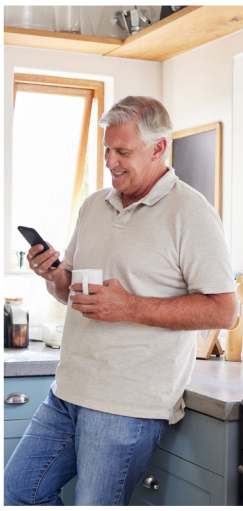
HARRISHEALTH SYSTEM

Taking Care of YOU



2024–2025 Benefits Guide

YOUR HARRIS HEALTH BENEFITS

This brochure includes a brief overview of your retiree benefit options, as well as the important information you need during enrollment. We encourage you to read through it carefully so you can make educated choices when you are electing benefits.

The benefits in this brochure are effective October 1, 2024 through September 30, 2025.

Where to Find More Information

Review our **Retiree Resources** site for more information, including official plan documents, policies, and certificates.

Annual Enrollment Is August 6 to 19, 2024!

This year, you can do one of two things:

- **Option 1: Remain in one of our traditional health plans if you are already enrolled.**
- **Option 2:** Elect the heath reimbursement arrangement (HRA) and use it to purchase individual Medicare coverage through Via Benefits Insurance Services. If you already elected the HRA, you cannot enroll in one of our traditional health plans.

The HRA is effective January 1, 2025, and all other benefits are effective October 1, 2024.

Dental DPPO plan enhancement: The maximum coverage for orthodontic treatments has increased to $1,500, and adult orthodontics will now be covered. **See page 12** for details.

If you are making changes to your benefit plans you will need to complete and submit the **Retiree Benefit/ Change Form by August 19, 2024**. On this form, you will indicate whether you choose one of the Harris Health traditional plans or the HRA.

If you're NOT making changes, you do NOT need to send in an enrollment form. Your current elections will roll over.

Adding new children to your Harris Health coverage? You must submit documentation for new dependent children by August 19, 2024.

If you are electing the health reimbursement arrangement (HRA) option, you will also need to complete your enrollment with Via Benefits. See pages 3 and 4 for more details and enrollment dates.

If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 15 for details.

HRA OPTION (THROUGH VIA BENEFITS)

You have the option of taking a health reimbursement (HRA) and using it to purchase individual Medicare coverage instead of staying on the Harris Health traditional plans. We have partnered with Willis Towers Watson's Via Benefits as our HRA plan administrator to bring you more options for health coverage. Via Benefits is the nation's largest private Medicare exchange.

Via Benefits is a subsidiary of Willis Towers Watson. They offer a broad range of plans nationwide and personalized support to help you determine which Medicare plan best fits your needs and budget. Via Benefits can work with you at no cost, to give you quotes on plans that are available to you outside of our Harris Health plans.

Eligibility

If you are a current retiree or retired prior to December 31, 2022, you had the opportunity to choose the group plan or elect the HRA. The group plan closed for new Retirees after December 31, 2022. Anyone retiring on or after January 1, 2023 will only be offered the HRA. We strongly encourage you to evaluate the HRA plan. **You and your spouse may be able to lower your insurance premium and out-of-pocket costs significantly. Please keep in mind: Once you move to the HRA plan, that move will be final and you will not be able to move back to our traditional Harris Health plans.**

Note about Enrolling in Supplemental Medicare Coverage

In order to enroll in any supplemental Medicare coverage through Via Benefits, you must already be enrolled in Medicare Part A and Part B. If you need to enroll in Part A and/or Part B, visit **ssa.gov/medicare** or call 800-633-4227 (TTY 877-486-2048). After you are enrolled, you can schedule a call with a Via Benefits licensed benefit advisor to choose and enroll in supplemental coverage that fits your needs.

Please note, a Via Benefits representative will reach out to discuss your options and schedule your enrollment call. You can also call Via Benefits directly at 844-436-4157.

- If you call, you may be asked to provide your Social Security number, home phone number and state of residence to confirm your eligibility.
- Via Benefits will also ask for the names of your prescription medications and your physicians. You can also enter this information online when setting up your online profile.
- Enrollment calls can vary in length from 1 to 3+ hours – depending on the number of plans you choose (you will also be asked to confirm the same information for each plan).

