of hire or within 31 days of a Qualifying Event.
- If your employment ends, your Medical benefits will terminate on your last day of work. Your Vision and Dental benefits will terminate on the last day of the month in which you terminate; unless you elect COBRA Medical, Vision, and Dental coverage or apply for retirement benefits.

If you miss this Annual Enrollment Period, you **cannot** change your benefit elections until your or your dependent's next Qualifying Event, or the next Annual Enrollment Period, whichever occurs first. A Qualifying Event may include: a change in marital status, the number or eligibility of dependents, employment status (i.e. hourly to salary or salary to hourly and part-time to full-time or vice versa) including retirement, geographic relocation (e.g. regional transfers), or an approved FMLA leave of absence. Changes in benefit enrollments may also result from court orders, gaining or losing coverage under another employer's plan, obtaining other coverage (e.g. enrolling under Part A or B of Medicare or Medicaid) or losing coverage under a governmental program including the Children's Health Insurance Program (CHIP), the Texas Healthy Kids Corporation (THKC), or the Exchange. Benefit Enrollment/Change Form and supportive documentation must be submitted within 31 days of a Qualifying Event.

A Special Qualifying Event window may apply to make benefit changes in certain situations, such as for Medicaid and CHIP eligibility, that may extend the traditional 31-day enrollment window to 60 days. Contact the Employee Benefits department at 713-566-6451 about the specific event to determine the appropriate benefit enrollment timeframe. Proof of Benefit Eligible Dependent status must be timely submitted to enroll and continue coverage. Dependent eligibility will be determined by the Employee Benefits department.

Refer to policy 6.04 for full Harris Health System Employee Benefit Plan Eligibility Requirements.

MEDICAL PLAN CHANGES



For the 2017-2018 plan year, there will be very few benefit changes. With the exception of the changes below, your benefit plans will remain the same.

Changes for 2017:

- Everyone enrolled in the medical plan will receive new insurance cards.
- Everyone will receive a separate prescription insurance card from OptumRx.
- The new vendor that will be handling the Flexible Spending Accounts and COBRA will be Flexible Benefit Administrators.
- The FSA Contribution Limit for 2017 will be \$2,600.
- The new vendor for the Employee Assistance Program will be Fei.
- Tier rate was added for partial wellness credit with only 50% penalty.
- Glumetza will now be excluded.

Pharmacy Plan Design Changes:

- Effective 3/1/2017 all “Me Too” drugs are being excluded. Me Too drugs include high cost drugs that have generic equivalents that include: Acne Products, Cough/Cold/Allergy Combo, NSAIDS, Biguanides & Combos (excludes Glumetza), AHDH, Analgesics, Estrogens, Vitamins, etc. Opiate Agonists are excluded from the “Me Too” exclusions list as this drug therapy class is currently under our Reference Based Pricing Structure.
- Also effective 3/1/2017 all non FDA approved pain patches and creams will be excluded.

Medical Plan Change:

- Telehealth— Telehealth is a new medical feature, which allows patients to consult with a health care professional at their convenience. Through Telehealth, licensed physicians are able to provide treatment plans and provide prescriptions for minor illnesses including but not limited to; cold, flu, sinuses, allergies, bronchitis, respiratory infections and ear infections. Addressing a minor health issue is now as easy as picking up the phone and making a call.



HOW DO I ENROLL OR RE-ENROLL FOR MY EMPLOYEE BENEFITS?

All employees who elect employee benefits coverage or make changes for the 2017-2018 plan year will do so via our PeopleSoft Self-Service module.

- You will need your PeopleSoft User ID and Password. If you don't know your User ID and/or Password, call the Help Desk at **713-566-HELP (4357)** for assistance. For PeopleSoft Navigation Instructions: Go to the intranet homepage; Click on Human Resources from the drop down box in the top center of the page; click on Benefits; click on Enrollment Materials. See PeopleSoft Enrollment Instructions.

REMEMBER—FLEXIBLE SPENDING ELECTIONS DO NOT AUTOMATICALLY ROLLOVER. YOU MUST MAKE A NEW ELECTION EACH YEAR.

DO I HAVE TO DO ANYTHING IF I AM NOT CHANGING BENEFIT ELECTIONS? **YES!**

Log into PeopleSoft and:

1. **Review your elections and print your confirmation statement.** Go to Employee Self-Service/Benefits/Benefits Enrollment/Annual Enrollment.
2. **Review and update your personal information.** Maintaining this information is critical to you as this is how all of the Harris Health System information reaches out to you via phone, email, and by mail. For assistance refer to the *PeopleSoft Tools* section of this guidebook. Be sure to update the following:
 - Phone Numbers
 - Email Addresses
 - Home and Mailing Address
 - Emergency Contact
3. **Confirm current information for each dependent:**
 - Name spelled correctly?
 - Date of birth correct?
 - Please ensure we have your dependent's correct social security number. If incorrect, contact the Employee Benefits Department in writing at benefitsdepartment@harrishealth.org.
 - Verify benefit plans that you have this dependent enrolled in.

See pages 9-10 for Adding a Dependent and Dependent Definitions and Requirement for Coverage.

If you enrolled new dependents, did you fax, email or hand deliver the required proof of eligible dependent documents to the Employee Benefits office at the time of enrollment? If not, you must do so by **Monday, January 23, 2017** for Annual Enrollment 2017 and within 31 days of all other events.

Fax: **713-440-5575**

Email: benefitsdepartment@harrishealth.org

ACCESSING YOUR EMPLOYEE BENEFITS INFORMATION

24/7 access to view or update your personal information!

As a Harris Health System employee, you can view your personal enrollment information at your convenience. Go to the Harris Health System intranet web page. Click on the PeopleSoft link. Sign in utilizing your User ID and Password then click on Self-Service and click on **Benefits**. Here you may choose to view your **Benefits Summary** which lists all benefit plans.

To view a particular benefit plan click on the link of such plan, once a benefit type has been selected, the system will display your name and display your elections as of the date of your inquiry. To change the date of your inquiry to a date in the past, type over the current date and click Go. You cannot view future dates to your inquiry.

HOW CAN I VIEW MY ENROLLMENT INFORMATION FOR THE MEDICAL, DENTAL OR VISION PLAN COVERAGE?

Click on **Benefits, Benefits Summary** and then click on the type of benefit, such as Medical, Dental, or Vision to see the plan name, plan provider, your coverage level, and names of covered dependents. After reviewing each type of benefit, click on **Return to Employee Benefit Summary** to start a new search.

HOW CAN I VIEW MY ENROLLMENT INFORMATION FOR JUST THE LIFE INSURANCE COVERAGE?

Click on **Benefits Summary** and then click on the type of benefit, such as Optional Life, Life and AD&D, Child Dependent Life, Optional AD&D, or Spouse Dependent Life to see the plan name, plan provider, and listed beneficiaries. After reviewing each type of benefit, click on **Return to Employee Benefit Summary** to start a new search.

HOW CAN I VIEW MY ENROLLMENT INFORMATION FOR FLEXIBLE SPENDING ACCOUNTS (FSA) COVERAGE?

Click on **Benefits, Benefits Information**, click on Flexible Spending Accounts, and you will see an account summary with coverage start date, your annual pledge, and account balance. Your annual pledge amount and your account balance contributions year-to-date should accurately reflect your FSA information. For approved claim payments or claims paid to date, current account balance, etc., you will need to contact the outsource vendor (See page 34).

HOW CAN I VIEW WHO I HAVE LISTED AS A DEPENDENT OR A LIFE INSURANCE BENEFICIARY?

Click on **Benefits**, click on **Dependent and Beneficiaries**, click on **Dependent/Beneficiary Coverage** and then click on the individual name to view personal information, status information, address, and telephone contact information. Click on the link **Return to Dependent/Beneficiary Coverage Summary** to return to the summary page. The beneficiary information listed in PeopleSoft is for Group Term Life insurance purposes only, and can be updated at any time. Contact Fidelity Investments at 800-343-0860 to review or update your 401K Plan and 457(b) Plan beneficiary records.

HOW CAN I VIEW THE SUMMARY OF BENEFITS COVERAGE?

Summary of Benefits (SBC) are available on the Human Resources-Benefits web page. Go to the intranet homepage; click on Human Resources, click on Benefits and click on Enrollment Materials.

HOW CAN I VIEW MY SUMMARY PLAN DESCRIPTIONS AND CERTIFICATES?

Summary Plan Descriptions (SPDs) and Certificates are available on the Human Resources-Benefits web page. Go to the intranet homepage; click on Human Resources, click on Benefits and click on Official Plan Documents under Important Disclaimer.

DEPENDENT RULES

Health and Related Employee Benefits eligibility rules are available 24/7 for all Harris Health System employees. Refer to Policy 6.04 on the intranet web page. Click on Policies, type in 6.04 and hit Search, then click on the policy description.

ADDING OR RE-ENROLLING A DEPENDENT

- If you are adding or re-enrolling a dependent, you must provide proof of eligible dependent status at the time of PeopleSoft enrollment but no later than the deadline.
- If you fail to timely submit the required proof of eligible dependent documents by the deadline, your dependent will not be added and you will have to wait until your next Qualifying Event or Annual Enrollment Period, whichever occurs first.
- Submitting your benefit elections (adding the dependent) into the PeopleSoft system alone does not constitute enrollment in the benefit plans. All dependents must meet proof of eligible dependent status as outlined in Policy 6.04 - Health & Related Employee Benefits. All proof of eligible dependent documents must be received and approved by the Employee Benefits department at the time of enrollment but no later than the deadline.
- Harris Health is required to report on the minimum essential coverage offered to you and your dependents utilizing you and your dependent's social security number or taxpayer identification number. Review your dependent's information and make the necessary updates to ensure that your dependent is properly reported. If your dependent does not have a social security number or taxpayer identification number, please notify the Employee Benefits Department in writing at the time of enrollment.
- Dependent Definitions and Requirements For Coverage are contained on page 10 of this document
- Contact the Employee Benefits office for eligibility questions or assistance with enrolling your dependents. Refer to Page 1 of this document for contact information.

Note: Cigna will NOT verify coverage or process any Medical claims for dependents until a Coverage Questionnaire has been completed. Log into the Cigna web site, myCigna.com and click on *Review My Coverage*. Click on *Enrollment* and complete the *Spouse/Partner Coverage Questionnaire* or the *Dependent Children Coverage Questionnaire* before Medical services are rendered.



DEPENDENT DEFINITIONS AND REQUIREMENTS FOR COVERAGE

TERMINATION OF DEPENDENT COVERAGE

Coverage provided to a Benefit Eligible Dependent will terminate upon the first of the following events to occur: The date the dependent no longer satisfies the requirements for a Benefit Eligible Dependent; or The date benefits coverage ends for the enrollee.

Note: If coverage is terminated, COBRA coverage will typically be offered retroactive back to the date of loss of coverage. Applicable COBRA premiums would apply.

INELIGIBLE DEPENDENT

If the Benefit Eligible Employee misses the Qualifying Event window to drop a dependent that is not a Benefit Eligible Dependent (Ineligible Dependent), the Ineligible Dependent shall be dropped from Medical, Dental and Vision plan benefits by the Employee Benefits department as allowed by the terms of the applicable plan(s) to ensure that no benefits are payable under the plan(s) for the benefit of the Ineligible Dependent. If termination of coverage for the Ineligible Dependent results in a level of coverage change for the Benefit Eligible Employee, the level of coverage change will be initiated by the Employee Benefits department with applicable premium changes, if allowed by the terms of the plan(s), as determined by the new level of coverage; however, the Benefit Eligible Employee will not be allowed to voluntarily make any other benefit changes at that time. No refund of any applicable back premiums will be made unless the Ineligible Dependent status was due to an administrative error on the part of Harris Health System. Applicable COBRA provisions will apply.

ELIGIBLE DEPENDENT

Below is information regarding the term “dependent” as it is used in the Medical, Dental and Vision plans offered by Harris Health System.

A Spouse is: The person to whom the Enrollee is married.

Requirements: A certified copy of a fully executed and valid Marriage License issued by a state, county or vital records office or a similar document from another country that is acceptable to the Employee Benefits Department; or A certified copy of a Texas Declaration and Registration of Informal Marriage filed with the appropriate county clerk’s office or a similar declaration that has been filed in another state that is acceptable to Benefits.

A Child is: A natural child; A stepchild; A legally adopted child (including a child placed with the Enrollee and/or the Enrollee’s Spouse pending finalization of adoption proceedings); or A child for whom the Enrollee and/or the Enrollee’s Spouse has obtained sole, permanent legal custody or permanent legal guardianship pursuant to a court order (for which no other person including the biological parent has any custodial rights).

Eligibility: Up to the end of the month in which the Child attains age twenty-six (26) or age twenty-six (26) or older who has a mental or physical disability of a permanent or of an indefinite but long duration.

Requirements: Birth certificate issued by a state, county or vital records office (or substantially equivalent documents issued outside the United States and approved by the Employee Benefits department) that evidences that the individual is the qualifying “child” of the Benefit Eligible Employee or the spouse of the Benefit Eligible Employee. A birth facts statement issued by the facility where the newborn was born may also be used to evidence that the newborn is the qualifying “child” of the Benefit Eligible Employee or the spouse of the Benefit Eligible Employee in the case of a newborn child (first 31 days from birth). Additional Requirement For Disabled Child: Proof of the child’s incapacity (in the form of a Social Security disability award letter) within 31 days of the end of the month in which the Child attains age 26 and at such other times as may be required by Harris Health or as allowed by applicable law.

A Grandchild is: A Child of your Child and/or a Child of your Spouse’s Child.

Eligibility: Up to the end of the month in which the grandchild turns age 26 and who is a dependent of the Benefit Eligible Employee for federal income tax purposes at the time application for coverage of the grandchild is made.

Requirements:

1. A copy of the birth certificate or birth facts sheet (for a newborn—first 31 days from birth) of the grandchild.
2. A copy of the birth certificate for the Benefit Eligible Employee’s child that is the birth parent of the grandchild.
3. A copy of the Benefit Eligible Employee’s federal income tax return evidencing that the grandchild will qualify as a dependent for the initial period of coverage must be submitted to the Employee Benefits department at time of enrollment or such later time as it is available but no later than April 15th of the following year, to confirm initial plan eligibility. Failure to timely submit required proof of initial eligibility documentation will result in loss of coverage.

Proof of Dependent eligibility must be provided to the Employee Benefits Department within the eligibility timeframes.

2017—2018 PREMIUM RATE SCHEDULE

THREE HARRIS HEALTH SYSTEM SELF-INSURED MEDICAL OPTIONS ADMINISTERED BY CIGNA

Your 2017 Medical Wellness premium rates have been established based on participation in our 2016 Healthy Living Tiered Benefits Campaign which asked that all employees covered under our Self-Insured Medical Plan voluntarily complete a confidential Health Assessment with Biometric Values between March 1st and August 31st and participate in either coaching calls, online coaching, or 12 hours of Harris Health physical/educational activity classes between June 1st and August 31st, 2016.

Partial Wellness Rate: Employees that partially fulfilled the 2016 Tiered Benefits Campaign by completing the Health Assessment with Biometric Values, but not the coaching or physical activities.

No Wellness Rate: Employees that failed to participate in the 2016 Tiered Benefits Campaign, which included completing the Health Assessment with Biometric Values and coaching or physical/educational activities.

		Bi-Weekly Rates				
		Medical Plan	Employee Only	Employee and Spouse	Employee and Children	Employee and Family
2017-2018 Medical Premium Rates	KelseyCare Plan	\$17.39	\$184.76	\$80.34	\$240.54	
	Low Deductible Plan	\$53.21	\$276.09	\$163.08	\$359.46	
	High Deductible Plan	\$17.39	\$184.76	\$80.34	\$240.54	
	Bi-Weekly Rates Partial Wellness Rates					
	KelseyCare Plan	\$40.47	\$207.84	\$103.41	\$263.62	
	Low Deductible Plan	\$76.29	\$299.17	\$186.16	\$382.54	
	High Deductible Plan	\$40.47	\$207.84	\$103.41	\$263.62	
	Bi-Weekly Rates No Wellness Rates					
	KelseyCare Plan	\$63.54	\$230.91	\$126.49	\$286.70	
	Low Deductible Plan	\$99.36	\$322.25	\$209.23	\$405.62	
	High Deductible Plan	\$63.54	\$230.91	\$126.49	\$286.70	

2017-2018 Dental Premium Rates		Bi-Weekly Rates			
		Dental Plan	Employee Only	Employee and Spouse	Employee and Children
	MetLife DHMO	\$0.41	\$4.28	\$4.28	\$6.06
	MetLife PPO	\$13.22	\$21.30	\$21.83	\$40.04

2017-2018 Vision Premium Rates		Bi-Weekly Rates			
		Vision Plan	Employee Only	Employee and Spouse	Employee and Children
	Davis Vision	\$0.25	\$1.92	\$1.92	\$3.43

Please note:

1. Annual Enrollment elections are scheduled to take effect March 1st.
2. Related premium deductions will appear on your March 10th paycheck. Please review your paycheck for correct premium deductions.

