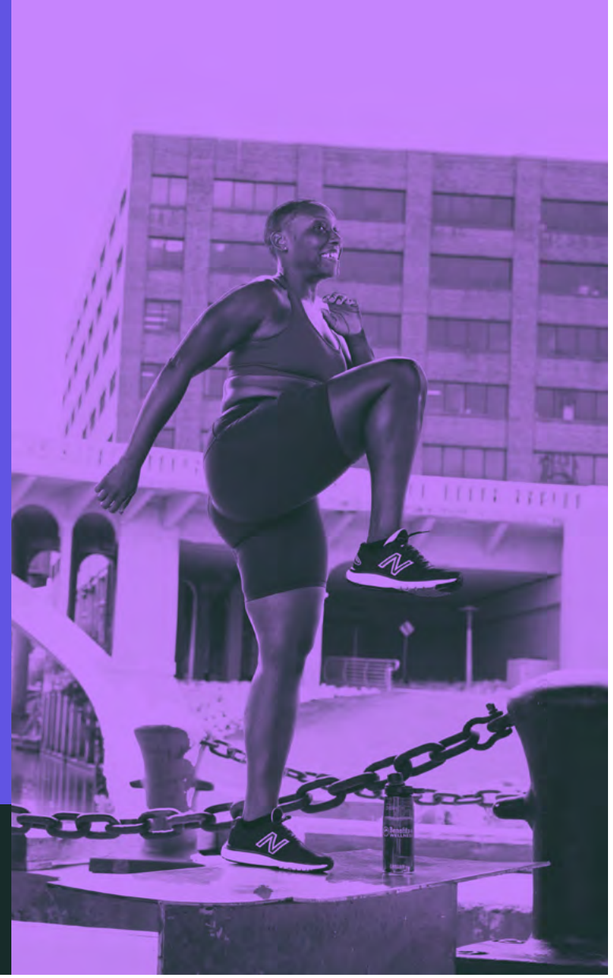
RETIREE

Benefits Guide

Your guide to understanding, selecting and using the benefits available to you and your family.

Benefits Built Around You



Keep It Simple

We always try to make healthcare enrollment as easy as possible. You can keep your current coverage as is or switch to any of the existing plans. Everyone can utilize the Base or Plus plans, and Medicare-eligible retirees and covered spouses also have the option to choose the Humana Medicare Employer PPO.

As always, details on all benefits are covered in this guide, and our team is here to support you as well. If you have any questions or would like a benefit explained in more detail, please reach out to Human Resources and Talent for the help you need.

The benefits described herein are effective January 1, 2026, through December 31, 2026. If there is any variation between the information provided in this Guide, the Plan Document or the Group Contracts, the Plan Document and Group Contracts will prevail. This guide briefly describes the benefits offered to you and your family. It is not intended to modify the group policies and/or contracts between the carriers and the County.

Easy Reference

Your Medical Plan Options

After you review the plan options and make your decision, follow the steps on page 7 to enroll

Harris County retiree medical plans now have three options available: Aetna Base PPO, Aetna Plus PPO and Humana Medicare Advantage PPO.

Your Medicare eligibility as a retiree or covered spouse determines which plan options are available for you.

Non-Medicare-Eligible Retiree, Spouse and/or Covered Children

- Aetna Base PPO Plan
- Aetna Plus PPO Plan

Medicare-Eligible Retiree and/or Spouse

- Aetna Base PPO Plan
- Aetna Plus PPO Plan
- Humana Medicare Advantage PPO Plan

When you or your covered dependent become Medicare-eligible, either due to age or disability, you must enroll in Medicare Parts A and B.

You may enroll in separate plans (Aetna Base/Plus PPO or Humana Medicare Advantage PPO) based upon your Medicare eligibility.

For example:

If you (the retiree) are not Medicare-eligible but your covered spouse is, you may enroll in/keep your Aetna Base or Plus PPO plan and your spouse may enroll in the Humana MA Plan.

If you (the retiree) are Medicare-eligible but you have covered dependents (children, grandchildren, spouse) that are not Medicare-eligible, you may enroll in the Humana MA PPO Plan and your covered dependents may stay in the Aetna Base/Plus PPO plan.

This new option to split enrollment based on Medicare eligibility helps you save on premiums paid for your covered members.

Eligibility & Enrollment

How to proceed once you've selected the plan that's best for you.

Health Plan Eligibility

Dependent Eligibility

Documentation is required to support the eligibility status of each of your dependents. Documents sent to the Benefits Office in a foreign language must be accompanied by a certified English translation. Harris County is required by law to provide healthcare coverage for children identified on National Medical Support Notices.[1]

Dependents must be covered for a full calendar year at the time of retirement in order to receive the County contribution for their premiums. You will be responsible for paying 100% of your dependent's premium cost if covered for less than one calendar year at your retirement.

WHO IS ELIGIBLE?	REQUIRED SUPPORTING DOCUMENTATION	ELIGIBILITY DETAILS
Spouse	• Copy of a filed marriage certificate or certificate of informal marriage • Documents written in a foreign language must be accompanied by a certified English translation	
Biological child	• Birth Certificate or other court document listing the retiree as the parent of the child • A Verification of Birth Facts or birth record may be submitted up to age 5. A Birth Certificate is required for children 5 and older.	• Coverage available up to age 26. Coverage ends on the last day of the month in which the dependent turns 26.
Adopted child	• Certified copy of court order or paperwork placing child in retiree's home	• Coverage available up to age 26. Coverage ends on the last day of the month in which the dependent turns 26.
Stepchild	• Birth Certificate or other court document listing the retiree's spouse as the parent of the child • Copy of a filed marriage certificate of the retiree and parent of the child	• Coverage available up to age 26. Coverage ends on the last day of the month in which the dependent turns 26.
Grandchildren	• Certification of Financial Dependency form (obtain from benefitsathctx.com >> Resources) • Birth Certificate of the grandchild • Birth Certificate of the grandchild's mother or father to prove relationship to retiree	• Grandchild must be related to the retiree by birth or adoption. • Cannot be retiree's step-grandchild. • Grandchild must be claimed as a dependent on the retiree's federal tax return every year to remain on the plan. • Grandchild audits occur every June. • Coverage available up to age 26. Coverage ends on the last day of the month in which the dependent turns 26.
Foster child	• Foster care placement agreement between the retiree and Texas Department of Family & Protective Services or its subcontractor	• Coverage available up to age 18. Coverage ends on the last day of the month in which the dependent turns 18.
Legal custody or guardianship	• Court documents signed by a judge that grant permanent legal custody or permanent legal guardianship to the retiree. Temporary orders will be denied.	• Coverage available up to age 18. Coverage ends on the last day of the month in which the dependent turns 18.
Disabled children age 26 and over	• Contact Benefits & Wellness to obtain the forms you and the doctor will complete and return to Aetna. A determination for your request to continue coverage will be communicated by Aetna to you and Harris County.	• Dependent children who are determined to be totally disabled according to the Social Security Administration Office are eligible. • Includes disabled children of retiree or retiree's spouse who became disabled before age 26 and have been continuously covered.

Failure to drop dependents after a divorce finalized by court may be considered insurance fraud and may result in a referral to the District Attorney's office for investigation. Any retiree committing insurance fraud will be liable to reimburse Harris County for claims activity.