You can also visit Via Benefits online:

- Medicare-eligible retirees: **my.viabenefits.com/harrishealthsystem**
- Pre-65 retirees: **marketplace.viabenefits.com/harrishealthsystem**

(continued on page 4)

Via Benefits Enrollment Dates

Pre-65 Retirees
Nov. 1– Dec.15, 2024

Medicare Eligible Retirees
Oct. 15 – Dec. 7, 2024

Valuable Support from Via Benefits

Via Benefits' goal is to make enrolling simple and hassle-free. This approach will provide you and your spouse with more choice and flexibility, access to multiple insurance plans, and a licensed benefits advisor to help with your healthcare coverage needs.

Via Benefits offers:

- Unbiased information about your individual marketplace options, the types of plans available to you, how much they cost and the benefits they cover.
- Advice and decision-making support, based on your current coverage and expected future medical needs.
- Help with enrollment.
- Help understanding how your new HRA will work.
- Ongoing support after enrollment, including help with claims and carrier questions.

HRA OPTION (THROUGH VIA BENEFITS)

HRA Contributions from Harris Health

If you elect the HRA option, Harris Health will establish a tax-free health reimbursement arrangement (HRA) to assist you with your healthcare costs. See the following table for the specific amounts. **These contributions are not taxable.** Instead of paying pretax out of your pension for coverage, you would receive a contribution from Harris Health, which you would be able to use to pay for individual coverage. Your new health plan benefits will begin on January 1, 2025 and automatic premium deductions from your pension check (if applicable) will cease.

Please note: You are responsible for the tax consequences associated with any withdrawals from your HRA. For more information, consult your personal tax advisor.

2025 HRA Employer Contribution Amounts		
	Retiree Amount	Dependent Amount
Medicare Eligible Retirees		
65 +	$2,281	$1,141
Pre-65 Retirees		
55	$7,651	$3,826
56	$8,347	$4,173
57	$9,042	$4,521
58	$9,738	$4,869
59	$10,433	$5,217
60	$11,129	$5,565
61	$11,825	$5,912
62	$12,520	$6,260
63	$13,216	$6,608
64	$13,911	$6,956

Can I Use Funds in my HRA to Pay Prescription Drug Copays?

Yes. Prescription copays are eligible for reimbursement from the HRA. However, there are special considerations for prescription out-of-pocket expenses. If you receive reimbursements for prescription drug out-of-pocket costs, it may take longer to reach Catastrophic Coverage, at which point you will have 100% coverage of prescription costs. As you are held responsible for compliance with CMS regulations and IRS reporting requirements, you may want to consult with a financial advisor regarding the use of HRA funds for prescription copays.

GETTING STARTED

Eligibility

Effective June 1, 2012 Harris Health System moved to a retiree healthcare eligibility point system. Retirees now need 80 points to be eligible for retiree healthcare benefits (e.g., HRA, dental or vision).

The point system, also known as the "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 Points
- Age 60 + 20 Years = 80 Points
- Age 62 + 18 Years = 80 Points
- Age 65 + 15 Years = 80 Points

Healthcare and Dependent Information

A benefit-eligible retiree who retired before December 31, 2022 may continue to carry medical, dental, or vision coverage into retirement if he or she was enrolled in that type of coverage on the day immediately preceding his or her date of termination from Harris Health.

1. A benefit eligible retiree cannot add any new plan type of coverage. However, if more than one plan type of coverage is offered, the benefit eligible retiree may switch coverage types (e.g., Medical PPO to HMO or Dental PPO to HMO and vice versa) within 31 days of the effective date of retirement.
2. A benefit eligible retiree may continue to cover his or her spouse and other dependents that he or she covered as a benefit eligible employee, but cannot add a spouse to any coverage at the time of or following his or her termination.
3. A benefit eligible retiree may enroll a qualifying child in medical, dental, or vision coverage at the time of and following his or her termination, during annual enrollment, and in other situations described in the applicable group health plan.
4. A benefit eligible retiree may drop coverage during annual enrollment and in other situations described in the applicable group health plan. Once coverage is dropped, coverage cannot be reinstated at a later date. When coverage is dropped, it will terminate of the last day of the month in which the coverage was dropped.
5. Failure to pay premiums on time for coverage provided to the benefit eligible retiree will result in loss of the coverage. After coverage is lost for failure to pay premiums on time, the coverage cannot be reinstated.
6. A benefit eligible retiree or benefit eligible dependent age 65 or over must be enrolled in both Part A and Part B of Medicare.

