Harris County Georgia

Employee Benefits Guide

Plan Year July 1, 2023 thru June 30, 2024

Enroll in your Benefits at

HarrisCounty.ZevoBenefits.com

TABLE OF CONTENTS

This booklet is a summary only. Please refer to each plan's certificate of coverage / plan document for a complete description of all benefits and exclusions. If there is any difference between the information provided in this booklet and any certificate of coverage / plan document, the certificate of coverage / plan document will govern. Copies of all certificates of coverage / plan documents are available at the Board of Commissioners' Office. In the event that some information changes, you will receive notice about the changes prior to the annual Open Enrollment. If you are a new employee, this information will help you to understand the benefit options available to you. If you're already covered by any of the benefit plans, you may refer to this booklet throughout the year as you use your benefits. This booklet also provides information regarding your COBRA rights and responsibilities.

You may view copies of all certificates of coverage / plan documents by following the below instructions:

Go to: **www.msibg.com**
Click on "Client Portal" at the top right of your screen
Username: harrisEE
Password: Benefits123

ELIGIBILITY

Newly hired full-time employees are eligible for benefits on the first day of the month following 30 days of employment. Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian. Dependent children are eligible up to age 26. All group health plans are now required by law to collect and supply to the Centers for Medicare Services the Social Security Numbers (SSN) of both employees and dependents on coverage. Please remember to bring this information with you to your enrollment.

CHANGES

Pre-Tax Deduction of Premiums (Section 125 Plan) - Health, dental, vision insurance premiums and FSA contributions are all deducted (if you have elected deductions) from your pay on a pre-tax basis (exempt from FICA, Federal and State tax) which in turn provides significant cost savings. This will continue and does not require any action on your part unless you desire to make changes. You will be able to make changes on any of your elections during the open enrollment period. Your selections cannot be changed until next year unless the revocation and new election are due to and consistent with a valid status change (e.g., marriage, divorce, death of a spouse or child, birth or adoption of a child or change of employment of your spouse as detailed in the Section 125 Regulations).

If you have a status change during the year you must notify the Board of Commissioners' Office within 30 days. Any request to make changes after 30 days will not be allowed until the next annual open enrollment. Please contact the Board of Commissioners' Office at (706) 628-4958 if you have any questions regarding the open enrollment period or changes.

MESSAGE FROM THE CHAIRMAN

To: All Full Time Employees
From: Chairman Grant
Subject: Employee Benefits

Harris County appreciates very much the hard work and dedication of all our employees and we recognize that a quality, comprehensive benefits package is a critical component in retaining skilled and seasoned employees as well as recruiting new talent when needed.

This handbook is provided to you as a quick reference tool for information regarding many features of the various benefit plans offered to our employees. You will find answers to many of your benefit questions in this handbook as well as contact information for a variety of resources.

Thank you for all of your hard work!

Robert Grant
Chairman
Harris County

BOARD OF COMMISSIONERS

Susan Andrews
Vice-Chair
District 5

Scott Lightsey
District 1

Greg Gantt
District 3

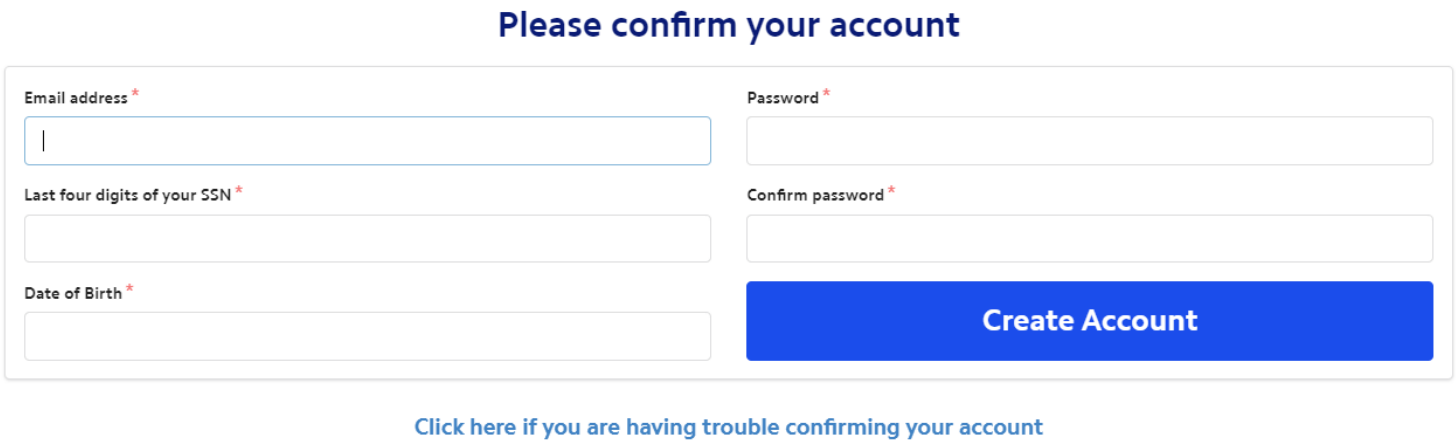
Bobby Irions
District 4

The Board of County Commissioners is composed of five members elected by the voters through district elections for four-year staggered terms. The Board selects a Chairman and Vice-Chairman every January. The Board, as the county's governing authority, is responsible for establishing policy for county operations, enacting ordinances and resolutions to promote the county's health, safety, and welfare, and approving the annual budget and millage rate which funds the operations of the departments under the Board's jurisdiction, other elected officials, and various outside agencies. The Board appoints a county manager to supervise the day-to-day operations of the county.

