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.

2016 EMPLOYEE BENEFITS RESOURCES GUIDEBOOK
including Annual Enrollment Materials

Annual Enrollment: January 4, 2016 - January 25, 2016
Retain this document as a resource tool for the upcoming year.
**Core Business Hours**  
Monday - Friday  
8:00 a.m. - 4:30 p.m.

**CONTACT INFORMATION**

**HEALTHCARE**  
Main Customer Service  
Benefitsdepartment@harrishealth.org  
Phone: 713-566-6451  
Fax: 713-440-5575 or 713-566-6445

**WELLNESS**  
Main Customer Service  
EmployeeWellness@harrishealth.org  
Phone: 713-634-1290  
Fax: 713-634-1282

**CIGNA HEALTHCARE ADVOCATE**  
Morgan Simmons  
morgan.sweetonsimmons@cigna.com  
Phone: 713-566-4391 or 1-888-244-6293 Ext. 2612828

**HEALTHCARE**

<table>
<thead>
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<th>Email</th>
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**RETIREMENT**

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<tbody>
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**WELLNESS**

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<tr>
<th>Name</th>
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**MANAGEMENT**

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<tr>
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<tr>
<td>Pat Rye</td>
<td>Retirement Supervisor</td>
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<tr>
<td>Carla Golemon</td>
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<td>713-566-6450</td>
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January 4, 2016

Dear Harris Health System Employee:

Welcome to the 2016 Benefits Resources Guidebook! This booklet was developed to be a resource for you as you make benefit selections for you and your eligible dependents during Annual Enrollment. More importantly, the Guidebook is especially helpful as you encounter benefit questions throughout the Plan Year, so we encourage you to keep this book handy as a quick reference. For a quick review of changes for FY17, please refer to page 7 of this booklet. Your 2016 Annual Enrollment elections are scheduled to take effect March 1, 2016.

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 you in premiums.

We are pleased to provide three medical plan options to our benefit eligible employees; KelseyCare, Low Deductible and High Deductible, all of which are administered through Cigna. More detailed information regarding the levels of coverage offered and premiums for these three medical options can be found in this guidebook.

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 that can be found on pages 11-13 of this booklet. Documentation for new dependents must be received by the Benefits Office by January 25, 2016; otherwise, they will not be covered under any Harris Health Benefit Plan. Please be sure that your name, employee number and telephone number is submitted with the dependent documentation.

Most importantly, please be sure that you have made your elections though PeopleSoft by January 25, 2016. We will not accept any changes after this 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,

Diane Poirot
Sr. Vice President, Human Resources

Benefits Main Line Number: 713-566-6451
Benefits FAX Number: 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 Location (appointments encouraged): 2525 Holly Hall, Houston, TX 77054
ANNUAL ENROLLMENT 2016

NOW IS THE TIME TO SELECT YOUR EMPLOYEE BENEFIT PLANS
FOR MARCH 1, 2016 - FEBRUARY 28, 2017

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

- Documentation submission deadline for new dependents is January 25, 2016.

IMPORTANT INFORMATION ABOUT PLAN BENEFIT ELECTIONS

If you do not make an active election change for the 2016 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.
The Harris Health Employee Benefits Department WILL NOT conduct on-site visits during the 2016 Annual Enrollment period.

PeopleSoft Enrollment assistance classes will be offered at:

9250 Kirby, Houston, TX 77054

See class schedule:

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ENROLLMENT HIGHLIGHTS

MEDICAL & PRESCRIPTION INSURANCE CARD
You will receive a new medical ID card after enrollment. You can also print a medical card anytime at myCigna.com. Your Cigna Medical card will also serve as your prescription card and will include the OptumRx coverage information on the back of the card.

DENTAL & VISION INSURANCE CARDS
Harris Health is partnering with a new dental carrier (MetLife) effective March 1, 2016.

DHMO enrollees: will receive a new ID card and it will be mailed after enrollment.

DPPO enrollees: a card is not required to receive services; therefore you will not automatically receive a card. If you would like an ID card you may print one online at metlife.com/mybenefits.

Vision enrollees: first time enrollees will receive a new ID card and it will be mailed after enrollment. Unless you make changes to your coverage, a new card will not be mailed to you. If you need a new vision card, you can request it by calling 800-999-5431.

FSA VISA DEBIT CARD
If you enroll in the Health Care Flexible Spending Account (FSA) for the first time this upcoming plan year, you will receive a FSA Visa debit card from Discovery Benefits. If you already have the FSA Visa debit card keep it, Discovery will reload it if you re-enroll in FSA benefits.

NETWORK DIRECTORIES
You may visit each carrier’s website to access a network directory. Website information and each carrier customer service

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.

BENEFIT CHANGES OUTSIDE OF ANNUAL ENROLLMENT
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.
CHANGES—PLAN DESIGN

Harris Health will continue to implement plan design changes effective in 2016 as part of a long term strategy aimed to comply with Healthcare Reform and align our benefits with the Texas Medical Center and national norm for healthcare systems in the U.S. These changes are necessary to avoid a potential Cadillac Tax initially estimated for Harris Health at $5.5 million dollars per year beginning in 2018. Based on our most recent plan design changes, our current Cadillac Tax estimate is now $0.

Below is a high level description of the major changes effective March 1, 2016. We encourage you to review the benefit details in each section of the Benefits Resources Guidebook for more specific information on each of these changes as well as the Healthcare Reform section which will give you a better understanding as to why these changes are necessary.

- Social Security numbers are now a mandated requirement for federal healthcare reporting purposes for all dependents enrolled in our medical plan. You need to ensure that Harris Health has the correct social security number on file for each eligible dependent so that healthcare coverage is properly reported and to avoid penalties imposed by the Internal Revenue Service (IRS). For additional details, refer to page 8.

- Due to regulatory changes you now have the opportunity to elect any of our medical plan options regardless of your participation in Tiered Benefits.

- For the Low Deductible Medical Option, the individual in-network deductible is increasing from $300 to $500. The family in-network deductible is increasing from $900 to $1,500.

- OptumRx and CatamaranRx have merged as one company. Your prescription drug benefits are a part of your medical plan benefits and are now administered by OptumRx.

- The PCP/Specialist copays on the High Deductible Medical Option are decreasing to $25/$35/$55.

- The Dispense as Written penalty regarding prescription drugs will not apply to the Out-of-Pocket Maximum.

- Amounts over the allowable Reference Based Pricing will not apply to the Out-of-Pocket Maximum.

- The Specialty Drug copay will change from $60 to $90.

- A new voluntary Hepatitis C outcomes Program is being implemented for members prescribed Harvoni who are diagnosed with Genotype 1 Hepatitis C Virus infection.

- Optum SECURE Compound Medication Management Program is being added.

- Please make note that Harris Health will now be partnering with Reliance Standard instead of The Standard to offer basic and voluntary life benefits.

- Harris Health will be partnering with MetLife as the replacement to United Healthcare for dental benefits effective March 1, 2016. There is a deadline for electing your DHMO provider. For additional details refer to page 38.

- Rule of 80—2017 date removed for Grandfathered employees.

- Medicare-Out-of-Network provider, the plan pays 200% of the Medicare allowable amount.

- Medicare A&B—Proof of timely enrollment is now required if age 65 or over and you become a Retiree.

- LTD Buy-Up is in an open enrollment period during this year’s Harris Health Annual Enrollment Period. If you did not enroll when first eligible, you can do so now without Evidence of Insurability.
NATIONAL HEALTHCARE REFORM IMPACT ON THE HARRIS HEALTH SELF-INSURED MEDICAL PLAN

2016

Reporting Social Security Numbers to Your Health Insurance Company—Questions and Answers

Q1. My health insurance company has requested that I provide them with my social security number and the social security numbers of my spouse and children. Is there some new reason why they need our social security numbers?

A1. Your health insurance company will be required to provide Form 1095-B to you and to the Internal Revenue Service. You will use the form to prepare your individual income tax return. Dependent SSNs will be reported on Form 1095-B.

Q2: Why is my health insurance company asking for this information now?

A2: The new reporting requirement will begin for the 2015 tax year and health insurance companies need advance time to program and test systems to make certain that this new reporting is done correctly and efficiently.

Q3: Is there a specific Internal Revenue Service form that will be mailed to me to provide the information to my health insurance company?