GETTING STARTED

Adding a Dependent

1. If you are adding a dependent during this enrollment period, you must complete a **Retiree Benefit Enrollment / Change Form** and provide proof of eligible dependent status at the time of the enrollment, but no later than the deadline. All proof of eligible dependent documents must be received and approved by MyHR.
2. 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.
3. See page 7 in this brochure for dependent definitions and requirements for coverage.
4. Contact MyHR for eligibility questions or assistance with enrolling your dependents. Call 713-566-6451 or send an email to **MyHR@harrishealth.org**.

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 retiree misses the qualifying event window to drop a dependent that is not a benefit eligible dependent (ineligible dependent), the ineligible dependent will be dropped from medical, dental and vision plan benefits by MyHR 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 retiree, the level of coverage change will be initiated by MyHR 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 retiree 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.

Note: Cigna will NOT verify coverage or process any medical claims for dependents until a **Coverage Questionnaire** has been completed. Log into the Cigna website, **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 you need any medical services.

DEPENDENT ELIGIBILITY

Dependent of the Participant [1]	Eligibility	Examples of Supporting Documents (required)
Spouse	Spouse as recognized by law	• Government-issued Marriage Certificate OR • Similar document from another country approved by MyHR
Common Law Spouse	Spouse as recognized by law	• Declaration of Informal Marriage filed with the county clerk's office
Biological Child[2]	Natural born child	• Government-issued Birth Certificate issued by a state, county or vital records office OR • Substantially equivalent document issued outside the United States • A Birth Facts Sheet issued by the facility where the newborn was born will only be accepted within the first 31 days of birth
Adopted Child[2]	Child is eligible at time of placement	• Adoption Certificate OR • Adoption Placement Agreement AND • Petition for Adoption
Stepchild[2]	Child is not required to live in participant's household	• Government-issued Marriage Certificate OR • Declaration of Informal Marriage with the county courthouse AND • Government-issued Birth Certificate issued by a state, county or vital records office OR • Substantially equivalent document issued outside the United States
Child of Managing Conservator	Child is identified in the managing conservatorship granted to the participant	• Managing Conservatorship court document signed by a judge
Foster Child[2]	Child must not have other governmental insurance	• Placement Order AND • Affidavit of Foster Child
Legal Ward Child[2]	Child is under the protection or in the custody of the participant	• Court order signed by a judge appointing participant as the child's guardian (documentation of legal custody) AND • Government-issued Birth Certificate issued by a state, county or vital records office OR • Substantially equivalent document issued outside the United States
Grandchild[3]	A Child of the Enrollee's Child and/or a Child of the Enrollee's Spouse's Child	• A certified 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 who 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 • Signed and notarized Affidavit from MyHR

1 Employee, retiree or other individual enrolled in program as recognized by Texas law

2 Covered children must be under the age of 26, and can be married or unmarried to be eligible for benefits. For more information visit the MyHR website.

3 A copy of the benefit-eligible employee's federal income tax return evidencing that the grandchild will qualify as a dependent for the initial period of coverage must be submitted to MyHR 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.

MEDICAL PLAN OPTIONS | CIGNA

We offer three traditional medical plan options designed to give you distinct choices, so that you can choose the one that fits your life best. Here's a detailed overview of each plan.

- To find network providers, go to **mycigna.com** and search using the network shown in the table below.
- The coinsurance percentages shown below represent what the PLAN pays after your deductible is met. You pay the remaining percentage.

