

Travis County

Employee Benefits Guide

FY 17

October 1, 2016 – September 30, 2017

Important Information About Your Benefits

Medical – Dental – Vision – Life Insurance – Disability – FSA – Wellness – Retirement

July 29, 2016

Benefits Participants,

Welcome to the 2017 Employee Benefits Guide! As a Travis County employee, you have access to a comprehensive benefits package, which includes health and welfare plans, retirement plans, wellness initiatives and paid time off.

This 2017 Employee Benefits Guide provides information about your benefits in easy to understand terms. It includes a summary of some of the benefits offered to you and your family including: health insurance, dental insurance, vision insurance, life insurance, short-term disability insurance, and flexible spending accounts. I am confident you will find this Benefits Guide useful in helping you to make informed decisions about benefits for yourself and your family.

Travis County is committed to maintaining a comprehensive and competitive benefits program. In turn, we ask you to take a proactive approach in using this guide to enhance your understanding of the available benefits options, in choosing the plans that make the most sense for you and using benefit plans to maximum advantage.

This guide is not intended to replace or override the policies and plan documents which govern the various benefit plans. The descriptions are very general and are not intended to provide complete details about any or all plans. Exact specifications for all plans are provided in the official Plan Documents, copies of which are available on Travis Central or by contacting the Human Resources Management Department. If benefit(s) change over the course of the fiscal year, this Benefits Guide will be updated in the on-line version which you can access on Travis Central.

If you have questions or need more information about any of your Travis County benefits please contact the Human Resources Management Department at 512.854.0404. We are here for you!

Shannon M. Steele
Benefits Manager
Human Resources Management Department

INTRODUCTION

This guide is designed to help you understand and utilize the benefit options available to you as an employee of Travis County and provide you with the information needed to select and manage your benefit elections for the 2017 benefit plan year. In this valuable resource guide you will find benefit summaries, eligibility requirements, costs, contact numbers and addresses as well as other general information.

HOW TO USE THIS GUIDE

The benefit guide is divided into sections, each covering a specific benefit program. It is very important that you review this guide so you can fully understand the benefit programs available to you and your family. This guide can be used to help make your benefit elections during your initial enrollment, consider benefit changes during the benefit plan year as well as a resource for considering upcoming benefit changes during Open Enrollment. Along with this guide the Human Resources Management Department has also posted benefit related information on Travis County intranet web site (<http://traviscentral>).

The information in this guide is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace any legal plan documents or contracts which contain the complete provisions of a program. In case of any discrepancy between this guide and the legal plan document or contract, the legal plan document or contract will govern in all cases. An employee may review the legal plan document or contract upon request.

KEY PLAN CHANGES AND ENHANCEMENTS FOR FY 17

Travis County Health Plans Changes:

- Reduced specialty office visit copay amount for using UHC Designated Tier 1 Specialists.
 - EPO and PPO will pay primary copay amount, and Consumer Choice is deductible/coinsurance.
- Outpatient Lab and X-Ray payment will depend on network status of Lab or Radiology provider.
- Laparoscopic surgeries will now be paid as any other surgery, with the exception of
 - Colonoscopies: both diagnostic and therapeutic (still paid at 100%)
 - Endoscopies: still paid at 100%
 - Mammograms: both diagnostic and therapeutic (still paid at 100%)
- Medical Necessity Review: All elective surgeries will now be reviewed by UHC for medical necessity prior to the procedure. Provider is responsible for submitting for review. No penalty to patient.
- Elimination of fourth quarter deductible carryover for the Consumer Choice Plan.

UHC Plan Enhancements:

- Spine and Joint Solutions
- Cancer Support Program
- Real Appeal
- Virtual Visits

Travis County Dental, Vision, Life, and Disability Plans

- No plan or rate changes for FY17.

Flexible Spending Account

- The FSA maximum contribution will continue at \$2550 annually.

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BENEFIT CONTACT INFORMATION

Travis County Human Resources Management Department

700 Lavaca Street, Suite 420
Austin, TX 78701

Benefit Line 512.854.0404
Main HR Line 512.854.9165
Benefit Fax Line 512.854.6677

Online Benefit Information: <http://traviscentral>
Contact the plans directly during normal business hours for:
ID cards, claims, benefits, or coverage information

<http://www.deeroaks.com>

Travis County Health Insurance Plans

Administered by: United Healthcare
Group #: 701254
P.O. Box 30555
Salt Lake City, UT 84130-0555
866.649.4873 (Members)
877.365.7949 (Nurseline)
877.237.8576 (Retiree Billing Questions)
<http://www.myuhc.com>