A3: No. Your health insurance company may mail you a written request which discusses these new rules.

Q4: How will I use this new Form 1095-B to prepare my return?

A4: Form 1095-B provides information needed to report on your income tax return that you, your spouse, and individuals you claim as dependents had qualifying health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Individuals who do not have minimum essential coverage and do not qualify for an exemption may be liable for the individual shared responsibility payment. You do not have to attach Form 1095-B to your tax return.

Q5: What if I refuse to provide this information to my health insurance company?

A5: The information received by the Internal Revenue Service will be used to verify information on your individual income tax return. If the information you provide on your tax return cannot be verified, you may receive an inquiry from the Internal Revenue Service. You also may receive a notice from the Internal Revenue Service indicating that you are liable for a shared responsibility payment.

2018:
All aspects of Healthcare Reform will be required and the Cadillac Tax impact will take place. The Cadillac Tax is an excise tax that will be charged to employers offering plans that are too rich in benefits. In 2013, the Cadillac Tax had been estimated to be $5.5 million. With the changes that Harris Health implemented in 2016, the tax has now been reduced to $0.

For a full list of Healthcare Reform impacts and changes please visit whitehouse.gov/healthreform.
HOW DO I ENROLL OR RE-ENROLL FOR MY EMPLOYEE BENEFITS?

All employees who elect employee benefits coverage or make changes for the 2016-2017 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; click on New Hire Onboarding Experience. See PeopleSoft Benefits Enrollment Instructions under Benefits.

**REMEMBER - FSA 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 11-13 for Adding a Dependent and Dependent Definitions and Requirement 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 25, 2016 for Annual Enrollment 2016 and within 31 days of all other events.

Fax: 713-566-6445 or 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 or pick a summary by category.

Once a summary 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 44).

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

Click on Benefits, click on Dependent/Beneficiary Info and then click on the individual name to view personal information, status information, address, and telephone contact information. Click on Return to Dependent/Beneficiary 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.

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.
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.

- Starting in 2016, Harris Health will be 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 Pages 12-13 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.
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.

Eligibility: The Enrollee’s spouse is eligible.

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:
- A copy of the birth certificate or birth facts sheet (for a newborn—first 31 days from birth) of the grandchild.
- A copy of the birth certificate for the Benefit Eligible Employee’s child that is the birth parent of the grandchild.
- 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.
THREE HARRIS HEALTH SYSTEM SELF-INSURED MEDICAL OPTIONS ADMINISTERED BY CIGNA

Your 2016 Medical premium rates have been established based on participation in our 2015 Healthy Living Tiered Benefits Campaign which asked that all active employees covered under our Self-Insured Medical Plan voluntarily take a confidential Health Assessment and Biometric Screening between March 1st and August 31st, 2015.

**Base Wellness Rate:** Employees that participated in the Healthy Living Tiered Benefits Campaign, which included completing the Health Assessment (with biometric values) or New Hires and Newly Eligible employees.

**No Wellness Rate:** Employees that failed to participate in the Healthy Living Tiered Benefits Campaign, which included not completing the Health Assessment with Biometric Values.

---

### 2016—2017 HEALTHCARE PREMIUMS: Bi-Weekly Rates

<table>
<thead>
<tr>
<th>Medical Plan</th>
<th>Employee Only</th>
<th>Employee and Spouse</th>
<th>Employee and Children</th>
<th>Employee and Family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KelseyCare</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base Wellness Rate</td>
<td>$17.39</td>
<td>$184.76</td>
<td>$80.34</td>
<td>$240.54</td>
</tr>
<tr>
<td><strong>No Wellness Rate</strong></td>
<td>$63.54</td>
<td>$230.91</td>
<td>$126.49</td>
<td>$286.70</td>
</tr>
<tr>
<td>Low Deductible Base Wellness Rate</td>
<td>$53.21</td>
<td>$276.09</td>
<td>$163.08</td>
<td>$359.46</td>
</tr>
<tr>
<td><strong>No Wellness Rate</strong></td>
<td>$99.36</td>
<td>$322.25</td>
<td>$209.23</td>
<td>$405.62</td>
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<tr>
<td>High Deductible Base Wellness Rate</td>
<td>$17.39</td>
<td>$184.76</td>
<td>$80.34</td>
<td>$240.54</td>
</tr>
<tr>
<td><strong>No Wellness Rate</strong></td>
<td>$63.54</td>
<td>$230.91</td>
<td>$126.49</td>
<td>$286.70</td>
</tr>
<tr>
<td>Dental Plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO</td>
<td>$0.41</td>
<td>$4.28</td>
<td>$4.28</td>
<td>$6.06</td>
</tr>
<tr>
<td>PPO</td>
<td>$13.22</td>
<td>$21.30</td>
<td>$21.83</td>
<td>$40.04</td>
</tr>
<tr>
<td>Vision Plan</td>
<td>$0.25</td>
<td>$1.92</td>
<td>$1.92</td>
<td>$3.43</td>
</tr>
</tbody>
</table>

**Please note:**

1. Annual Enrollment elections are scheduled to take effect March 1st.
2. Related premium deductions will appear on your March 11th paycheck. Please review your paycheck for correct premium deductions.
**MEDICAL SUMMARY**

**KELSEYCARE**

<table>
<thead>
<tr>
<th>ANNUAL DEDUCTIBLE - per calendar year, applies to most covered services</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANNUAL OUT-OF-POCKET LIMIT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$750</td>
</tr>
<tr>
<td>Family</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIFETIME MAXIMUM</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHYSICIAN VISIT COPAY</td>
<td>$15</td>
</tr>
<tr>
<td>SPECIALIST VISIT COPAY</td>
<td>$30</td>
</tr>
<tr>
<td>ROUTINE PHYSICALS/IMMUNIZATIONS</td>
<td>100%</td>
</tr>
<tr>
<td>ROUTINE GYNECOLOGICAL EXAM &amp; PAP SMEAR</td>
<td>100%</td>
</tr>
<tr>
<td>ROUTINE MAMMOGRAPHY</td>
<td>100%</td>
</tr>
<tr>
<td>ROUTINE DIGITAL RECTAL EXAM (DRE) AND PROSTATE ANTIGEN TEST (PSA)</td>
<td>100%</td>
</tr>
</tbody>
</table>

| COLONOSCOPY AND SIGMOIDOSCOPY | 100% |
| ANNUAL ROUTINE HEARING EXAM | 100% |
| HEARING AID* - 1 pair per 36 months | 100% |
| OUTPATIENT SERVICES | 100% |

| OUTPATIENT FACILITY | $100 copay/visit and then 100% |

| 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 |

| ROUTINE CHOLESTEROL TEST | 100% |
| DIAGNOSTIC X-RAY AND LABORATORY | 100% After Office Visit copay |

| PCP | 100% |
| Outpatient Facility/Independent Lab | 100% |

| HIGH TECH RADIOLOGY | 100% |

| CT/CTAs, MRI/MRA, PET scans, Nuclear Tests | 100% |
| Physician's Office | 100% |
| Outpatient Facility | 100% |
| Emergency Room | 100% |

<table>
<thead>
<tr>
<th>HOSPITAL SERVICES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Coverage</td>
<td>$100 per day copay up to 5 days, then 100%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$200 per visit copay then 100% (copay waived if admitted)</td>
</tr>
</tbody>
</table>

| URGENT CARE PROVIDER | $30 per visit then 100% (copay waived if admitted) |

| CONVENIENCE CARE** | Not Covered |

*Members will need to obtain hearing aids from a Cigna contracted provider that will dispense the device.