	KelseyCare	High Deductible		Low Deductible	
	In-Network ONLY	In-Network	Out-of-Network	In-Network	Out-of-Network
Network	Kelsey-Seybold	Open Access Plus (OAP)		Open Access Plus (OAP)	
Deductible Individual Family[1]	 None None	 $1,500 $4,500	 $3,000 $9,000	 $750 $2,250	 $1,500 $4,500
Out-of-Pocket Maximum[2] Individual Family[1]	 $750 $1,500	 $3,750 $10,500	 $6,600 $19,800	 $3,000 $9,000	 $6,000 $18,000
Coinsurance After Deductible[3]	100%	80%[3]	60%[3]	90%[3]	60%[3]
Preventive Care	No charge	No charge	60%[3]	No charge	60%[3]
Physician Office Visits Primary Care Specialist	 $15 copay $30 copay	 $25 copay $35 Tier 1 / $55 Non-Tier 1	 60%[3] 60%[3]	 $25 copay $35 Tier 1 / $55 Non-Tier 1	 60%[3] 60%[3]
Telehealth (Virtual Visits)	$10 copay	$10 copay	N/A	$10 copay	N/A
Diagnostic X-Ray and Lab PCP or Specialist Outpatient Facility/ Independent Lab	 No charge No charge	 Office visit copay 80%[3]	 60%[3] 60%[3]	 Office visit copay 90%[3]	 60%[3] 60%[3]
Urgent Care	$30 copay (waived if admitted)	$55 copay	$55 copay	$55 copay	$55 copay
Emergency Room	$200 copay (waived if admitted)	80%[3]		90%[3]	
Outpatient Surgery (Facility Fee)	$100 copay	$100 copay, then 80%[3]	60%[3]	$100 copay, then 90%[3]	60%[3]
Hospital Stay (Facility Fee)	$100 per-day copay, up to 5 days, then 100%	$100 per-day copay, up to 5 days, then 80%[3]	60%[3]	$100 per-day copay, up to 5 days, then 80%[3]	60%[3]
Mental Health	Covered the same as other physician and hospital services	Covered the same as other physician and hospital services		Covered the same as other physician and hospital services	

1 If you're covering dependents, each member's covered expenses accumulate toward the family out-of-pocket maximum.

2 Out-of-pocket maximum amounts shown in this chart include the deductible.

3 Coinsurance in this chart refers to the percentage of costs the PLAN pays after the deductible is met. You pay the remaining percentage.

If you are enrolled in the KelseyCare plan, let the front desk at your doctor's visit know that you have KelseyCare Cigna as secondary coverage.

KNOW BEFORE YOU GO

Get the right care, at the right time, in the right place.

1. **Virtual urgent care** is more affordable than in-person urgent care or an emergency room visit. With visits available by phone or video, you can connect with a doctor in minutes without leaving work or home.
2. **Local providers** can treat general health issues, provide preventive care, perform routine checkups, administer vaccinations, etc. You may be charged a copay, coinsurance, and/or deductible. Appointments are usually needed with short wait times.
3. **Urgent care centers** treat medical conditions that aren't life threatening, such as fever and flu symptoms, sprains, cuts, minor respiratory symptoms, etc. You will pay a lower copay than an emergency room visit. Urgent care centers are open most days of the week, often with extended hours, though wait times can vary.
4. **Emergency rooms** are for immediate treatment of critical injuries or illnesses. Emergency rooms are open 24/7/365 but are the most expensive option.

FINDING CARE

Telehealth

Save money on convenient healthcare!

Telehealth services through Cigna Telehealth Connection let you see and talk to a doctor from your computer or mobile device without an appointment. You can "visit" the doctor from wherever you are, for a $10 copay. This program is available to employees and dependents enrolled in any of our three plan options.

Most visits are quick and can help with a variety of non-emergency medical conditions. Save time and register NOW so you can get care even faster when you need it!

- **Best for:** When your doctor isn't available, you get sick while traveling or when you don't have time to go to the doctor.
- **Not good for:** Anything requiring an exam, injuries or complex or chronic conditions.