MEDICAL SUMMARY



	KELSEY CARE		HIGH DEDUCTIBLE		LOW DEDUCTIBLE	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	
ANNUAL DEDUCTIBLE - per plan year, applies to most covered services Individual / Family	None	\$1,500 / \$4,500	\$3,000 / \$9,000	\$500 / \$1,500	\$1,000 / \$3,000	
ANNUAL OUT-OF-POCKET LIMIT Individual / Family	\$750 / \$1,500	\$3,000 / \$9,000	\$6,600 / \$19,800	\$1,850 / \$3,700	\$6,000 / \$18,000	
PHYSICIAN VISIT COPAY	\$15	\$25	60% after deductible	\$25	60% after deductible	
SPECIALIST VISIT COPAY	\$30	\$35 CCN Specialist \$55 Non CCN Specialist	60% after deductible	\$35 CCN Specialist \$55 Non CCN Specialist	60% after deductible	
ROUTINE EXAMINATIONS/ IMMUNIZATIONS Routine Examinations include; additional services outlined in the plan document. Contact Cigna for further information	100%	100%	60% after deductible (Immunizations are covered at no charge for children ages 0—5.)	100%	60% after deductible (Immunizations are covered at no charge for children ages 0—5.)	
HEARING AID - 1 pair per 36 months	100%	80% after deductible	60% after deductible	90% after deductible	60% after deductible	
OUTPATIENT SERVICES (facility) - except in physician's office when office visit copay applies	100%	80% after deductible, \$100 copay for surgical treatment	60% after deductible	90% after deductible, \$100 copay for surgical treatment	60% after deductible	
ALLERGY TREATMENT - allergy serum, allergy injections and injectable drugs	\$15/ \$30 PCP or Specialist copay Serum is paid at 100% if dispensed in PCP office	\$25/\$35/\$55-PCP or Specialist copay Serum is paid at 100% if dispensed in PCP office	60% after deductible	\$25/\$35/\$55-PCP or Specialist copay Serum is paid at 100% if dispensed in PCP office	60% after deductible	
DIAGNOSTIC X-RAY AND LABORATORY PCP or Specialist Outpatient Facility/Independent Lab	100% after office visit copay	100% after copay 80% after deductible	60% after deductible	100% after copay 90% after deductible	60% after deductible 60% after deductible	
HIGH TECH RADIOLOGY - Outpatient Facility & Emergency Room & Physicians Office CT/CTAs, MRI/MRA, PET scans, Nuclear Tests	100%	80% after deductible	60% after deductible ER—80% after deductible	90% after deductible	60% after deductible ER - 90% after deductible	
HOSPITAL SERVICES Inpatient Coverage Emergency Room	\$100 per day copay up to 5 days, then 100% \$200 per visit copay then 100% (copay waived if admitted)	\$100 per day copay up to 5 days, then 80% after deductible 80% after deductible	\$500 per confinement deductible then 60% after plan deductible 80% after deductible	\$100 per day copay up to 5 days, then 90% after deductible 90% after deductible	\$500 per confinement deductible then 60% after plan deductible 90% after deductible	
URGENT CARE PROVIDER	\$30 per visit then 100% (copay waived if admitted)	\$55 copay per visit	\$55 copay per visit	\$55 copay per visit	\$55 copay per visit	
CONVENIENCE CARE	Not Covered	\$25 PCP Copay	60% after deductible	\$25 PCP copay	60% after deductible	
SKILLED NURSING FACILITY - up to 60 days per calendar year	100%	80% after deductible	60% after deductible	90% after deductible	60% after deductible	
HOME HEALTH CARE - 100 days per calendar year, 16 hour max per day	100%	80% after deductible	60% after deductible	90% after deductible	60% after deductible	

MEDICAL SUMMARY



	KELSEY CARE		HIGH DEDUCTIBLE		LOW DEDUCTIBLE	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	
HOSPICE CARE						
Inpatient Coverage		80% after deductible	60% after deductible	90% after deductible	60% after deductible	
Outpatient Coverage	100%	80% after deductible	60% after deductible	90% after deductible	60% after deductible	
SHORT-TERM REHAB <i>includes physical therapy, occupational therapy, and speech therapy 60 days per calendar year</i>	\$15/ \$30 PCP or Specialist copay, then 100%	\$35 copay, then 100%	60% after deductible	\$35 copay, then 100%	60% after deductible	
REHAB PERFORMED AT QUENTIN MEASE, BEN TAUB, LBJ HOSPITALS	Not Covered	100%	N/A	100%	N/A	
CHIROPRACTIC OUTPATIENT CARE <i>up to 20 days per calendar year</i>	\$15/ \$30 PCP or Specialist copay, then 100%	\$35 copay, then 100%	60% after deductible	\$35 copay then 100%	60% after deductible	
CARDIAC REHAB - unlimited days per year	\$15/ \$30 PCP or Specialist copay, then 100%	\$35 copay, then 100%	60% after deductible	\$35 copay then 100%	60% after deductible	
ACUPUNCTURE COVERAGE <i>\$500 maximum per calendar year</i>	Not Covered	\$25/\$35/\$55 PCP or Specialist copay, then 100%	60% after deductible	\$25/\$35/\$55 PCP or Specialist copay, then 100%	60% after deductible	
AMBULANCE	100%	80% after deductible	60% after deductible	90% after deductible	90% after deductible	
DIALYSIS	100%	80% after deductible	Not covered	90% after deductible	Not Covered	
DURABLE MEDICAL EQUIPMENT <i>unlimited max per calendar year</i>	100%	80% after deductible	60% after deductible	90% after deductible	60% after deductible	
MOUTH, JAWS AND TEETH	\$15/ \$30 PCP or Specialist copay, then 100%	\$25/\$35/\$55 PCP or Specialist copay, applies to office visits	60% after deductible	\$25/\$35/\$55 PCP or Specialist copay, applies to office visits	60% after deductible	
Physicians office						
Inpatient coverage		\$100 per day copay up to 5 days, then 80% coinsurance after deductible	\$500 per confinement deductible then 60% after plan deductible	\$100 per day copay up to 5 days, then 90% coinsurance after deductible	\$500 per confinement deductible then 60% after plan deductible	
Outpatient coverage		\$100 per facility copay, then 80% coinsurance after deductible	60% after deductible	\$100 per facility copay, then 90% coinsurance after deductible	60% after deductible	
MATERNITY						
Physician Services	Payable as any other covered expense/costs vary based on facility in which it is performed	\$25/\$35/\$55 PCP or Specialist copay, then 100%	60% after deductible	\$25/\$35/\$55 PCP or Specialist copay, then 100%	60% after deductible	
All subsequent Prenatal and Postnatal visits <i>(Delivery is covered the same as plan's hospital benefit)</i>		80% after deductible	60% after deductible	90% after deductible	60% after deductible	
INFERTILITY TREATMENT <i>excludes in-Vitro, GIFT, ZIFT, etc.</i>	\$15/ \$30 PCP or Specialist copay, then 100%	70% after deductible	50% after deductible	70% after deductible	50% after deductible	
Physician Services		\$100 per day copay up to 5 days, then 70% coinsurance after deductible	\$500 per confinement deductible then 60% after plan deductible	\$100 per day copay up to 5 days, then 70% coinsurance after deductible	\$500 per confinement deductible then 60% after plan deductible	
Inpatient Coverage		\$100 per facility copay, then 70% coinsurance after deductible	50% after deductible	\$100 per facility copay, then 70% coinsurance after deductible	50% after deductible	
Outpatient Coverage						
ALCOHOL & SUBSTANCE ABUSE SERVICES AND MENTAL HEALTH SERVICES <i>unlimited visits per calendar year</i>	\$100 copay per day up to 5 days, then 100%	\$100 copay per day up to 5 days, then 80% after deductible	\$500 per confinement deductible, then 60% after plan deductible	\$100 copay per day up to 5 days, then 90% after deductible	\$500 per confinement deductible, then 60% after plan deductible	
Inpatient Coverage		80% after deductible	60% after deductible	90% after deductible	60% after deductible	
Outpatient Coverage	100%					
Office Visit	\$15 copay	\$25 copay	60% after deductible	\$25 copay	60% after deductible	

PRESCRIPTION DRUG SUMMARY



Your prescription drug benefits are part of your medical plan benefits and are administered by OptumRx. If you are enrolled in one of our medical plan options administered through Cigna you will automatically be enrolled in the prescription drug coverage through OptumRx. You may reach OptumRx at **1-800-880-1188** or via web at OptumRx.com. Please review the OptumRx benefit information below.

Rx OUT OF POCKET MAXIMUM—Annual amounts of \$3,600 for individual and \$4,200 for family, apply to all three options.

Once the out of pocket limit is reached, copays will no longer apply and the plan will pay 100% of allowable amount.

MANDATORY GENERIC NOTE—If there is a Generic equivalent to your prescription, you will be required to either use the Generic equivalent or pay the copay plus the difference in cost of the Brand name drug. If Generic equivalent is available and you fill Brand, you pay regular copay plus cost difference between Brand and Generic.

BRIOVA Rx SPECIALTY DRUGS—The Briova Rx is a mandatory program. After one fill you will be required to use the program, paying a \$90 copay for a 30-day supply.

BREAST CANCER PREVENTIVE DRUGS—Breast Cancer Drugs for women may now be covered at 100%, if pre-authorized and approved by OptumRx.

SMOKING CESSATION DRUGS—Smoking cessation drugs are covered at 100% after a \$30 copay up to a 90-day limit per calendar year.

REFERENCE BASED PRICED DRUGS—Effective 3/1/2014, Brand name and Generic prescription products in some categories of drugs have limited coverage under a “reference based pricing” arrangement. The plan will limit the amount it pays for a prescription for one of these products to a set dollar amount per pill or unit dose. There will not be a fixed dollar co-payment associated with these products. The portion that is the member’s responsibility will depend on the number of pills dispensed.

If you find that your prescription has a reference based priced, you may wish to talk to your physician about changing to a less expensive alternative. If you have any questions regarding your plan copay for one of these drugs, please call the OptumRx Customer Care Department at 1-800-880-1188.

RETAIL (30 - DAY SUPPLY)

Generic

10% copay
Minimum \$3—Maximum \$9

Brand name formulary

20% copay
Minimum \$15—Maximum \$45

Brand name non-formulary

30% copay
Minimum \$30—Maximum \$90

MAIL ORDER (31 - 90 DAY SUPPLY)

Generic

10% copay
Minimum \$6 - maximum \$18

Brand name formulary

20% copay
Minimum \$30 - maximum \$90

Brand name non-formulary

30% copay
Minimum \$60 - maximum \$180



Referenced Based Pricing

Drug Therapy Name	RBP	Drug Therapy Name	RBP
Nonsteroidal Anti-Inflammatory Agents	\$.50	Opioid Agonists	\$1.00
Anti-hyperintensive Combinations	\$1.00	Proton Pump Inhibitors	\$2.00
Fibric Acid Derivatives	\$1.00	Statins	\$2.00
Anti-Inflammatory Agents—Topical	\$1.00		

STEP THERAPY PROGRAM—Proton Pump Inhibitors will be subject to a Step Therapy Program where members must first use a generic or over the counter drug if available.

PREFERRED DIABETIC SUPPLIES—In conjunction with Diabetes America, not only is your office visit copay waived, so is your prescription drug copay for preferred diabetic supplies (BD lancets, Accu-chek test strips and One Touch Ultra test strips). Please be certain to visit an in network pharmacy to obtain these specific diabetic supplies at a \$0 copay.

SPECIALTY DRUGS—Special drugs that are used to treat complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

COMPOUND DRUGS—Drugs which require a prescription from a doctor, and are prepared by a pharmacist who mixes or adjusts drug ingredients to customize a medication to meet a patient's individual needs.

FORMULARY—A formulary, or preferred drug list, is the list of prescription drugs covered by your health plan. All drugs on a formulary are chosen by medical experts for their effectiveness and value.

Here are some other important facts.

- **Different drugs have different costs.** You'll pay less for generic medications than you will for brand-name versions. Some brand-name drugs cost more than others.
- **Everything on the formulary is safe and effective.** All drugs on the list have been approved by the Food and Drug Administration (FDA). Drugs that have not been approved by the FDA will not be covered.
- **It covers most conditions.** The formulary is wide enough to include drugs that treat most medical conditions. However, it does not include all drugs for all conditions – some drugs may be excluded if they're overly expensive, not effective or not approved by the FDA. Most formularies do not include cosmetic, weight loss or lifestyle drugs.
- **Formularies can change.** Our formulary is evaluated and updated regularly as the prescription drug market evolves. New drugs are added, some drugs are removed and new generics replace other generics from time to time.

Please Note the Following Important Items:

- The Dispense as Written penalty for the cost difference between Brand and Generic will not apply to the Out-of-Pocket Maximum.
- Any amount over Reference Based Pricing allowable will not apply to the Out-of-Pocket Maximum.
- A voluntary Hepatitis C Outcomes Program has been implemented for members prescribed Harvoni as initial therapy when diagnosed with Genotype 1 Hepatitis C Virus infection. As a member enrolled in this program you will be monitored during the entire treatment regimen. Your prescription fills under this program must go through Briova Rx Specialty Drugs, the first fill at retail does not apply to this program. Harvoni is FDC approved, has a cure rate of 94% to 99% and it is a single pill taken daily.
- **Optum SECURE** Compound Medication Management Program.
 - 1) Required prior authorization on compounds greater than \$300. If denied, the member can file an appeal through OptumRx.
 - 2) Exclusions on all bulk chemicals and all compound kits.

PRESCRIPTION DRUG SUMMARY CONTINUED

STOP PAYING TOO MUCH FOR YOUR PRESCRIPTIONS

Compare prices, print free coupons & save up to 80%.

HOW GOODRx WORKS

Drug prices vary wildly between pharmacies. Good Rx finds the lowest prices and discounts. How?

1. **Collect and compare prices** for every FDA approved prescription drug at more than 70,000 US pharmacies.
2. **Find free coupons** to use at the pharmacy.
3. **Show the lowest price** at each pharmacy near you.

SOUNDS GREAT. SO WHAT'S THE CATCH?

GoodRx is free to consumers, and does not require personal information to search drugs and receive discounts. GoodRx does not sell your personal health information to anyone. They make money from advertisements on their site and referral fees. This revenue enables them to continue to make the best, free product to help Americans afford the prescriptions they need.

THE #1 REASON AMERICANS DON'T TAKE THEIR MEDICATIONS AS PRESCRIBED: COST

- 45% of Americans have trouble paying for the prescriptions they need
- 26% of Americans have not filled a prescription because they cannot afford it.
- Even if you can afford your prescriptions, you're probably paying too much. It costs as little as one cent to manufacture a pill, so why do our prescriptions cost \$10, \$100 or even \$1,000?

WHY WE PAY TOO MUCH FOR OUR PRESCRIPTIONS

Prices for prescription drugs vary widely between pharmacies. U.S. drug prices are neither fixed nor regulated. The cost of a prescription may differ by more than \$100 between two pharmacies across the street from each other!

HOW GOODRx CAN HELP

Every week GoodRx collects millions of prices and discounts from pharmacies, drug manufacturers and other sources. Here's how you can use it to save:

- Use GoodRx's drug price search to compare price (just like you do for travel or electronics on other sites) for your prescription at pharmacies near you. We don't sell the medications, we tell you where you can get the best deal on them.
- GoodRx will show you prices, coupons, discounts and savings tips for your prescription at pharmacies near you.
- **Download GoodRx's iPhone or Android app (mobile) to get drug prices and coupons on the go.**
- If you prefer, GoodRx can send you a discount savings card which you keep in your wallet or purse.
- Visit www.GoodRX.com to sign up.

HIGH AND LOW DEDUCTIBLE OPTIONS—NETWORK BENEFITS & CLAIMS FILING

IN-NETWORK OR OUT-OF-NETWORK EMPLOYEE BENEFITS

When you are enrolled in our Self-Insured Medical Deductible Options, you may receive In-Network or Out-of-Network Medical benefits. The level of coverage depends on the provider you choose. Cigna has a nationwide network of health care providers and is solely responsible for determining which providers participate in its network. You may select an In-Network provider by contacting the Cigna customer service line at **1-800-244-6224** or visiting myCigna.com. If you already have a provider, you may check with Cigna or your provider to see if your provider is part of the Cigna Care Network (CCN).