**Kelsey-Seybold offers Saturday ILL-Care in lieu of Convenience Care. See page 17 for details.
### MEDICAL SUMMARY

**KELSEY CARE CONTINUED**

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SKILLED NURSING FACILITY</strong></td>
<td>100%</td>
</tr>
<tr>
<td>up to 60 days per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>HOME HEALTH CARE</strong></td>
<td>100%</td>
</tr>
<tr>
<td>up to 100 days per calendar year, 16 hour max per day</td>
<td></td>
</tr>
<tr>
<td><strong>HOSPICE CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Coverage</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Coverage</td>
<td>100%</td>
</tr>
<tr>
<td><strong>SHORT-TERM REHAB</strong></td>
<td></td>
</tr>
<tr>
<td>includes physical therapy, occupational therapy, speech therapy up to 60 days per calendar year</td>
<td>$15/$30 PCP or Specialist copay, then 100%</td>
</tr>
<tr>
<td><strong>REHAB PERFORMED AT QUENTIN MEASE, BEN TAUB, LBJ HOSPITALS</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>CHIROPRACTIC OUTPATIENT CARE</strong></td>
<td></td>
</tr>
<tr>
<td>up to 20 days per calendar year</td>
<td>$15/$30 PCP or Specialist copay, then 100%</td>
</tr>
<tr>
<td><strong>CARDIAC REHAB</strong></td>
<td>$15/$30 PCP or Specialist copay, then 100%</td>
</tr>
<tr>
<td>unlimited days per year</td>
<td></td>
</tr>
<tr>
<td><strong>ACUPUNCTURE COVERAGE</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>AMBULANCE</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>DIALYSIS</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>DURABLE MEDICAL EQUIPMENT</strong></td>
<td>100%</td>
</tr>
<tr>
<td>unlimited max per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>MOUTH, JAWS AND TEETH</strong></td>
<td>$15/$30 PCP or Specialist copay, then 100%</td>
</tr>
<tr>
<td><strong>MATERNITY</strong></td>
<td>Payable as any other covered expense/costs vary based on facility in which it is performed $15/$30 PCP or Specialist copay</td>
</tr>
<tr>
<td><strong>INFERTILITY TREATMENT</strong> - excludes in-Vitro, GIFT, ZIFT, etc.</td>
<td></td>
</tr>
<tr>
<td><strong>ALCOHOL &amp; SUBSTANCE ABUSE SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>unlimited visits per calendar year</td>
<td></td>
</tr>
<tr>
<td>Inpatient Coverage</td>
<td>$100 copay per day up to 5 days, then 100%</td>
</tr>
<tr>
<td>Outpatient Coverage</td>
<td>100%</td>
</tr>
<tr>
<td>Office Visit</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>unlimited visits per calendar year</td>
<td></td>
</tr>
<tr>
<td>Inpatient Coverage</td>
<td>$100 copay per day up to 5 days, then 100%</td>
</tr>
<tr>
<td>Outpatient Coverage</td>
<td>100%</td>
</tr>
<tr>
<td>Office Visit</td>
<td>$15 copay</td>
</tr>
</tbody>
</table>

Pages 17-18 outline some of the KelseyCare services and how the network is tailored to fit your needs.

KelseyCare members may visit [myKelseyOnline.com](http://myKelseyOnline.com) to schedule appointments and review most test results. For general KelseyCare information please visit [kelsey-seybold.com](http://kelsey-seybold.com).

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Harris Health’s Plan for quality, convenience and value!

Your Health

- See the doctor you want from more than 400 Kelsey-Seybold physicians at 19 Houston-area locations - with no referral required.
- Kelsey-Seybold physicians partner with over 4,000 medical specialists and premier hospitals including Texas Children’s Hospital, CHI St. Luke’s Health, the Texas Heart Institute, select Houston Methodist facilities, HCA The Woman’s Hospital of Texas and HCA Clear Lake Regional.
- State-of-the-art clinics offering advanced diagnostics, electronic medical records and on-site pharmacies.

Your Benefits

- No Deductible!
- Experience savings with the lowest copays for physician office visits compared to any other plan.
  - $15 for Primary Care
  - $30 for Specialist
- No extra out-of-pocket expenses for routine laboratory tests and X-rays.
- Lowest cost for hospital admissions.
- No copay for advanced imaging.
- Out-of-area network available for covered dependents through the Cigna Guest Privileges Program.
- Urgent Care network access available through Cigna.

Complete Access to Care 24/7

- You can trust Kelsey-Seybold Clinic for quality care and medical excellence. We offer 19 convenient locations all over the Greater Houston area.
- Same day and next day appointments available.
- See any Kelsey-Seybold doctor - including specialists - NO REFERRAL NEEDED.
- We’re here for you - 24 hours a day, seven days a week. Call 713-442-0000 to reach our After-Hours Nurse Hotline or to make an appointment.
- Exclusive Concierge Service
  KelseyCare Concierge is here to assist you with your health related questions or billing concerns. Call 713-442-0006.
- Saturday hours for ill-care appointments available from 9 a.m. to 2 p.m. at four locations - Clear Lake, Fort Bend, Spring/1960 and Tanglewood/Galleria.
- Email your doctor’s office, receive most test results and directly schedule appointments with primary care physicians and an expanding list of specialists through our secure patient portal, MyKelseyOnline.com.
- Secure Electronic Medical Record (EMR)
  See any Kelsey-Seybold doctor at any location. Your secure, confidential EMR follows you wherever you go.
- Refill prescriptions online with your MyKelseyOnline account or at kelsey-seybold.com/refills. Get free mail-order delivery to your home or office.
### Kelsey Pharmacy Locations

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear Lake Clinic</td>
<td>713-442-4360</td>
</tr>
<tr>
<td>Cypress Clinic</td>
<td>713-442-4059</td>
</tr>
<tr>
<td>Downtown at The Shops at Houston Center 4</td>
<td>713-442-6337</td>
</tr>
<tr>
<td>Fort Bend Medical and Diagnostic Center</td>
<td>713-442-9475</td>
</tr>
<tr>
<td>Summer Creek (Humble)</td>
<td>713-442-2079</td>
</tr>
<tr>
<td>Katy Clinic</td>
<td>713-442-4179</td>
</tr>
<tr>
<td>Kingwood Clinic</td>
<td>713-442-2179</td>
</tr>
<tr>
<td>Main Campus</td>
<td>713-442-0079</td>
</tr>
<tr>
<td>Meyerland Plaza Clinic</td>
<td>713-442-3200</td>
</tr>
<tr>
<td>Pasadena Clinic</td>
<td>713-442-7179</td>
</tr>
<tr>
<td>Spring Medical and Diagnostic Center</td>
<td>713-442-1779</td>
</tr>
<tr>
<td>The Vintage</td>
<td>713-442-1549</td>
</tr>
<tr>
<td>The Woodlands Clinic</td>
<td>713-442-1975</td>
</tr>
<tr>
<td>Tanglewood Clinic (Galleria area)</td>
<td>713-442-2450</td>
</tr>
<tr>
<td>Pearland Clinic</td>
<td>713-442-7200</td>
</tr>
</tbody>
</table>

### KelseyCare Telephone Numbers

**TTY/TDD** - Text communication for individuals using a telecommunications device.

- 713-442-5818

**24-Hour Appointment Scheduling** - Our Customer Service Contact Center operates 24 hours a day, 7 days a week for your convenience.

- 713-442-0000

**KelseyCare Concierge** - Call your KelseyCare Concierge Monday-Friday, 8 a.m. to 5 p.m. for personalized assistance in scheduling appointments and selecting physicians.

- 713-442-0006

**After-Hours Nurse** - Speak with a Kelsey-Seybold nurse after regular business hours, on holidays and on weekends. Our After-Hours Nurse can assist you and refer you for care.