[1] Upon receipt of a Medical Support Notice from the Texas Attorney General or presiding court, or upon receipt of any similar such legal mandate by a court or agency having jurisdiction over the County, the County must comply with any such directive, subject to the terms of our plans. Such directives may not be overturned except through revised documentation received from the applicable agency overturning any prior directives. No refunds will be issued.

Enrollment & When to Enroll

It's important to carefully consider the benefit options available to you and your dependent(s) as there are only two opportunities to select your coverage or make changes to your benefits.

1. During Open Enrollment

This is a great time to review benefits and make any needed updates. During this time you can change your medical plan selection.
Retirees cannot add dependents during Open Enrollment.

- For the 2026 plan year, the Open Enrollment period is October 1 – 31, 2025. You may finalize your new benefit choices using one of the following methods:
  - Return your completed form by email to benefits@harriscountytx.gov.
  - Return your completed form by mail (postmarked by October 31, 2025) addressed to Benefits & Wellness Office, 1111 Fannin St., 6th Floor, Houston, TX 77002
  - **Call the Benefits & Wellness Office** at 713-274-5500, Option 1, to confirm your enrollment election. A confirmation email will be sent with your selected elections.
- **If you are not making any changes to your benefits, do not return your enrollment form.** Your current benefits will stay the same. If you do make changes during Open Enrollment, they will take effect January 1, 2026.

2. After Qualified Life Events

Life happens, and your benefits plan has the flexibility to adjust with you. When you experience a qualified life event, submit the Retiree Health & Related Benefits Change form within the same calendar year the event takes place unless otherwise noted. Contact the Benefits & Wellness Office at **713-274-5500** or **benefits@harriscountytx.gov** to request the form.

- Please be aware that you will be responsible for absorbing the entire cost for your existing and newly added dependents. Retirees may drop dependents at any time without a qualified life event.

Qualified life events that allow you to make changes to your benefits:

- Marriage
- Divorce — must submit changes within 60 days to avoid forfeiture of COBRA rights
- Birth
- Adoption or placement of a foster child
- Death
- Spouse and/or dependent gains or loses coverage through employment or other insurance provider
- Significant change in the financial terms of health benefits provided through a spouse's employer or another carrier
- Unpaid leave of absence taken by spouse
- Change in Medicare or Medicaid eligibility status
- Loss of State Children's Health Insurance Program (SCHIP), but not gain of SCHIP benefits
- Out-of-country dependents moving to the United States

Coverage for Newborns

Aetna provides automatic coverage for newborns of mothers insured by the plan for the first 31 days from the date of birth. For your newborn to remain covered beyond 31 days, you must add him/her to the plan. If you add your newborn to your plan after 31 days, coverage will not be retroactive to the date of birth, and you will be responsible for the medical claims incurred during the uncovered period.

Turning 65?

The Step You Should Take to Prepare

1. Enroll in Medicare three months before the month you turn 65.
2. If you're eligible for premium-free Medicare Part A (hospitalization), sign up for it through the Social Security Administration. Apply for Medicare at www.ssa.gov/medicare, by visiting your local Social Security office, or by calling Social Security at 1-800-772-1213 (TTY: 1-800-325-0778).
3. Buy Medicare Part B (outpatient care; doctor visits) through the Social Security Administration as soon as you can enroll. **You must buy and maintain Medicare Part B to be eligible for all Harris County retiree health plans offered.** The Social Security Administration can confirm your Part B premium.
4. Review the Medicare enrollment and Humana Medicare Advantage PPO & Prescription Drug Plan information you may get in the mail.
5. Harris County Benefits & Wellness will send you a packet with a form asking for your Medicare Beneficiary Identifier (MBI) number. This number is on your Medicare ID card.
6. Complete and return the form or call Benefits & Wellness at 713-274-5500.
7. You will have the option to enroll in the Humana Medicare Advantage PPO & Prescription plan or remain in your current Aetna PPO plan. The next opportunity you will have to change your plan will be during the annual open enrollment period.

Medicare becomes the primary insurer when a retiree, or a dependent of a retiree, turns 65 or becomes eligible due to disability. To be eligible for Harris County retiree health insurance, Medicare-eligible retirees and their Medicare-eligible spouses must enroll in Medicare Parts A and B. Medical benefits then become secondary to Medicare.

Aetna Base & Plus PPO Plans:

Coordinates benefits with Medicare Parts A & B. Since Medicare is the primary insurance, it must pay benefits first before the Base or Plus PPO plan will pay benefits. The plan will pay benefits as if Medicare Part B paid first even if you are not enrolled in Medicare Part B. This will cause a gap in your coverage if you do not enroll in Medicare Part B as a retiree.

Humana Medicare Advantage PPO & Prescription Drug Plan:

A Medicare Advantage plan pays in place of Medicare. The Humana Medicare Advantage plan covers all that Original Medicare covers plus additional benefits customized by Harris County in addition to prescription drugs. You are required to enroll in Medicare Parts A & B to be eligible.

Harris County Medicare eligible retirees and covered spouses should NOT enroll in Part D — Medicare Prescription Drug Plan. Enrollment in a Medicare Prescription Drug Plan is voluntary, but Harris County's medical plans administered through Aetna (Base/Plus PPO) and Humana (Medicare Advantage) provide comprehensive prescription drug coverage.

Monthly Premiums

Harris County continues to pay a significant portion of the cost for your healthcare coverage. Premiums for the Base and Plus plans will take effect on January 1, 2026.

Non-Medicare Eligible Retiree Rates

SPOUSE NOT ENROLLED IN HUMANA MEDICARE ADVANTAGE PPO PLAN

Premiums in this chart are for retirees not yet Medicare-eligible plus those with a covered spouse who choose not to enroll in the Humana Medicare Advantage PPO plan, either due to eligiblity for the plan or by choice. The retiree and their covered dependents are all enrolled in the same Aetna plan — either Base or Plus PPO.

	AETNA BASE PPO			AETNA PLUS PPO		
	You Pay	County Pays	Total	You Pay	County Pays	Total
You Only	$236.25	$907.74	$1,143.99	$315.00	$1,251.04	$1,566.04
You + Child(ren)	$472.50	$1,334.82	$1,807.32	$630.00	$1,757.51	$2,387.51
You + Spouse	$498.75	$1,382.91	$1,881.66	$708.75	$1,896.05	$2,604.80
You + Family	$656.25	$1,661.43	$2,317.68	$866.25	$2,197.28	$3,063.53

SPOUSE ENROLLED IN HUMANA MEDICARE ADVANTAGE PPO PLAN

Premiums in this chart are for retirees not yet Medicare-eligible plus those with a covered spouse who choose to enroll in the Humana Medicare Advantage PPO plan. The retiree and their other covered dependents, if any, are enrolled in the same Aetna plan — either Base or Plus PPO. The shaded monthly premiums in the chart show the price decrease (and cost savings) with the chart above.

	AETNA BASE PPO			AETNA PLUS PPO		
	You Pay	County Pays	Total	You Pay	County Pays	Total
You Only	$236.25	$907.74	$1,143.99	$315.00	$1,251.04	$1,566.04
You + Child(ren)	$472.50	$1,334.82	$1,807.32	$630.00	$1,757.51	$2,387.51
You + Spouse	$397.94	$929.97	$1,327.91	$476.69	$1,273.27	$1,749.96
You + Family	$555.44	$1,208.49	$1,763.93	$634.19	$1,574.50	$2,208.69

Retirees who were eligible to retire by February 28, 2011, will need to subtract $105 for their monthly premium cost.
If you are currently covering dependents, Harris County may pay a portion of the cost of your dependents' coverage as well. If you retired after March 1, 2002, or if you retired with less than 10 years of Harris County service, your rates may vary. Please review your enrollment form to determine the monthly rate for the 2026 plan year for you and your currently covered dependents.