THE ADVANTAGES OF CHOOSING AN IN-NETWORK PROVIDER

When a procedure or service requires preauthorization, your Cigna provider will handle the preauthorization.
Cigna providers file your claims and Cigna will reimburse the provider - little to no upfront money comes out of your pocket.
Cigna will provide you with an Explanation of Benefits (EOB) that explains your financial responsibility including deductibles, copays and coinsurance. You will also see your savings due to negotiated, In-Network allowances.
Cigna network providers will not bill you for amounts higher than indicated on your EOB.

THE HAZARDS OF CHOOSING AN OUT-OF-NETWORK PROVIDER

	You are required to obtain preauthorization from Cigna on certain services and procedures.
	You may be required to pay the provider's bill in full at time of service. You must then file a claim with Cigna for reimbursement.
	Your Explanation of Benefits (EOB) explains your financial responsibility, including deductibles, copays and coinsurance. You will not receive a discount off billed charges and your claim will be processed according to Reasonable and Customary charges.
	Out-of-Network providers may bill you for amounts over Reasonable and Customary charges as indicated on your EOB.

PLAN

DEADLINE

Medical claims with Cigna		In-Network providers have 90 days after the date of service to submit their claims. Out-of-Network claims must be filed within 180 days of date incurred.
FSA claims with Flexible Benefit Administrators - Claims incurred from 3/1/17—5/15/18		File by 6/15/18
Dental PPO claims with MetLife		File Out-of-Network claims within 365 days of date incurred.
Vision claims with Davis Vision		File Out-of-Network 20 days after incurred date.
Life Insurance claims with Insurance Point/Reliance Standard		File 90 days but not later than one year.
Life Insurance - Waiver of Premium		File 12 months after end of waiting period.

DIABETES AMERICA

Harris Health System and Diabetes America have created a comprehensive diabetes program to help you manage your diabetes and live well. Diabetes America Locations provide comprehensive best-in-class, one-stop care facilities built expressly to fulfill the unique needs of adult diabetic patients, all under one roof. Highly trained Medical professionals and Certified Diabetes Educators will work closely with you to help control blood sugar levels, treat complications and promote wellness through individualized care programs and education in a setting devoted entirely to diabetes care.

Diabetes America also saves you money, as there is **NO COPAY** for clinics or lab work. You can also get your lab work done right on-site. Diabetes America is not in the KelseyCare network. To find a Diabetes America location call **1-866-693-4223** or visit the website diabetesamerica.com.

SERVICES INCLUDE

- Care from a Diabetes Specialist
- On-Site Mail Order Pharmacy
- Case Management and Monitoring
- Eye, Foot and Cardiovascular Screenings
- Certified Diabetes Education
- Exercise and Lifestyle Counseling and Support
- Telephonic Support/Website Access
- On-Site Lab



OUTPATIENT REHAB SERVICES AT HARRIS HEALTH FACILITY

QUENTIN MEASE, BEN TAUB & LYNDON B. JOHNSON GENERAL HOSPITAL

Exceptional Rehabilitation Close to You!

The Outpatient Rehabilitation Centers at Quentin Mease Community Hospital, Ben Taub and Lyndon B. Johnson General Hospitals are a part of the Cigna network, but are not in the KelseyCare network. No copay is required for rehabilitation services provided at one of our facilities for members of the Deductible Plans, subject to plan limits.

Making an appointment at one of our Outpatient Rehabilitation Centers is simple and convenient.

To schedule an appointment call the Scheduling Line at **713-218-8250**.

YOUR HEALTH FIRST - *Free Health Advocate Coach*

Your Health First is a program offered through Cigna at no cost to you to help you or your family members cope with a chronic condition. Cigna’s solution weaves through all the health issues affecting an individual with a chronic health condition into one ongoing conversation through personalized support from a dedicated health advocate.

The advocacy program works with the individual to create a plan to help them successfully reach their health goals. The dedicated health advocate coach focuses on members with a one-on-one relationship approach to establish trust and drive higher engagement. Whether assistance is needed in managing a condition, knowing what to expect or understanding medications, the advocate team is there to help. Contact a Cigna health advocate coach today by calling **1-855-246-1873** or visit myCigna.com.

NURSELINE - *Free Health Guidance*

Have a health question? Cigna’s Health Information Line gives you 24-hour, toll-free access to a team of registered nurses experienced in providing information on a variety of health topics. This valuable service can help you learn about health conditions and Medical procedures, or to improve the way you communicate with your doctor.

The Health Information Line also includes access to hundreds of Cigna’s latest podcasts on a variety of health topics which are available to you to listen to in English or Spanish.

Call the Health Information line at 1-800-244-6224.

HEALTHY BABIES - *Free Pregnancy Educational Tools*

Healthy Babies is a collection of Cigna educational mailings available to members as part of your Medical benefit plan. In addition to the educational mailings, you have access to other services to assist with pregnancy such as a 24/7 Health Information Line, High Risk Maternity Case Management, and Neonatal Intensive Care.

You also have access on myCigna.com to tools that help you create a plan for a healthy pregnancy, monitor your pregnancy week by week, prepare for labor and delivery, and care for your baby. For more information call Cigna at **1-800-244-6224** or visit myCigna.com.

CIGNA NUTRITIONAL COUNSELING

Cigna covers routine Nutritional Counseling at 100% with no deductible or copay. Eligible plan participants can receive up to a maximum of 3 visits per calendar year. Call Cigna today at **1-800-244-6224** to confirm if you are eligible to participate in Nutritional Counseling.



CIGNA—PRECERTIFICATION REQUIREMENTS & NURSE CASE MANAGEMENT

Cigna care management is designed to help you access the services that are most appropriate for you. Through precertification (finding out in advance if a service is covered) and nurse case managers, Cigna can help you lower costs, avoid unnecessary procedures and support you as you recover after a procedure.

WHAT IS PRECERTIFICATION?

Precertification is the process of determining in advance whether a procedure, treatment or service will be covered under your medical plan. It also helps ensure you get the right care in the right setting – potentially saving you from costly and unnecessary services.

WHO IS RESPONSIBLE FOR GETTING THE PRECERTIFICATION?

- **In-Network services:** Your doctor is responsible.
- **Out-of-Network services:** You're responsible if you choose to see an Out-of-Network doctor and your plan covers Out-of-Network services. To get precertification, call the toll-free number on your Cigna ID card, **1-800-244-6224**. You'll need the name of the doctor or facility, the procedure or procedure code and the date of service when you call. Remember, when you go out-of-network, your out-of-pocket costs will be higher, your coverage may be reduced or denied and you may be subject to a \$500 penalty if you fail to precertify.

WHAT SERVICES NEED TO BE PRECERTIFIED?

Your doctor will help you decide which procedures require a hospital stay and which can be handled on an outpatient basis. Inpatient services include procedures, treatments and services that you receive in a hospital or related facility that require you to stay overnight. Outpatient services don't require an overnight stay. Here are some services requiring precertification*.

INPATIENT SERVICES

- All inpatient admissions and non-obstetric observation stays such as:
 - ✧ Acute hospitals
 - ✧ Skilled nursing facilities
 - ✧ Rehabilitation facilities
 - ✧ Long-term acute care facilities
 - ✧ Hospice care
 - ✧ Transfers between inpatient facilities
- Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (Cesarean section)

OUTPATIENT SERVICES

- Certain outpatient surgical procedures
- High-tech radiology (MRI, CAT scans, PET scans)
- Injectable drugs (other than self-injectable)
- Durable medical equipment (insulin pumps, specialty wheelchairs, etc.)
- Home health care/home infusion therapy
- Dialysis (to direct to a participating facility)
- External prosthetic appliances
- Speech therapy
- Reconstructive procedures in conjunction with underlying medical condition or accident
- Infertility treatment
- Nuclear cardiology
- Radiation therapy

* **Note:** This list does not include all services requiring precertification.

WHAT OTHER SERVICES ARE AVAILABLE TO ME?

If you or a covered family member needs care beyond a traditional hospital stay, our experienced nurse case managers work closely with you and your doctor to help you sort out your options, arrange care, or access helpful community resources and programs. Whether your need is for home care, explaining your medications or finding additional services, your case manager helps you find the care you need to help you get better.

WHAT IF I HAVE QUESTIONS ABOUT MY COVERAGE?

Visit [myCigna.com](https://mycigna.com) or call the toll-free number **1-800-244-6224** which is on your Cigna ID card.

CIGNA—CONVENIENCE CARE & URGENT CARE CLINICS

There is a new and improved reason not to wait at an emergency room for the treatment of a sudden illness or an unexpected injury. You have the option of visiting Convenience Care or Urgent Care Clinics for minor health needs. If it is critical then neither of these clinics should be used and the patient should be directed to the emergency room.

One of our highest cost factors continues to be the use of Emergency Room visits. We continue to steer Medical plan participants towards Convenience Care and Urgent Care Clinics when possible. Deductible Plan members should visit mycigna.com to find Convenience Care and Urgent Clinics and KelseyCare members should visit mycigna.com to find an Urgent Care Clinic and myKelseyCare.com to schedule a Saturday ILL—Care appointment.

Convenience Care Clinics are designed to treat common ailments such as sinus infections, flu or strep throat. They provide basic healthcare and are authorized to write prescriptions in order to treat you and your dependents' symptoms. The Convenience Care Clinics are designed to be convenient and low-cost.

KelseyCare members will not have access to the same Convenience Care Facilities as our other Harris Health sponsored plans. However, Kelsey-Seybold offers Saturday ILL-Care appointments for adults and children at select locations throughout the greater Houston area. Call the Kelsey-Seybold Contact Center at **713-442-0000** after 5pm on Friday or Saturday morning for a Saturday appointment.

Urgent Care Clinics are similar to Convenience Care Clinics but serve the patients who are suffering from acute illnesses and injuries, which are beyond the capacities of a Convenience Care Clinic. Urgent Care Clinics are open for extended hours and are open for patients with non-life threatening injuries and illnesses.



CONVENIENCE CARE CLINICS—HIGH & LOW DEDUCTIBLE OPTIONS

Helping you and your doctor better manage your health

When you need treatment for common ailments and injuries, you have more choices. Now you can get high-quality, affordable services for a wide variety of routine Medical conditions through Convenience Care Clinics located throughout the country.

Because we believe that your doctor has primary responsibility for your care and treatment, the results of your diagnosis and treatment are sent to your doctor with your permission. If you have a more severe condition, or require treatment in a different setting, the Convenience Care clinician will refer you to your doctor or an Emergency Room.

The Medical care you receive at a Convenience Care Clinic is covered by your health plan just like any other service you receive from a health care professional.

Find a Convenience Care Clinic in or near your favorite retail store, with hours that fit into your busy schedule.

Receive high-quality Medical care in a facility overseen by doctors and staffed by certified nurse practitioners and physician assistants.

CONVENIENCE CARE CLINICS MAY HELP WITH THE FOLLOWING CONDITIONS:

- Allergies
- Bladder
- Cold sores
- Ear infections
- Impetigo
- Infections
- Influenza
- Laryngitis
- Minor burns
- Mononucleosis
- Pink eye and sties
- Poison ivy
- Pregnancy testing
- Rashes
- Ringworm
- Sinus infections
- Strep throat
- Swimmer's ear

CLINICS ALSO PROVIDE VACCINATIONS FOR:

- DTaP (Diphtheria, Tetanus, Pertussis)
- Influenza
- Hepatitis A & B
- Polio
- Meningitis

CIGNA—TELEHEALTH CONNECTION

Cigna Telehealth Connection lets you get the care you need - including most prescriptions - for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat or phone, without leaving your home or office. When, where and how it works best for you.

Choose When: Day or night, weekdays, weekends and holidays.

Choose Where: Home, work or on the go.

Choose How: Phone or video chat.

Televisits can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. **Costs are the same or less than a visit with a primary care provider.** Giving employees an easy-to-use and cost effective alternative to care can help reduce costs and non-urgent ER visits.

USE CIGNA TELEHEALTH CONNECTION TO CONNECT WITH A DOCTOR ABOUT:

- Acne
- Allergies
- Colds and flu
- Fevers
- Headaches
- Rashes
- Sore throats
- Stomachaches
- Urinary tract infections and more

Visit the Website or call to register:

MDLIVE
888-726-3171
MDLIVEforCigna.com

Amwell
855-667-9722
AmwellforCigna.com

*Amwell is not available in Texas at this time, but offered in other states around the country.

CIGNA CARE NETWORK (CCN) - HIGH PERFORMANCE NETWORK—HIGH & LOW DEDUCTIBLE OPTIONS

The Cigna Care Network is an innovative high performance network strategy that steers specialty care to physicians who meet volume and medical cost efficiency standards. Under the Harris Health System plan you will pay lower out-of-pocket costs when you choose a Cigna Care Designated Specialist for covered services. This means your cost will be lower with a Cigna Care Specialist than with a specialist in the Cigna network who does not have this designation. To find a Cigna Care Specialist go to myCigna.com. The Cigna Care Network doctors are easily identified with a C symbol and will appear at the top of the list.

CIGNA CARE NETWORK (CCN) SPECIALTY TYPES

- | | | |
|----------------------------|-------------------------|---------------------------|
| • Allergy/Immunization | • Cardiology | • Cardio-Thoracic Surgery |
| • Colon and Rectal Surgery | • Dermatology | • Ear, Nose and Throat |
| • Endocrinology | • Gastroenterology | • General Surgery |
| • Hematology/Oncology | • Nephrology | • Neurology |
| • Neurosurgery | • Obstetrics/Gynecology | • Ophthalmology |
| • Orthopedics and Surgery | • Pulmonology | • Rheumatology |
| • Urology | | |

SPECIALIST TYPE	LOW & HIGH DEDUCTIBLE OPTIONS
In-Network CCN Specialist	\$35 copay
In-Network non-CCN Specialist whose specialty falls within the CCN Network	\$55 copay
In-Network non-CCN Specialist whose specialty does not fall within the CCN Network	\$35 copay
Out-of-Network Specialist	60 % after deductible

CIGNA—FREE PREVENTIVE CARE

Cigna’s preventive care coverage complies with Healthcare Reform. Services designated as preventive care include periodic well visits, routine immunizations and certain designated screenings for symptom-free or disease-free individuals.

Healthcare Reform requires that non-grandfathered health plans cover preventive care services with no cost sharing. Most plans cover the full cost of preventive care services for individuals with Cigna coverage, including copay and coinsurance. Typically, these services must be provided by In-Network healthcare professionals. There are some exceptions.

For more information regarding the preventive recommendations of these resources, please see the federal government website: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>.

CODING FOR PREVENTIVE SERVICES

Correctly coding preventive care services is key to receiving accurate payment for those services.

- Preventive care services must be submitted with an ICD-9 code that represents encounters with health services that are not for the treatment of illness or injury. The ICD-9 code must be placed in the first diagnosis position of the claim form. A positive result on a preventive screening exam does not alter the classification of that service as a preventive service.
- If claims for preventive care services are submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim, the service will not be identified as preventive care and your claims will be paid using your normal medical benefits rather than preventive care coverage.
- Use CPT coding designated as “Preventive Medicine Evaluation and Management Services” to differentiate preventive services from problem-oriented evaluation and management office visits. Non-preventive care services incorrectly coded as “Preventive Medicine Evaluation and Management Services” will not be covered as preventive care.

Payment of preventive services by Cigna is dependent on claim submission using diagnosis and procedure codes which identify the services as preventive. Additional information about preventive care guidelines is available in the health care professionals section of Cigna’s Informed on Reform website: InformedonReform.com.

This information does not supersede the specific terms of an individual’s health coverage plan, or replace the clinical



Cigna Wellness is a free program available to all of our Medical plan participants. This program is designed to support healthy behavior at home and in the workplace. This program promotes a healthy lifestyle through various activities, workshops and health fairs. Harris Health System has partnered with Cigna to find fun and active ways to educate our Medical plan participants on how to live a healthy life. The wellness categories that follow contain more information about the Cigna program, tips and wellness resources.

WE’LL HELP YOU GET WHAT YOU NEED IF YOU’RE SUFFERING FROM A CHRONIC HEALTH CONDITION

Connect with a dedicated health advocate to help you:

- Manage a chronic health condition.
- Create a personal care plan.
- Understand medications or your doctor’s orders.
- Identify triggers that affect your condition.
- Make educated decisions on your treatment options.
- Know what to expect if you need to spend time in the hospital.
- Improve your lifestyle by coping with stress, quitting tobacco use, maintaining good eating habits, and managing or losing weight.

Take charge of your health using online tools

We can also help you with a variety of Self-Service resources to help you better understand your condition and overcome barriers to better health with:

- A tool to help you understand your condition and make more informed treatment decisions.
- Articles and podcasts on hundreds of health topics.
- Online programs with email campaigns to help you with lifestyle issues.