- 713-442-0000

**Nutrition Counseling** - Provides individual and group nutrition counseling by a Registered Dietitian.

- 713-442-3277

**Diabetes Services** - Provides individual and group classes by diabetes educators.

- 713-442-3277

**Release of Information** - Provides authorization for release of healthcare information.

- 713-442-5700

Kelsey-Seybold is nationally recognized for quality care.
## MEDICAL SUMMARY

### HIGH DEDUCTIBLE

<table>
<thead>
<tr>
<th>Annual Deductible - per calendar year, applies to most covered services</th>
<th>In-Network Benefits</th>
<th>Out-Of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$4,500</td>
<td>$9,000</td>
</tr>
</tbody>
</table>

### Annual Out-Of-Pocket Limit

| Individual | $3,000 | $6,600 |
| Family | $9,000 | $19,800 |

### Lifetime Maximum

| | None | None |

### Physician Visit Copay

| | $25 | 60% after deductible |

### Specialist Visit Copay

| | $35 CCN Specialist | 60% after deductible |
| | $55 Non CCN Specialist | 60% after deductible |

### Routine Physicals/Immunizations

| | 100% | 60% after deductible (Immunizations are covered at no charge for children ages 0—5.) |

### Routine Gynecological Exam & PAP Smear

| | 100% | 60% after deductible |

### Routine Mammography

| | 100% | 60% after deductible |

### Routine Digital Rectal Exam (DRE) and Prostate Antigen Test (PSA)

| | 100% | 60% after deductible |

### Colonoscopies and Sigmoidoscopies

| | 100% | 60% after deductible |

### Annual Routine Hearing Exam

| | 100% | 60% after deductible |

### Hearing Aid - 1 pair per 36 months

| | 80% after deductible | 60% after deductible |

### Outpatient Services (facility) - except in physician’s office when office visit copay applies

| | 80% after deductible, $100 copay for surgical treatment | 60% after deductible |

### Allergy Treatment - allergy serum, allergy injections and injectable drugs

| | $25/$35/$55-PCP or Specialist | 60% after deductible |

### Routine Cholesterol Test

| | 100% | 60% after deductible |

### Diagnostic X-Ray and Laboratory

| PCP or Specialist | 100% after copay | 60% after deductible |
| Outpatient Facility/Independent Lab | 80% after deductible | 60% after deductible |

### High Tech Radiology - Outpatient Facility & Emergency Room & Physicians Office

| CT/CTAs, MRI/MRA, PET scans, Nuclear Tests | 80% after deductible | ER—80% after deductible |

### Hospital Services

| Inpatient Coverage | $100 per day copay up to 5 days, then 80% after deductible | $500 per confinement deductible then 60% after plan deductible |
| Emergency Room | 80% after deductible | 80% after deductible |

### Urgent Care Provider

| | $55 | 60% after deductible |

### Convenience Care

| | $25 PCP Copay | 60% after deductible |

### Skilled Nursing Facility - up to 60 days per calendar year

| | 80% after deductible | 60% after deductible |

---

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## MEDICAL SUMMARY

### HIGH DEDUCTIBLE CONTINUED

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>IN-NETWORK BENEFITS</th>
<th>OUT-OF-NETWORK BENEFITS</th>
</tr>
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<tr>
<td><strong>HOME HEALTH CARE</strong> - 100 days per calendar year, 16 hour max per day</td>
<td>80% after deductible</td>
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</tr>
<tr>
<td><strong>HOSPICE CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Coverage</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Coverage</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
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<td></td>
<td></td>
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</tr>
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<td>60% after deductible</td>
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<td><strong>DIALYSIS</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
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<td><strong>MATERNITY</strong></td>
<td></td>
<td></td>
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<td><strong>INFERTILITY TREATMENT</strong> excludes in-Vitro, GIFT, ZIFT, etc.**</td>
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<td>Outpatient Coverage</td>
<td></td>
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</tr>
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<tr>
<td>Outpatient Coverage</td>
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<td>60% after deductible</td>
</tr>
<tr>
<td>Office Visit</td>
<td></td>
<td></td>
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<tr>
<td><strong>MENTAL HEALTH SERVICES</strong> unlimited visits per calendar year</td>
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<td>$25 copay</td>
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<tr>
<td>Office Visit</td>
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<td></td>
</tr>
</tbody>
</table>

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## MEDICAL SUMMARY

### LOW DEDUCTIBLE

<table>
<thead>
<tr>
<th>ANNUAL DEDUCTIBLE - per calendar year, applies to most covered services</th>
<th>IN-NETWORK BENEFITS</th>
<th>OUT-OF-NETWORK BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

### ANNUAL OUT-OF-POCKET LIMIT

| Individual | $1,850 | $6,000 |
| Family | $3,700 | $18,000 |

### LIFETIME MAXIMUM

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>None</th>
</tr>
</thead>
</table>

### PHYSICIAN VISIT COPAY

<table>
<thead>
<tr>
<th></th>
<th>$25</th>
<th>60% after deductible</th>
</tr>
</thead>
</table>

### SPECIALIST VISIT COPAY

| | $35 CCN Specialist $55 Non CCN Specialist | 60% after deductible |

### ROUTINE PHYSICALS/IMMUNIZATIONS

| | 100% | 60% after deductible (Immunizations are covered at no charge for children ages 0—5.) |

### ROUTINE GYNECOLOGICAL EXAM & PAP SMERAR

| | 100% | 60% after deductible |

### ROUTINE MAMMOGRAPHY

| | 100% | 60% after deductible |

### ROUTINE DIGITAL RECTAL EXAM (DRE) AND PROSTATE ANTIGEN TEST (PSA)

| | 100% | 60% after deductible |

### COLONOSCOPIES AND SIGMOIDOSCOPIES

| | 100% | 60% after deductible |

### ANNUAL ROUTINE HEARING EXAM

| | 100% | 60% after deductible |

### HEARING AID - 1 pair per 36 months

| | 90% after deductible | 60% after deductible |

### OUTPATIENT SERVICES (facility) - except in physician’s office when office visit copay applies

| | 90% after deductible, $100 copay for surgical treatment | 60% after deductible |

### ALLERGY TREATMENT - allergy serum, allergy injections and injectable drugs

| | $25/$35/$55-PCP or Specialist copay Serum is paid at 100% if dispensed in PCP office | 60% after deductible |

### ROUTINE CHOLESTEROL TEST

| | 100% | 60% after deductible |

### DIAGNOSTIC X-RAY AND LABORATORY

| | 100% after copay | 60% after deductible |

### HIGH TECH RADIOLOGY - Outpatient Facility & Emergency Room & Physicians Office

| | 90% after deductible | 60% after deductible |

### CT/CTAs, MRI/MRA, PET scans, Nuclear Tests

### HOSPITAL SERVICES

| | $100 per day copay up to 5 days, then 90% after deductible | $500 per confinement deductible then 60% after plan deductible |

### INPATIENT COVERAGE

| | 90% after deductible | 90% after deductible |

### EMERGENCY ROOM

| | $55 | 60% after deductible |

### SKILLED NURSING FACILITY - up to 60 days per calendar year

| | 90% after deductible | 60% after deductible |

### CONVENIENCE CARE

| | $25 PCP copay | 60% after deductible |
### MEDICAL SUMMARY

#### LOW DEDUCTIBLE

<table>
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<tr>
<th>Service</th>
<th>In-Network Benefits</th>
<th>Out-Of-Network Benefits</th>
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<tr>
<td><strong>DIALYSIS</strong></td>
<td>90% after deductible</td>
<td>Not Covered</td>
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<tr>
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OptumRx and CatamaranRx have merged as one company. Your prescription drug benefits are part of your medical plan benefits and are now administered by OptumRx. If you are enrolled in one of our medical options administered through Cigna you will automatically be enrolled in the prescription drug coverage through OptumRx. The ID card you receive from Cigna will serve as the medical and prescription ID card and will contain both carriers’ information. The back of your medical ID card will have the prescription contact information. You may reach OptumRx at 1-800-880-1188 or via web at OptumRx.com/MyCatamaranRx.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**

<table>
<thead>
<tr>
<th>Drug Therapy Name</th>
<th>RBP</th>
<th>Drug Therapy Name</th>
<th>RBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonsteroidal Anti-Inflammatory Agents</td>
<td>$.50</td>
<td>Opioid Agonists</td>
<td>$1.00</td>
</tr>
<tr>
<td>Anti-hyperintensive Combinations</td>
<td>$1.00</td>
<td>Proton Pump Inhibitors</td>
<td>$2.00</td>
</tr>
<tr>
<td>Fibric Acid Derivatives</td>
<td>$1.00</td>
<td>Statins</td>
<td>$2.00</td>
</tr>
<tr>
<td>Anti-Inflammatory Agents—Topical</td>
<td>$1.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HYDROCODONE—All Hydrocodone combination drugs require a hard copy prescription every time you fill the medication due to new DEA guidelines.

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.

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.

- The Specialty Drug copay will be changing from $60 to $90.

- A new voluntary Hepatitis C Outcomes Program is being 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 is being added. This consists of
  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.
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.
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).