Connect with Cigna Telehealth (MDLIVE)

- Call 888-726-3171
- Or visit **mdliveforcigna.com**

KelseyCare Video Visits and E-Visits

- **Video Visits:** Log in to your MyKelseyOnline account, request a video visit and have a real-time conversation with a board-certified provider.
- **E-Visits:** Log in to your MyKelseyOnline account, request an e-visit and receive a response in an hour or less.

Find Affordable Care on the myCigna Website and App

- The myCigna app and **mycigna.com** can help you take control of your healthcare costs and the way you use your medical benefits.
- If you're a first-time user, click on **Register Now** and complete the registration process. Then log in to:
  - Find in-network providers
  - See cost estimates for medical procedures
  - Compare quality of care for doctors and hospitals

Centers of Excellence

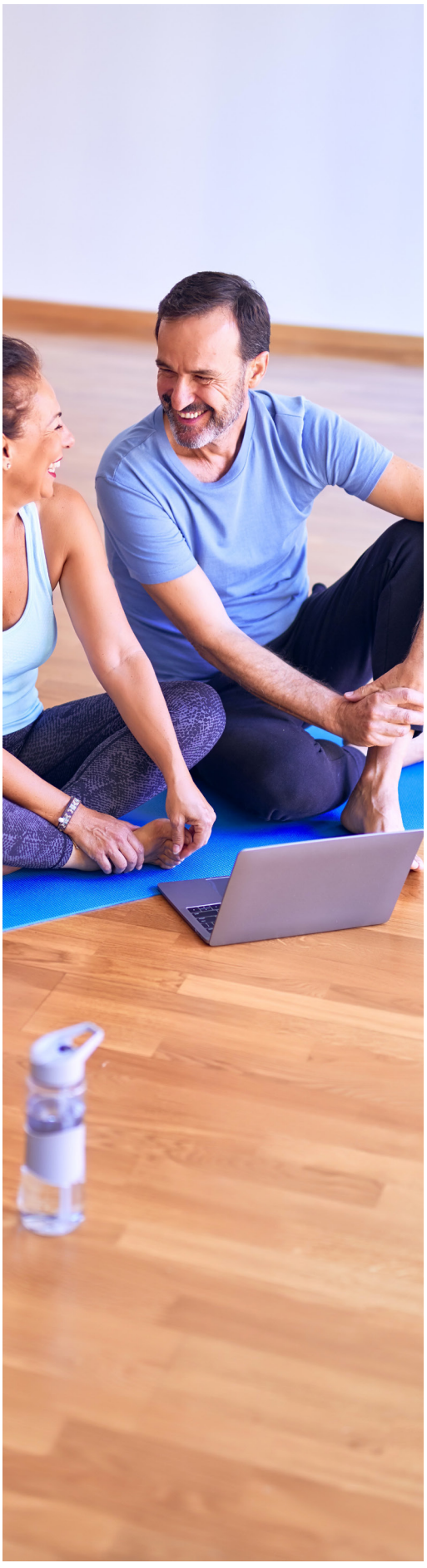
Some hospitals in our plans' network have been rated as Cigna Centers of Excellence. That means they have earned a **top rating for their health outcomes AND they have lower costs on average**.

Consider a Center of Excellence when you're planning a surgery or procedure! To find them, search for in-network hospitals on your **mycigna.com** account and look for the ones with the Center of Excellence symbol (shown above).

Tier 1 Providers

If you're enrolled in the Low Deductible or High Deductible plan, your copay for visiting a Tier 1 specialist is $20 less, compared to a specialist in the network who is not Tier 1. These providers have proved to deliver high-quality, cost-efficient care.

You can find Tier 1 providers through Cigna's provider directory on **mycigna.com** or the myCigna app. Look for the Tier 1 Provider label.



FREE CIGNA PROGRAMS AND SERVICES

Your Health First: Free Health Advocate Coach

Your Health First can help you or your family members cope with a chronic condition. You get ongoing, personalized support from a dedicated health advocate.

- Work one-on-one with your health advocate coach to create a plan to successfully reach your goals.
- Whether you need help 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 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.