Medicare-Eligible Retiree Rates

BOTH RETIREE AND SPOUSE NOT ENROLLED IN HUMANA MEDICARE ADVANTAGE PPO PLAN

Premiums in this chart are for retirees who are Medicare-eligible plus those with a covered spouse who choose not to enroll in the Humana Medicare Advantage PPO plan, either due to eligiblity for the plan or by choice. The retiree and their covered dependents are all enrolled in the same Aetna plan — either Base or Plus PPO.

	AETNA BASE PPO			AETNA PLUS PPO		
	You Pay	County Pays	Total	You Pay	County Pays	Total
You Only	$0.00	$907.74	$907.74	$78.75	$1,251.04	$1,329.79
You + Child(ren)	$236.25	$1,334.82	$1,571.07	$393.75	$1,757.51	$2,151.26
You + Spouse	$262.50	$1,382.91	$1,645.41	$472.50	$1,896.05	$2,368.55
You + Family	$420.00	$1,661.43	$2,081.43	$630.00	$2,197.28	$2,827.28

BOTH RETIREE AND SPOUSE ENROLLED IN HUMANA MEDICARE ADVANTAGE PPO PLAN

Premiums in this chart are for Medicare-eligible retirees plus those with a covered spouse who choose to enroll in the Humana Medicare Advantage PPO plan. If the retiree covers other dependents, they are enrolled in an Aetna plan — either Base or Plus PPO. The shaded monthly premiums in the chart show the price decrease (and cost savings) with the chart above.

	AETNA BASE PPO			AETNA PLUS PPO		
	You Pay	County Pays	Total	You Pay	County Pays	Total
You Only	$0.00	$186.11	$186.11	$0.00	$186.11	$186.11
You + Child(ren)	$236.25	$613.19	$849.44	$315.00	$692.58	$1,007.58
You + Spouse	$161.69	$208.34	$370.03	$161.69	$208.34	$370.03
You + Family	$319.19	$486.86	$806.05	$319.19	$509.57	$828.76

RETIREE ENROLLED IN HUMANA MEDICARE ADVANTAGE PPO PLAN AND SPOUSE ENROLLED IN AETNA BASE/PLUS PPO PLAN

Premiums in this chart are for retirees who are Medicare-eligible and choose to enroll in the Humana Medicare Advantage PPO plan. If a non-Medicare eligible spouse is covered, then the spouse is enrolled in an Aetna plan — either Base or Plus PPO — along with any additional depedents who are covered.

	AETNA BASE PPO			AETNA PLUS PPO		
	You Pay	County Pays	Total	You Pay	County Pays	Total
You Only	$0.00	$186.11	$186.11	$0.00	$186.11	$186.11
You + Child(ren)	$236.25	$613.19	$849.44	$315.00	$692.58	$1,007.58
You + Spouse	$262.50	$661.29	$923.78	$393.75	$831.12	$1,224.87
You + Family	$420.00	$939.80	$1,359.80	$551.25	$1,132.35	$1,683.60

The amount of Harris County's contribution is determined annually and is currently based on your years of Harris County service and age at retirement. As a general rule, if you retired before March 1, 2002, with at least 10 years of Harris County service, for the 2026 benefit year Harris County will pay 100% of the cost of your Aetna Base PPO plan or Humana Medicare Advantage PPO plan that includes dental, vision and life insurance coverage if you are Medicare eligible.

Retiree premium payments are processed one month in arrears. If you made changes during Open Enrollment, your updated payment amount will be reflected in February, covering your January premium. Your January payment will remain unchanged, as it applies to your December coverage.

Aetna PPO & Prescription Drug Plans

How to proceed once you've selected the plan that's best for you.

Base PPO Plan

The Base plan is designed to keep your monthly costs low through higher deductibles and out-of-pocket maximums. You'll pay more for services that you use, but you'll pay the lowest premiums.

VS

Plus PPO Plan

With the Plus plan, you'll pay a higher monthly premium, but your deductibles, out-of-pocket maximums and costs for services will be lower.

Additional Terms to Know

Beneficiary
A person named to receive the income or inheritance from a will, insurance policy, trust, etc.

Coinsurance
The amount you pay, as a percentage of the cost of your allowed services, after you reach the deductible until you reach the plan's out-of-pocket maximum.

Copayment
The fixed dollar amount you will pay for a healthcare service.

Deductible
When applicable, the initial amount you pay before your insurance begins covering certain services.

Dependent
A person who is eligible for coverage under a policyholder's health insurance coverage.

Out-of-Pocket Maximum
The most you will pay per calendar year for covered, in-network healthcare expenses, including prescription drugs. Once this limit is met, the plan pays 100% on eligible expenses for the remainder of the calendar year.

Premium
The amount you pay for insurance. In most cases, Harris County pays all or a portion of the premium.

Aetna Plans Comparison

Use this overview of services/costs for a deeper comparison of the Base and Plus plans. In all cases, staying in-network provides the best value. In the overview, "You Pay" refers to the amount you are responsible for of eligible expenses. Note that this is not a comprehensive list of services, limitations or exclusions. Please log in at **aetna.com** for more covered services and to estimate your out-of-pocket cost and additional provisions.

Medicare Primary: If you or your dependent have Medicare as your primary insurance, your Harris County plan (Aetna) will coordinate as secondary for in-network covered services once the Medicare Part B deductible is met.

	BASE		PLUS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Individual Family	 $600 $1,800	 $1,000 $3,000	None	 $1,000 $3,000
Maximum Out-of-Pocket Individual Family	 $7,350 $14,700	 $10,000 $30,000	 $6,350 $12,700	 $10,000 $30,000
Lifetime Maximum	Unlimited (unless otherwise noted)	Unlimited	Unlimited (unless otherwise noted)	Unlimited
OFFICE SERVICES	YOU PAY			
Preventive Services*	$0	50% coinsurance after deductible is met	$0	50% coinsurance after deductible is met
Walk-In Clinic CVS Minute Clinic Other Walk-in Clinics	 $0 $30	50% coinsurance after deductible is met	 $0 $25	50% coinsurance after deductible is met
Primary Care Visit (Telehealth and Office Visit)	$20	50% coinsurance after deductible is met	$15	50% coinsurance after deductible is met
Specialist Office Visit (Telehealth and Office Visit)	$40	50% coinsurance after deductible is met	$30	50% coinsurance after deductible is met
Urgent Care	$50	50% coinsurance after deductible is met	$50	50% coinsurance after deductible is met
EMERGENCY CARE	YOU PAY			
Ambulance Service	10% coinsurance after deductible is met	10% coinsurance after deductible is met	$0	$0 after deductible is met
Emergency Room If admitted, copay is waived. You are still responsible for inpatient services.	$300	$300	$300	$300

*Preventive Services — In accordance with the Affordable Care Act (ACA), includes age-appropriate care, screenings and standard immunizations. See the summary plan description for more detailed information on covered preventive services.

Aetna Plans Comparison (cont.)