<table>
<thead>
<tr>
<th>THE ADVANTAGES OF CHOOSING AN IN-NETWORK PROVIDER</th>
<th>THE HAZARDS OF CHOOSING AN OUT-OF-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a procedure or service requires preauthorization, your Cigna provider will handle the preauthorization.</td>
<td>You are required to obtain preauthorization from Cigna on certain services and procedures.</td>
</tr>
<tr>
<td>Cigna providers file your claims and Cigna will reimburse the provider - little to no upfront money comes out of your pocket.</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Cigna network providers will not bill you for amounts higher than indicated on your EOB.</td>
<td>Out-of-Network providers may bill you for amounts over Reasonable and Customary charges as indicated on your EOB.</td>
</tr>
</tbody>
</table>

PLAN

<table>
<thead>
<tr>
<th>Medical claims with Cigna - Claims incurred from 3/1/15 - Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSA claims with Discovery - Claims incurred from 3/1/15—5/15/16</td>
</tr>
<tr>
<td>Dental PPO claims with MetLife</td>
</tr>
<tr>
<td>Vision claims with Davis Vision</td>
</tr>
<tr>
<td>Life Insurance claims with Insurance Point/Reliance Standard</td>
</tr>
<tr>
<td>Life Insurance - Waiver of Premium</td>
</tr>
</tbody>
</table>

DEADLINE

| 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. |
| File by 6/15/16 |
| File Out-of-Network claims within 365 days of date incurred. |
| File Out-of-Network 20 days after incurred date. |
| File 90 days but not later than one year. |
| 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
- Certified Diabetes Education
- On-Site Mail Order Pharmacy
- Exercise and Lifestyle Counseling and Support
- Case Management and Monitoring
- Telephonic Support/Website Access
- Eye, Foot and Cardiovascular Screenings
- 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.

Harris Health System Medical plan participants, with a physicians referral, can receive therapy from our expert therapists. Many of our therapists are board certified and fellowship trained in areas such as orthopedics and neurology. Our rehabilitation department has three Certified Hand Therapists who rehabilitate patients who have suffered hand, elbow and shoulder injuries. We also offer outpatient pediatric occupational and physical therapy.

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 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 $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 examples of

**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
- Experimental and investigational procedures
- Cosmetic procedures
- 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
- Biofeedback
- Speech therapy
- Cosmetic or reconstructive procedures
- 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 or call the toll-free number 1-800-244-6224 which is on your Cigna ID card.
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
- Athlete's foot
- Bladder
- Chlamydia
- Cold sores
- Deer tick bites
- Ear infections
- Impetigo
- Infections
- Influenza
- Laryngitis
- Minor burns
- Minor sunburn
- Mononucleosis
- Pink eye and sties
- Poison ivy
- Pregnancy testing
- Rashes
- Ringworm
- Sinus infections
- Strep throat
- Swimmer's ear
- Swimmer's itch
- Wart removal

**CLINICS ALSO PROVIDE VACCINATIONS FOR:**

- DTaP (Diphtheria, Tetanus, Pertussis)
- Influenza
- Hepatitis A & B
- Polio
- Meningitis
URGENT CARE CLINICS—HIGH, LOW DEDUCTIBLE & KELSEYCARE PLANS

Urgent Care Clinics provide great care for non-life-threatening situations. Staffed by physicians, nurses and fully-trained assistants, these walk-in clinics can perform basic x-rays and lab work and dispense prescriptions. Waiting time at an Urgent Care Clinic can be shorter than in the Emergency Room (ER), where life-threatening conditions are treated first. Cost is also another factor to consider when weighing the use of an Urgent Care Clinic versus the ER. Visiting an In-Network Urgent Care Clinic will be less costly than a visit to an In-Network ER facility. Find an Urgent Care Clinic via myCigna.com (click on find a doctor or service, find a place by type and type in urgent care followed by address, city, state or zip code. You can also call the Cigna customer service line at 1-800-244-6224 for assistance).

URGENT CARE CLINICS MAY HELP WITH THE FOLLOWING CONDITIONS:
- Coughs, colds and sore throats
- Allergic reactions
- Rash or other skin irritations
- Animal bites
- Ear infections
- Fever or flu-like symptoms

YOU SHOULD GO TO THE EMERGENCY ROOM IF YOU HAVE . . .
- Chest pain
- Difficulty breathing
- Loss of consciousness
- Poisoning
- Signs of a stroke
- Severe bleeding or head trauma
- Sudden loss of vision or blurred vision
- Complicated fractures or broken bones

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

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

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.
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 judgment of the treating physician with respect to appropriate and necessary care for a particular patient.
CIGNA—FREE WELLNESS PROGRAMS & ON-LINE TOOLS

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

HARRIS HEALTH SYSTEM IS DESIGNATED AS A MOTHER-FRIENDLY WORKSITE
Employee Wellness maintains multiple rooms to provide a private space for lactating 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, health clubs and activity classes are available Contact Employee Wellness for details at 713-634-1290.

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

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

FEED YOUR BODY, MIND AND SOUL WITH THESE CLASSES AND PROGRAMS:
Cooking Classes • Stress Relief Series • Financial Freedom • Smoking Cessation

COMMITE 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!
713-634-1290
employeewellness@harrishealth.org

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2016 TIERED BENEFITS CAMPAIGN

We are excited to announce that Harris Health will once again offer a Healthy Living Tiered Benefits Campaign for the coming year. Specific details pertaining to the 2016 Healthy Living Tiered Benefits Campaign are not yet available at this time.

Program specifics will be announced through a system-wide HR Communication in the Spring of 2016, with additional HR Communications to follow throughout the program.

In the meantime, we continue to promote living a healthy lifestyle by eating healthy and exercising daily. Our Employee Wellness group offers a large variety of programs to help with exercise and diet. Most programs are at no cost to the participant and oftentimes offer reward incentives for participation. For program information keep an eye out for Beat Brief articles, articles on the Harris Health home page or visit the Employee Wellness web page.

Additionally, we encourage all of our staff to be wise healthcare consumers by utilizing the lowest level effective intervention when medical care is warranted, which is oftentimes the lowest-cost effective intervention. Use Generic Equivalent or Generic Alternative medications, when possible. Don’t delay! Get your routine and preventive exams each year.

Our Harris Health medical plans offer a variety of 100% covered services so that every plan participant can manage their own health proactively. It’s proven that routine and preventative exams save lives and there is no life of more value than your own. Don’t just get your routine or preventative exam for you, but for those you love.

100% Preventative Services
Routine Physical/Immunizations
Routine Gynecological Exam and Pap Smear
Routine Mammography
Routine Digital Rectal Exam (DRE) and Prostate Antigen Test (PSA)
Colonoscopies and Sigmoidoscopies – Age Based
Annual Routine Hearing Exam
Routine Cholesterol Test
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.
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 deductibles, out-of-pocket limits, annual limits, etc. is based on the calendar year. Annual enrollment and premium changes are based on the Harris Health System recognized Plan Year of 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.
DENTAL PLANS

Effective March 1, 2016 Harris Health will be partnering 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, 2016). For those enrolled in the DPPO who would like to have an ID card after March 1, 2016; you can print one online when you login at metlife.com/mybenefits.

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. Please note that if you are a current participant enrolled in a MetLife DHMO dentist’s office, you will not have coverage effective March 1, 2016 if you do not re-enroll under MetLife’s plan.

For Annual Enrollment 2016, the cut-off date for electing your DHMO provider is a hard stop date of February 25, 2016 (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 on the MetLife Employee Benefits website. 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: 1-888-466-8673

To register for metlife.com/mybenefits you will need your member and group number from your dental ID card or your Social Security number to create a new login.

Website Features! - On the site, you can view and print Explanations of Benefits (EOB), print your ID card, find a dental cost calculator, or find a 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) 1-888-466-8673 (DPPO)

BENEFIT SUMMARY

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

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.