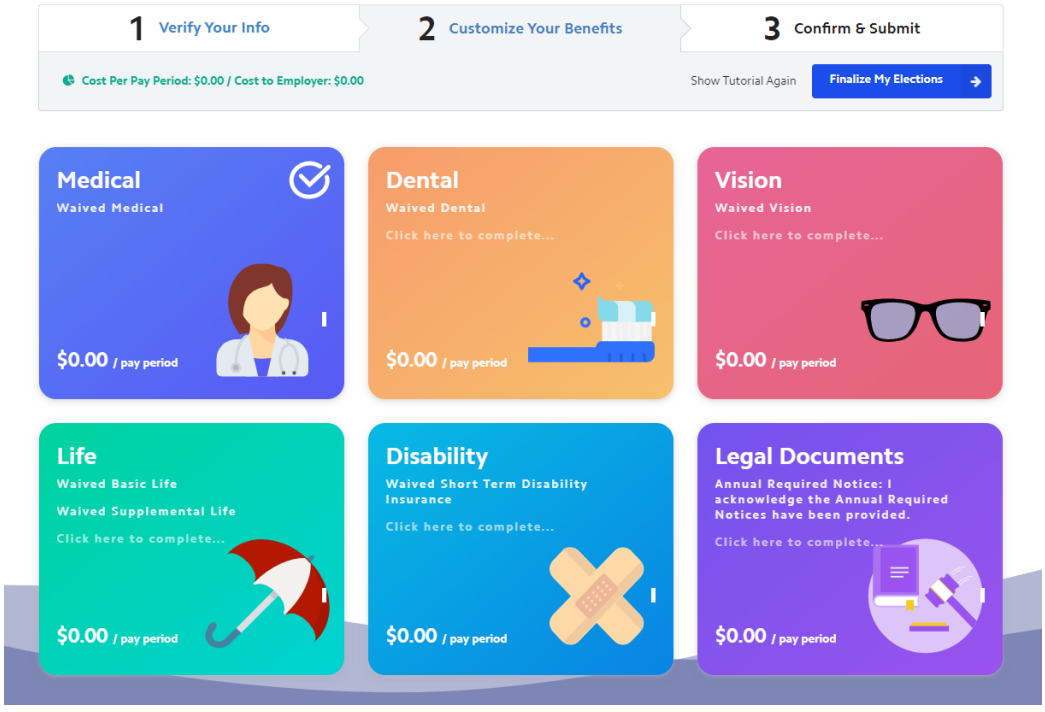
ONLINE ENROLLMENT INSTRUCTIONS

How do I enroll online?
Simply follow the below instructions to confirm your new benefit elections…
Go to: harriscounty.zevobenefits.com

Go to the link above to reach the login page. If you are a returning user, click "Your Portal" in the top-right corner of the screen. If you are enrolling for the first time, click "Get Started Now" on the middle of the page to create an account. You will then see the screen below:



This will prompt you to type in a valid work or personal email address, the last 4 digits of your SSN, your birthdate, and then create a password that you will use for future access to this account.



If you have any issues getting logged into the system please call MSI Benefits Group at **1-800-580-1629** or local number at (770-425-1231) Monday-Friday 8:00 AM - 5:00 PM.

Medical Insurance

Harris County offers medical insurance through Cigna to benefit eligible employees. The costs per pay period for coverage are listed in the table below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) document and/or the plan document, policy, or certificate of coverage.

EMPLOYEE MEDICAL DEDUCTIONS Bi-Weekly (26 deductions per year)	
Tier of Coverage	**DEDUCTION**
Employee Only	**$ 0.00**
Employee + Spouse	**$136.82**
Employee + Child(ren)	**$123.79**
Employee + Family	**$234.53**

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com.
When completing search criteria, select Open Access Plus network.

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the medical plan is provided as a supplement to this booklet being distributed to new hires and existing employees during Open Enrollment. The summary is an important item in understanding the employee's benefit options. The SBC is only a summary of the plan's coverage. A copy of the SBC and/or group certificate of coverage may be requested from Human Resources or is available as follows:

Go to: www.msibg.com
Username: harrisEE
Password: Benefits123

Key Terms

Deductible - The amount of money a patient or family must pay before costs (or percentages of costs) are covered by the health plan or insurance company per year. Paid deductible amounts are applied to the annual out of pocket maximum.

Coinsurance - Coinsurance is the percentage of covered expenses paid by you each year after you have met your deductible (20% coinsurance means that you pay 20% of the expenses.) Paid coinsurance amounts are applied to the annual out of pocket maximum.

Copay - The copay or copayment is a dollar amount defined in the insurance plan and paid by the insured person each time certain medical services are used.

Out of Pocket Maximum - The most you have to pay for covered services in a calendar year. After you spend this amount on deductibles, copayments, and coinsurance, your health insurance pays all other medical costs at 100% for the rest of the calendar year.

Open Access - An Open Access plan allows Employees to see a Specialist without a referral from their Primary Care Physician.

Cigna Open Access Plus - OAP Plans At-A-Glance

	MEDICAL
IN-NETWORK	
Individual Annual Deductible	$1,000
Family Annual Deductible	$2,000
Co-Insurance (Member Pays)	0%
Co-Insurance (Plan Pays)	100%
Individual Out-of-Pocket Maximum (Includes deductible and co-pays)	$7,150
Family Out-of-Pocket Maximum (Includes deductible and co-pays)	$14,300
Physician Copay	$25
Specialist Physician Copay	$50
Preventive Care Services	$0
Urgent Care Copay	$60
Emergency Room Copay	$150
OUT-OF-NETWORK	
Individual Annual Deductible	$10,000
Family Annual Deductible	$20,000
Co-Insurance (Member Pays)	30%
Co-Insurance (Plan Pays)	70%
Individual Out-of-Pocket Maximum (Includes deductible)	$15,000
Family Out-of-Pocket Maximum (Includes deductible)	$30,000
PRESCRIPTION DRUG COPAYMENTS	
Retail per 30 day supply	
Generic	$10
Preferred Brand	$35
Non-Preferred Brand	$75
Specialty	$150
Retail and Home Delivery per 90 day supply	
Generic	$25
Preferred Brand	$88
Non-preferred Brand	$188

Cigna Care Designation

The Cigna Care Designation identifies those doctors in the Cigna network who have achieved top results on Cigna's quality and cost-efficiency measures. Cigna evaluates network doctors, using nationally recognized industry standards for quality and cost-efficiency. To earn the Cigna Care Designation, a doctor must qualify for both quality and cost efficiency ratings for an eligible specialty. There are 18 common medical specialties and 3 primary care categories represented within the CCD network.

Get help choosing a hospital, too.

Just look for the Centers of Excellence Designation. Choose an in-network hospital that's right for you. Cigna reviews how successful a hospital is in treating 27 common conditions. Cigna's ratings are based on actual patient outcomes, average lengths of stay, and average costs gathered from outside sources. Hospitals that demonstrate better health outcomes at lower costs for one of the reviewed conditions earn Cigna's top rating – the Cigna Centers of Excellence designation. See Cigna's hospital ratings on **myCigna.com**.

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit **www.mycigna.com**.