	BASE		PLUS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
INPATIENT CARE	YOU PAY			
Hospital Services Precertification and continued stay review required for all inpatient admissions.	20% coinsurance after deductible is met	50% coinsurance after deductible is met	$600	50% coinsurance after deductible is met
Physician Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met	$0	50% coinsurance after deductible is met
Skilled Nursing Facility Up to 100 days per calendar year. Requires precertification.	10% coinsurance after deductible is met	50% coinsurance after deductible is met	$0	50% coinsurance after deductible is met
OUTPATIENT CARE	YOU PAY			
Facility Outpatient Surgery	20% coinsurance after deductible is met	50% coinsurance after deductible is met	$400	50% coinsurance after deductible is met
Diagnostic X-ray & Laboratory	$0	50% coinsurance after deductible is met	$0	50% coinsurance after deductible is met
Diagnostic Mammogram Includes 3D	$0	50% coinsurance after deductible is met	$0	50% coinsurance after deductible is met
Outpatient Dialysis Treatment	$0	Not covered	$0	Not covered
Complex Imaging MRI, CAT scan, PET scan, etc. Requires precertification.		50% coinsurance after deductible is met		50% coinsurance after deductible is met
Maximum Savings Providers	$0		$0	
Non-Maximum Savings Providers	10% coinsurance after deductible is met		$100	
Rehabilitation/ Therapy Physical, speech and occupational. Limited to 60 visits per calendar year.	$25 per visit	50% coinsurance after deductible is met	$20 per visit	50% coinsurance after deductible is met
Basic Infertility Services Diagnosis and Treatment Only	Payable as any other expense; 50% coinsurance after deductible is met for insemination; fertility drugs excluded	50% coinsurance after deductible is met; fertility drugs excluded	Payable as any other expense; 50% coinsurance for insemination; fertility drugs excluded	50% coinsurance after deductible is met; fertility drugs excluded

	BASE		PLUS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
MATERNITY	YOU PAY			
Initial Office Visit (Specialist copay)	$40	50% coinsurance after deductible is met	$30	50% coinsurance after deductible is met
Subsequent Visits	$0	50% coinsurance after deductible is met	$0	50% coinsurance after deductible is met
Hospital Delivery Covers mom and baby.	20% coinsurance after deductible is met	50% coinsurance after deductible is met	$600	50% coinsurance after deductible is met
Breastfeeding Equipment	$0	50% coinsurance after deductible is met	$0	50% coinsurance after deductible is met
OTHER MEDICAL	YOU PAY			
Acupuncture	$0 for up to 10 visits per calendar year	$0 for up to 10 visits per calendar year	$0 for up to 10 visits per calendar year	$0 for up to 10 visits per calendar year
Allergy Treatment Includes serum, injections and injectable drugs.	$0 for up to 150 doses per calendar year	50% coinsurance after deductible is met	$0 for up to 150 doses per calendar year	50% coinsurance after deductible is met
Chiropractic Care	$0 for up to 10 visits per calendar year	50% coinsurance after deductible is met	$0 for up to 10 visits per calendar year	50% coinsurance after deductible is met
Durable Medical Equipment	10% coinsurance after deductible is met	50% coinsurance after deductible is met	$0	50% coinsurance after deductible is met
Hearing Aids 1 pair every 36 months	20% coinsurance; no deductible	20% coinsurance after deductible is met	20% coinsurance; no deductible	20% coinsurance after deductible is met
Home Healthcare 100 visits per calendar year	10% coinsurance after deductible is met	50% coinsurance after deductible is met	$0	50% coinsurance after deductible is met
Hospice Care	10% coinsurance after deductible is met	50% coinsurance after deductible is met	$250 + 10% coinsurance	50% coinsurance after deductible is met
Residential Treatment Facility	20% coinsurance after deductible is met	50% coinsurance after deductible is met	$600	50% coinsurance after deductible is met

Prescription Drugs

Prescription drug coverage is included in your medical plan and is provided by Aetna. Aetna has a 4-tier prescription drug program that divides covered medications into tiers or coverage/cost levels. Typically, the higher the tier, the greater the cost of the medication.

YOUR PRESCRIPTION MEDICATION COSTS		
	RETAIL	**HOME DELIVERY / 90-DAY RETAIL**
Tier 1 — Generics	25% min $5 / max $50	25% min $10 / max $100
Tier 2 — Preferred Brands	30% min $25 / max $150	30% min $50 / max $300
Tier 3 — Non-preferred Brands	35% min $50 / max $250	35% min $100 / max $500
Tier 4 — Specialty Medications	30% min $75 / max $350	–

Know What's Covered and Estimate Your Cost

Medications can be reclassified in different tiers, so whether you have a new prescription or one you take regularly, it's wise to determine if your medication is covered and at what tier. You can also estimate your costs in advance if you're purchasing at an in-network pharmacy or through Aetna's CVS Caremark® Mail Service Pharmacy.

To see if your medication is covered:
Download the Aetna Standard Plan and Preventive Generic List at **benefitsathctx.com**.

To find an in-network pharmacy and estimate the cost of your medication:
Log in (or register) at **aetna.com** or use the Aetna Health℠ mobile app.

Questions?
Talk with an Aetna representative at **800-228-6481.**

Prescription Drugs — Key Terms to Know

No-Cost Preventive Generic Medications

Preventive medications are used to prevent conditions like high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack, stroke and prenatal nutrient deficiency. Harris County and Aetna cover certain preventive generic medications at 100%, or no cost ($0) to you.

90-Day Prescription Refills

You can fill your maintenance medication in a 90-day or 30-day supply at a retail pharmacy. Aetna offers a retail pharmacy network that gives you more choices for where you can fill your 90-day prescriptions. Some major pharmacies include CVS, Walmart, H-E-B and Kroger. Log in at aetna.com or use the Aetna Health℠ mobile app to compare cost and find a nearby, participating retail pharmacy.

Prior Authorization

Under your plan, certain medications need approval from Aetna first before they're covered. These medications have a (PA) next to them on your drug list and will only be covered by your plan if your doctor requests and receives approval from Aetna. Types of medications that typically need approval are those that:

- May be unsafe when combined with other medications
- Have lower-cost, equally effective alternatives available
- Should only be used for certain health conditions
- Are often misused or abused

For medications, prior authorizations are typically handled by your doctor's office, which will work directly with Aetna. Aetna will then contact you with the results to let you know if your drug coverage has been approved or denied, or if they need more information.

Specialty Medications

Specialty medications are used to treat complex conditions like multiple sclerosis, hepatitis C and rheumatoid arthritis.

PrudentRx

CVS Caremark® has collaborated with PrudentRx exclusively for a program that may help you save money when you fill eligible specialty medications.

How it Works

A PrudentRx trained member advocate will be able to assist you through a high-touch, proactive engagement process to facilitate enrollment and help you obtain non-need-based manufacturer assistance where applicable.* Participating members will have a $0 out-of-pocket cost on eligible specialty medications!

* Not all specialty prescriptions offer manufacturer assistance. Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change. Copay assistance program may not be used with any federal health care program.

Understanding In-Network vs. Out-of-Network

Whether you choose the Base or the Plus medical plan, the coverage is through the Aetna Choice POS II (Open Access) network. It's a large network of providers and facilities covering almost every medical service you may need.