BENEFIT SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exams</td>
<td>$10 copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Lenses</td>
<td>$20 copay</td>
<td></td>
</tr>
<tr>
<td>Contact lens</td>
<td>$20 copay</td>
<td></td>
</tr>
<tr>
<td>evaluation, fitting &amp; follow up</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exams (every 12 months)</strong></td>
<td>100% after copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td><strong>Lenses (every 12 months)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>100% after copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Bifocal</td>
<td>100% after copay</td>
<td>Up to $60</td>
</tr>
<tr>
<td>Trifocal</td>
<td>100% after copay</td>
<td>Up to $80</td>
</tr>
<tr>
<td>Lenticular</td>
<td>100% after copay</td>
<td>Up to $80</td>
</tr>
<tr>
<td><strong>Frames (every 12 months)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail</td>
<td>Up to $130</td>
<td>Up to $45</td>
</tr>
<tr>
<td>Davis Collection</td>
<td>Up to $130, Fashion Level-Included, Designer Level-Included, Premier Level-$25 copay</td>
<td></td>
</tr>
<tr>
<td><strong>Contact Lenses (every 12 months)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-collection, elective</td>
<td>Up to $105</td>
<td>Up to $105</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>Included</td>
<td>Up to $210</td>
</tr>
<tr>
<td>Davis Collection</td>
<td>Up to 4 boxes included</td>
<td>N/A</td>
</tr>
</tbody>
</table>

VALUE-ADDED FEATURES

**LENS123**

*Replacement Contact Lenses By Mail*

- A mail-order contact lens replacement program
- Purchase replacement contact lenses at significant savings
- Lowest prices guaranteed

**LASER VISION**

- Nationwide credentialed network of renowned ophthalmologists and eye surgeons at pre-eminent Eye Centers of Excellence
- Up to 25% off the provider’s Usual and Customary; or 5% off promotional price (whichever is lower)
- Usual and customary fees: $1,000-$2,400 per eye
- Davis Vision typical pricing: $895-$1,800 per eye

**FREE ONE-YEAR BREAKAGE WARRANTY**

All plan eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses, for a period of one year from the date of delivery. The one year breakage warranty applies to all plan-covered eyeglasses. (i.e. spectacle lenses, Davis Vision exclusive collection frames and national retailer frames where our exclusive collection is not displayed).
LIFE INSURANCE

Effective March 1, 2016 Harris Health will be partnering 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 and/or Optional AD&D insurance. 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.

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.

*See pages 12 and 13 for definitions of eligible dependents

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

<table>
<thead>
<tr>
<th>Employee Age</th>
<th>Amount of Coverage ÷ $1,000</th>
<th>x</th>
<th>Optional Life Rate</th>
<th>=</th>
<th>Per Month Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>$50,000 ÷ 1,000 = 50</td>
<td>x</td>
<td>$0.124</td>
<td>=</td>
<td>$6.20 (50 x 0.124)</td>
</tr>
</tbody>
</table>

OPTIMAL LIFE RATES

<table>
<thead>
<tr>
<th>Employee/Spouse monthly rate, per $1,000 of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 and under</td>
</tr>
<tr>
<td>30 - 34</td>
</tr>
<tr>
<td>35 - 39</td>
</tr>
<tr>
<td>40 - 44</td>
</tr>
<tr>
<td>45 - 49</td>
</tr>
<tr>
<td>50 - 54</td>
</tr>
<tr>
<td>55 - 59</td>
</tr>
<tr>
<td>60 - 64</td>
</tr>
<tr>
<td>65 - 69</td>
</tr>
<tr>
<td>70 - 74</td>
</tr>
<tr>
<td>75 and up</td>
</tr>
</tbody>
</table>

CHILD DEPENDENT LIFE BENEFIT

<table>
<thead>
<tr>
<th>Dependent Child</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly rate per $1,000 of coverage</td>
<td>$0.25</td>
</tr>
</tbody>
</table>

OPTIMAL AD&D

<table>
<thead>
<tr>
<th>Employee Only</th>
<th>$0.015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>$0.026</td>
</tr>
</tbody>
</table>
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, multiplied by the appropriate percentage below:

<table>
<thead>
<tr>
<th>MEMBER AGE</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 through 69</td>
<td>65%</td>
</tr>
<tr>
<td>70 or over</td>
<td>50%</td>
</tr>
</tbody>
</table>

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 or 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 75% 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 5% of the AD&D insurance benefit, subject to a minimum of $1,000 and a maximum of $5,000 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.

Day Care Benefit:
Reliance Standard will pay an additional monthly benefit equal to actual Day Care charges incurred up to 2% of the Insured Person’s or Insured Spouse’s AD&D benefit, not to exceed $2,400 in any one calendar year for each 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 4 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 remaining 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
If you are a new enrollee in the plan you will receive a Visa debit card from Discovery Benefits if you enroll in a FSA benefit plan. The Visa debit cards are not reissued for current members unless they request one through Discovery Benefits. 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 Discovery Benefits 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 Discovery Benefits 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, 2016 — May 15, 2017, to incur expenses (services must be actually rendered).
- June 15, 2017 to submit claim(s) to Discovery 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, 2016– February 28, 2017) 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 $2,550 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 discoverybenefits.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: DISCOVERY BENEFITS
Customer Service Hours: Monday - Friday, 7 am to 7 pm CST
Customer Service: 1-866-451-3399
Customer Service Fax: 1-866-451-3245
Customer Service Email: customerservice@discoverybenefits.com
Web address: discoverybenefits.com

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.
EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program (EAP) is a free program available through MHN 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 1-800-535-4985 or visit members.mhn.com - company access code: hchd

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 MHN, a customer service representative will talk with you to find out what kind of help you need. If it’s an emergency, MHN will connect you to a clinician immediately. Whether you opt for a phone or web-video appointment, you will speak to a licensed clinician who works out of a private, professional office and follows strict laws governing confidentiality.

FINANCIAL SERVICES - What are your financial goals?

MHN 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 members.mhn.com and enter company access code: hchd, click Financial under the Work and Life tab.

WELLNESS COACHING PROGRAM - Are you ready to make a change?

You don’t have to do it alone. Our wellness coaching services offer extra support when you’re ready to change your life – helping you make a plan, and then offering the support, resources and accountability you need to succeed. Our certified coaches can help you with all sorts of health issues, including:

- Weight Management
- Tobacco Cessation
- Fitness and Exercise
- Stress Management
- Lifestyle support for chronic conditions such as asthma, diabetes and cardiovascular disease

MHN COUNSELORS HELP WITH SUCH ISSUES AS:

- 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
EMPLOYEE ASSISTANCE PROGRAM CONTINUED

Just give us a call, and we’ll help you schedule an initial goal-setting consultation with your coach. In this phone call, you and your coach will talk about your health status now and what has and hasn’t worked for you in the past. Then you can work together to set goals that are realistic and achievable. Because this is a highly personalized program, you and your coach will decide what kind of help you need to reach your goals. You can:

- Schedule follow-up calls with your coach (participants average about four 15–30 minute consultations).
- Reach out as needed via phone, email or IM (coaches are available Monday through Friday from 9:00 a.m. to 8:00 p.m. Eastern time).
- Access multimedia programs, health assessments, menu planners, fitness trackers, and more through a secure, personalized web portal.
- Receive personalized emails and coach-chosen materials.

This is the right time to make a change, and we’re here to help.

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).
- **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 MHN member web site has tools and information that can help. You can:

- Ask an expert an emotional health question.
- Assess your wellbeing and receive a personal wellbeing report with tips for living better.
- Make a change with self-help programs for stress, weight management, nutrition, fitness and tobacco cessation.
- Take advantage of interactive e-learning programs.
- Find articles and videos on emotional health, physical health and making healthy choices.

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 licensed attorney or mediator from the EAP network. When you find a network attorney or mediator that is right for you, you are entitled to a FREE 60 minute office or telephone consultation per separate legal matter. If you want to retain an attorney or a mediator 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: Thousands of sample legal forms to cover most of your legal situations.

Legal Library: Hundreds of professionally written articles covering a wide range of legal topics.

*Matters involving Medical malpractice or disputes or actions between members and their employer, MHN or Health Net, Inc. 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 or for designation to a specific employee. 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 800-244-6224.

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 12-month 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.

This Annual Enrollment Period will be an open enrollment period for first time purchase of LTD Buy-Up coverage. If you did not elect LTD Buy-Up as a new hire or when you were first eligible, you may elect it at this time. 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.
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 713-566-6065.

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
- Program in Diagnostic Medical Sonography
- Graduate Fellowship in Computed Tomography (CT)
- 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.