Travis County Employee Health Clinic

Downtown Clinic - 512.854.5509
Airport Blvd Clinic - 512.854.7998
Del Valle Clinic - 512.854.1282

Travis County CARE Program

512.854.CARE (2273)
careprogram@traviscountytexas.gov

Pharmacy Benefit Manager

Administered by: EnvisionRx
2181 East Aurora Road Suite 201
Twinsburg, OH 44087
800.361.4542
800.607.6861 (Costco mail order)
866.443.0060 (Costco specialty)
<https://www.envisionrx.com>

Vision Insurance

Administered by: Davis Vision
800.999.5431
<http://www.davisvision.com>

Dental Insurance Plans

Administered by: Assurant Dental
Group #: 5451628
P.O. Box 2940
Clinton, IA 52733-2940
877.743.1454
<http://www.assurantemployeebenefits.com>

Employee Assistance Program

Administered by: Deer Oaks EAP -
866.327.2400

Flexible Spending Accounts

Administered by: TASC
2302 International Lane
Madison, WI 53704-3140
800.422.4661
608.245.3623 (Fax)
<http://www.tasconline.com>

Basic Life Insurance

Administered by: United Healthcare
Group Policy #: 304781

Supplemental Life, Disability and AD&D

Administered by: Cigna
1601 Chestnut Street
Philadelphia, PA 19192
800.36.Cigna (800.362.4462)
<http://www.Cigna.com>

Texas County & District Retirement System (TCDRS)

P.O. Box 2034
Austin, TX 78768-2034
800.823.7782 or 512.328.8889
<http://www.tcdrs.org>

Deferred Compensation Plan 457(b)

Administered by: Empower Retirement
(formerly Great West Financial)
Moody Bank Building
400 W 15th Street # 317
Austin, TX 78701-1641
800.701.8255
866.613.6189
<http://www.empower-retirement.com>

Local Empower Retirement Representative

Chara Green
512.739.9987
chara.green@empower-retirement.com

EMPLOYEE ELIGIBILITY

As a Travis County employee, benefits are available to you based on your employment status. The following benefits are available to County employees;

Regular Employee

If you are in a regular budgeted position scheduled to work 30 hours or more per week you are considered eligible to participate in:

- Travis County Health Insurance
 - Includes Employee Health Clinic
- Dental Insurance
- Vision Insurance
- County Retirement Program through TCDRS (mandatory enrollment)
- Basic Life and AD&D Insurance
- Supplemental Life and AD&D Insurance
- Supplemental Dependent Life Insurance
- Supplemental Spouse Life Insurance
- Cigna Personal Accident Insurance
- Flexible Spending Accounts (Medical & Dependent Care)
- Long Term Disability
- Short Term Disability
- Deferred Compensation Plan 457(b)
- Employee Assistance Plan (EAP)
- Travis County Wellness Program
- Qualified Transportation Benefit
- Worker's Compensation
- Long Term Care Insurance

Temporary Employee

If you are a temporary employee with an assignment 6 months or longer or a regular employee scheduled to work less than 30 hours per week, you are considered eligible to participate in:

- County Retirement Program through TCDRS (mandatory enrollment)
- Worker's Compensation

Temporary employees may be eligible for health, dental and vision benefits if working an average of 30 hours per week or more. Eligibility and enrollment dates will be determined using the measurement, administrative and stability periods in accordance with 26 Code of Federal Regulations Part 54.4980H. Travis County has elected to utilize a 12 month look back period in determining eligibility and enrollment dates.

DEPENDENT ELIGIBILITY

Legal Spouse

Defined as a spouse who is legally married to the employee. This includes the eligible surviving legal spouse of a deceased Travis County retiree. An Employee may only cover one adult as a dependent.

Common Law Spouse

Defined as a spouse of the opposite sex who has provided a copy of a completed and filed Declaration and Registration of an Informal Marriage for the State of Texas. This includes the eligible surviving legal spouse of a deceased Travis County retiree. An Employee may only cover one adult as a dependent.

Domestic Partner (same or opposite sex) of an eligible employee

Defined as a person who shares the same permanent residence and the common necessities of life; and has provided the Plan Sponsor with a completed Certificate of Domestic Partnership form that includes the names and any required information for any unmarried eligible children of the domestic partner for whom coverage is sought. A Domestic Partner or a Domestic Partner's child is not eligible for COBRA. An Employee may only cover one adult as a dependent.