Yet a great benefit of your healthcare plan is that you aren't limited to in-network providers. You always have the choice to decide when, where and how to receive medical care. So if you prefer to select a primary care physician (PCP) or other provider who isn't part of the network, you always have that freedom. Just be aware that if you use an out-of-network provider or facility, you will be responsible for paying the difference between the covered amount and the amount charged by the provider/facility.

In-Network Only!

Bariatric Surgery & Dialysis

For these services, you will be responsible for the entire cost if you use an out-of-network provider/facility.

Your Best Value

We want you and your dependents to have the care you need, so considerable effort has been made to ensure that the network offers a wide range of qualified choices. When you select an in-network provider or facility, you'll get the lowest costs. The County will save money, too.

> To see if a provider or facility is part of the network, go to aetna.com or use the Aetna Health℠ app.

Your Benefits, Your Way

Manage your health care at home or on the go.

Stay on top of your benefits

- Review your benefits and what's covered
- Track your spending
- View and pay claims on your member website
- See your ID card online
- Get cost info before you get care1

Connect to care

- Find in-network providers, including virtual care
- Locate walk-in clinics and urgent care centers near you
- See reviews of providers

Get the Aetna Health℠ App Today!

Visit **MyAetnaWebsite.com** to register for your member website.

Download the Aetna Health℠ app:
Scan the QR code **or** text "AETNA" to 90156 to receive a download link. Message and data rates may apply.[2]

[1] Estimated costs are not available in all markets or for all services. We provide an estimate for the amount you would owe for a particular service based on your plan at that very point in time. It is not a guarantee. Actual costs may differ from an estimate for various reasons, including claims processing times for other services, providers joining or leaving our network or changes to your plan. Health maintenance organization (HMO) members can only get estimated costs for doctor and outpatient facility services.

[2] Terms and Conditions: Aet.na/Terms. Privacy Policy: Aetna.com/legal-notices/privacy.html. By texting 90156, you consent to receive a one-time marketing automated text message from Aetna® with a link to download the Aetna Health℠ app. Consent is not required to download the app. You can also download by going to the Apple® App Store® or Google Play®.

Employee Assistance Program

Aetna Resources for Living

You balance a lot — work, home, family and more. You don't have to do it alone. Aetna Resources for Living is here to help you stress less and live more.

As an employee or retiree, EAP is provided by Aetna to you at no additional cost. These services are also available to family members living in your home, even if they are not on your insurance policy.

Emotional Wellbeing Support

Access up to 8 counseling sessions per issue each year. You can also call us 24 hours a day for in-the-moment emotional wellbeing support.

Counseling sessions are available face to face, via televideo or chat therapy. Services are free and confidential.

Identity Theft

One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

Legal Services

30-minute consultation with an attorney for topics such as family law, elder law and estate planning, real estate transactions, wills and other document preparation, and many other services.* If you opt for services beyond the initial consultation you can get a 25 percent discount. You also have free access to legal documents and forms on your member website.

Daily Life Assistance Program

Personalized guidance to find resources to support childcare, parenting and adoption, school and financial aid research, caregiver support, and even resources to assist with your home repair.

Financial Services

30-minute telephone consultation with a qualified specialist on topics such as budgeting, retirement or financial planning, credit and debt issues, and college funding. You can get a 25 percent discount on tax preparation services. You also have access to financial articles, calculators and a financial assessment on your member website.

For help and for information on any EAP service:

- Call Aetna 24/7 at **833-657-2111**
- Log in **ResourcesForLiving.com**
  username: Harris County
  password: EAP

*Employment-related legal issues are not covered.

Humana Medicare Advantage PPO & Prescription Drug Plan

Plan Benefits

Harris County has a custom group Medicare Advantage Passive PPO plan. This is not the same as plans marketed to individuals during annual open enrollment on TV. This PPO plan has the exact same benefits in and out-of-network. So, whether you use an in-network provider or an out-of-network provider, the member's cost share is the same. The provider simply needs to participate in Medicare and agree to bill to Humana.

Switching to the Humana Medicare Advantage plan may result in premium savings for retirees who cover Medicare-eligible spouses. Please refer to your Open Enrollment worksheet to review your monthly premiums.

What does this plan cover?

All Medicare-covered services are covered by this plan. Humana's Medicare Advantage plan follows all Medicare guidelines to determine medical necessity. In addition to Medicare covered services, Medicare Advantage plans are also allowed to add on services. As examples, Humana offers Well Dine and Go365. Well Dine provides up to 28 flash-frozen meals delivered to your home upon discharge from the hospital or a skilled nursing facility. Go365 is a wellness program where a person can earn rewards through different wellness activities, for example getting an annual physical.

Does the plan require me to have a referral to see a specialist?

No, the plan does not require referrals. You are welcome to see any provider who accepts Medicare and is willing to bill Humana. Please be aware that there are some specialties where it is more common for the physician's office to require you to have a referral, in order to be seen. Some examples are endocrinologists, neurologists and cardiologists. If a provider requests a referral that is at their office's discretion; this Humana plan does not require referrals.

What happens when I travel?

Retirees have access to the same level of benefits throughout Humana's service area, which includes all 50 states, Puerto Rico and U.S. Territories. When traveling outside Humana's service area, retirees have worldwide emergency care subject to a $100 deductible, 20% coinsurance and a $25,000 maximum benefit. Please refer to the Evidence of Coverage for additional details.

Harris County's plan also includes coverage for routine chiropractic care, routine acupuncture services, routine hearing exams and aid coverage, routine transportation coverage, and a $25 quarterly over-the-counter drug and supply allowance.

Humana Medicare Advantage PPO Plan

OVERVIEW

Your medical plan includes a $100 annual deductible for both in and out-of-network benefits. Once the $100 deductible has been satisfied, there are no additional copays applied under the medical portion. Therefore, the annual out-of-pocket maximum equals $100.

Use this overview to gain an understanding of the services and associated costs for the Humana Medicare Advantage PPO plan. This PPO plan has the exact same benefits in and out-of-network. So, whether you use an in-network provider or an out-of-network provider, your cost share is the same. The provider simply needs to participate in Medicare and agree to bill to Humana.

	IN & OUT-OF-NETWORK
	YOU PAY
Annual Deductible, per individual	$100 (combined in and out-of-network)
Maximum Out-of-Pocket, per individual	$100
Primary Care Office Visit	$0 after combined annual deductible
Specialist Office Visit	$0 after combined annual deductible
Virtual Care Visit	$0
Urgent Care Center	$0
Emergency Room	$0
Inpatient Hospital Care	$0 after combined annual deductible
Outpatient Hospital Services	$0 after combined annual deductible

Please refer to your Humana Welcome Kit for a comprehensive list of services, limitations and exclusions.

Humana Medicare Advantage Rx Plan

OVERVIEW

Humana's Group Plus Formulary offers the most extensive employer coverage and covers most drugs. Your plan has a 4-Tier structure. Tier 1 = Preferred Generic, Tier 2 = Preferred Brand, Tier 3 = Non-Preferred Drugs and Tier 4 = Specialty Drugs. Tier 4 is defined by CMS as high-cost medications that treat rare, complex and chronic health conditions. As defined for 2024 these drugs' cost exceeds $950 for a 30-day supply.