When completing search criteria, select Open Access Plus network.

EXPRESS SCRIPTS® PHARMACY

Our home delivery pharmacy

Express Scripts® Pharmacy, our home delivery pharmacy, is a convenient option if you're taking a medication on a regular basis to treat an ongoing health condition. Express Scripts® Pharmacy, which is a Cigna company, is one of the country's largest home delivery pharmacies.

What are the benefits of using Express Scripts® Pharmacy?

Express Scripts® Pharmacy helps make it easy for you to get your medication. With just a few simple clicks of your mobile phone, tablet or computer, your important medications will be on their way to your door (or location of your choice).

- Easily order, manage, track and pay for your medications **on your phone or online**
- Standard shipping **at no extra cost**[1]
- **Fill up to a 90-day supply** at one time
- Helpful pharmacists **available 24/7**
- **Automatic refills**[2] **and refill reminders** so you don't miss a dose
- **Flexible** payment options

Three easy ways to switch to home delivery

1. **Log in to the myCigna® App or myCigna.com to move your prescription electronically.** Click on the Prescriptions tab and select My Medications from the dropdown menu. Then simply click the button next to your medication name to move your prescription(s).
2. **Call your doctor's office.** Ask them to send a 90-day prescription (with refills)[3] electronically to Express Scripts Home Delivery. Or,
3. **Call Express Scripts® Pharmacy at 800.835.3784.** They'll contact your doctor's office to help transfer your prescription. Have your Cigna ID card, doctor's contact information and medication name(s) ready when you call.

Got a new prescription?

Ask your doctor to send it to Express Scripts® Pharmacy using one of these methods:

1. **Electronically:** For fastest service, they can send your prescription electronically to Express Scripts Home Delivery, NCPDP 2623735.
2. **By fax:** They can call 888.327.9791 to get a Fax Order Form.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company or its affiliates.

Use the myCigna® App or website. It's your "go-to" for everything you need to know about your plan's coverage.

- **Easily manage all of your prescriptions on the My Medications page.** Click on the Prescriptions tab and select My Medications from the dropdown menu.
  - View all of the prescriptions you've filled within the last 18 months.
  - Use the **myCigna** App to review your medications with your doctor during an office visit.
  - Move your prescription from a retail pharmacy to home delivery with the click of a button.
  - For home delivery fills: Refill your prescriptions, get real-time order status and tracking, sign up for automatic refills, pay your bill online, sign up for a payment plan, and more.
  - For retail pharmacy fills: View where and when you last filled your medications.
  - For specialty medications: Easily connect to your online Accredo account to manage orders.[4]
- **See which medications your plan covers.** You have hundreds of generic, preferred brand, and non-preferred brand medications to choose from.
- **Use the Price a Medication tool to see how much your medication costs.** You can also see if there are lower-cost alternatives available.[5]
- **View your plan information.** See your pharmacy claim history, coverage details, and account balances.

Call 800.835.3784

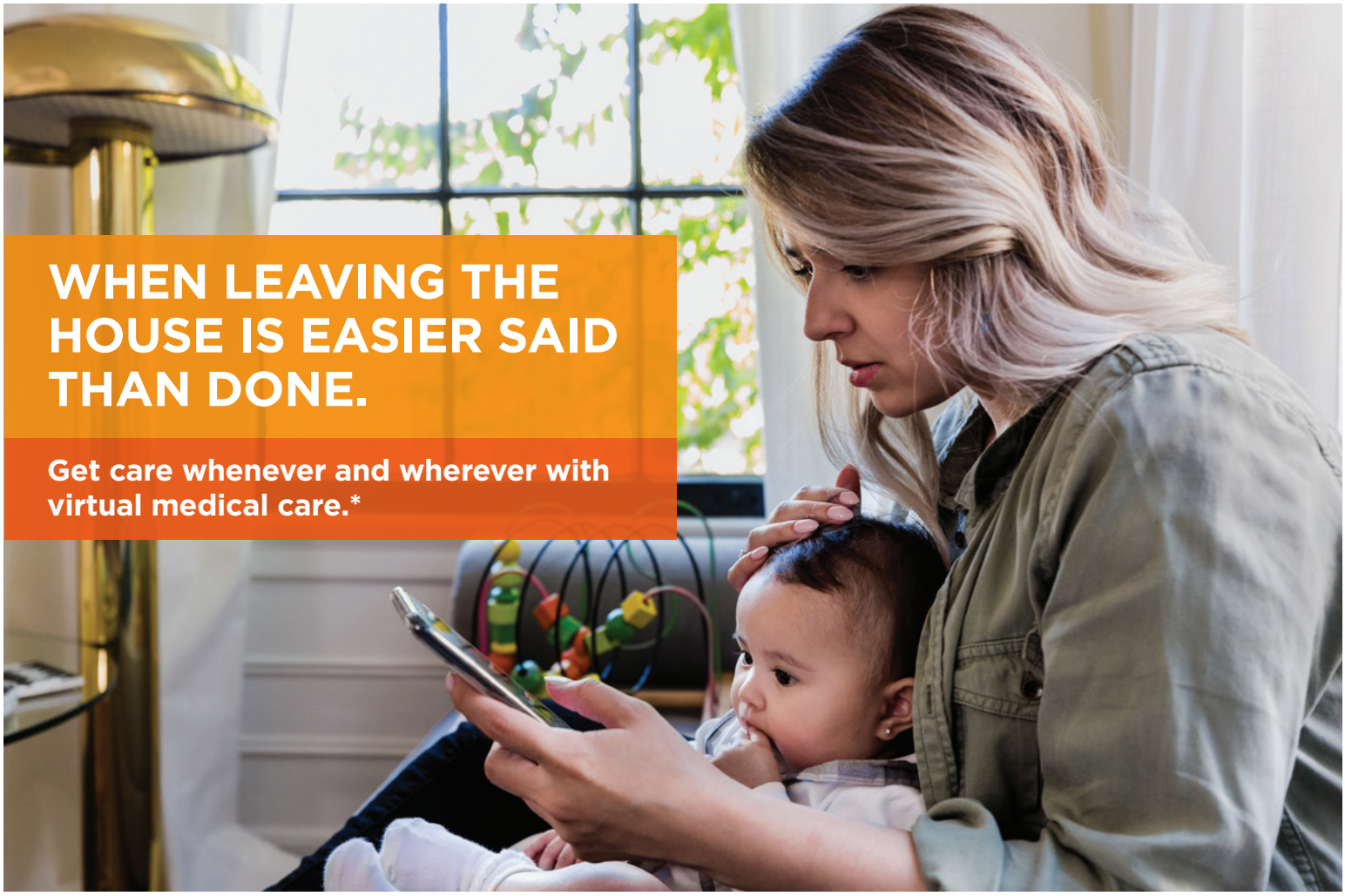
Place an order

Talk to customer service about an order

Talk to a pharmacist about your medication

1. Standard shipping costs are included as part of your prescription plan.
2. Express Scripts® Pharmacy can automatically refill certain medications. Log in to the myCigna App or website or call 800.835.3784 to sign up.
3. Certain medications may only be packaged in less than a 90-day supply. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.
4. Not all plans offer Accredo as a covered pharmacy option. Please log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network.
5. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.