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 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.
PEOPLESOF T OOLS—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. Sign in utilizing your User ID and Password. Click on Employee Self-Service, click on Personal Information and then click on 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. Sign in utilizing your User ID and Password. Click on Employee Self-Service, click on Personal Information and then click on 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. Sign in utilizing your User ID and Password. Click on Employee Self-Service, click on Home and Mailing Address 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. Sign in utilizing your User ID and Password. Click on Employee Self-Service, click on Personal Information and then click on 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.
DIRECT DEPOSIT - Can I change my Direct Deposit? Yes, you can!
As a Harris Health System employee, you can change your Direct Deposit any time you so desire. First, go to the Harris Health System intranet web page. 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 Direct Deposit. This will allow you to view your current payroll Direct Deposit Authorization(s). If you wish to sign up or change your Direct Deposit Authorization(s) go back to the Harris Health System intranet web page. Click on Form, click on Payroll and then select Authorization Agreement For Direct Deposit. Print the form, complete the required fields and attach a voided check or deposit slip to the form. Fax your new Authorization Agreement for Direct Deposit to the Payroll department at 713-566-4338. Your request will be processed within a few business days and the PeopleSoft systems will be updated accordingly.

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 2016. 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 Employee Self-Service, click on Payroll and Compensation and then click on View Paycheck. The system will display your latest Pay Advice. You can then click on Print (View) Check to print your Pay Advice. 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.

TURBO TAX ACKNOWLEDGEMENT - You can send my W-2 information to Intuit, that's way cool!
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 Employee Self-Service, click on Payroll and Compensation and then click on Turbo Tax Acknowledgement. Follow the online instructions.

W-2 TAX FORM - How do I obtain my W-2 for IRS tax reporting purposes?
Need a copy of your W-2? Go to the Harris Health System intranet web page. 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 View and Print. Select the appropriate tax year and click SUBMIT. Print your W-2, it’s that easy!

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?
Need to see or change your W-4? It’s just a few clicks away. Go to the Harris Health System intranet web page. 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-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.
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 website www.theworknumber.com (link: 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 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.

2016 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 $265,000.
4. Maximum Harris Health System Match is $13,250.

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 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 at your earliest convenience.
For questions or assistance with the Pension Plan contact the HR-Benefits department, Pension office at 713-566-6231, Monday through Friday, 8:00 - 4:30 p.m.
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 60 + 20 Years = 80 Points

Age 62 + 18 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.

Please note 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.

**PLEASE NOTE:**

To retain this status, you must maintain continuous employment with Harris Health System. Terminating your employment and rehiring at a later date voids your grandfathered status.

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**EARLY RETIREE MEDICAL PLAN RATE SCHEDULE EFFECTIVE JUNE 1, 2012**

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<th>If Your Age at Your Date of Retirement is:</th>
<th>The Percent of the HCHD Monthly Premium You will Pay until Age 65 will be:</th>
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MEDICARE REQUIREMENTS

IMPORTANT NOTICE -
HARRIS HEALTH SYSTEM SPONSORED SELF-INSURED GROUP MEDICAL PLAN

Medicare – Coverage Types
Medicare is our country’s traditional health insurance program for people Age 65 or older and 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 Social Security Administration (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 employees receive Part A coverage automatically at Age 65. They do not have to pay a monthly premium for Part A because they or a spouse paid certain employment taxes while they were working.

Part B - Medical insurance that helps pay for doctors’ services and other Medical services and supplies not covered by the hospital insurance under Part A.
- The 2016 regular Part B monthly premium is $121.80. Some people may pay a higher premium based on personal adjusted income.

Part D - Prescription drug coverage helps pay for medications doctors prescribe for treatment. Participants in the Harris Health System Medical Plan should not enroll in Medicare Part D because prescription drug coverage is provided through the Medical Plan.

COORDINATION OF BENEFITS
HARRIS HEALTH SYSTEM ELIGIBILITY RULES - ACTIVE EMPLOYEE AND ACTIVE EMPLOYEE DEPENDENT

At Any Age
As long as you meet Harris Health System eligibility guidelines and you participate in the Medical Plan, the Medical Plan will be primary to Medicare regardless of your age or the age of your eligible Dependent.

Age 65 or Over
If you are Age 65 or older and covered by one of our Medical Plans or covered under a group Medical plan like our Medical Plans, either from your own or your spouse’s current employment, you may delay enrolling in Medicare without having to wait for the Medicare General Enrollment Period and paying a Medicare premium surcharge for late enrollment. You are therefore encouraged to enroll in Medicare Part A and Part B no later than the month your active employment or your spouse’s active employment ends if you are Age 65 or older.

HARRIS HEALTH SYSTEM ELIGIBILITY RULES - SOCIAL SECURITY APPROVED DISABILITY

Under Age 65 – Disabled Retiree and Disabled Dependent of a Retiree
Effective January 1, 2011 Medicare Part A and Part B are required for a Social Security approved under Age 65 Disabled Retiree and under Age 65 Disabled Dependent of a Retiree to be eligible for our Medical Plan coverage. Each under Age 65 Retiree and each under Age 65 Retiree Dependent who is: (1) covered under our Medical Plan and (2) eligible to participate in Medicare Part A and Part B because of a Social Security approved disability will be required to participate in both Medicare Part A and Part B as of the date the under Age 65 Disabled Retiree or under Age 65 Disabled Dependent of a Retiree becomes eligible for Medicare. There is no requirement to enroll in Medicare Part D.

Medicare will provide primary coverage and our Medical Plan will provide secondary coverage. Secondary benefits under our Medical Plan will be conditioned upon mandatory participation in both Medicare Part A and Part B. Failure to participate in both Medicare Part A and Part B will result in our Medical Plan claims administrator not being able to verify coverage or process otherwise eligible Medical Plan expenses. Failure to participate in both Part A and Part B of Medicare will result in the Harris Health System Retiree continuing to pay the regular Medical Plan premium even though the under Age 65 Disabled Retiree or the under Age 65 Disabled Dependent of a Retiree will not be entitled to benefits under our Medical Plan until he or she successfully enrolls in both Part A and Part B of Medicare.
HARRIS HEALTH SYSTEM SPONSORED SELF-INSURED GROUP MEDICAL PLAN

As an offset of the cost to carry Medicare coverage, the Medical Plan will waive the Retiree’s cost share of our Medical Plan monthly premium rate based on the Retiree only level of coverage until the under Age 65 Disabled Retiree or the under Age 65 Disabled Dependent of a Retiree attains Age 65. This premium rate reduction assumes the under Age 65 Disabled Retiree or the under Age 65 Disabled Dependent remains covered under our Medical Plan and in Social Security Disabled status until Age 65. A limit of one premium rate reduction per month per eligible Retiree will apply.

**What actions you need to take:**

1. If you are a Medicare approved under Age 65 Disabled Retiree or an under Age 65 Disabled Dependent of a Retiree, you need to ensure that you or your Disabled Dependent are not only enrolled in the Medical Plan but that you or your Disabled Dependent are also enrolled in both Part A and Part B of Medicare. The Medical Plan will be secondary to Medicare and will generally remain the secondary coverage as long as you or your Disabled Dependent continues to meet Medical Plan eligibility rules.

2. If you are a Medicare approved under Age 65 Disabled Retiree or an under Age 65 Disabled Dependent of a Retiree but do not currently meet this Medical Plan eligibility rule, immediately contact Medicare about enrollment for both Medicare Part A and Part B.

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

**Qualifying for Medicare** – Medicare is available to those individuals under Age 65 who have received Social Security Disability Income (SSDI) benefits for 24 months. However, 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.

SSDI beneficiaries with specific conditions may qualify for Medicare sooner than the traditional 30-month qualifying period. At present, individuals with:

- ALS or Lou Gehrig’s Disease qualify for Medicare the first (1st) month SSDI benefits are received;
- End Stage Renal Disease or Kidney Failure qualify for Medicare after the third (3rd) 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.

**Age 65 or Over - Retiree and Retiree Dependent**

As a Retiree Age 65 or over and as a Retiree Dependent Age 65 or over Medicare will be your primary coverage. When you first become eligible for Medicare, you have a seven (7) month period (your initial enrollment period) in which to enroll in Medicare. A delay on your part will cause a delay in Medicare coverage. If you are eligible for Medicare at Age 65, your initial enrollment period begins three (3) 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. If you enroll in Medicare during the first three (3) months of your initial Medicare enrollment period, your Medicare coverage will start with the month you are first eligible. If you enroll during the last four (4) months, your Medicare coverage will start from one (1) to three (3) months after you enroll. If you do not enroll in Medicare during your initial Medicare enrollment period, 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 premium will increase for each month that you were eligible to enroll but did not timely enroll in Medicare. For more information go to [ssa.gov](https://www.ssa.gov) or [medicare.org](https://www.medicare.org) web sites.
HARRIS HEALTH SYSTEM SPONSORED SELF-INSURED GROUP MEDICAL PLAN

If you are an enrollee in the Harris Health System Medical Plan and Medicare is your primary coverage, you must be enrolled in Part A and Part B of Medicare in order to receive benefits under our Medical Plan. You DO NOT need to enroll in Medicare Part D coverage.