	30-DAY STANDARD RETAIL/MAIL ORDER (from $0 to Catastrophic)	90-DAY STANDARD RETAIL/MAIL ORDER (from $0 to Catastrophic)
Tier 1 – Generic or Preferred Generic	25% $5 min / $50 max	25% $10 min / $100 max
Tier 2 – Preferred Brand	30% $25 min / $150 max	30% $50 min / $300 max
Tier 3 – Non-Preferred Drug	35% $50 min / $250 max	35% $100 min / $500 max
Tier 4 – Specialty Drug	30% $75 min / $350 max	N/A
30-Day Standard Cost Sharing from Catastrophic to Unlimited	$0	$0
Part D Maximum Out-of-Pocket	$2,100	$2,100

Notes:

- Member pays $0 for Smoking Cessation Drugs.
- Part D vaccines recommended by the Advisory Committee on immunization Practices (ACIP) for adults may be available at no cost.
- Plan covered insulin products will not exceed $35 for a one-month supply no matter what cost-sharing tier they're on.

Medicare ABCD's

What is Part A, Part B, Part C and Part D?

Parts A and B are called Original Medicare. Part A and Part B is what you sign up for with Social Security. Most people do not have to pay for Part A but everyone is required to pay for Medicare Part B.

Medicare Part A is hospital insurance. It helps pay for inpatient care in a hospital or skilled nursing facility. It also pays for some home healthcare and hospice care.

Medicare Part B is medical insurance. Part B helps cover medically necessary doctors' services, outpatient care and other medical services and supplies. Part B also covers some preventive services.

Medicare Part C, commonly called Medicare Advantage, is available through private insurance companies. Medicare Part C covers everything parts A and B cover, including hospital and medical services. You still have Medicare if you elect Medicare part C coverage. Also, you do not need to sign up for a Medicare Supplement plan. Lastly, Medicare Advantage plans give you access to programs (like wellness, clinical and educational) at no additional cost to you. Medicare Advantage plans give you the ease of one card and one place to call with questions. With Humana's plan, members have access to programs such as Go365 which is Humana's wellness program.

Medicare Part D is prescription drug coverage.

What's the difference?

Medicare Supplement, Medicare Secondary, & Group Medicare Advantage

Medicare Supplement Plan

Medicare Supplement Insurance (also known as Medigap) is extra insurance you can buy from a private health insurance company to help pay your share of out-of-pocket costs in Original Medicare. There are 10 standardized plans available for Medicare-eligible individuals to purchase. With these plans you can see any provider nationally that accepts Medicare. Generally, you must have Original Medicare — both Part A and Part B — to buy a Medigap policy. These plans are individually priced and may be medically underwritten.

Medicare Secondary Plan

Your current group Aetna plan provides Medicare Secondary coverage with benefits defined by Harris County. This plan pays after Medicare and therefore is considered "secondary" coverage.

Group Medicare Advantage Plan

A Group Medicare Advantage plan pays in place of Medicare. Medicare Advantage plans cover all that Original Medicare covers plus additional benefits customized by the plan sponsor (Harris County). You only need to use your Humana ID card when receiving services. Please keep your Medicare card (red, white and blue) in a safe place. Do not present it to your providers when receiving services.

Should I buy another supplement plan or another Medicare Advantage plan?

No, you should not. It is illegal for anyone to knowingly sell a Medicare Advantage member a supplement plan as the two plans do not coordinate. Medicare only permits an individual to have one Medicare Advantage Plan. If you independently sign up for an Individual Medicare Advantage or Part D plan after being enrolled, the federal government will remove you from your Group Medicare Advantage plan through Harris County.

Enrollment Information

Required items to enroll in a Medicare Advantage plan per CMS

- Members must have Part A and be enrolled in Part B
- Member must have a U.S. residential address for purposes of enrollment. A PO Box is not accepted for purposes of enrollment. Once enrolled, you may receive mail from Humana at a PO Box.
- Members must reside in the U.S. at least 6 months out of the year
- Members must have their Medicare Beneficiary Identification (MBI) number

Do I need to continue paying my Medicare Part B premium?

Yes. In order to have this plan, you must have Part A and Part B. Your enrollment on this plan is shared with the Federal government. If you stop paying your Medicare premium(s) to Social Security, Medicare will inform Humana that you are no longer eligible for this plan.

If I enroll in the Humana Medicare Advantage plan, have I lost original Medicare?

No, you have not. Humana enters a contract with Centers for Medicare and Medicaid Services (CMS) to administer the benefits of Original Medicare Part A and Part B along with extra services and benefits above Original Medicare on behalf of CMS. Only people who are Medicare members are eligible for a Medicare Advantage Plan. In order to have this plan, you must have Part A and Part B.

Additional Benefits & Services

Your Harris County medical benefits include a variety of programs that can help you improve your health and quality of life, as well as save you money.

Vision

A variety of vision benefits are provided by Davis Vision to all members covered by Harris County's retiree medical plans.

Fully Covered: Frames at Visionworks

As a Davis Vision member, you have access to over 750 Visionworks stores, which offer the industry's largest in-store frames assortment. With an average of 2,000 frames per store, you'll find the right shape, style, color and brand for you at no out-of-pocket cost. Members also receive 50% off additional pairs of eyewear. (Maui Jim frames are excluded from this benefit.)

Fully Covered: Frames from The Exclusive Collection

The Exclusive Collection can be found at nearly 9,000 independent provider locations nationwide. These frames are available to you for no out-of-pocket cost and include options that have retail values of up to $195. To find an Exclusive Collection provider near you, log in to the mobile app or at **davisvision.com/member**.

Fully Covered: Contacts from The Exclusive Collection

Available at participating provider locations, The Exclusive Collection of contact lenses features many popular brands and is fully covered along with fitting and follow-up care.

Vision Summary of Benefits

This is only a summary of benefits. For a complete list of benefit details, please refer to Harris County's Certificate of Coverage or your Member Welcome Kit.

BENEFITS SUMMARY	
Services/Products	**IN-NETWORK**
Frequency of Services (Exams/Lenses/Frames)	Once every calendar year
Copayments (Exams/Lenses)	$10 / $25
Frames • Allowance • Visionworks • The Exclusive Collection[1]	$150 allowance Fully covered frames[2] Fully covered frames
Covered Lenses Options	Clear plastic, single-vision, lined bifocal, trifocal or lenticular lenses. Tinting, scratch-resistant and kids' polycarbonate lenses are also covered.
Contact Lenses (in lieu of eyeglasses) • Allowance • The Exclusive Collection[1]	$150 allowance Fully covered up to: 4 boxes for planned replacement 8 boxes for disposable lenses
Contacts Fitting Fee • Standard • Specialty • The Exclusive Collection[1]	15% discount[3] 15% discount[3] Fully covered
LASIK	$300 lifetime allowance

[1]The Exclusive Collection is available at participating provider locations and is subject to change.

[2]The fully covered frames benefit is available at all Visionworks locations nationwide and includes all frames except Maui Jim eyewear.

[3]Additional discounts not applicable at Walmart, Sam's Club or Costco locations.