Para obtener ayuda en español llame al número en su tarjeta de Cigna.



WHEN LEAVING THE HOUSE IS EASIER SAID THAN DONE.

Get care whenever and wherever with virtual medical care.*

Life is demanding.

It's hard to find time to take care of yourself and your family members as it is, never mind when one of you isn't feeling well. That's why your health plan includes access to virtual medical care.

Whether it's late at night and your doctor isn't available or you just don't have the time or energy to leave the house, you can:

- Get care via video or phone, 24/7/365 – even on weekends and holidays.
- Connect with quality board-certified doctors and pediatricians.
- Have a prescription sent directly to your local pharmacy, if appropriate.

Convenient? Yes. Costly? No.

Virtual care for minor medical conditions costs less than ER or urgent care visits, and maybe even less than an in-office primary care provider visit.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company or its affiliates.

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Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections

Connect with virtual care your way.

- Contact your in-network provider
- Talk to an MDLIVE medical provider on demand on **myCigna.com**
- Schedule an appointment with an MDLIVE provider on **myCigna.com**
- Call MDLIVE 24/7 at 888.726.3171

Contact your Cigna in-network provider for a virtual visit, or visit myCigna.com, and click on the "Talk to a doctor" callout.

Cigna®

* Cigna provides access to virtual care through participating in-network providers. Not all providers have virtual capabilities. Cigna also provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. All health care providers are solely responsible for the treatment provided to their patients; providers are not agents of Cigna. Refer to plan documents for complete description of virtual care services and costs.

EASY TO REGISTER.
EASY TO USE.

Get to know the full value of myCigna.

From programs that help improve your health to tools that help manage your health spending, there's so much you can do on myCigna.com or the myCigna® app.

- Find in-network doctors, hospitals and medical services
- Manage and track claims
- See cost estimates for medical procedures
- Compare quality of care information for doctors and hospitals
- Access a variety of health and wellness tools and resources

The myCigna website and app both have an easy, interactive health assessment to help you learn more about your health and what you can do to improve it.

Register today

You can register online or through the app.

1. Go to the **myCigna.com** website or launch the **myCigna app** and select "Register Now"
2. **Enter** your requested information
3. **Confirm** your identity
4. **Create** your security information and provide your primary email address
5. **Review** and submit

Feel better-protected

Cigna is as committed to helping protect your health information as we are to protecting your health and well-being. That's why we take certain steps to enhance the security of your personal health information on the myCigna website and app.

- **Enhanced registration**
- **Two-step authentication**

Together, all the way.®

Cigna®

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Enhanced registration

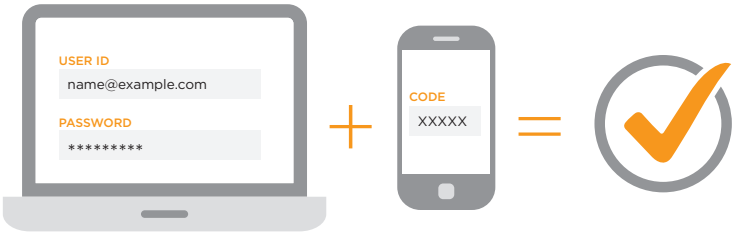
When you register for the first time on the myCigna website or app, you'll be required to provide a primary email address. Having an email address helps Cigna better protect the information in your myCigna account. We can send automatic alerts when you update your email or password. Your email address also can be used when you need help recovering your myCigna user ID or password.

Two-step authentication

With two-step authentication, you have the option of adding an extra layer of security to your myCigna account to further protect your claim, health and account information.

1. First, you'll be encouraged **to add, update and verify contact information – email addresses and mobile phone numbers.**

2. Once you enable two-step authentication and log in to your myCigna account, you'll be asked **to enter your user ID and password, as well as a six digit code that will be sent to either your email address or mobile phone number**. You'll also be offered to select "Remember this Device." If this choice is selected, you won't be prompted for a code each time you log in to your myCigna account from that device.



Questions?

If you have any questions about your myCigna account or your plan benefits, call the number on the back of your Cigna ID card. Customer service representatives are ready to speak with you 24/7/365.

Now compatible with iPhone® X devices

The Apple® Face ID® feature for iPhone X devices is a new way to unlock and authenticate your myCigna app. It's even more convenient than the Touch ID® tool, and makes authenticating fast and easy. Other iPhone users can still use Touch ID to log in to the app.*

Together, all the way.®

Cigna®

* Please refer to your phone's manufacturer for your phone's specific capabilities. The downloading and use of the myCigna app is subject to the terms and conditions of the app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

Dental Insurance

Harris County offers a dental insurance plan through Cigna to benefit eligible employees. The costs per pay period for coverage are listed in the table below and a brief summary of benefits is provided on the following pages. For more detailed information about the dental plans, please refer to the certificate of coverage.

EMPLOYEE DENTAL DEDUCTIONS Bi-Weekly (26 deductions per year)		
Tier of Coverage	**BASE**	**BUY-UP**
Employee Only	**$ 4.46**	**$11.00**
Employee + Spouse	**$13.38**	**$26.45**
Employee + Child(ren)	**$12.49**	**$26.19**
Employee + Family	**$22.30**	**$41.93**

Group Certificate of Coverage

A copy of the **Group Certificate of Coverage** may be requested from Human Resources or is available as follows:

Go to: www.msibg.com
Username: harrisEE
Password: Benefits123

Can I go to any dentist?