- Learn about health conditions and medical procedures.
- Improve the way you communicate with your doctor.
- Access hundreds of Cigna's latest podcasts on a variety of health topics (available in English and Spanish).

Call the Health Information Line at 800-244-6224.

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 see if you are eligible to participate in nutritional counseling.

PRESCRIPTION DRUGS | OPTUMRX

Prescription drug benefits are automatically part of your medical plan benefits, and they are the same for all three medical plans. The following chart shows how much you'll pay. Log in to **optumrx.com** or the OptumRx app to get started with mail order, look up the price of a medication and more.

	Retail	Retail	Mail Order or Walgreens Only
	Maintenance fills 1–2	Maintenance fills 3+	Maintenance fills
	30-day supply	30-day supply	90-day supply
Deductible[1]	$100 per member		
Out-of-Pocket Maximum	$3,600 individual / $4,200 family		
Generic	$10 copay[2]	$20 copay[2]	$20 copay[2]
Brand Formulary	20%[1] up to $60	20%[1] up to $100	20%[1] up to $100
Brand Non-Formulary	30%[1] up to $120	30%[1] up to $200	30%[1] up to $200
Specialty (through Optum SpecialtyRx after first fill)	$120 copay	N/A	N/A

1 The prescription drug deductible applies to brand name drugs only. Once a member reaches their deductible amount, they'll pay a percentage of the cost up to a maximum amount (shown in the table above).

2 If the cost of your prescription is less than the copay amount, you will pay the lower amount.

Save More on Maintenance Medications

For prescriptions you take every month, using **mail order or Walgreens** gives you 3x the supply for 2x the retail cost! Manage medications online at **optumrx.com** or download the OptumRx app.

Important Prescription Drug Coverage Rules

Mandatory Generics

When a generic drug is available and you get the brand name version instead, you will be responsible for the brand name copay PLUS the difference in cost between the generic and brand name drugs.

Step Therapy and Prior Authorization

Our plan requires step therapy or prior authorization for before covering certain drugs (as indicated on our prescription drug list/formulary). Your doctor may need to provide information about why you're taking it OR you may need to try other medications before the plan will cover one you're requesting.

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.

Save on Medications with Livongo

Livongo participants who use their meter to test their glucose or blood pressure at least four times per month will be eligible to receive their anti-hypertensive and diabetes medications for FREE beginning the 15th of the following month. Eligibility will be adjusted each month based on Livongo reports. You will need to meet these requirements each month to continue getting medications for free. If you are retired and age 65+, you are not eligible for the Livongo program.

Email **employeewellness@harrishealth.org** or call 346-426-1597 for more details.

DENTAL PLAN OPTIONS | METLIFE

New Benefit!

Did you know that regular dental checkups keep your smile bright and also help keep your whole body healthy? We offer two dental plan options: a DPPO and a DHMO.

- The **DHMO** requires you to select a MetLife DHMO provider for each covered member, and it doesn't cover any services from out-of-network providers.
- The **DPPO** gives you access to see any provider in the nationwide network, and includes both in- and out-of-network benefits. Keep in mind, providers in the network charge discounted rates, so you'll save money by staying in-network.

	DHMO	DPPO
	In-Network ONLY	In-Network / Out-of-Network
Plan Year Deductible	None	$50 per person / $150 per family
Annual Benefit Maximum	None	$1,750 per person
Preventive Services	Copay varies	100% no deductible
Basic Services	Copay varies	80% after deductible
Major Services	Copay varies	50% after deductible (6-month waiting period)
Orthodontia	Copay varies (adults and children covered)	50% up to a **$1,500** lifetime max (coverage for children and **adults**; 12-month waiting period for new enrollees)

DHMO: Top Things to Know

If you elect the DHMO, you have to select a provider for each covered member. The cut-off for selecting your DHMO provider is the 25th of each month.

- Go to **metlife.com/dental** and select **Find a Dentist**. You can also call **800-880-1800** to reach customer service.
- Type in the ZIP code where you would like to find a dentist, and select **Dental HMO/ Managed Care**.
- Select the plan name **Met290**, then click **Search**. A list of providers in your area will appear.