Out-of-Network Benefits

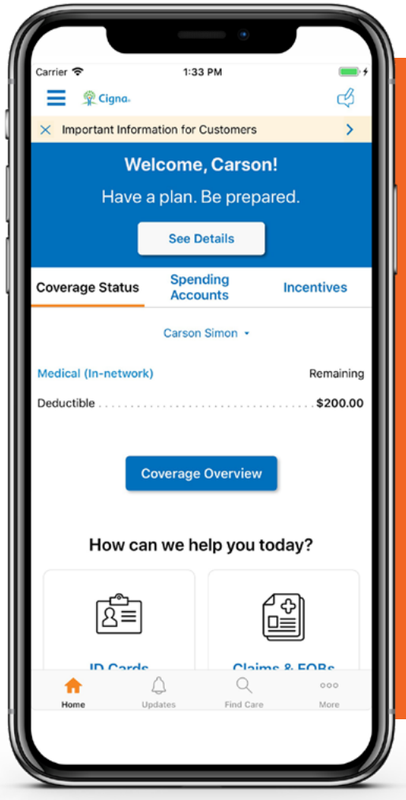
You'll get the greatest value and maximize your benefit dollars by using an in-network provider, but reimbursements are available as follows if you receive services from an out-of-network provider:

Eye Examination:	**$35**	Trifocal Lenses:	**$45**
Frames:	**$70**	Lenticular Lenses:	**$80**
Single-Vision Lenses:	**$25**	Elective Contact Lenses:	**$80**
Bifocal/Progressive Lenses:	**$40**	Visually Required Contacts:	**$150**

Dental

Dental benefits are provided by Cigna to all members covered by Harris County's retiree medical plans.

- You can choose to use any licensed dentist, though you'll get the biggest savings if you use a dentist in the Cigna dental network. You can also see a specialist without a referral.
- The amount your plan pays depends on:
  - The coinsurance level for the service you received
  - Which dentist you visit — in-network or out-of-network
  - If you've paid your deductible and/or reached your maximum benefit
- Once you reach the plan's maximum annual benefit, your plan will no longer pay a portion of your costs during that calendar year.
- Note that ID cards are not automatically mailed, but must be requested. For safety purposes, you will receive a generic ID card without your personal information shown.



Get Started with myCigna:

To look for an in-network dentist, estimate the cost of care and more, use your myCigna account. If you haven't registered for a **myCigna.com** account, here's how:

1. **Go to myCigna.com** and select "Register."
2. **Enter your personal details** like name, address and date of birth.
3. **Confirm your identity** with secure information like your Cigna ID or social security number, or complete a security questionnaire. This will ensure only you can access your information.
4. **Create a user ID and password.**
5. **Review and submit.**

Dental Summary of Benefits

DENTAL COVERAGE SUMMARY	
Services/Products	**IN-NETWORK / OUT-OF-NETWORK[1]**
Deductible (calendar year) Individual Family	 $50 $150
Maximum Benefit (calendar year) Applies to Class I, II, III, VII, IX expenses	$1,750
BENEFIT HIGHLIGHTS	**YOU PAY**
Class I: Diagnostic & Preventive Oral Evaluations, Routine Cleanings, X-rays (routine, non-routine), Fluoride Application, Sealants (per tooth), Space Maintainers (non-orthodontic)	No charge No deductible
Class II: Basic Restorative Emergency Care to Relieve Pain, Restorative (fillings), Periodontics (minor and major), Oral Surgery (minor and major), Anesthesia (general and IV sedation), Repairs (bridges, crowns, inlays, dentures and denture relines), Rebases and Adjustments	20% + deductible
Class III: Major Restorative Inlays and Onlays, Prosthesis over Implant, Crowns (prefabricated stainless steel/resin, permanent cast and porcelain), Bridges and Dentures	50% + deductible
Class IV: Orthodontia Lifetime Benefits Maximum of $1,500 (per covered member)	50% No deductible
Class VII: Endodontics	20% + deductible
Class IX: Implants	50% + deductible

6-month benefit waiting period for new employees and newly covered dependents on Class III, VII and IX procedures.

[1]Reimbursement levels for in-network services are based on contracted fees. Reimbursement levels for out-of-network services are based on the maximum allowable charge.

Cigna Oral Health Integration Program

Enhanced dental coverage is available for plan members with the following medical conditions: diabetes, heart disease, stroke, head and neck cancer radiation, organ transplant, chronic kidney disease and pregnancy. Members who qualify can get 100% reimbursement of their coinsurance for certain related dental procedures along with additional benefits.

> To enroll, log in at **myCigna.com** or call Cigna at **800-244-6224**.

Life Insurance

Life Insurance is provided by BlueCross BlueShield of Texas. This benefit helps protect your family in the event of your death. The County currently provides a basic level of insurance to eligible retirees at no cost. Retirees have a Life Insurance benefit of $15,000. Please keep your beneficiaries updated. Your beneficiary with TCDRS will not apply to your Harris County life insurance policy. If you are not sure who you have designated as your Life Insurance beneficiary, please call the Benefits & Wellness Office at **713-274-5500** or email **benefits@harriscountytx.gov** to request the form.

Retiree Wellness

Become a healthier you by taking advantage of these programs, services and incentives. It is the mission of Harris County Employee and Retiree Wellness to promote the wellbeing of employees and retirees through initiatives that:

- Encourage healthy habits
- Educate on factors and resources that improve quality of life
- Empower employees and retirees to take responsibility for their own health

Featured Services and Programs

Get Active
- Employee 5K
- Fitness classes and challenges
- Gym discounts

Be Informed
- Mental Health First Aid
- Health education classes
- Awareness campaigns

Stay Well
- Onsite health services
- Health coaching
- Weight management

How to Find Wellness Services and Information

ONLINE
benefitsathctx.com

EMAIL
wellness@harriscountytx.gov

PHONE
713-274-5500

SOCIAL
benefitsandwellnesshctx
@benefitsandwellnesshctx
Harris County Benefits & Wellness

Legal Notices

For questions or any information you haven't found in this guide, use the contact list on page 35 to get answers.

Plan Documents

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

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

You may obtain a detailed description of coverage provisions including the Summary of Benefits Coverage (SBC) and the Glossary of Terms — both of which are available in English and Spanish — and/or the Summary Plan Document (SPD) from Human Resources and Talent (HRT) Employee Benefits. They are also available on the Benefits & Wellness website at **benefitsathctx.com**.

You may obtain a printed copy of the SBC or the Glossary of Health Coverage and Medical Terms at no charge by contacting the Benefits & Wellness Division at **713-274-5500**, or toll free at **866-474-7475** and it will be sent to you within seven business days.

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can request access to this information. Review it carefully.

This Notice is for participants and beneficiaries in the Plan.

As a participant or beneficiary of the Plan, you are entitled to receive this Notice of the Plan's privacy practices with respect to your health information that the Plan creates or receives (your "Protected Health Information" or "PHI"). Our "Notice of Privacy Practices" was updated to comply with new changes to the Health Insurance Portability and Accountability Act ("HIPAA") effective as of October 1, 2018.

This Notice is intended to inform you about how we will use or disclose your PHI, your privacy rights with respect to PHI, our duties with respect to your PHI, your right to file a complaint with us or with the Secretary of the United States Health and Human Services (HHS), and how to contact our office for further information about our privacy practices.

This Notice and the most updated Notice of Privacy Practices will be posted at **benefitsathctx.com**, or you may request a copy by calling **713-274-5500**.

COBRA Notification Obligations

The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides group health insurance continuation rights to employees, spouses and dependent children if they lose group health insurance due to certain qualifying events. Two qualifying events under COBRA require you, your spouse or dependent children to follow certain notification rules. You are required to notify Harris County of a divorce or if a dependent child ceases to be a dependent child under the terms of the group health insurance plan.