If you fail to enroll in Medicare Part A and Part B your Medical expenses will NOT be covered by our Medical Plan and the plan administrator will not be able to verify coverage or process Medical expenses for you. Additionally, your failure to enroll in Medicare Part A and Part B will result in the Retiree continuing to pay Medical Plan premiums even though you will NOT be entitled to our Medical Plan coverage until you successfully enroll in Medicare Part A and Part B.

Harris Health System sponsored Retiree Medical plan premiums are deducted from the monthly Pension check or by bank draft. Special arrangements must be made for self-pay premiums. Failure to timely pay the Retiree portion of the Medical Plan premium will result in loss of coverage after a 30-day grace period. If the Harris Health System Medical Plan coverage is lost, Retiree coverage cannot be reinstated and applicable COBRA provisions will apply.

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 web site 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 in more detail you may contact the HR-Benefits department 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 Part A and Part B to
COMMUNITY HEALTH CHOICE, INC. (CHC)

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 providing access to coordinated, high-quality, affordable, health care services. Through our network of more than 10,000 doctors and 70 hospitals, Community serves nearly 300,000 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](http://www.yourtexasbenefits.com).

Community Health Choice is located at 2636 South Loop West, Suite 900, 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 July 31, 2015. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

<table>
<thead>
<tr>
<th>U.S. Department of Labor</th>
<th>U.S. Department of Health and Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Benefits Security Administration</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>1-866-444-EBSA (3272)</td>
<td>1-877-267-2323, Menu Option 4, Ext. 61565</td>
</tr>
</tbody>
</table>

OMB Control Number 1210-0137 (expires 10/31/2016)
ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

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

ARIZONA – CHIP
Website: http://www.azdhs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid and CHIP
Medicaid Website: http://www.colorado.gov/
Medicaid Phone: 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidplrecovey.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then
Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

IDAHO – Medicaid and CHIP
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/
PremiumAssistance/tabid/1510/Default.aspx
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhs/off/public-assistance/index.html
Phone: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.mass.gov/MassHealth
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-800-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwws.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: dhhs.nh.gov/oiu/documents/hippapp.pdf
Phone: 603-267-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/
dmahs/client/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/Medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov
http://hijosaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dwp.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.ri.gov/healthcare/medicaid/
Phone: 1-800-302-2713 ext. 15473

SOUTH CAROLINA – Medicaid
Website: http://www.scdhss.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx

MONTANA – Medicaid
Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/Medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov
http://hijosaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dwp.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.ri.gov/healthcare/medicaid/
Phone: 1-800-302-2713 ext. 15473

SOUTH CAROLINA – Medicaid
Website: http://www.scdhss.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://www.dhrw.wv.gov/bms/Medicaid%20Expansion/Pages/
default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: http://www.health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

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.
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

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!
INTRODUCING THE DISCOVERY BENEFITS MOBILE APPLICATIONS

We’re excited to introduce to you the Discovery Benefits Mobile Applications for the iPhone, iPad, and Android Devices. It’s never been easier or more convenient to access your account information! This App will allow you to upload receipts, check your balances anywhere, view final filing dates, view claim detail, contact customer service, and even file a claim!

Your data transfer is secure as we utilize 128-bit SSL on all mobile transmissions and a passcode is required each time you enter the App. No pictures are stored on the phone, so you can rest assured that your information is safe.

The Discovery Benefits Mobile Application will simplify how you use your Flexible Spending Account. Available FREE on the iTunes Store and Android Market.

Upload Receipts - Check Balances – File Claims - View Filing Dates - Contact Us - Secure Transmission

The MHN EAP QR code is easy to use!

There are a number of applications on the iPhone, Android, HTC, and Windows marketplaces members can download to scan the code. For example, on the iPhone, there is "QR Reader for iPhone", "Bakodo", "Quick Scan - QR Code Reader", and many others which are free to download.

Some of the same Apps may be available in the Android marketplace as well; either with the same name or slightly different. Once they are downloaded, members use their camera function to snap a picture of the code or merely hover over the code while the app automatically scans the code. Once scanned, the application will take members directly to the MHN member website for Harris Health System.
## VENDOR CONTACT INFORMATION

### BENEFITS ENROLLMENT OR ELIGIBILITY

Employee Benefits Department
713-566-6451
benefitsdepartment@harrishealth.org

### MEDICAL

<table>
<thead>
<tr>
<th>VENDOR CONTACT INFORMATION</th>
<th>BENEFITS ENROLLMENT OR ELIGIBILITY</th>
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<tbody>
<tr>
<td>CUSTOMER SERVICE - CIGNA</td>
<td>800-244-6224</td>
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<tr>
<td>DEDICATED ADVOCATE-CIGNA</td>
<td>713-566-4391</td>
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<tr>
<td>HEALTH FIRST COACHING PROGRAM - CIGNA</td>
<td>855-246-1873</td>
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<tr>
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<tr>
<td>CIGNA HEALTH AND NURSELINE INFORMATION</td>
<td>800-244-6224</td>
</tr>
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<tr>
<td>HEALTHY BABIES - CIGNA</td>
<td>800-564-9286</td>
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<tr>
<td>KELSEYCARE CONCIERGE SERVICE</td>
<td>713-442-0006 or 866-609-1630</td>
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### DENTAL

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<th>VENDOR CONTACT INFORMATION</th>
<th>BENEFITS ENROLLMENT OR ELIGIBILITY</th>
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<tbody>
<tr>
<td>DENTAL PPO - METLIFE</td>
<td>800-880-1800</td>
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<td>DENTAL HMO - METLIFE</td>
<td>888-466-8673</td>
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### VISION

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<th>VENDOR CONTACT INFORMATION</th>
<th>BENEFITS ENROLLMENT OR ELIGIBILITY</th>
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<tr>
<td>Davis Vision</td>
<td>800-999-5431</td>
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### LONG TERM DISABILITY

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<th>VENDOR CONTACT INFORMATION</th>
<th>BENEFITS ENROLLMENT OR ELIGIBILITY</th>
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<tr>
<td>Reliance Standard</td>
<td>800-351-7500</td>
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### PRESCRIPTION DRUGS

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<tr>
<th>VENDOR CONTACT INFORMATION</th>
<th>BENEFITS ENROLLMENT OR ELIGIBILITY</th>
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<tbody>
<tr>
<td>OPTUMRx</td>
<td>800-880-1188</td>
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<tr>
<td>OPTUMRx (MAIL ORDER)</td>
<td>800-881-1966</td>
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### FLEXIBLE SPENDING ACCOUNT

<table>
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<tr>
<th>VENDOR CONTACT INFORMATION</th>
<th>BENEFITS ENROLLMENT OR ELIGIBILITY</th>
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<tbody>
<tr>
<td>Discovery Benefits</td>
<td>866-451-3399 (option 1)</td>
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### OTHER

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<th>VENDOR CONTACT INFORMATION</th>
<th>BENEFITS ENROLLMENT OR ELIGIBILITY</th>
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<tbody>
<tr>
<td>COBRA-DISCOVERY BENEFITS</td>
<td>866-451-3399</td>
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<td>DIABETES AMERICA</td>
<td>866-693-4223</td>
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<td>EMPLOYEE ASSISTANCE PROGRAM (EAP)-MHN</td>
<td>800-535-4985</td>
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<tr>
<td>LIFE INSURANCE - EMPLOYEE BENEFITS</td>
<td>713-566-6451</td>
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<tr>
<td>PHYSICAL THERAPY &amp; REHAB - HARRIS HEALTH SYSTEM</td>
<td>713-218-8250</td>
</tr>
<tr>
<td>FIDELITY INVESTMENTS</td>
<td>800-343-0860</td>
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