Cigna may be calling you in order to take steps toward a healthier life. You may be eligible for an incentive when you participate. We do our best to suggest programs you might be interested in. Be on the lookout for communications regarding the following topics:

- | | | | |
|-----------------------|----------------------------|------------------------------|-------------------------|
| • Immunizations | • Breast Cancer Screenings | • Cervical Cancer Screenings | • Cholesterol Screening |
| • Diabetes | • Flu Shots | • High Blood Pressure | • Men’s Health Tips |
| • Women’s Health Tips | • Prostate Cancer | • Skin Cancer | • Back Care |
| • Cold and Flu Tips | • Fitness and Exercise | • Chronic Conditions | • Stress Management |

Call Cigna today!

1-855-246-1873 or visit myCigna.com



HARRIS HEALTH—FREE EMPLOYEE WELLNESS PROGRAMS

These programs are available to the Medical plan participants. They aim to promote a healthy work environment and healthy lifestyles through health education, health risk screenings, and risk factor reduction projects and services. Our programs are overseen by health professionals with expertise and training in health risk management, adult education, and behavior change. These wellness programs are offered at no cost to you. The programs are 100% employer paid and offer free activities for Medical plan participants to enjoy.

THE MISSION OF HARRIS HEALTH SYSTEM EMPLOYEE WELLNESS INCLUDES:

- Assuring good health and maximum effectiveness of employees while on the job.
- Increasing awareness among employees about wellness and healthy lifestyles.
- Establishing health risk reduction programs.
- Developing and facilitating weight management programs with an emphasis on healthy eating, increased physical activity and self-awareness.



LBJ Hospital Harris Health Employee Pregnancy Classes Becoming a Mom™ Course

- Offering an 8-lesson class to all pregnant employees who are under 32 completed weeks. (Program can be finished in 3 visits)
- Upon completion of each lesson you will receive 1,000 Harris Health Rewards points.
- Classes meet on Tuesdays and Saturdays, 1:00 pm - 2:45 pm, at LBJ Hospital, room 2G-14 (by the second floor GREEN elevators).
- To enroll call Meredith Yaker, RNC at 713-566-4818.

Course Lessons

You and Pregnancy	Things to Avoid	Prenatal Care	Labor and Birth
Healthy Eating	Caring for Baby	Stress and Relationships	Caring for You

HARRIS HEALTH SYSTEM IS DESIGNATED AS A MOTHER-FRIENDLY WORKSITE

Employee Wellness maintains multiple rooms to provide a private space for breast feeding mothers to express and store milk during the workday. To find out where your lactation area is contact Employee Wellness.

DISCOUNT HEALTH AND FITNESS OPTIONS

Discounts at gyms and health clubs are available

Basketball • Boot Camps • Dance • Flag Football • Zumba • Martial Arts • Pilates • Softball • Aerobics • Volleyball • Yoga

Join our FREE Employee Wellness Activities Today! Spouses and dependents over 18 years old are welcome.

FEED YOUR BODY, MIND AND SOUL WITH THESE CLASSES AND PROGRAMS:

Cooking Classes • Stress Management • Nutrition and Physical Activities Challenges • Smoking Cessation

COMMIT TO A HEALTHY LIFESTYLE CHANGE WITH:

Health Coaching • Lifestyle Programs • Disease Management • Healthy Babies • Diet • Sleep • Diabetes • Maternity Coaching • Fitness • Counseling Hypertension • Lactation Support • Prevention • Relaxation • Chronic Conditions • Health Education

Contact us to get started today! 713-566-6686

employeehealth@harrishealth.org

MEDICAL PLAN—DEFINITIONS

ANNUAL OUT-OF-POCKET MAXIMUM

The most you pay for covered expenses each year. Once reached, the Plan pays 100% for most covered expenses for the rest of the year. If you are also covering dependents, each member's covered expenses accumulate toward the Family Out-Of-Pocket Maximum.

COINSURANCE

After you've met your Annual Deductible for In-Network or Out-of-Network charges, you begin paying the coinsurance or a percentage of the allowed amount for most medical services and supplies until you reach the Annual Out-Of-Pocket Maximum.

COORDINATION OF BENEFITS (COB)

A group policy provision that helps determine the primary carrier in situations where a plan enrollee is covered by more than one policy. This provision prevents the individual from receiving claims overpayments.

COPAY

The dollar amount you are responsible for paying when you incur certain eligible medical expenses. Services are generally those provided by physicians/practitioners, surgical facilities, emergency rooms and prescription drugs.

DEDUCTIBLE

The dollar amount you must pay each year for In-Network services and/or Out-of-Network services before the Plan begins paying a benefit toward eligible expenses.

FAMILY DEDUCTIBLE

The maximum dollar amount any one family will pay out in individual deductibles in a year.

FULLY INSURED

Under this plan the employer purchases coverage from an insurance company. The insurance company assumes the risk to pay all health claims. Beyond the listed deductibles and co-pays, and subject to lifetime maximums, the insurance company assumes the risk if premiums do not cover the allowable claims.

FORMULARY

A list of preferred prescription drugs that are approved for coverage by OptumRX's pharmacy benefits service. It includes brand name and generic drugs approved by the U.S. Food and Drug Administration (FDA). Preferred drugs on the formulary usually have lower copays than non-formulary drugs.

GENERIC

A prescription drug that contains the same active ingredients in the same amount as its brand name counterpart. The U.S. Food and Drug Administration (FDA) considers generic drugs to be as effective as brand name drugs. A generic drug can usually be sold when the patent on a brand name drug expires.

MEDICALLY NECESSARY

Services or supplies that are appropriate for or consistent with a diagnosis according to accepted medical standards as described in the Covered Benefits section of the Plan.

MEDICAL PLAN—DEFINITIONS CONTINUED

NETWORK

Doctors, hospitals and other health care providers who have a contract with a health insurance/health benefits company to provide services at a negotiated rate of payment.

NON-FORMULARY

A list of approved but non-preferred prescription drugs. It includes many brand name and generic drugs approved by the U.S. Food and Drug Administration (FDA). Non-preferred drugs on the formulary list usually have higher copays than preferred formulary drugs.

OPEN ACCESS PLAN

This means you can see a Specialist without having to get a referral from a Primary Care Physician first.

PLAN YEAR

The Plan Year for annual enrollment plan design changes, premium changes, deductibles, out-of-pocket maximums, etc., are based on the Harris Health recognized Plan Year (March 1st to the end of February).

PRECERTIFICATION

Precertification is the process of determining in advance whether a procedure, treatment or service will be covered under your medical plan. It also helps ensure you get the right care in the right setting – potentially saving you from costly and unnecessary services.

QUALIFYING EVENT

Events (such as marriage, divorce, childbirth or change in job status) that qualify you to change your level of coverage during the year without waiting until Annual Enrollment.

REASONABLE AND CUSTOMARY CHARGES

Allowable expenses that the Plan will pay for medical services provided by Out-of-Network providers. Reasonable and Customary charges are consistent with those normally charged for the same services or supplies that are within the same geographical area. When you use an In-Network provider, you pay only the applicable copay or coinsurance based on a negotiated allowance, not Reasonable and Customary, for that contracted provider. When you use an Out-of-Network provider, the Plan pays 200% of the Medicare allowable amount.

SELF-INSURED MEDICAL PLAN

A plan in which the employer assumes the financial risk for providing benefits to its participants. A self-Insured plan lets the employer provide tailored programs to meet the special needs of its participants better than a “one size fits all” insurance offering, and there are financial benefits that can reduce the overall cost of the program, resulting in lower payments for both the employer and its participants.

Harris Health partners with MetLife to offer two options for Dental coverage: a **DPPO** and **DHMO**. Identification cards will be mailed out after enrollment for DHMO plan participants. Please note that if you are a DPPO plan participant, you are not required to show an ID card to your dentist as proof of coverage. Just call your selected participating dentist to schedule an appointment any time after your effective date (March 1, 2017). For those enrolled in the DPPO who would like to have an ID card after March 1, 2017; you can print one online when you register/log-in to your MyBenefits website at www.metlife.com/mybenefits. You can also access your ID card (and other features) through the MetLife mobile app, which can be downloaded via iTunes or Google Play by searching “MetLife”. Please note you must register via the website prior to downloading the app.

MetLife PPO

The MetLife DPPO plan has a network of over 380,000 participating providers nationwide who have agreed to provide services for a negotiated fee. The DPPO plan gives you access to your choice of providers and provides benefits both in-and-out-of-network. By going to a MetLife In-Network dentist you will benefit from greater discounts and reduced out-of-pocket costs.

METLIFE HMO

The MetLife DHMO plan requires you to select a MetLife DHMO provider. You may select a different provider for each covered family member.

For Annual Enrollment 2017, the cut-off date for electing your DHMO provider is a hard stop date of February 25, 2017 (and the 25th of each month thereafter for non Annual Enrollment enrollees). To find your DHMO provider, go to www.metlife.com/dental, and select “Find a Dentist.” Type in the zip code where you would like to find a dentist, and select “Dental HMO/Managed Care.” Select the plan name “Met290,” and then click the search button. A list of providers in your area will appear.

With this plan you do not have access to Out-of-Network coverage. The plan runs on a copayment fee schedule for all covered services. You may access the copayment fee schedule when you log-in to your MyBenefits page (www.metlife.com/mybenefits). For specialist services you must be referred for treatment by your designated MetLife general dentist. There are no claims to file; therefore, you will not receive an Explanations of Benefits (EOB).

MetLife Website: metlife.com

MetLife DHMO Phone Number: 1-800-880-1800

MetLife DPPO Phone Number: 1-800-942-0854

To register for metlife.com/mybenefits you will need your Social Security number to create a new log-in. Once registered, you may update your username and password. You will only need your Social Security number for the initial log-in.

Website Features! - Your MyBenefits page offers a variety of information and features including, your Explanation of Benefits, your dental ID card, finding and updating your DHMO dentist (complete with Google map directions)! You can access the site from your smart phone. If you have questions, Customer Care is ready to help! 1-800-880-1800 (DHMO) 1-800-942-0854 (DPPO)

BENEFIT SUMMARY

	METLIFE DHMO	METLIFE DPPO
Plan Year Deductible <i>(does not apply to preventive services)</i>	\$0	\$50 per person / \$150 per family
Annual Benefit Maximum <i>(for In-Network and Out-of-Network)</i>	No annual maximum	\$1,750 per person
Preventive Services <i>(cleanings, exams and x-rays)</i>	Copay varies	100% no deductible
Basic Services <i>(fillings, root canals and extractions)</i>	Copay varies	80% after deductible
Major Services <i>(bridges, crowns and dentures)</i>	Copay varies	50% after deductible-6 month waiting period
Orthodontia	Copay varies Adult & children covered	50% up to a \$1,000 lifetime max Only children up to age 19 covered 12 month waiting period for new enrollees.

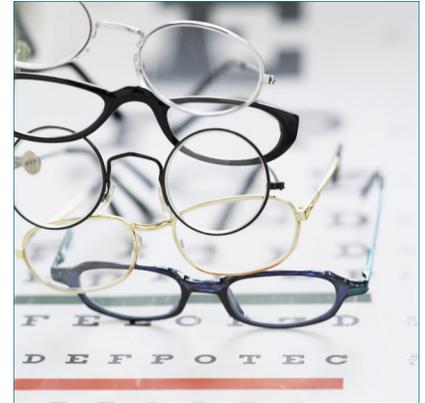
Note: Dental plan benefits are calculated on a calendar year basis. Annual deductibles and annual maximums start over each January. Some services have a waiting period associated before coinsurance is applied. See official plan documents for additional details.

VISION PLAN

Vision care is important to your overall health and can be a valuable part of your total benefits package. Davis Vision is our Vision care provider, providing benefits through a nationwide network that includes private practice and retail optical providers.

By selecting an In-Network provider you may receive a higher level of benefits and pay less out of your pocket. You will also enjoy the convenience of In-Network providers handling the claims process for you. To find an In-Network Provider visit davisvision.com or call **1-800-999-5431**.

When you use an Out-of-Network provider, you may pay more money out of your pocket at the time services are rendered and you are required to file the claim for reimbursement.



VISION EMPLOYEE BENEFIT SUMMARY

	COPAYS & ALLOWANCES	OUT-OF-NETWORK REIMBURSEMENTS*
Exams (every 12 months)	\$10 copay	Up to \$40 reimbursement
Lenses (every 12 months)		
Single Vision	\$20 copay	Up to \$40 reimbursement
Bifocal	\$20 copay	Up to \$60 reimbursement
Trifocal	\$20 copay	Up to \$80 reimbursement
Lenticular	\$20 copay	Up to \$80 reimbursement
Frames (every 12 months)		
Retail	Up to \$130 allowance	Up to \$45 reimbursement
The Exclusive Collection	Fashion Level - \$0 copay Designer Level - \$0 copay Premier Level - \$25 copay	N/A N/A N/A
Contact Lenses (every 12 months)		
Non-collection, elective	Up to \$105 allowance	Up to \$105 reimbursement
Visually Required	\$0 copay	Up to \$210 reimbursement
Contact lens evaluation, fitting & follow up	\$20 copay	N/A
The Exclusive Collection of Contact Lenses	\$0 copay - Up to 4 boxes included	N/A

*Out-of-network reimbursement form must be submitted

VALUE-ADDED FEATURES

DAVISVISIONCONTACTS.COM

- Purchase replacement contact lenses at discounted prices (service is considered out-of-network)
- Convenient home delivery
- Partial reimbursement available of up to \$105
- Free shipping on orders over \$99

LASER VISION CORRECTION

- Special pricing available for Davis Vision members - 40% to 50% off national average price for traditional LASIK
- Over 900 locations nationwide
- Flexible financing available—12 months interest free.

FREE ONE-YEAR BREAKAGE

WARRANTY

Available on all Exclusive Collection and in-network retail eyewear produced in a Davis Vision lab.

In 2017 Harris Health will continue our partnership with Reliance Standard to offer both Basic and Voluntary Life insurance. You are automatically provided Employee Basic Life and Accidental Death and Dismemberment (AD&D) coverage through Harris Health System. All full and part-time employees are eligible for Group Term Life insurance. Basic Life pays an amount equal to two (2) times your base annual salary, to a combined maximum of \$1,000,000 (Basic and Optional Life combined), to your beneficiary in the event of your death. There is no legal requirement as to who your beneficiary may be. Employee Basic AD&D will pay an additional amount equal to two (2) times your base annual salary if your death is the result of an accident. You may receive a full or partial benefit if you lose limbs or eyesight due to an accident while covered under the Plan.

OPTIONAL LIFE INSURANCE

Please Note this is **NOT** an open enrollment period for first time Optional Life participants. Guaranteed issue is only offered to new hires. If you did not elect Optional Life insurance as a new hire or when you were first eligible for the coverage you will be considered a "Late Entrant" and will be subject to Evidence of Insurability (EOI).

EMPLOYEE OPTIONAL LIFE INSURANCE

To provide your family with additional financial protection in the event of your death you can enroll in Employee Optional Life Insurance. This supplemental insurance offers protection in addition to the coverage Harris Health System provides through your Basic Life coverage. You may purchase Optional Life coverage equal to one (1) times your base annual salary to a combined maximum of \$1,000,000 (Basic and Optional Life combined). If you are a Late Entrant electing any amount of Optional Life or a New Hire or first time eligible participant electing coverage in excess of \$100,000, Evidence of Insurability will be required.

The cost of Optional Life Insurance is determined by your age and election amount and is payroll deducted on a pre-tax basis.

OPTIONAL AD&D INSURANCE

You may apply for amounts of one to ten times your base annual salary, up to \$500,000. If you are insured for Optional AD&D, you may also elect to insure your eligible dependents*. Spouse Only: 60% of Employee amount, Child(ren) Only: 15% of Employee amount; Spouse and Children; Spouse 50% of Employee amount and child(ren) 10% of Employee amount.

SPOUSE DEPENDENT LIFE INSURANCE

You may purchase Spouse Dependent Life Insurance in multiples of \$10,000 not to exceed one times your base annual salary. If you are a Late Entrant electing any amount of Spouse Dependent Life or a New Hire or first time eligible participant electing Spouse Dependent Life in excess of \$30,000, Evidence of Insurability will be required. Spouse Dependent Life rates are based on the employee age. You must be enrolled in Optional Employee Life Insurance in order for your spouse to be eligible for Spouse Dependent Life. Premiums are payroll deducted on a Post-tax basis. Note: There is no auto increase for spouse dependent life if an employee gets a pay increase during the year.

CHILD DEPENDENT LIFE INSURANCE

Child Dependent Life Insurance provides financial resources in the event of the death of a dependent child. The plan will pay a benefit of \$10,000. **If you and another Harris Health System employee have the same eligible dependents*, only one of you may cover the eligible dependent(s).** Premiums are payroll deducted on a Post-tax basis. You must be insured for Basic Life Insurance in order to elect Child Dependent Life Insurance.