Each covered employee, spouse or dependent child is responsible for notifying Harris County within 60 days after the date of the divorce or the date the dependent child ceased to be a dependent, as defined under the terms of the Group Health Insurance Plan. Failure to properly notify Harris County within the required 60 days will forfeit all COBRA rights that may have arisen from these two qualifying events.

Notice of Wellness Program Participation — Aetna PPO Plans

Harris County wellness programs and services are voluntary and available to all insurance-eligible retirees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information

Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you may be asked to complete a voluntary health risk assessment or HRA that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes or heart disease). You may also be asked to complete a biometric screening, which will include a blood glucose and/or cholesterol test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Aetna at **800-228-6481.**

The information from your HRA and the results from your biometric screening, if applicable, will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Harris County may use aggregate information it collects to design a program based on identified health risks in the workplace, Harris County Benefits & Wellness will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is(are) a Aetna health coach(es) in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you promptly in accordance with state and/or federal law.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Director of Harris County Human Resources and Talent or the Director's designee (713-274-5000). If you have questions or concerns about disclosures of your health information, please contact the designated Privacy Officer in the County Attorney's Office at 713-755-5101.

Form 1095-C

The 2024 Affordable Care Act (ACA) reporting rules no longer require the employer (Harris County) to automatically send the 1095-C form to employees and retirees eligible for health insurance. The form for Tax Year 2025 is available upon request.

If you need a copy of this form, please contact Benefits & Wellness at **713-274-5500** or **benefits@harriscountytx.gov**.

Contacts

Human Resources and Talent

BENEFITS & WELLNESS

713-274-5500
benefits@harriscountytx.gov
benefitsathctx.com
Out-of-Area Toll-Free
866-474-7475

MEDICAL & PRESCRIPTION DRUGS

Aetna Member Services
800-228-6481
aetna.com
Dedicated Representatives
713-274-5500

Humana Group Medicare Customer Care
866-561-1725
humana.com

DENTAL COVERAGE

Cigna Member Services
800-244-6224
mycigna.com
Dedicated Representative
713-274-5500

VISION COVERAGE

Davis Vision
800-999-5431
davisvision.com

LIFE INSURANCE

BlueCross BlueShield of Texas
877-442-4207
bcbstx.com/ancillary

DEFERRED COMPENSATION/457 PLANS

Corebridge Financial (Valic)
corebridgefinancial.com

VOYA Financial Services
voyaretirement.voya.com

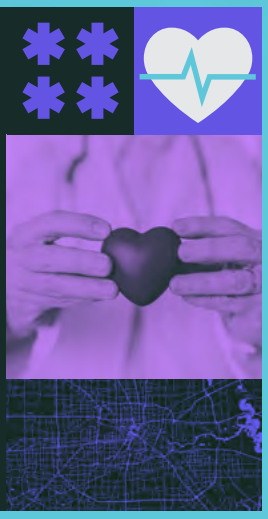
Nationwide
nrsforu.com

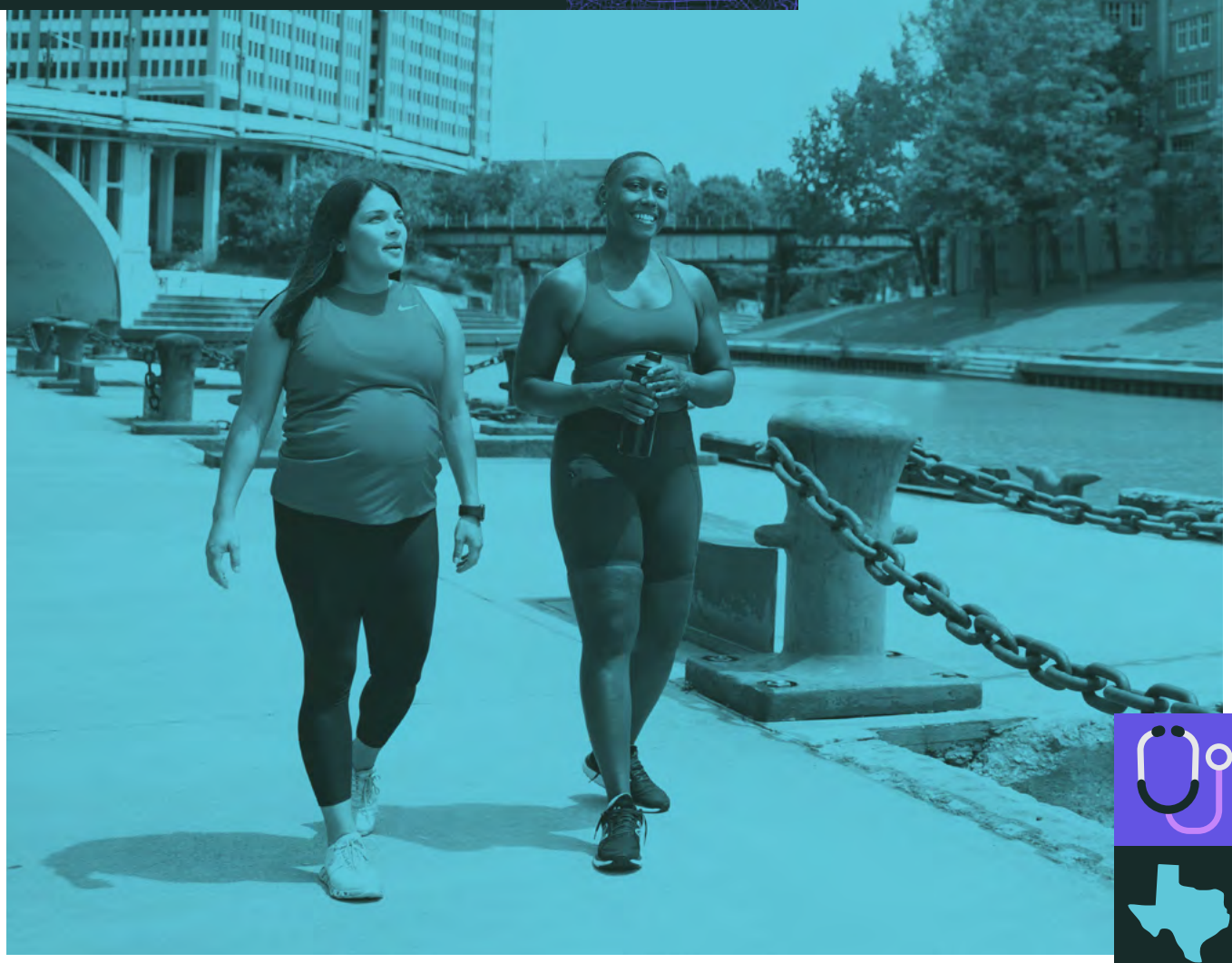
RETIREMENT

Texas County & District Retirement System (TCDRS)
800-823-7782
tcdrs.org

You served Harris County.

So, from health insurance to wellness programs to retirement, your Harris County benefits are here to serve you.





HARRIS COUNTY
HUMAN RESOURCES AND TALENT

Benefits & WELLNESS

1111 Fannin St., 6th Floor, Houston, TX 77002
Call: 713-274-5500
Fax: 713-274-5501
Email: benefits@harriscountytx.gov
Web: benefitsathctx.com
Toll-Free: 866-474-7475