You will typically spend less when you visit a Cigna network dentist because Cigna has negotiated discounted rates with these dentists. When you stay in the network you'll save as long as the procedure is listed on the dentist's discount schedule. These savings apply even if you reach your plan maximum. If you go out-of-network, you will not receive Cigna network discounts and the dentist may bill you for the difference between the payment they receive from Cigna and their usual fees.

Do I pay up front and submit a claim or will the dentist submit claims for me?

In most instances, if you are using an in-network dentist, they will submit claims on your behalf and will bill you for any deductible or coinsurance payment that you owe. If you use an out-of-network dentist, you may need to file your own claims after payment.

What information is available to help me choose a dentist?

As you choose your network dentist or specialist, you have several important factors to consider such as cost, experience and location. The **myCigna** directory helps you find a dentist by providing helpful digital tools, such as:

- **Brighter Score™.** Use this scoring method to compare dentists. The score is based on things like affordability, patient experience and professional history.
- **Dental office reviews and comparisons.** Find detailed information to compare dental offices. View dentist profiles with photos and videos. Read verified patient reviews. Write your own review after your appointment.
- **Online appointment scheduling.** With dental offices that offer this service, you can make an appointment right from your laptop or mobile device, and even receive appointment reminders.
- **Enhanced search and transparent pricing.** Search for a dentist by service. Information is personalized for your specific plan. Shows price with coinsurance and deductibles.

Can you explain the deductible, maximum and percentages listed?

The deductible is the amount you need to pay for covered services before your benefits begin. You will pay for your dental treatment until you reach that amount. Then, you and your plan begin to share a percentage of your covered dental costs, known as coinsurance. **The percentage** shown on your plan materials is the percentage the plan pays for the listed procedures, and then you pay the difference.

The maximum is the most your plan will pay for your dental claims during the plan year. Once you reach that maximum, your plan will no longer pay a percentage of your costs for the rest of that plan year. Even after you reach the maximum, however, dentists in the network may continue to offer you discounted fees for the services

Cigna DPPO Dental Plans At-A-Glance

Network	BASE	BUY-UP
Calendar Year Maximum Deductible Per Member		
Class I, II, III Expenses	$1,000	$2,000
Plan Year Deductible		
Per Member	$50	$50
Per Family	$150	$150
Class I Expenses: Preventive & Diagnostic Care		
Oral Exams	Plan pays 100% Deductible Waived	Plan pays 100% Deductible Waived
Cleanings		
Routine X-rays		
Fluoride Application		
Non-Routine X-rays		
Emergency Care to Relieve Pain		
Class II Expenses: Basic Restorative Care		
Fillings	Plan pays 80%, After Deductible	Plan pays 80%, After Deductible
Oral Surgery - Simple Extractions		
Oral Surgery - All Except Simple Extraction		
Surgical Extraction of Impacted Teeth		
Anesthetics		
Periodontics		
Root Canal Therapy / Endodontics		
Relines, Rebases & Adjustments		
Repairs—Bridges, Crowns, Inlays & Dentures		
Brush Biopsy		
Class III Expenses: Major Restorative Care		
Crowns/Inlays/Onlays	Plan pays 50%, After Deductible	Plan pays 50%, After Deductible
Stainless Steel/Resin Crowns		
Bridges		
Dentures		
Class IV Expenses: Orthodontia		
Lifetime Maximum	Not Covered	$1,000
Benefit *(Dependent child less than 19 years of age)*		50%

Locate a Provider
To search for a participating provider, contact Cigna's customer service or visit ww.mycigna.com. When completing search criteria, select Cigna Total DPPO network.

Late Entrant Provisions
You are considered a late entrant if you elect the insurance more than 30 days after you become eligible for it; or you again elect it after you cancel your payroll deduction.

Class I and II are paid at the amounts set forth in the schedule. All other classes of service are paid at 50% of the amounts set forth in the schedule. After a person has been continuously insured for 12 months, this limit no longer applies.

Vision Insurance

Harris County offers vision insurance through Cigna to benefit eligible employees. The costs per pay period for coverage are listed in the table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to the certificate of coverage.

EMPLOYEE VISION DEDUCTIONS Bi-Weekly (26 deductions per year)	
Tier of Coverage	**Employee Cost**
Employee Only	**$ 2.41**
Employee + Spouse	**$ 4.21**
Employee + Child(ren)	**$ 4.59**
Employee + Family	**$ 6.99**

Group Certificate of Coverage

A copy of the **Group Certificate of Coverage** may be requested from Human Resources or is available as follows:

Go to: **www.msibg.com**
Username: **harrisEE**
Password: **Benefits123**

Make the Most of Your Vision Coverage

With your vision plan through Cigna, you and your covered family members have access to quality vision care. Your plan provides coverage for routine eye exams and may include glasses and/or contact lenses. Check your plan materials for details. Also, make sure you know the difference between in-network and out-of-network coverage.

In-Network

You'll save the most money if you pick an eye doctor from Cigna Vision's large network. And you'll have lots of choices. We offer one of the largest specialty networks of optometrists, ophthalmologists and nationally recognized eye care retailers.

Out-of-Network

If you choose a doctor who's not in the network, you'll have to pay the total amount due at your appointment. To get reimbursed, you'll need to submit a Cigna Vision claim form with an itemized receipt. You can find the claim form on **myCigna.com** on the "Forms" page. The whole amount may not be covered. You're responsible for paying any charges not covered under your plan.

Plan Year Deductible

There is no plan year deductible.

Plan Year Out-of-Pocket Maximum

There is no out-of-pocket maximum. However, there are benefit reimbursement maximums for certain services.

Eye-Opening Information

A routine eye and vision exam can help your doctor test your vision and spot the early stages of eye disease. It's important to get your eyes dilated during the exam. This can help spot certain eye diseases, including the early stages of diabetes.