*See page 10 for definitions of eligible dependents

OPTIONAL LIFE RATES	
<i>Employee/Spouse monthly rate, per \$1,000 of coverage</i>	
29 and under	\$0.048
30 - 34	\$0.057
35 - 39	\$0.067
40 - 44	\$0.086
45 - 49	\$0.124
50 - 54	\$0.228
55 - 59	\$0.371
60 - 64	\$0.523
65 - 69	\$1.102
70 - 74	\$1.197
75 and up	\$2.06

CHILD DEPENDENT LIFE BENEFIT

Dependent	Life Benefit
Dependent Child	\$10,000
Monthly rate per \$10,000 of coverage	\$1.00

OPTIONAL AD&D	
<i>Monthly rate per \$1,000 of coverage</i>	
Employee Only	\$0.015
Family	\$0.026

EXAMPLE: 46 year old wants to purchase \$50,000 in Optional Life Insurance

Employee Age	Amount of Coverage ÷ \$1,000	x	Optional Life Rate	=	Per Month Cost
46	\$50,000 ÷ 1,000 = 50	x	\$0.124	=	\$6.20 (50 x 0.124)

GROUP TERM LIFE INSURANCE

This Group Term Life coverage is a fully insured plan. As such, all employee benefit determinations, inclusive but not limited to the following are made by the underwriter. Policy provisions such as: effective date of coverage, active at work, evidence of insurability, waiting period provisions including waiver of active at work requirements, exclusion of coverage and portability of insurance are all determined by Harris Health System and Reliance Standard.

Other terms and conditions may apply to this summary; see the Certificate of Coverage for further details.

Beneficiary(ies) - Can I change my beneficiary at any time?

You should maintain current beneficiary information at all times for the different types of Group Term Life Insurance coverage you carry. You can change your named beneficiary at any time and you can name anyone or anything to be your beneficiary. To make a beneficiary change go to the PeopleSoft Self-Service module. Click on Employee Self-Service, then on Benefits, next on Dependents and Beneficiaries, and then on Insurance Beneficiary Summary. Make the Beneficiary changes you deem appropriate.

Suicide - Policy exclusion for Employee and Dependent AD&D Insurance Coverage.

The AD&D policy does not cover any loss caused by suicide or intentionally self-inflicted injuries. An AD&D benefit will not be payable for such a loss.

Reductions in Policy Coverage - When will my policy coverage be reduced?

An automatic reduction of insurance applies when you, the employee, reach the age shown below. Spousal Life insurance reductions also occur for your spouse when you reach the age shown below. The amount of insurance will be the amount determined by Reliance Standard, reduced to the applicable percentage below and rounded to the next higher \$500.

MEMBER AGE	PERCENTAGE
65 through 69	65%
70 or over	50%

Right to Convert - Can I take my life insurance with me when I leave Harris Health System?

All Group Term Life Insurance coverage ends on the date of your last day of employment with Harris Health System unless a Waiver of Premium has already been obtained from Reliance Standard. You will have 60 days after the date of your Qualifying Event (loss of coverage) to convert your insurance excluding AD&D insurance, to an individual policy. If you die during the conversion period, the underwriter will pay a death benefit equal to the maximum amount you had a Right to Convert, whether or not you applied for an individual policy.

Waiver of Premium - Is there a time that I would not be required to pay a premium?

Yes. Life insurance will be extended if you become totally disabled while insured under age 60, the total disability lasts for at least 6 months and you provide proof of total disability. After proof of total disability is approved by Reliance Standard, you are no longer required to pay premiums and any premiums paid from the start of total disability will be refunded. **Waiver of Premium** means all insurance under the group policy, except AD&D insurance.

Total Disability as used in Waiver of Premium, means the complete inability to engage in any type of work for wage or profit for which you are suited by education, training or experience.

Accelerated Benefit - Immediate Financial Assistance May Be Available at Time of Terminal Illness

While insured under the Group Policy, if you have an illness or physical condition that is certified by a physician to reasonably be expected to result in death in 24 months or less, you may submit a written request to accelerate your life benefit. The Accelerated Benefit will be an amount equal to 80% of your combined Basic and Optional Life, subject to a maximum of \$500,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to by you and Reliance Standard. The Accelerated Benefit is payable one time only. Other terms and conditions apply; see the Certificate of Coverage for further details.

Enhanced AD&D Benefits - *Are there any extra benefits that might be payable to you or your family in a time of need?*

Below are short excerpts of benefits that may be available to you or your beneficiary under the Group Term Life and/or Accidental Death & Dismemberment (AD&D) Policy. If any discrepancy exists between this summary and the life policy provisions, the life policy provisions shall prevail.

Seat Belt Benefit:

The Seat Belt Benefit will pay a benefit equal to 10% of the Accidental Death Benefit payable under the policy.

Air Bag Benefit:

The Air Bag Benefit will pay a benefit equal to 5% of the Accidental Death Benefit payable under the policy.

Education Benefit:

Reliance Standard will pay 6% of the AD&D insurance benefit, subject to a minimum of \$1,000 and a maximum of \$6,000 annually for each of the Insured's dependent children who is: enrolled as a full-time student in any Institute of Higher Learning beyond the 12th grade level on the date of the Insured's accident; or in the 12th grade on the date of the Insured's accident and subsequently enrolls as a full-time student in an Institute of Higher Learning within 1 year of the date of the Insured's death' provided the child remains enrolled for the school year. Benefits will be paid for up to 4 consecutive years of enrollment.

Reliance Standard will pay the actual tuition expense incurred by the Insured's dependent spouse, up to \$10,000 annually if: such spouse attends an Institute of Higher Learning for the purpose of obtaining a source of support and maintenance and the tuition expense is incurred within 30 months after the date of the Insured's death.

If at the time of the Insured's death, he/she has no surviving Insured Dependents that are eligible for the Education Benefits, Reliance Standard will pay a one time lump sum benefit equal to \$1,000 to the designated beneficiary.

Note: Institute of Higher Learning includes, but is not limited to: any university, college, trade school or professional school.

Day Care Benefit:

Reliance Standard will pay an additional monthly benefit equal to actual Day Care charges incurred up to 25% of the Insured Person's or Insured Spouse's AD&D benefit, not to exceed \$5,000 in any one calendar year for each insured dependent child who is under 14 years of age. The benefit will terminate on the earlier of: the date the child turns 14 years of age; or the end of the period of 3 consecutive years from the death of the Insured Person or the Insured Spouse. If at the time of the Insured's death, there are no surviving dependents that are eligible for the benefits, Reliance Standard will pay a one time, lump sum benefit equal to \$1,000 to the designated beneficiary.

Termination of Coverage - *When does coverage end?*

For termination of employment purposes, coverage ends on the date your employment terminates. See the policy for further coverage termination provisions.

Payable Benefit - *Is there a time when the policy might not be payable?*

Refer to your Certificate of Coverage. The Certificate of Coverage is located on the Human Resources intranet web page for the Harris Health System. Go to Human Resources, click on benefits, click on official plan documents link under disclaimer and then click on the GTL Certificate or the AD&D Certificate.



FLEXIBLE SPENDING ACCOUNTS



Use flexible benefits to bring home more of your paycheck. That's what you'll get when you take advantage of a Flexible Spending Account (FSA). A FSA allows you to set aside a portion of your pre-tax salary, to pay for qualified Medical, Dental, Vision and dependent care expenses. Because that portion of your income is not taxed, you end up with more money in your pocket!

Employees must enroll in the Flexible Spending Accounts each plan year. **This employee benefit will not automatically rollover.**

USE IT OR LOSE IT

The FSA plans are on a use it or lose it basis and any unused dollars at the end of the plan year will be forfeited so it is important to plan accordingly when selecting your contributions for the year. Please remember that you cannot change your FSA elections mid-year; unless there is an IRS approved Qualifying Event and you make your employee benefit changes within 31 days of the IRS recognized Qualifying Event.

VISA DEBIT CARD

You will receive a Visa debit card from Flexible Benefit Administrators if you enroll in a FSA benefit plan. The Visa debit card gives you immediate access to your funds and can be used when purchasing qualifying expenses. If lost or stolen, you will need to contact Flexible Benefit Administrators for a replacement card. Please note that the Visa debit card does not eliminate the need for verification of eligible expenses. It is important that you save your receipts when using the FSA Visa debit card as Flexible Benefit Administrators may ask you to verify your expenses. If you do not provide receipts upon request, your Visa debit card may be shut off until the requested receipts are received and any funds spent without supporting documentation may be requested for repayment.

By enrolling in a Harris Health sponsored Health Care and/or Dependent Care Flexible Spending Account (FSA) plan, you voluntarily agree to payroll contributions for participation in one or both of these plans. You understand that as a plan participant you will be issued a FSA debit card by the third party administrator. Through use of your FSA debit card you voluntarily agree that if any portion of a deemed improper payment remains outstanding after attempts to recover the improper payment through deactivation of your debit card, through demand for repayment and after substantiation or offset of other eligible claims to resolve the improper payment, you are voluntarily authorizing Harris Health to withhold the amount of the improper payment from your pay or other compensation, to the full extent allowed by law. Furthermore, if you remain indebted to Harris Health for a FSA debit card payment, you are authorizing Harris Health, consistent with its business practice, to treat the improper payment as it would any other business indebtedness.

RECEIPTS

Reminder notices for receipts are sent out on: Day 1, 30, and 72. Receipts may be submitted via: Online, fax, iPhone and android applications.

CLAIMS

Submit claims via fax, mail, email or online. There is a two day turnaround timeframe for claims to be processed and reimbursed via direct deposit or mailed with a live check.

TIMELINES TO INCUR AND FILE CLAIMS

- March 1, 2017 — May 15, 2018, to incur expenses (services must be actually rendered).
- June 15, 2018 to submit claim(s) to Flexible Benefit Administrators before the *Use It or Lose It* provision applies. (Terminated Employees have 105 days after the last day of active service.)

CONTRIBUTION TIMELINES

Contributions are made on a biweekly basis (every payroll). Contributions are deducted on a fiscal year basis (March 1, 2017– February 28, 2018) but are reported to the IRS on a calendar year basis (January 1st - December 31st).

TERMINATION OF EMPLOYMENT OR NON-BENEFIT BEARING STATUS

If you terminate employment or transfer into a non-benefit bearing employment category with Harris Health System, you will no longer be allowed to contribute to the FSA Plan. However, you may still file claims for expenses incurred from the date your FSA became effective until your change in employment status.

HEALTH CARE FSA

You may set aside a maximum of \$2,600 annually to pay for eligible copays, coinsurance, deductibles and out-of-pocket health care costs that are not covered by Medical, Dental or Vision employee benefits. Examples include:

- Acupuncture
- Copays/Coinsurance/Deductibles
- Dental Implants
- Hearing Exam/Hearing Aid
- Chiropractor
- Corrective Eye Surgery (Lasik)
- Dentures
- Orthodontia
- Contact Lenses and Lens Solution
- Dental Fillings/Bridges/Crowns
- Eyeglasses (Lenses and Frames)
- Prescription Drugs

See www.flex-admin.com for a complete list of eligible expenses.

Receipt Reimbursement

If you submit eligible receipts totaling more than you have currently contributed to your account, you will be reimbursed up to the amount you requested or up to the amount you elected to contribute this plan year, whichever is less.

DEPENDENT CARE FSA

You may set aside up to \$5,000 per year, tax-free, to pay for dependent care expenses for eligible dependents up to age 13 who you claim on your IRS taxes, a disabled dependent of any age or a disabled spouse. But, to be eligible for this type of FSA account, both you and your spouse (if applicable) must work, be looking for work or be full-time students. Eligible expenses include:

- Placement fees for a dependent care provider
- Before and after-school care (other than tuition expenses)
- Care of an incapacitated adult who lives with you at least 8 hours per day
- Childcare at a day camp, nursery or private sitter
- Late pick-up fees
- Summer or holiday-day camps, including registration fees



Ineligible Expenses

Remember, you cannot claim costs already claimed as a Dependent Care Tax Credit on your IRS tax return. You also cannot claim nursing home, respite care or other residential care center costs. And, you cannot claim services provided by one of your dependents or for expenses while on vacation.

Receipt Reimbursement

If you submit receipts totaling more than you have contributed to your Dependent Care Flexible Spending Account, you will be reimbursed only up to the balance in your account. The remainder will be issued automatically as the funds become available.

The Dependent Care maximum contribution amount is \$5,000, unless married and filing separate IRS tax returns, then you may only contribute \$2,500.

Plan Administrator:	Flexible Benefit Administrators
Customer Service Hours:	Monday - Friday, 8:30 am to 5:00 pm EST
Customer Service:	800-437-3539
Customer Service Fax:	757-431-1155
Web address:	www.flex-admin.com
Create Account/Login:	www.mywealthcareonline.com/fba

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program (EAP) is a free program available through FEI to all of our employees and family members living in the home. This program will help you find ways to handle personal problems concerning family, finances, health, emotional stress and more.

COUNSELING SERVICES - *Where can you turn for help?*

Harris Health System provides you with a resource to help you and your family in times of trouble. Services are confidential, private and available 24 hours a day, 7 days a week at NO cost to you. Flexible times are available for morning, evening and weekend appointments with consultations ranging from 15 - 50 minutes depending on your individual need. Call **1-800-638-3327** or visit www.feieap.com - user name: **hhs**

If you need to talk about a personal, work related or family problem your EAP benefits are available to assist you with that need. Your EAP program offers up to three FREE sessions a year for each type of problem you may need to address.

When you call FEI, your call will be answered by a Master's level EAP Counselor. They will talk with you about your concern and explain how the EAP benefit works. As appropriate, based upon the initial phone consultation, FEI will connect you with a local Counselor for in-person support. Or, you may opt for a telephonic appointment, where you will also speak with a Master's level EAP Counselor. In both situations, Counselors work out of private, professional office settings and follow strict laws governing confidentiality.

FINANCIAL SERVICES - *What are your financial goals?*

FEI certified financial counselors can help you take control of your finances.

- Tax Planning
- Debt and Budgeting Assistance
- Credit Counseling
- Planning for Retirement

For each financial issue, you are eligible for a consultation, at NO cost to you. Helpful financial tools, calculators, worksheets and information are available 24/7. Log onto www.feieap.com and enter user name: **hhs**

FEI COUNSELORS HELP WITH

- Stress and Anger Management
- Family/Parenting Issues
- Anxiety/Depression
- Child/Elder Care
- Coping with a Cancer Diagnosis
- Dealing with Difficult People
- Insomnia
- Suicide Prevention
- Weight Management
- Alcohol/Substance Abuse Problems
- Marital/Relationship Issues
- Legal/Financial Services
- Coping with Grief & Loss
- Dealing with Pre-Teens & Teenagers
- Successful Single Parenting
- Eldercare Issues

WORK & LIFE SERVICES - *Is your juggling act a bit too much?*

Ever feel dizzy trying to juggle all of life's responsibilities? You are in luck! With your Employee Assistance Program (EAP) you have enhanced Work & Life Services, a true life-saver for those times when childcare falls through, your roof starts leaking and you're in dire need of a massage all in the same week. Your EAP benefits can provide you with:

- **Adoption Assistance** - Contact information for agencies and attorneys.
- **Childcare** - Family daycare, daycare centers, before and after-school care, in-home care and care for children with special needs (contact information for up to five providers with confirmed openings). Colleges and Universities; Two or four-year private and public schools for continuing education needs.
- **Daily Living Services** - Referrals to consultants and businesses that can help with everyday errands, travel, event planning and more (does not cover the cost nor guarantee vendor services). Eldercare; Assisted living, residential and Medical care facilities, information on senior meal services and other community resources (contact information for up to five providers with confirmed openings).

WORK & LIFE SERVICES - Continued

- **Daily Living Services** - Referrals to consultants and businesses that can help with everyday errands, travel, event planning and more (does not cover the cost nor guarantee vendor services). Eldercare; Assisted living, residential and Medical care facilities, information on senior meal services and other community resources (contact information for up to five providers with confirmed openings).
- **Financial Services** - Budgeting, credit and financial guidance (investment advice, loans and bill payments not included), assistance with retirement and tax planning.
- **Identity Theft Recovery Services** - Information on ID theft prevention, plus an ID theft emergency response kit and help from a fraud resolution specialist if you are victimized.
- **K-12 Education** - Contact information for public and private schools, tutoring and special needs.

HEALTH & WELLNESS - Take charge of your well-being!

Living well is not always easy, but it is worth the effort. The FEI member web site, LifeCycle[®] Connect, has tools and information that can help.