You pay copays for all covered services. You can find the copay schedule by logging in to **metlife.com/mybenefits**.

If you need specialist services, you'll have to get a referral from your designated provider first.

There are no claims to file, so you won't receive an Explanation of Benefits (EOB) after any visits.

ID Cards

DHMO participants will receive ID cards.

DPPO participants don't need ID cards, and won't receive ID cards. However, if you'd like to have an ID card, you can find and download one by logging in to **metlife.com/mybenefits** or the **MetLife US** app. Call **800-942-0854** for DPPO Plan customer service.

VISION PLAN | DAVIS VISION BY METLIFE

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

	Vision Plan	
	In-Network	Out-of-Network Reimbursement
Exams (every 12 months)	$10 copay	Up to $40
Lenses (every 12 months) Single Vision Bifocal Trifocal Lenticular	 $20 copay $20 copay $20 copay $20 copay	 Up to $40 reimbursement Up to $60 reimbursement Up to $80 reimbursement Up to $80 reimbursement
Frames (every 12 months) Retail The Exclusive Collection	 Up to $130 allowance Fashion Level - $0 copay Designer Level - $0 copay Premier Level - $25 copay	 Up to $45 reimbursement N/A
Contact Lenses (every 12 months) Non-collection, elective Visually required Contact lens evaluation/fitting/follow-up The Exclusive Collection	 Up to $105 allowance $0 copay $20 copay $0 copay - Up to 4 boxes included	 Up to $105 reimbursement Up to $210 reimbursement N/A N/A

Ordering Contacts

Purchase replacement contact lenses at discounted prices through **davisvisioncontacts.com**. This service is considered out-of-network, so you'll have to pay out-of-pocket up front and then submit a claim for reimbursement.

- Convenient home delivery
- Partial reimbursement available of up to $105
- Free shipping on orders over $99

Laser Vision Correction

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

Free One-Year Breakage Warranty

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

MEDICAL, DENTAL AND VISION PREMIUM RATES

Current Retiree (retired prior to June 1, 2012, or retired after June 1, 2012 with grandfathered status)				
	Retiree Only	Retiree and Spouse	Retiree and Children	Retiree and Family
Medical Plans				
KelseyCare	$42.14	$447.81	$194.72	$583.03
High Deductible	$42.14	$447.81	$194.72	$583.03
Low Deductible	$176.17	$907.20	$535.97	$1,032.80
Dental and Vision Plans				
Dental HMO	$0.88	$9.28	$9.28	$13.13
Dental PPO	$36.41	$58.67	$60.13	$110.30
Vision Plan	$0.56	$4.33	$4.33	$7.74

Rule of 80 Retiree (retired after June 1, 2012 without grandfathered status)				
	Retiree Only	Retiree and Spouse	Retiree and Children	Retiree and Family
Low Deductible				
Age 55	$683.44	$1,742.73	$1,578.72	$2,268.97
Age 56	$648.32	$1,653.17	$1,497.58	$2,152.37
Age 57	$613.20	$1,563.60	$1,416.45	$2,035.77
Age 58	$578.07	$1,474.04	$1,335.31	$1,919.16
Age 59	$542.95	$1,384.48	$1,253.87	$1,802.55
Age 60	$507.83	$1,294.92	$1,173.05	$1,685.95
Age 61	$472.61	$1,205.35	$1,091.92	$1,569.34
Age 62	$437.58	$1,115.79	$1,010.79	$1,452.73
Age 63	$402.46	$1,026.23	$929.66	$1,336.12
Age 64	$367.33	$936.67	$848.52	$1,219.53
KelseyCare and High Deductible				
Age 55	$561.97	$1,433.00	$1,298.12	$1,865.70
Age 56	$505.12	$1,288.05	$1,166.81	$1,676.98
Age 57	$491.72	$1,253.87	$1,135.85	$1,632.48
Age 58	$456.59	$1,164.31	$1,054.72	$1,515.88
Age 59	$421.48	$1,074.75	$973.59	$1,399.27
Age 60	$386.35	$985.19	$892.45	$1,282.66
Age 61	$351.23	$895.62	$811.32	$1,166.06
Age 62	$316.10	$806.06	$730.19	$1,049.46
Age 63	$290.98	$716.50	$649.06	$932.85
Age 64	$245.86	$626.94	$567.92	$816.24
Dental and Vision Plans				
Dental HMO	$0.88	$9.28	$9.28	$13.13
Dental PPO	$36.41	$58.67	$60.13	$110.30
Vision Plan	$0.56	$4.33	$4.33	$7.74