Keep an Eye on Your Kids

Eye exams aren't just for adults. They're also important for children. According to the American Optometric Association, one in four children has a vision problem that can affect their learning. Your kids may get a vision test at school or at their pediatrician's office. But these exams might not catch a serious eye disorder. That's why it's important to have your child visit an eye doctor, such as an optometrist or ophthalmologist. These specialist can help check your child's vision and eye health.

cigna healthcare℠

Vision Plan At-A-Glance

Cigna Vision Network		
Services	**In-Network**	**Out-of-Network**
Eye Exam	$10 Copay	Up to $45 Reimbursement
Frequency of Services (Calendar year basis)		
Examination	Once per 12 months	
Lenses	Once per 12 months	
Frames	Once per 24 months	
Contact Lenses	Once per 12 months	
Lenses		
Single	$10 Copay then covered 100%	Up to $40 Reimbursement
Bifocal		Up to $65 Reimbursement
Trifocal		Up to $75 Reimbursement
Frames		
Eye Glass Frames	$130 Retail Allowance	Up to $71 Retail Allowance
Contact Lenses*		
Elective *(Includes Fitting, Evaluation & Follow-up)*	Up to $130 Allowance	Up to $105 Allowance
Non-Elective; Medically Necessary *(Prior Authorization Required)*	Covered 100%	Up to $210 Allowance

Healthy Rewards® - Vision Network Savings Program

When you see a Cigna Vision Network Eye Care Professional, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

Locate a Provider

Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans. Choosing an eye doctor is easy with Cigna. There are three ways to find a quality in-network eye doctor in your area:

1. Log into **myCigna.com**, click "Coverage", and select "Vision page". Click on "Visit Cigna Vision". Then select "Find a Cigna Vision Network Eye Care Professional, Serviced by EyeMed" to search the Cigna Vision Directory.

2. Don't have access to **myCigna.com**? Go to **Cigna.com**, At the top of the page select "Find A Doctor, Dentist or Facility", then click "Cigna Vision Directory", under Additional Directories.

3. Call the toll-free number found on your Cigna Vision ID card and talk with a Cigna customer service representative.

What's Not Covered

Plan deductibles, coinsurance, copays, frequency limitations, allowances, and options may apply. In general, Cigna Vision plans do not cover the following: (a) Orthoptic or vision training and any associated supplemental testing; (b) Medical or surgical treatment of the eyes; (c) Any eye examination, or any corrective eyewear, required by an employer as a condition of employment; (d) Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related; (e) Charges in excess of the usual and customary charge for the Service or Materials; (e) Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy; (f) Experimental or non-conventional treatment or device (g) Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage; (h) VDT (video display terminal)/computer eyeglass benefit; and (i) Claims submitted and received in excess of twelve (12) months from the original Date of Service. Depending on the terms of your specific plan, the following also may not be covered: (a) Any non-prescription eyeglasses, lenses, or contact lenses; (b) Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage; (c) Prescription sunglasses; (d) Two pair of glasses, in lieu of bifocals or trifocals; and (e) Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage. Your vision plan's actual terms may vary. Refer to your plan documents for the coverage details of your specific vision plan.

BASIC LIFE AND AD&D INSURANCE

Below is a brief description of Harris County's group life insurance policy issued to your employer by The Standard. The summary highlights some of the features of the Group Policy, but it is not intended to be a detailed description of coverage. Your Certificate and Summary Plan Description will contain more detailed information, including the full text of the definitions, exclusions, limitations, reductions and terminating events that apply to the Group Policy. Only the Master Policy contains all the controlling terms and provisions of coverage.

Active Employees -

Premium Contributions:	**Harris County pays 100% of the cost for Your Basic Life and AD&D Insurance.**
Life Insurance Amount:	$25,000
AD&D Amount:	$25,000
Reductions in Insurance:	Life and AD&D insurance reduces by 35% at age 65, 60% at age 70 and 75% at age 75.
Continuation of Life insurance While totally disabled as defined by the Group Policy:	Total disability or totally disabled means your inability to do your job and any other job for which you may be fit by education, training or experience, due to injury or sickness. Please note that this benefit is only available after you have participated in the Basic Term Life Plan for 1 year and it is only available to the employee.
Seat Belt Benefit:	The Seat Belt Benefit is payable if an insured person dies as a result of injuries sustained in an accident while driving or riding in a private passenger car and wearing a properly fastened seat belt. In such case, his or her benefit can be increased by 10 percent of the Full Amount - but not less than $1,000.
Portability (included):	The option to continue term insurance under a different policy when coverage terminates. Minimums, maximums and other conditions apply.
Grief Counseling:	Grief Counseling is included with Basic Life at no additional cost to the employer or the employee.

VOLUNTARY TERM LIFE and AD&D

Life Insurance Amount:

Employee: Increments of $10,000 to a maximum of $500,000. Not to exceed eight times annual salary when combined with Basic Life Amount.
Spouse: Increments of $5,000 to a maximum of $100,000.
Child: $10,000
Note: Spouse Life amount cannot exceed 50% and Child Life amount cannot exceed 100% of employee's elected amount.

Guaranteed Issue Amounts
Employee (under 60)**: $100,000**
Spouse (under 60)**: $ 25,000**
Child: $ 10,000

No eligible individual may be covered more than once under this plan. If a person is covered as an employee, he/she cannot be covered as a spouse or dependent. If an employee and spouse are employed by the same employer, their eligible dependents may be insured as dependents of only one employee

Benefit Reduction Schedule:
No Age Reduction.

Continuation of Life insurance while totally disabled as defined by the Group Policy:
Total disability or totally disabled means your inability to do your job and any other job for which you may be fit by education, training or experience, due to injury or sickness. Please note that this benefit is only available after you have participated in the Basic Term Life Plan for 1 year and it is only available to the employee.

Portability (included):
The option to continue term insurance under a different policy when coverage terminates. Minimums, maximums and other conditions apply.

Accidental Death & Dismemberment (AD&D): Matches Life Amount
AD&D insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable. The benefit amount is equal to the life amount elected by you. Cost included in the rates below.

Table of Covered Losses for AD&D:

Covered Loss	Supplemental AD&D	Supplemental Dependent AD&D
Life	100%	100%
Hand	50%	50%
Foot	50%	50%
Arm	75%	75%
Leg	75%	75%
Sight of One Eye	50%	50%
Combination of a Hand, Foot, and/or Eye	100%	100%
Thumb & Index Finger on the Same Hand	25%	25%
Speech and Hearing	100%	100%
Paralysis of Both Arms and Both Legs	100%	100%
Brain Damage	100%	100%
*Maximum Amount payable for all Covered Losses sustained in one accident is caped at 100% of the Full Amount		