Content Areas:

- Quarterly *EAPost* Newsletter, and *EAPost* Archives
- Video Library
- Monthly Webinar Schedule
- Helpful Telephone Numbers
- Glossaries
- Tests and Questionnaires
- Employee Toolbox
- Monthly Featured Articles

Featured topics on a wide range of subjects including:

- Addictions
- Anger Management
- Child and Elder Care
- Exercise
- Legal and Financial Issues
- Medical Disorders
- Nutrition
- Parenting
- Wellness and Personal Development

International areas:

- Studying Abroad
- Living and Working Abroad
- Families Abroad
- Cultural Adjustment
- Expat Blogs and Websites

Website features:

- A detailed description of your EAP benefits as well as a collection of resources to support work, care giving and wellness issues
- A menu containing more than 90 topics
- Thousands of pages of the most current and comprehensive behavioral health news and articles



Website features — Continued:

- Numerous categorized videos and hyperlinks to information on specific conditions, treatments, associations and support groups
- Screening quizzes and glossaries
- Google translations feature for 50+ languages

Searchable provider databases:

- Child care
- Elder care

Monthly webinars:

- Register for monthly webinars (online seminars) that cover a variety of topics
- Archive of webinars

Mobile App:

- LifeCycle[®] Connect available for use on mobile devices
- Quick and easy accessibility to FEI's wealth of resources. Simply use the LifeCycle[®] Connect username and password
- Step-by-step installation process provided
- Available for both Apple and Android products

LEGAL SERVICES - *Buying or selling a home, confronting foreclosure or bankruptcy, coping with divorce and custody issues?*

You can call for a referral to a local licensed attorney as part of the FEI EAP benefit, *you are entitled to a FREE 30 minute office or telephone consultation per separate legal matter.* If you want to retain an attorney after your initial consultation, you will receive 25 percent off the normal hourly rate.

Some examples of included Legal Services are:

Civil and Consumer Issues: Problems with purchases or warranties, governmental entitlements and benefits, advice on small claims court.

Personal and Family Legal Services: Adoption and guardianship, custody and support matters, divorce, separation and annulment issues, name changes.

Financial Matters: Bankruptcy representation and defense for lending-related legal issues.

Business Legal Services: Advice, consultation and representation for contracts, incorporation, partnerships and other commercial activities.

Real Estate: Buying or selling property, lease and rental agreements and property boundary disputes.

Criminal Matters: The defense of both misdemeanor and felony criminal acts of all kinds.

Organizing Personal Affairs: Obtain advice on organizing vital documents and arranging final details for a loved one.

Some examples of Online Legal Tools include:

Estate Planning Tools: Create a will, power of attorney, or record of your preferred final arrangements.

Legal Forms: Sample legal forms to cover most of your legal situations.

Legal Information: Hundreds of professionally written documents covering a wide range of legal topics.

**Matters involving Medical malpractice or disputes or actions between members and their employer, FEI are specifically excluded from this plan. Also excluded are matters that, in the attorney's opinion, lack merit. Court costs, filing fees and fines are the responsibility of the member.*

ABSENCE MANAGEMENT PROGRAMS AND ASSISTANCE

AMERICANS WITH DISABILITIES ACT (ADA)- Does Harris Health Comply with ADA regulations?

Absolutely! HR Employee Services handles all ADA requests. To speak with someone about ADA regulations or accommodations please contact the Program Manager for Leave and Disability at 713-566-6991.

BEREAVEMENT LEAVE- Can I be off work during my family's time of need?

Harris Health System provides time off from work to grieve, make funeral arrangements or attend services for an immediate family member. Refer to policy 6.25 for more information.

CATASTROPHIC ILLNESS PTO POOL- You can help, why not donate?

Employees facing a continuing catastrophic illness or injury may apply for additional compensation from the Catastrophic Illness Paid Time Off (PTO) Pool. Active employees may voluntarily donate accrued PTO hours to the Catastrophic PTO Pool for use by other employees. Refer to policy 6.06 for more information.

DISASTER RELIEF PROGRAM- Possible assistance in your time of need.

The Employee Disaster Relief Program can provide assistance to help you meet your financial obligations based on documented catastrophic losses. Refer to policy 6.05 for more information or call 713-566-6423.

FMLA- Does Harris Health System comply with the Family Medical Leave Act (FMLA)?

Yes. Employees may contact Harris Health System's third party administrator for FMLA, FMLASource, at 877-462-3652 to initiate a claim. Refer to policy 6.29 for more information.

JURY DUTY AND OTHER LEGAL PROCEEDINGS-Will I be excused from work?

Harris Health System supports employees who are summoned to serve on a jury. Refer to policy 6.23 for more information.

MILITARY LEAVE-Does Harris Health System comply with the Uniformed Services Employment and Re-Employment Rights Act (USERRA)?

Yes. Harris Health System provides employment and re-employment benefits for employees ordered into active military service and for military reserve training. To initiate Military Leave please contact Harris Health System's third party administrator, FMLASource, at 877-462-3652. Please refer to policy 6.26 for more information.

PAID TIME OFF (PTO)- How much time off do I get?

Harris Health System PTO replaces traditional vacation, holiday and sick pay plans. Refer to policy 6.03 for more information.

WORKERS' COMPENSATION BENEFITS- Injured on the job?

If you have incurred a work related injury, you should immediately notify your direct line of management and file an electronic incident report. Harris Health System utilizes an online self-reporting system, E-Incident Reporting, available on the intranet. Refer to policy 6.34 for more information or call 713-566-6423.

SHORT TERM DISABILITY & ADDED BENEFITS



Short Term Disability (STD) benefits are offered to all regular full-time employees following a one-year waiting period of continuous employment. This benefit is 100% employer funded and offered on a pre-tax basis.

After a 30-day disability elimination period and subject to carrier approval as well as Harris Health Policy and Procedure 6.32 – Short-Term Disability benefit provisions, the scheduled monthly STD benefit is 60% of monthly eligible pre-disability earnings, calculated off base salary. The maximum weekly benefit is \$4,500 and the minimum weekly benefit is \$25. This policy offers up to a 24-week maximum benefit period, based on a case-by-case evaluation basis.

Additional services include, but are not limited to:

- Return to work incentive benefit.
- Unlimited trial work days.
- Pre-Disability vocational services.
- Vocational rehabilitation services.
- Social Security advocates.

For more information refer to Harris Health Policy and Procedure 6.32 or contact Cigna at 1-800-362-4462 or 1-866-562-8421 (Español).

LONG TERM DISABILITY—BASIC, BUY-UP & FREE SERVICES



BASIC LTD

Basic Long Term Disability (LTD) benefits are offered to all active regular full-time employees after a one-year waiting period from last date of hire. This benefit is 100% employer funded and offered on a pre-tax basis.

After a 180-day disability elimination period and subject to carrier approval, the scheduled monthly LTD benefit is 55% of monthly eligible pre-disability earnings, calculated off base salary. The maximum monthly benefit is \$17,500 and the minimum monthly benefit is \$100.

LTD BUY-UP

All regular full-time employees are also offered an LTD Buy-Up option. This Buy-Up option offers an additional 10% benefit (increasing Basic LTD from 55% to 65%), is 100% employee funded and offered on a post-tax basis to eligible participants through payroll deduction.

If you did not elect LTD Buy-Up as a new hire or when you were first eligible, you may elect during Annual Enrollment. LTD Buy-Up is subject to salary limitations. The cost for coverage is \$0.22 per \$100 of payroll on a monthly basis.

The LTD policy includes other value added benefits such as:

- Child Care Expense benefit.
- Temporary Recovery benefit.
- Managed Rehabilitation Employment benefit.
- Catastrophic Care benefit.
- Survivor benefit.
- Travel Assistance benefit.

To learn more contact Reliance Standard at 800-351-7500.

HARRIS HEALTH—EMPLOYEE RECOGNITION & EDUCATIONAL ASSISTANCE

EMPLOYEE RECOGNITION

EMPLOYEE RECOGNITION - *How do our Harris Health System award programs work?*

Employee recognition for Service Awards is based on five-year service increments. Refer to Policy 6.18 on the Harris Health System intranet web page. Click on *Policies*, type in 6.18 and hit *SEARCH* then click on the policy description. Recognition programs vary, listed below are some of the more common ones.

- Service First Hero Program
- "On-the-Spot"
- Annual Service Awards, and
- Retirement Recognition Program

For more information contact HR-Employee Services at 713-566-6624.

EDUCATIONAL ASSISTANCE

CLINICAL INTERNSHIPS - *To find out if Harris Health System has an approved Affiliation Agreement with an educational program:*

Contact the Learning and Resource Center (LRC) at **713-873-8725**.

EDUCATIONAL CLASSES - *Help, I need a training class!*

The LRC provides essential learning and development resources to Harris Health System employees. Employees and management are encouraged to contact the LRC at **713-873-8725** about all of their learning needs. LRC staff can help with:

- Mandatory/Regulatory Education
- New Employee Orientation
- Student and Contractor Orientation
- Professional Development
- Leadership/Management Education
- Special Developed Program



SCHOOL OF DIAGNOSTICS MEDICAL IMAGING - *Training the next generation!*

The Harris Health System School of Diagnostics Medical Imaging is a two-year hospital based program. For more information call Harris Health System School of Diagnostic Medical Imaging at **713-634-1550**.

Current programs Include:

- Program for Diagnostic Medical Radiography
- Graduate Fellowship in Computed Tomography (CT)
- Program in Diagnostic Medical Sonography
- Graduate Fellowship in Magnetic Resonance Imaging (MRI)

STUDENT LOANS and TUITION REIMBURSEMENT - *Is financial assistance available?*

Harris Health System supports employees who are in pursuit of a degree or licensure and who are seeking to qualify for an identified job classification within our own facilities. There are no up front student loans. Employees are only reimbursed once a course has been completed. Refer to **Policy 106** for further details. Go to the Harris Health System intranet web page. Click on *Policies*, type in 106 and hit *SEARCH*, then click on the policy description. Contact the LRC at **713-873-8725** for further details.

HARRIS COUNTY HOSPITAL DISTRICT FOUNDATION

FOSTERING PROGRAM INNOVATION AND SUPPORTING HARRIS HEALTH STAFF

The mission of the Harris County Hospital District Foundation is to enhance the broad healthcare mission of the Harris Health System by soliciting and raising funds for, and increasing the community's awareness of Harris Health System. The Foundation makes an impact by working hand-in-hand with the Harris Health Administration to fund projects and initiatives that have been identified as "the greatest need" in the community. It is of prime importance that the projects supported by the Foundation directly impact the improvement of quality and access to care for the uninsured and underinsured people of Harris County. Our work also aims to enhance the quality of the workplace found at Harris Health sites for all employees.

Some of the initiatives are:

- Employee Disaster Relief Fund: Funds are used to support employees in time of need.
- Employee Contribution Fund: Applications are received on a quarterly basis for projects that benefit employees.
- Nursing Leadership Fund: Funds raised each year to provide scholarships for books and fees for nursing staff
- Honorariums & Memorials: To honor a loved one or a colleague's contribution to our Harris Health community, a donation can be made in their name and used to support a specific program in Harris Health.
- Bricks, Benches, and Trees: Make a last tribute at Harris Health – Buy an engraved Brick, Tree, or Bench to be placed in one of three healing gardens (Ben Taub Hospital, Lyndon B. Johnson Hospital, and Smith Clinic).

For more information or to make a donation, please call the HCHD Foundation office at 713-566-6409 or send us an email to HCHDFoundation@harrishealth.org.



PEOPLESOFT TOOLS—YOUR PERSONAL CONTACT INFORMATION

Need to access or update your personal information? You have 24/7 access!

EMAIL ADDRESSES - *How can I update my personal email address?*

As a Harris Health System employee, you can update your email addresses at your convenience. Go to the Harris Health System intranet web page. Click on the PeopleSoft link. Under “One-Click” Select Employee then Address & Phone and then click on Change Email Addresses. The system will display your current email contact information. Follow the on-screen instructions to delete or add email addresses as needed. Be sure to click the SAVE button to store your requested changes. This same information may also be updated by simply accessing the Personal Information Summary page.

EMERGENCY CONTACTS -*Who do I have listed as my Emergency Contact?*

As a Harris Health System employee, you can view and modify your Emergency Contacts at any time. Go to the Harris Health System intranet web page. Click on the PeopleSoft link. Under “One-Click” Select Employee then Address & Phone and then click on Change Emergency Contacts. The system will display your current Emergency Contacts. Follow the on-screen instructions to delete or add your Emergency Contacts or to change or add a primary contact. This same information may also be updated by simply accessing the Personal Information Summary page.

HOME AND MAILING ADDRESS - *Where is my Harris Health System information being mailed?*

Have you checked the PeopleSoft system to determine if your personal address information is correct? Oftentimes our employees move and fail to notify us. This results in all Harris Health System information being returned to our corporate mail room. It is therefore imperative that you maintain your current contact information to ensure timely notification of all employer and vendor mail being directed to your home. As a Harris Health System employee, you can view and modify your Home and Mailing Address at any time. Go to the Harris Health System intranet web page. Click on the PeopleSoft link. Under “One Click” Select Employee then Address & Phone and then click on Change Home/Mailing Addresses and edit the information as needed. This same information may also be updated by simply accessing the Personal Information Summary page.

PHONE NUMBERS - *What phone numbers do you have on file for me?*

As a Harris Health System employee, you can view and modify your Phone Numbers at any time. Go to the Harris Health System intranet web page. Click on the PeopleSoft link. Under “One-Click” Select Employee then Address & Phone and then change Phone Numbers. The system will display your current Phone Numbers. Follow the on-screen instructions to delete or add your Phone Numbers. Be sure to click the SAVE button to store your requested changes. Your work phone number will automatically be updated in Outlook as a result of this change within the next 24-hour period. It's that simple! This same information may also be updated by accessing the Personal Information Summary page.



HARRIS HEALTH—PAYROLL PROCESSES AND ASSISTANCE

DIRECT DEPOSIT - *Can I change my Direct Deposit?*

Go to the Harris Health System intranet web page. Click on the PeopleSoft link. Sign in utilizing your User ID and Password. Click on Self-Service, click on Payroll and Compensation and then click on Direct Deposit. This will allow you to view your current payroll Direct Deposit Authorization(s). If you sign up or change your Direct Deposit Authorization(s), Click the; “Add Account” button. Your first bank account must be a “Balance” account which can be edited, but cannot be deleted. Click on the Direct Deposit QRG link for detailed instructions on setting up your direct deposit information which is mandatory per Harris Health System policy 6.21, Section II.

HOLIDAY SCHEDULE - *What is our approved Holiday schedule?*

The approved Holiday Schedule is posted on the Harris Health System intranet web page. Go to Forms, click on Payroll, then click on Payroll Schedule for the Year 2017. The first page contains the Payroll Schedule Calendar and the second page of the attachment is the Holiday Schedule.

PAY ADVICE - *How do I print my biweekly Pay Advice (i.e. Pay stub)?*

As a Harris Health System employee, you can print your most recent or a prior paycheck stub at your convenience. Go to the Harris Health System intranet web page. Click on the PeopleSoft portal link. Sign in utilizing your User ID and Password. Click on Self-Service, click on Payroll and Compensation and then click on View Paycheck. You can then click on “View Paycheck” link. If you wish to print a previous Pay Advice, click View A Different Payment. From the View Paycheck screen select the Payroll Period End Date that you require. For all other Pay Advice assistance call **713-566-6743**. For detailed instructions on Printing/Viewing paychecks, see the QRG (Quick Reference Guide) on PeopleSoft “How To’s” Link on the Home Page.

TURBO TAX ACKNOWLEDGEMENT - *You can send my W-2 information to Intuit*

As a Harris Health System employee, you can elect to have your W-2 information sent directly to Intuit if you wish to use TurboTax to prepare your income tax return. Go to the Harris Health System intranet web page. Click on the PeopleSoft portal link. Sign in utilizing your User ID and Password. Click on Self-Service, click on Payroll and Compensation and then click on Turbo Tax Acknowledgement. Follow the online instructions.

W-2 ELECTRONICALLY - *Don't wait for the US Mail. Sign up to receive your W-2 ELECTRONICALLY.* Click on the PeopleSoft link. Sign in utilizing your User ID and Password. Click on Employee Self-Service, click on Payroll and Compensation and then click on W-2/W-2c Consent. Check the box and SUBMIT.

W-2 TAX FORM - *How do I obtain my W-2 for IRS tax reporting purposes?*

Go to the Harris Health System intranet web page. Click on the PeopleSoft link. Sign in utilizing your User ID and Password. Click on Self-Service, click on Payroll and Compensation and then Click on W-2/W-2C Forms, Select Year End Form or Select “View a Different Tax Year”. Hover cursor at the bottom of form to view the Print icon.