HEALTH PLAN NOTICES

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Harris Health System has determined that the prescription drug coverage offered by Optum Rx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Harris Health System coverage may be affected. The Harris Health System drug plan will move from the primary to secondary payer should you enroll in Medicare Part D and you are a Harris Health retiree. If you are an active employee your current Harris Health coverage will not be affected.

Since the existing prescription drug coverage under Optum Rx is creditable (e.g. as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Harris Health System prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Harris Health System and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact the Main Customer Service for further information at 713-566-6451. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Harris Health System changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription Drug Coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/31/24

Name of Entity/Sender: Harris Health System

Contact--Position/Office: Amanda Jones-Duncan, Manager of Benefits and Shared Services

Address: 4800 Fournace, Attn: Human Resources, Bellaire, TX 77401

Phone Number: 713-566-MyHR

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HEALTH PLAN NOTICES

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 **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed on the following page, 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 877-KIDS NOW or **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 **askebsa.dol.gov** or call 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

ALABAMA – Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: www.myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: www.myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (
Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: www.in.gov/fssa/hip
Phone: 1-877-438-4479
All other Medicaid
Website: www.in.gov/medicaid
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: www.kancare.ks.gov
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
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://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

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

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

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

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

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website- FAMIS: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Website- HIPP: https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ and http://www.mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

HEALTH PLAN 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 MyHR at 713-566-MyHR.

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 Health Parity Act, the Harris Health System Plan provides 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

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.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Harris Health System describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

Deadline for Filing Lawsuit Under ERISA after Exhaustion of All Claims Procedures

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan-specific statute of limitations.

Summary of Material Modification

This Benefits Guide constitutes a Summary of Material Modification (SMM) to the Harris Health System 2023–2024 Summary Plan Description **(SPD)**. It is NOT meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

This brochure summarizes the healthcare and income protection benefits that are available to Harris Health System employees and their eligible dependents. Official plan documents, policies, and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through MyHR.

Information provided in this brochure is not a guarantee of benefits.

BENEFITS CONTACTS

Benefit	Contact	Phone Number	Website
Medical	Cigna	Customer Service and Nurseline: 800-244-6224 Dedicated Advocate: 713-566-4391 Healthy Babies: 800-564-9286 Health First Coaching: 855-246-1873	**myCigna.com**
Medical	Kelsey-Seybold	24-Hour Contact Center: 713-442-0000 KelseyCare Concierge: 713-442-0006 or 866-609-1630 MyKelseyOnline: 713-442-6565	**kelsey-seybold.com** **mykelseyonline.com**
Medical / Heath Reimbursement Arrangement	Via Benefits	Pre-65 Retirees: 844-816-3756 Medicare Eligible Retirees: 844-436-4157	Pre-65 Retirees: **marketplace.viabenefits.com/HarrisHealthSystem** Medicare Eligible Retirees: **my.viabenefits.com/HarrisHealthSystem**
Prescription Drugs	OptumRx	800-880-1188 Mail Order: 800-881-1966	**optumrx.com**
Dental	MetLife	Dental PPO: 800-942-0854 Dental HMO: 800-880-1800	**metlife.com**
Vision	Davis Vision by MetLife	800-999-5431	**davisvision.com**

MyHR Department Contacts

Core Business Hours

Monday – Friday

8:00 a.m. – 4:30 p.m.

MyHR

MyHR@harrishealth.org

Phone: 713-566-MyHR (select option 1)

Fax: 713-440-5575

Cigna Healthcare Advocate – Crystal Cunningham
HarrisHealth@Cigna.com
Phone: 346-302-4248