VOLUNTARY SUPPLEMENTAL TERM LIFE and AD&D

EMPLOYEE LIFE AND AD&D OPTIONS BI-WEEKLY DEDUCTIONS (26 / Year)									
AGE	**<35**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70+**
$10,000	$0.44	$0.50	$0.72	$1.00	$1.64	$2.70	$3.64	$3.64	$3.64
$20,000	$0.88	$1.01	$1.44	$2.00	$3.28	$5.40	$7.27	$7.27	$7.27
$30,000	$1.32	$1.51	$2.16	$3.00	$4.92	$8.10	$10.91	$10.91	$10.91
$40,000	$1.75	$2.01	$2.88	$4.01	$6.55	$10.80	$14.55	$14.55	$14.55
$50,000	$2.19	$2.52	$3.60	$5.01	$8.19	$13.50	$18.18	$18.18	$18.18
$60,000	$2.63	$3.02	$4.32	$6.01	$9.83	$16.20	$21.82	$21.82	$21.82
$70,000	$3.07	$3.52	$5.04	$7.01	$11.47	$18.90	$25.46	$25.46	$25.46
$80,000	$3.51	$4.02	$5.76	$8.01	$13.11	$21.60	$29.10	$29.10	$29.10
$90,000	$3.95	$4.53	$6.48	$9.01	$14.75	$24.30	$32.73	$32.73	$32.73
$100,000	$4.38	$5.03	$7.20	$10.02	$16.38	$27.00	$36.37	$36.37	$36.37
$110,000	$4.82	$5.53	$7.92	$11.02	$18.02	$29.70	$40.01	$40.01	$40.01
$120,000	$5.26	$6.04	$8.64	$12.02	$19.66	$32.40	$43.64	$43.64	$43.64
$130,000	$5.70	$6.54	$9.36	$13.02	$21.30	$35.10	$47.28	$47.28	$47.28
$140,000	$6.14	$7.04	$10.08	$14.02	$22.94	$37.80	$50.92	$50.92	$50.92
$150,000	$6.58	$7.55	$10.80	$15.02	$24.58	$40.50	$54.55	$54.55	$54.55
$200,000	$8.77	$10.06	$14.40	$20.03	$32.77	$54.00	$72.74	$72.74	$72.74

SPOUSE LIFE and AD&D OPTIONS BI-WEEKLY DEDUCTIONS (26 / Year) (Based on Spouse Age)									
AGE	**<35**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70+**
$5,000	$0.22	$0.25	$0.36	$0.50	$0.82	$1.35	$1.82	$1.82	$1.82
$10,000	$0.44	$0.50	$0.72	$1.00	$1.64	$2.70	$3.64	$3.64	$3.64
$15,000	$0.66	$0.75	$1.08	$1.50	$2.46	$4.05	$5.46	$5.46	$5.46
$20,000	$0.88	$1.01	$1.44	$2.00	$3.28	$5.40	$7.27	$7.27	$7.27
$25,000	$1.10	$1.26	$1.80	$2.50	$4.10	$6.75	$9.09	$9.09	$9.09
$30,000	$1.32	$1.51	$2.16	$3.00	$4.92	$8.10	$10.91	$10.91	$10.91
$35,000	$1.53	$1.76	$2.52	$3.51	$5.73	$9.45	$12.73	$12.73	$12.73
$40,000	$1.75	$2.01	$2.88	$4.01	$6.55	$10.80	$14.55	$14.55	$14.55
$45,000	$1.97	$2.26	$3.24	$4.51	$7.37	$12.15	$16.37	$16.37	$16.37
$50,000	$2.19	$2.52	$3.60	$5.01	$8.19	$13.50	$18.18	$18.18	$18.18
DEPENDENT LIFE and AD&D OPTIONS					**BI-WEEKLY DEDUCTIONS (26 / Year)**				
$10,000 - $1.01									

VOLUNTARY SHORT TERM DISABILITY

Below is a brief description of the Voluntary Short Term Disability insurance coverage. The summary highlights some of the features of the Policy, but it is not intended to be a detailed description of coverage. Certificates, which will be provided at a later date, will contain more detailed information, including the full text of the definitions, exclusions, limitations, reductions and terminating events that apply to the Policy. Only the Master Policy contains all the controlling terms and provisions of coverage.

Short Term Disability insurance is designed to pay you a percentage of your salary or regular earnings if you are absent from work due to an off the job accident or illness.

- **Eligibility**
  All Active Full-Time Employees working 30 hours or more per week.
- **Benefits**
  Plan replaces **50%** of your Basic Weekly Earnings **up to a maximum weekly benefit of $1,000.**
- **Benefit Waiting Period**
  14 Days for Injury; 14 Days for Illness
- **Maximum Benefit Duration**
  90 Days
- **Pre-Existing Condition Limit**
  Last Entrant - 60-day benefit waiting period for sickness or pregnancy during their first 12 months in the plan.
- **Occupational Benefits are excluded**
- **Maternity coverage same as any other disability**

How to Calculate Your Individual Premium
To calculate your per-paycheck cost for this coverage, complete the calculations below. **Note:** *If your weekly salary exceeds $2,000.00, use $2,000.00 as your weekly salary in the calculation.*

_____ ÷ 52 = _____ X _____50%_____ = _____
Annual Salary | Weekly Salary | Benefit% | Your Weekly Benefit

_____ ÷ 10 = _____ X ____$0.356____ = _____
Your Weekly Benefit | **AGE RATE** | Your Monthly Cost

_____ X 12 = _____ ÷ _____26_____ = _____
Your Monthly Cost | Annual Cost | # Paychecks per Year | **Cost per Paycheck***

*Final Cost may vary slightly due to rounding.

VOLUNTARY LONG TERM DISABILITY

Long Term Disability Insurance is designed to provide income protection in the form of a monthly benefit during periods of disability occurring as a result of a covered accident or sickness. Coverage is not to provide direct payment for basic hospital, basic medical-surgical or major medical expenses. Instead, approved payments are made directly to you when you are not able to work. Disability means that, during an own-occupational period, an employee is unable to perform all material and substantial duties of his or her regular occupation, which results in at least a 20 percent loss in pre-disability earnings. During an any-occupational period, an employee is unable to perform the material and substantial duties of any gainful occupation, which results in at least a 40 percent loss in pre-disability earnings. The employee must also be receiving regular care from a physician for the illness or injury. Pregnancy or complications of pregnancy are covered the same as an illness.

- **Eligibility**
  All active full time employees working 30 or more hours per week

- **Benefit Amount**
  50% of your basic monthly income (Max. - $4,000). The benefit amount is the payment an employee will receive should he or she become disabled as provided under the policy. The monthly benefit is reduced by any deductible income the employee receives or is eligible to receive as part of the disability.