W-2 REPORTING - *New W-2 reporting rule.*

The health care reform law from 2010 requires employers to report the cost of employer-sponsored group health plan coverage provided to employees and family members. This reporting is done through the form W-2 and it is known as the “W-2 reporting Rule”. The W-2 Reporting Rule must be followed starting with the 2012 tax year. Employers must report the aggregate cost of employer sponsored Medical coverage. This new reporting requirement first appeared on your W-2 from January 2013.

W-4 TAX FORM - *How do I view my current W-4 elections for IRS tax reporting purposes?*

Go to the Harris Health System intranet web page. Click on the PeopleSoft link. Sign in utilizing your User ID and Password. Click on Self-Service, click on Payroll and Compensation and then click on W-4 to view your current elections. Should you wish to make changes to your current W-4 Tax Form, type in the changes and click SUBMIT. **WARNING:** Checking the EXEMPT box means that no Federal Income Taxes (FIT) will be withheld.

EMPLOYMENT VERIFICATION

EMPLOYMENT VERIFICATION - *Need proof of your income?*

Harris Health System staff members are constantly on the move. If you or another person needs to obtain employment information for: buying a home, moving into an apartment, purchasing or leasing a car, or for some other reason refer interested parties to The Work Number at **1-800-367-5690** or visit www.theworknumber.com to obtain the information needed. Please provide the interested party our company code: 12990.

In order to create your account in The Work Number website you will need the following information:

- Employer Code: 12990
- Social Security #: Your social security number.
- Your PIN: For first time users, this will be the last four (4) digits of your social security number. (PIN is only required for compensation verification.)
- For Income Verification, please create a salary key and provide it to the verifier.

To create a Salary Key:

- ✧ Please go to the web site www.theworknumber.com (link: [theworknumber.com](http://www.theworknumber.com))
- ✧ Click *I'm an employee*
- ✧ Click *enter site*
- ✧ Enter Employer Code **12990**
- ✧ Click *I want to provide proof of employment and income*
- ✧ Enter SSN
- ✧ Enter PIN (last 4-digits of your SSN, if you have not already created your account)
- ✧ Follow the enrollment process
- ✧ Look for an option to create a **SALARY KEY** (6 or 8 digits)

Once you have the Salary Key (code), please give this number to the verifier. The verifier will then be able to view your income information.



HARRIS HEALTH SPONSORED—401K & 457(b) RETIREMENT SAVINGS PLANS



Harris Health System offers its employees two defined contribution savings plans to help employees prepare for the future, a 401K Plan and a 457(b) Plan. Both the Harris County Hospital District 401K Plan (“the 401K Plan”) and the Harris County Hospital District 457(b) Plan (“the 457(b) Plan”) are deferred compensation plans.

CONTACTING THE RECORD KEEPER

Fidelity is the record keeper and trustee for both our 401K and 457(b) plans. You have access to one call center, one on-site representative, and one website for both plans. Beneficiary changes, loan requests, and retirement payouts are automated under the one website.

With one phone call or a single sign on to the Fidelity website you can enroll in one or both plans, learn about investments in one or both plans, and change your contributions in one or both plans. To learn more visit [fidelity.com/atwork](https://www.fidelity.com/atwork) or call Fidelity at **1-800-343-0860**.

You should know that:

- Enrolling in the retirement savings plans is NOT an annual enrollment event. You can enroll in one or both plans at any time.
- You can enroll in one or both plans at the same time and make election changes 24/7 via the web.
- Regular full-time and part-time employees are eligible to participate in both plans.
- There is no minimum service requirement that an eligible employee must meet in order to participate in either plan.
- Contributions are made each payroll period by employee pre-tax salary deferral contributions.
- Contributions made by a participant and earnings on those amounts are credited to the participant’s account under both the 401K and 457(b) Plans.
- All employee contributions are 100% vested under both plans.
- Plan assets, including contributions and earnings, are held in a trust account under the 401K Plan and are held in a separate trust account under the 457(b) Plan, both for the exclusive benefit of the plan participants and their beneficiaries.
- The 401K Plan is funded by contributions from employees and, in some cases, by Harris Health System through matching contributions. The 457(b) Plan is funded by employee contributions only.
- Matching contributions under the 401K Plan vest on death and completion of three (3) years of full-time creditable service. Matching Contributions are made each pay period. Maximize your annual Matching Contributions by making employee contributions each pay period. The 457(b) Plan has no matching contributions.

2017 IRS LIMITS – BOTH PLANS

1. Elective Deferral (contribution) Limit is \$18,000.
2. Catch-Up Contribution Limit for age 50 or over plan participants is \$6,000.
3. Annual Compensation Limit is \$270,000.
4. Maximum Harris Health System Match is \$13,500.

HOW CAN I CHANGE MY LEVEL OF PARTICIPATION IN THE 401K SAVINGS PLAN AND THE 457(b) SAVINGS PLAN?

Contact Fidelity Investments at [fidelity.com/atwork](https://www.fidelity.com/atwork) or at **800-343-0860**. Fidelity can assist you with both retirement plans.

HOW CAN I DETERMINE WHAT MY BENEFIT IS UNDER THE PENSION PLAN?

The Pension Plan is valued on an annual basis. A calendar year end statement is mailed to all full-time active employees who are in the Pension Plan each year. The actuary mails personalized annual statements to identified plan participants at their last known mailing address in the late Spring, early Summer timeframe.

If you opted out of the Pension Plan, your Pension statement will read: "Your Normal Retirement Income is payable to you every month for your lifetime, beginning on your Normal Retirement Date. You will not earn any Credited Service for benefit accrual nor will your compensation be counted after 12/31 of the year you opted out of the Pension Plan."

If you are a regular full-time employee who was hired or rehired on or after January 1, 2007 or if you opted out of the Pension Plan you are not accruing a benefit in the Pension Plan. To ensure that you are contributing an adequate amount to meet your future retirement needs and to ensure that you are contributing a sufficient amount to maximize your 401K employer match, contact Fidelity at **1-800-343-0860** or visit [fidelity.com/atwork](https://www.fidelity.com/atwork) at your earliest convenience.

For questions or assistance with the Pension Plan contact the HR-Benefits department, Pension office at **713-566-6231** or **713-566-6453**, Monday through Friday, 8:00 - 4:30 p.m.

RETIREE HEALTHCARE ELIGIBILITY—RULE OF 80

ABOUT YOUR RETIREMENT

Effective June 1, 2012 the Harris Health System moved to a Retiree Healthcare eligibility point system. Employees now need 80 points to be eligible for Retiree Healthcare benefits (i.e. Medical, Dental or Vision).

The point system, also known as a “Rule of 80”, is based on age and creditable years of full-time regular employment as of your date of retirement. **Minimum retirement age is Age 55.**

Point System Examples:

Age 55 + 25 Years = 80 Age 62 + 18 Years = 80 Points
 Age 60 + 20 Years = 80 Points Age 65 + 15 Years = 80 Points

The percent of the total monthly Retiree Medical premium rate that you will pay will be based on your age at the time of your retirement.

The chart (right) provides you with the schedule of monthly premium percentage rates that early Retiree’s can expect to pay when retiring on or after June 1, 2012. The same percentage rate will be paid until the early Retiree reaches Age 65. Retiree premium rates may change each year, subject to Board approval.

EARLY RETIREE MEDICAL PLAN RATE SCHEDULE EFFECTIVE JUNE 1, 2012

If Your Age at Your Date of Retirement is:	The Percent of the HCHD Monthly Premium You will Pay until Age 65 will be:
55	80%
56	75%
57	70%
58	65%
59	60%
60	55%
61	50%
62	45%
63	40%
64	35%



MEDICARE REQUIREMENTS

WHEN ENROLLMENT IN MEDICARE IS REQUIRED TO CONTINUE RECEIVING HARRIS HEALTH MEDICAL PLAN BENEFITS AFTER RETIREMENT/DISABILITY

BENEFIT ELIGIBLE RETIREES AGE 65 OR OLDER AND THEIR DEPENDENTS AGE 65 OR OLDER MUST BE ENROLLED IN BOTH MEDICARE PART A AND B

For as long as you are a Benefit Eligible Employee enrolled in one of Harris Health's Medical Plan options, that Medical Plan option will have primary responsibility for paying your qualifying medical claims regardless of your age or health status. Consequently, when you reach age 65 and qualify to enroll in Medicare, you do not have to enroll in Medicare coverage in order to continue to receive benefits under the Harris Health Medical Plan option in which you are enrolled as a Benefit Eligible Employee.

When you retire from Harris Health and cease to be a Benefit Eligible Employee, the Medical Plan option coverage you received as a Benefit Eligible Employee will stop. If you qualify as a Benefit Eligible Retiree, you will be eligible to enroll in a Harris Health Medical Plan option. However, if you are age 65 or older when you retire you will have to be enrolled in both Medicare Part A and Part B in order to receive any benefits under the Medical Plan option in which you enroll. Similar rules apply to your qualifying dependents who are age 65 or older.

If you are not already receiving benefits from Medicare, you should contact the Social Security Administration (SSA) about three months before your 65th birthday to enroll in Medicare Part A and consider when you will need to enroll in Medicare Part B. You can sign up for Medicare even if you plan to continue working after you reach age 65. Many individuals can receive Medicare Part A at no cost, but there is a monthly premium charged for Medicare Part B coverage. While you are not required to have either Medicare Part A or Part B as long as you are a Benefit Eligible Employee (even if you are over 65), once you retire you *must* have both Part A and Part B to receive benefits under a Harris Health Medical Plan option as a Benefit Eligible Retiree. To avoid gaps in coverage, you should contact the SSA and ensure that Part A and Part B coverage is in place at the time of your retirement.

In addition, if you retire due to a disability that the SSA determines qualifies you to receive Social Security Disability Income, you will have to be enrolled in Medicare Part A and Part B as of the first day you are eligible for Medicare Part A and Part B coverage to continue to receive benefits under the Harris Health Medical Plan option in which you enroll as a Benefit Eligible Retiree. Similar rules apply to your qualifying disabled dependents.

For these reasons it is important for you and your dependents to have a basic understanding of Medicare coverage so that you and your dependents can enroll in Medicare *as soon as necessary to ensure you will continue to receive benefit under the Harris Health Medical Plan option in which you are enrolled*. Below, you will find a brief description of those parts of Medicare coverage that you need to consider, and the conditions under which you and your dependents will need Medicare coverage to remain eligible for plan benefits under a Harris Health Medical Plan option.

Medicare – Coverage Types

Medicare is our country's traditional health insurance program for people age 65 or older. It helps with the cost of healthcare, but it does not cover all medical expenses or the cost of most long-term care. Medicare benefits are managed by the Centers for Medicare & Medicaid Services (CMS), but you apply for Medicare through the SSA. Medicare is financed by a portion of payroll taxes paid by workers and their employers. It is also financed in part by monthly premiums deducted from SSA checks. Medicare has several parts to it.

Part A: Hospital insurance that helps pay for inpatient care in a hospital or skilled nursing facility and some home healthcare and hospice care.

Most individuals are required to enroll with the SSA to receive Medicare Part A.

Medicare Part A recipients who have worked for ten years or more (or whose spouses have worked for ten years or more) generally do not have to pay a monthly premium for Part A coverage. For everyone else, there is a monthly premium.

Part B: Medical insurance that helps pay for doctors' services, and other medical services and supplies not covered by the hospital insurance provided under Part A.

You must enroll with the SSA (and pay the monthly premium) to receive Medicare Part B coverage.

The 2017 regular Part B monthly premium is \$134.00. Some people may pay a higher premium based on personal adjusted income.

MEDICARE REQUIREMENTS CONTINUED

Part D: Prescription drug coverage that helps pay for medications doctors prescribe for treatment. Benefit Eligible Retirees and their dependents enrolled in and receiving benefits under a Harris Health Medical Plan option should not enroll in Medicare Part D because prescription drug coverage is included as a part of the Harris Health Medical Plan coverage.

You Must Be Enrolled in Medicare if you are a Benefit Eligible Retiree, or a Benefit Eligible Dependent of a Retiree, and Age 65 or Over

As a Benefit Eligible Retiree age 65 or over, you must be enrolled in both Medicare Part A and Part B in order to receive benefits under a Harris Health Medical Plan option. You DO NOT need to enroll in Medicare Part D coverage. Likewise, a Benefit Eligible Retiree's Benefit Eligible Dependent who is age 65 or over must be enrolled in both Medicare Part A and Part B in order to receive benefits under a Harris Health Medical Plan option. If you or your dependent who must be enrolled are not enrolled in Medicare Part A and Part B, your (or your dependent's) medical expenses will NOT be paid by the Harris Health Medical Plan option in which you are enrolled and the plan administrator of the Medical Plan will not be able to verify coverage or process medical expenses for that individual during the period he or she is not enrolled. Additionally, the failure to have both Medicare Part A and Part B coverage will result in your continuing to pay Harris Health Medical Plan premiums for the coverage in which you are enrolled even though you will NOT be entitled to payment of medical expenses until you (or your dependent) are enrolled in both Medicare Part A and Part B and the enrollment in both parts is effective.

It is important for you to understand how to obtain Medicare coverage since that coverage must be in place on the date you retire (or reach age 65 if you retire early). Likewise, it is important for you and your dependents to understand how your dependents obtain Medicare coverage since that coverage must be in place on the date you retire (if your dependent is age 65 or older) or the date your dependent reaches age 65 (if you retire before your dependent reaches age 65).

When you first become eligible for Medicare, you have a seven month period (your initial Medicare enrollment period) in which to enroll in Medicare. A delay in enrolling may cause a delay in Medicare coverage. If you become eligible for Medicare at age 65, your initial enrollment period begins three months before the month of your 65th birthday, includes the month you turn age 65, and ends three months after the month of that birthday (for a total of seven months). If you enroll in Medicare during the first three months of your initial Medicare enrollment period, your Medicare coverage will start the first day of the month you are first eligible. If you enroll during the last four months, your Medicare coverage will start from one to three months after you enroll. You should consider these dates when planning for retirement to ensure your and your dependents' Medicare Part A and Part B coverage will be in effect on the date you retire. Remember that as a Benefit Eligible Retiree age 65 or over, you cannot receive benefits under a Harris Health Medical Plan option unless you are also enrolled in Medicare Part A and Part B. For this reason, to avoid gaps in coverage, you should contact the SSA and ensure that Part A and Part B coverage is in place at the time of your retirement.

If you do not enroll in Medicare during your initial Medicare enrollment period described above, you will have another chance each year to sign up during a "General Enrollment Period" from January 1st to March 31st. Your Medicare coverage would then begin the following July 1st. However, the monthly Medicare Part B premium will increase for each month that you were eligible to enroll but did not timely enroll in Medicare (there is an exception for employees and spouses covered by an employer-provided group health plan – see next paragraph). For more information, go to the ssa.gov or medicare.org websites.

In addition to your initial Medicare enrollment period and the Medicare General Enrollment Period each year, you will have an opportunity to enroll in Medicare when you retire if you continue to work after reaching age 65.

A similar rule applies if you have coverage through your spouse's employer-provided group health plan after reaching age 65. While in these situations you do not need to be enrolled in Medicare Part A or Part B while you have employer-provided group medical plan coverage, if you will be covered under a Harris Health Medical Plan option when you retire, you need to ensure your enrollment in both Medicare Part A and Part B is effective beginning the day after you retire or lose your spouse's coverage. *Only in cases where your enrollment in Medicare was delayed due to your or your spouse's continuing employment and associated healthcare coverage* will delaying enrollment in Medicare not require you to wait for the Medicare General Enrollment Period or necessitate your paying a Medicare premium surcharge for late enrollment. There are limits to this exception, so we strongly advise you to contact the CMS for more information. However, to prevent delays in any future benefits coverage, you are encouraged (but not required) to enroll in Medicare Part A, which is free, immediately upon reaching age 65, and arrange for Medicare Part B coverage to begin no later than the month your active employment or your spouse's active employment ends if you will enroll in a Harris Health Medical Plan option when you retire.

MEDICARE REQUIREMENTS CONTINUED

If you retire from Harris Health before reaching age 65 and are a Benefit Eligible Retiree enrolled in one of Harris Health's Medical Plan options, that Medical Plan option will provide your primary medical coverage only until you reach age 65. When you reach age 65, the Medical Plan option in which you are enrolled will stop providing your primary medical coverage, and will not provide any coverage unless you are enrolled in both Medicare Part A and Part B. Consequently, your enrollment in both Medicare Part A and Part B must be effective by the date you reach age 65 or you will not receive medical benefits under the Harris Health Medical Plan option in which you are enrolled.