- **Elimination Period**
  90 days. The elimination period is how long an employee must be disabled before benefits begin.

- **Pre-Existing Conditions**
  An illness or injury for which an ordinarily prudent person would have received treatment within 3 months prior to the employee's effective date is considered a pre-existing condition within the first 12 months after the insured employee's effective date.

HOW TO CALCULATE YOUR INDIVIDUAL PREMIUM

To calculate your per-paycheck cost for this coverage, complete the calculations below.

_____ ÷ 100 = _____ X _____ = _____
Annual Salary — **AGE RATE** (Use Table Below) — Annual Cost

_____ ÷ 26 = _____
Annual Cost — # Paychecks per Year — **Cost per Paycheck***

AGE RATES							
Under 35	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65 +**
$0.120	**$0.240**	**$0.350**	**$0.630**	**$0.870**	**$1.000**	**$1.000**	**$0.730**

FSA Overview

Harris County offers a Flexible Spending Account (FSA) administered through Admin America. The FSA plan year is from July 1 to June 30.

If an employee or family member(s) has predictable health care expenses, then the employee may benefit from participating in an FSA. An FSA allows an employee to set aside money from the employee's paycheck for reimbursement of health care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from the employee's paycheck and deposited into the FSA. During the year, the employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. A participating employee must re-elect the dollar amount to be deducted each plan year.

Health Care FSA

This account allows participant to set aside up to an annual maximum of $3,050 (minimum: $260). This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. A participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

Please Note: The entire Health Care FSA election is available for use on the first day coverage is effective.

A sample list of qualified expenses eligible for reimbursement include, but not limited to, the following:

- ✓ Ambulance
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees
- ✓ Diagnostic Tests/Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees
- ✓ Prescription Drugs
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

Admin America

Important Rules

You will be allowed to carry over up to $610 of your account balance (unused funds) into the next plan year. The IRS requires that any unused portion of your account balance above $610 remaining at the end of the year be forfeited. It is important to estimate your expenses carefully. The "run out period" after the end of the plan year to submit all expenses incurred during the preceding year is decided by your employer. If you were enrolled in an FSA and would like to continue that election, you must re-enroll every year. Be sure to retain documentation from the provider should substantiation of your claim be required.

Additional FSA Information

Here's How it Works

Estimate how much money you will spend in the coming year for eligible healthcare expenses. Once calculated, the FSA allows you to set aside a portion from your check each payday *(example: if you elect $650 annual then your employer will deduct $25 out of each pay check the entire year for 26 pay periods)*. The amount you allocate to your account is taken out of your pay before taxes are calculated and withheld, meaning the FSA is tax-free. You will then receive a debit card that will be loaded with the entire annual amount you have elected. You are then eligible to use the card to pay for health care expenses during the year. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. AdminAmerica may request supporting documentation for expenses paid with a debit card. This card will not expire at the end of the benefit year. Please keep the issued card for use next year.

Rollover Feature

With our FSA, you may rollover up to $610 of unused money from one plan year to the next if you continue to participate.

Runout Period

You may file for a reimbursement on a qualified unpaid FSA expense even after the plan year has ended but must do so within 90 days (this means you have until September 30th to file for a reimbursement). As an example, if you had a charge in June that was eligible for reimbursement (where you did not use your debit card) you can request for a reimbursement out of your account by completing a paper FSA claim form but would need to do so by September 30th. Forms can be provided by contacting MSI Benefits Group or Human Resources.

More Convenience

› **Your FSA account is integrated with your benefit** information, so it's easy to manage both in one convenient place: **www.adminamerica.com**.
› **Use your health care debit card for immediate access** to your FSA funds.
› **You can also submit your FSA reimbursement claims** with our simple-to-use online claim form.
› **Monitor your account from almost anywhere with** the AdminAmerica Mobile App. *
› **You'll have immediate access to all the money in your** FSA account from the first day.

Changing Your Election

- You can change your election once a year during the open enrollment period.
- It is important to know that federal law places restrictions on changing your election at other times during the year. For this reason, if you participate in the program, you are generally not allowed to change or cancel the amount you allocate until the next annual enrollment period.
- The events that might permit you to make a change are: Family status changes, including your marriage or divorce, the birth or adoption of a child, or the death of your spouse or dependent.

Note: Keep in mind that the only requirement is that the change you make must be consistent with the particular event that has occurred.

HARRIS COUNTY HEALTH PLAN

Introduction

You are receiving this notice because you have recently become eligible for the Harris County health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan**,** qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child"

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice **in writing** to: **Harris County Commissioners Office, Kris Summerall, P.O. Box 365, Hamilton, GA 31811.**

CONTINUATION COVERAGE RIGHTS UNDER COBRA

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Information about the plan and COBRA continuation coverage can be obtained on request from:

Harris County Commissioners
Kris Summerall
P.O. Box 365
Hamilton, GA 31811
Phone: 706-628-4958

IMPORTANT CONTACT INFORMATION

HARRIS COUNTY
Kris Summerall
Payroll and Benefits Specialist
Tel: 706-628-4958
ksummerall@harriscountyga.gov

MEDICAL / DENTAL / VISION PLANS
Cigna
Tel: 866-494-2111
www.mycigna.com

LIFE INSURANCE
The Standard
Phone: (800) 628-8600
www.standard.com

SHORT TERM / LONG TERM DISABILITY
The Standard
STD Phone: (800) 368-2859
LTD Phone: (800) 368-1135
www.standard.com

FLEXIBLE SPENDING ACCOUNT (FSA)
Admin America
Tel: 800-366-2961
www.adminamerica.com

EMPLOYEE ASSISTANCE PROGRAM
The Standard
Phone: (888) 293-6948
www.standard.com

MSI BENEFITS GROUP, INC.
Administrative Contact
Tel: 800-580-1629 / 770-425-1231
Fax: 800-580-2675 / 770-425-4722
Email: helpme@msibg.com
www.msibg.com

To view copies of all certificates of coverage and plan documents go to:
www.msibg.com

Click on “Client Portal” at the top right of page
Username: **harrisEE**
Password: **Benefits123**

MSI Benefits Group
245 TownPark Drive, Suite 100
Kennesaw, GA 30144
Tel: 800-580-1629 / 770-425-1231
Fax: 800-580-2675 / 770-425-4722
www.msibg.com