BENEFIT ELIGIBLE RETIREES AND BENEFIT ELIGIBLE DEPENDENTS WHO ARE DISABLED MUST BE ENROLLED IN BOTH MEDICARE PART A AND B

Effective January 1, 2011, a Social Security approved under age 65 Disabled Benefit Eligible Retiree or under age 65 Disabled Benefit Eligible Dependent of a retiree must be enrolled in both Medicare Part A and Part B to be eligible for Harris Health Medical Plan coverage. The retiree or dependent must be enrolled in both Medicare Part A and Part B as of the date the under age 65 Disabled Benefit Eligible Retiree or under age 65 Disabled Benefit Eligible Dependent becomes eligible for Medicare. There is no requirement to enroll in Medicare Part D.

Individuals under age 65 can enroll after they have received Social Security Disability Income (SSDI) benefits for 24 months. Due to the five month waiting period from the start of the disabling condition for individuals who qualify for SSDI benefits, Medicare coverage cannot start sooner than the beginning of the 30th month after the start of the qualifying disability. However, in order to receive Harris Health Medical Plan benefits, you should enroll in Medicare as soon as you are allowed by the SSA to do so.

SSDI beneficiaries with specific conditions may begin receiving Medicare benefits sooner than the traditional 30 month qualifying period. At present, individuals with:

ALS or Lou Gehrig's Disease qualify for Medicare the first month SSDI benefits are received;

End Stage Renal Disease or Kidney Failure qualify for Medicare after the third month of receiving SSDI benefits; and

Kidney problems in which the individual receives a kidney transplant qualify for Medicare in the month the individual receives the transplant.

If you are already receiving Social Security benefits for a Social Security approved disability, the SSA will send you information a few months before you become eligible for Medicare. In most cases, you will be automatically enrolled in Medicare Part A and Part B. However, because you must pay a premium for Part B coverage, you can choose to turn it down. If you accept automatic enrollment in Medicare Part B, or if you enroll during the first three months of your initial enrollment period, your coverage will start the month you are first eligible.

Failure to retain both Medicare Part A and Part B coverage will result in Harris Health's Medical Plan claims administrator not being able to verify coverage or process otherwise eligible medical expenses. Failure to enroll in both Part A and Part B of Medicare will result in the Benefit Eligible Retiree continuing to pay the regular Medical Plan option premium, even though the under age 65 Disabled Benefit Eligible Retiree or under age 65 Disabled Benefit Eligible Dependent will not be entitled to benefits under the Harris Health Medical Plan option until he or she successfully enrolls in both Part A and Part B of Medicare. The Medical Plan option will be secondary to Medicare and will generally remain the secondary coverage as long as you remain eligible for a Harris Health Medical Plan option.

There is an exception to the general rule described above. An under age 65 Disabled Benefit Eligible Retiree or under 65 Disabled Benefit Eligible Dependent *who was awarded prior to September 30, 2010 Medicare eligibility as a result of a Social Security approved disability* is considered to be under grandfather status and therefore exempt from this Medicare enrollment requirement. For these individuals the Harris Health sponsored plan option will continue to provide coverage until such time as the grandfathered participant enrolls in Medicare Parts A and B or attains age 65, whichever occurs first.

As an offset to the cost to carry Medicare Part B coverage, *Harris Health's Medical Plan will waive the Benefit Eligible Retiree's cost share of the Medical Plan's monthly premium rate based on the Benefit Eligible Retiree only level of coverage until the under age 65 Disabled Benefit Eligible Retiree or under age 65 Disabled Benefit Eligible Dependent attains age 65.* This premium rate reduction assumes the under age 65 Disabled Benefit Eligible Retiree or dependent remains covered under the Medical Plan option and in Social Security disabled status until age 65. A limit of one premium rate reduction per month per eligible Benefit Eligible Retiree will apply.

MEDICARE REQUIREMENTS CONTINUED

Questions or Benefits Assistance:

Medicare – Questions

If you have questions about eligibility for and enrolling in Medicare, Social Security retirement benefits, or disability benefits, call the Social Security Administration at 1-800-772-1213 or TTY 1-800-325-0778. You may also visit Medicare online at their website: SocialSecurity.gov. For general questions about Medicare call 1-800-MEDICARE, 1-800-633-4227 or TTY 1-877-486-2048.

Medical-Benefits Assistance

If you would like to discuss the Harris Health System Medical Plan options in more detail, you may contact the Employee Benefits Department of Harris Health at 713-566-6451, Monday-Friday, 8:00 a.m. – 4:30 p.m. or visit our offices at 2525 Holly Hall, Suite 100, Houston, TX 77054.

Note: In order to avoid coverage interruption, submit a copy of your Medicare card indicating enrollment in Part A and Part B to the Benefits Department as soon as possible upon enrollment.

COMMUNITY HEALTH CHOICE, INC. (COMMUNITY)

Community Health Choice, Inc. (Community) is a non-profit Health Maintenance Organization (HMO) licensed by the Texas Department of Insurance (TDI). Community is more than a health plan. We were founded to increase access to quality health care for those who need it most. Our mission is to improve the health of under-served residents of Southeast Texas by opening doors to coordinated, high-quality, affordable, health care and health-related services. Through our network of more than 10,000 doctors and 70 hospitals, Community serves over 360,000 Members with the following:

- **Medicaid State of Texas Access Reform (STAR):** Program for low-income children and pregnant women
- **Children's Health Insurance Program (CHIP):** Program for the children of low-income parents--includes perinatal benefits for the unborn in the form of free prenatal care for the unborn child, even if the mother does not qualify for Medicaid
- **Health Insurance Marketplace (Marketplace):** Plan that offers premium assistance and cost-sharing reductions for individual health coverage that includes preventive care, emergency services, prescription drugs, and hospitalization available to all, regardless of pre-existing conditions

Eligibility for STAR and CHIP benefits are income based. To learn if you are eligible, go to www.yourtexasbenefits.com.

Community Health Choice is located at 2636 South Loop West, Suite 125, Houston, TX. 77054. Hours of operation are 8:00 a.m. – 5:00p.m. Contact us at 713-295-2222 or 1-877-635-6736.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2017)



<p>ALABAMA – Medicaid Website: www.myalhipp.com Phone: 1-855-692-5447</p>
<p>ALASKA – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529</p>
<p>COLORADO – Medicaid Medicaid Website: http://www.colorado.gov/hcpf Medicaid Phone : 1-800-221-3943</p>
<p>FLORIDA – Medicaid Website: https://www.flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268</p>
<p>GEORGIA – Medicaid Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507</p>
<p>INDIANA – Medicaid Website: http://www.in.gov/fssa Phone: 1-877-438-4479 Website: http://www.indianamedicaid.com Phone: 1-800-403-0864</p>
<p>IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562</p>
<p>KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512</p>
<p>KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>
<p>LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447</p>
<p>MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711</p>
<p>MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120</p>
<p>MINNESOTA – Medicaid Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739</p>
<p>MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p>MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
<p>NEBRASKA – Medicaid Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633</p>
<p>NEVADA – Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>
<p>NEW HAMPSHIRE – Medicaid Website: dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</p>

<p>NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p>NEW YORK – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p>NORTH CAROLINA – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>
<p>NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
<p>OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
<p>OREGON – Medicaid Website: http://www.oregonhealthykids.gov http://hijosaludablesoregon.gov Phone: 1-800-699-9075</p>
<p>PENNSYLVANIA – Medicaid Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462</p>
<p>RHODE ISLAND – Medicaid Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300</p>
<p>SOUTH CAROLINA – Medicaid Website: http://www.scdhhs.gov Phone: 1-888-549-0820</p>
<p>SOUTH DAKOTA – Medicaid Website: https://dss.sd.gov Phone: 1-888-828-0059</p>
<p>TEXAS – Medicaid Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493</p>
<p>UTAH – Medicaid and CHIP Medicaid Website: http://health.utah.gov/medicaid Chip Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
<p>VERMONT – Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
<p>VIRGINIA – Medicaid and CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282</p>
<p>WASHINGTON – Medicaid Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473</p>
<p>WEST VIRGINIA – Medicaid and CHIP Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p>WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002</p>
<p>WYOMING – Medicaid Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531</p>

MANDATORY NOTICES

HIPAA - Special Enrollment Rights

Loss of Other Coverage If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if your or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your spouse or your dependents' other coverage). However, you must request enrollment within 31 days after your spouse or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

New Dependent by Marriage, Birth, Adoption or Placement for Adoption In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Certain Changes in Medicaid or CHIP Coverage If you or your eligible dependent are eligible to enroll in the Plan, but are not enrolled, you or your dependent will be entitled for coverage under the Plan if:

- You or your eligible dependent were covered under a Medicaid plan or under a State child health plan and that coverage was terminated because you or your eligible dependent lost eligibility for coverage; or
- You or your eligible dependent become eligible under a Medicaid plan or under a State child health plan for assistance with your premium payments under the Plan.

However, you must request enrollment in the Plan no later than 60 days after the date of termination of the Medicaid plan or State child health plan coverage or the date you or your eligible dependent is determined to be eligible for the assistance.

HIPAA - Notice of Privacy Practices

You May Obtain a Copy of the Notice of Privacy Practices The Notice of Privacy Practices for the Plans explains how the Harris Health System Plan use and disclose personal health information (PHI) of individual covered by the Plans. Harris Health System has previously provided you with a copy of that notice. The Plans are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to periodically advise you of the availability of the Notice of Privacy Practices adopted by the Plans and how to obtain a copy. The Notice of Privacy Practices for the Plans may be obtained by contacting Employee Benefits at 713-566-6451 or you may mail your request to: Harris Health System 2525 Holly Hall, Houston, TX 77054, Attn: Benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") generally prohibits group health plans such as the Harris Health System Plan from using genetic information of plan participants to discriminate in providing coverage or benefits. The Plan is administered by Harris Health System to comply with the applicable requirements of "GINA."

MENTAL HEALTH PARITY ACT

Per the Mental Healthy Parity Act, the Harris Health System Plan provide mental health benefits comparable to the Medical benefits offered to you. Deductibles, copays, out-of-pocket expenses, visits or frequency of treatments are no longer more restrictive than the requirements or limitations to your Medical benefits.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The Plans are in compliance with this law.

Under the Act, the Medical plan and the claim administrators that offer mastectomy coverage under the plans must, for any participant or beneficiary who elects breast reconstruction in connection with a mastectomy, cover:

Reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema.

The covered procedures will be performed in a manner determined in consultation with the attending physician and the patient and will be subject to the same annual deductibles and co-insurance provision consistent with those established for other benefits under the applicable plan.

VENDOR PHONE APPS

Phone Apps have become increasingly popular due to their convenience; they allow consumers quick and easy access to various products.

MYCIGNA MOBILE APP

Introducing the simple, personalized myCigna Mobile App. You're busier than ever. At Cigna, we get that. While we can't wave a magic wand and make all the frustrating, time-consuming aspects of your life go away, we can give you a tool to help make your life easier and healthier.

The all-new myCigna Mobile App gives you a simple way to personalize, organize and access your important health information – on the go. It puts you in control of your health, so you can get more out of life.

LITTLE APP. BIG FEATURES.

HEALTH CARE PROFESSIONAL DIRECTORY

- Search for a doctor or health care facility from the Cigna national network and compare quality-of-care ratings
- Access maps for instant driving directions

ID CARDS

- Quickly view ID cards (front and back) for entire family
- Easily print, email or scan right from smartphone

CLAIMS

- View and search recent and past claims
- Bookmark and group claims for easy reference

ACCOUNT BALANCES

- Access and view health fund balances
- Review plan deductibles and coinsurance

HEALTH WALLET

- Store and organize all important contact information for doctors, hospitals and more
- Add health care professionals to contact list right from a claim or directory search



Get the myCigna Mobile app from the app StoreSM or Google Play.

OPTUM MOBILE APP



FIND THE OPTUM

MOBILE APP.

The mobile app provides easy, on-the-go access to your personalized health information. Once you receive your Member ID number, download the App to take advantage of the benefits your pharmacy plan offers.

EASY ACCESS ANYTIME, ANYWHERE

- Show your doctor exactly what drugs you are taking. Pull up your medication history anytime.
- Stay on top of medication refills. See when refills are due, get refill reminders and quickly contact your pharmacy.
- Find network pharmacies by ZIP code or location, then check and compare current prescription prices.



... And much more!

VENDOR PHONE APPS CONTINUED

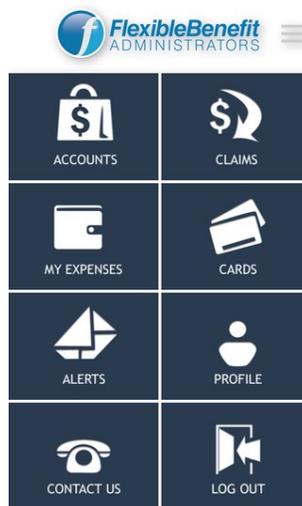
FBA MOBILE APP

INTRODUCING THE FLEXIBLE BENEFIT ADMINISTRATORS MOBILE APPLICATION

We're excited to introduce to you the Flexible Benefit Administrators Mobile Applications for your iPhone or Android Smartphone. Simply search the App Store for Flexible Benefit Administrators from your iPhone or the Google Play Store for FBA Mobile and install the app.

Some of the features of the new mobile app are:

- Check your account balance
- View recent **transactions**
- View emails / account notifications
- Submit your claims and documentation



Date	My Responsibility	My Remaining Responsibility
11/29/2015	\$33.00	\$11.00
Reimbursable		
07/30/2015	\$112.00	\$112.00
Reimbursable		
07/30/2015	\$72.50	\$72.50
Reimbursable		
07/30/2015	\$22.80	\$22.80
Reimbursable		
07/30/2015	\$11.50	\$11.50
Reimbursable		
07/30/2015	\$14.00	\$14.00
Reimbursable		

FEI EAP MOBILE APP

LifeCycle[®] Connect

At one time or another, most of us will face a personal problem or family care issue that impacts the quality of our home life, relationships, health or ability to do our best at work. By providing your employees with the resources and support they need to focus on and enjoy their jobs, you help your business attract and keep expert people.

The LifeCycle[®] Connect App offers a comprehensive online tool with resource links to support a wide range of work, family, care giving, wellness and daily living issues

- LifeCycle[®] Connect available for use on mobile devices
- Quick and easy accessibility to FEI's wealth of resources. Simply use the LifeCycle[®] Connect username and password
- Step-by-step installation process provided
- Available for both Apple and Android products



VENDOR CONTACT INFORMATION

BENEFITS ENROLLMENT OR ELIGIBILITY

Employee Benefits Department
713-566-6451

benefitsdepartment@harrishealth.org

MEDICAL

<p>CUSTOMER SERVICE - CIGNA 800-244-6224 myCigna.com</p>	<p>DEDICATED ADVOCATE-CIGNA 713-566-4391</p>	<p>HEALTH FIRST COACHING PROGRAM - CIGNA 855-246-1873 myCigna.com</p>
<p>CIGNA HEALTH AND NURSELINE INFORMATION 800-244-6224 myCigna.com</p>	<p>HEALTHY BABIES - CIGNA 800-564-9286 myCigna.com</p>	<p>TELEHEALTH CONNECTION - CIGNA 888-726-3171 MDLIVEforCigna.com</p>
<p>KELSEY-SEYBOLD 24-HOUR CONTACT CENTER 713-442-0000 Kelsey-Seybold.com</p>	<p>KELSEY-CARE CONCIERGE SERVICE 713-442-0006 or 866-609-1630</p>	<p>MYKELSEYONLINE 713-442-6565 myKelseyOnline.com</p>

DENTAL

<p>DENTAL PPO - METLIFE 800-942-0854 metlife.com</p>	<p>DENTAL HMO - METLIFE 800-880-1800 metlife.com</p>
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VISION

<p>DAVIS VISION 800-999-5431 DavisVision.com</p>
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LONG TERM DISABILITY

<p>RELIANCE STANDARD 800-351-7500</p>
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PRESCRIPTION DRUGS

<p>OPTUMRx 800-880-1188 optumrx.com</p>	<p>OPTUMRx (MAIL ORDER) 800-881-1966</p>
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FLEXIBLE SPENDING ACCOUNT

<p>FLEXIBLE BENEFIT ADMINISTRATORS 800-437-3539 Flex-admin.com</p>

OTHER

<p>COBRA-FLEXIBLE BENEFIT ADMINISTRATORS 800-437-3539 Flex-admin.com</p>	<p>DIABETES AMERICA 866-693-4223 DiabetesAmerica.com</p>	<p>EMPLOYEE ASSISTANCE PROGRAM (EAP)-FEI 800-638-3327 www.feieap.com User name - hhs</p>
<p>LIFE INSURANCE - EMPLOYEE BENEFITS 713-566-6451</p>	<p>PHYSICAL THERAPY & REHAB - HARRIS HEALTH SYSTEM 713-218-8250</p>	<p>FIDELITY INVESTMENTS 800-343-0860 www.Fidelity.com/atwork</p>

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