Sponsored Dependent of an Eligible Employee

Defined for the purposes of this plan as:

Related by blood to the employee (such as over-age dependent child, or an unmarried parent of employee) and

- Is at least 18 years old; and
- Is unmarried by either formal marriage or common law; and

- Is not related to the eligible employee by marriage; and
- Is not employed by Travis County or the eligible employee; and
- Is not in active service in the armed forces; and
- Has been living with the eligible employee for at least six consecutive months, before applying for coverage, and
- Is currently living with the eligible employee; and
- Shares the same permanent residence and the common necessities of life ; and
- Completion of Sponsored Dependent form

A Sponsored Dependent is not eligible for COBRA. An Employee may only cover one other adult as a dependent.

Child of Eligible Employee/Spouse/Domestic Partner

Child includes any of the following:

- A natural child (child of the employee);
- A legally adopted child or a child placed in the home for adoption;
- Any other child who is mainly dependent on the employee for care and support and for whom a completed guardianship document has been obtained;
- A child for whom the employee/spouse/Domestic Partner is the legal guardian;
- A child for whom the employee /spouse/Domestic Partner is required by a qualified medical child support order (QMCSO) or court order to provide coverage.

Children can be covered from birth through their 26th birthday. Qualifying disabled children are allowed to be covered at any age. Please see the Summary Plan Document for the complete list of eligible dependents.

DEPENDENT DOCUMENTATION

The addition of any dependent to the Travis County Health Plan requires certification by Employee that the dependent information is true and correct. Any false information may result in loss of coverage of the dependent in question and the requirement to reimburse the plan for any claims paid on an ineligible dependent. The following are the documentation requirements for each category of dependent. The documentation must be presented before enrollment.

- Spouse (formal ceremony): Marriage certificate
- Spouse (common-law): Copy of filed Declaration and Registration of Informal Marriage
- Domestic Partner (same or opposite sex): Birth Certificate or Driver’s License and Completion of Certificate of Domestic Partnership affidavit form
- Child (natural child of Participant): Birth Certificate
- Child (natural child of Participant’s spouse): Birth Certificate and Marriage Certificate.
- Child (natural child of Participant’s Domestic Partner): Completion of the Certificate of Domestic Partnership and Birth Certificate
- Child (legal adoption): Final order of adoption showing Participant as child’s parent
- Child (legally adopted child of Participant’s Spouse): Final order of adoption showing Participant’s Spouse as child’s parent and Marriage Certificate or Declaration and Registration of Informal Marriage for Participant and Spouse
- Child (legally adopted child of Participant’s Domestic Partner): Final order of adoption of child showing participant’s domestic partner as child’s parent and completion of Certificate of Domestic Partnership
- Sponsored Dependent: Birth Certificate(s) verifying relationship and age and completion of online Certificate of Sponsored Dependent
- Child with Handicap or Disability: Supporting medical documentation

ENROLLMENT

The Travis County Benefit Plan Year begins on October 1st of each year and continues through September 30th of the following calendar year. As an employee you are allowed to make elections and/or changes only during certain enrollment periods. Your first opportunity to enroll in benefit coverage is during your Initial Enrollment period which begins on your date of hire and lasts for 30 days. Once you are past your Initial Enrollment period you can enroll or make changes only if you have an approved Qualified Life Event (QLE) or during Open Enrollment. Please review the additional information in the following sections regarding the enrollment periods.

Initial Enrollment

As a new employee of Travis County, employees will be eligible for most group insurance benefits on the first of the month following 30 days of benefit-eligible employment. New employees will be given an initial enrollment period of 30 days after their hire or eligibility date to make benefit elections for the remaining of the benefit plan year. During this time employees are allowed to make, add, delete or change benefit elections. Any requests for enrollment in benefits or changes to benefit elections made after the 30 day initial enrollment period or outside of the Open Enrollment period, must follow IRS Qualifying Event and/or HIPAA Special Enrollment rules.

Enrollment will be conducted through the Employee Self-service website in SAP (SAP ESS). The following benefits are available to new eligible employees on the first of the month following 30 days of employment:

- Travis County Health Insurance
- Dental Insurance
- Vision Insurance
- Basic Life and AD&D Insurance
- Supplemental Life and AD&D Insurance
- Supplemental Dependent Life Insurance
- Supplemental Spouse/Domestic Partner Life Insurance
- Personal Accident Insurance
- Flexible Spending Accounts (Medical & Dependent Care)
- Short and Long Term Disability

Eligible employees will be automatically enrolled in the County's retirement benefit. For eligibility and enrollment requirements for the other available benefit programs listed in this guide please view the related section.

Open Enrollment

Travis County offers benefit eligible employees an Open Enrollment period each year to review their current benefits and make elections for the upcoming benefit plan year. Since the benefit plan year starts the October 1st of each year the Human Resources Management Department will typically conduct Open Enrollment in the month of August. During Open Enrollment you are allowed to add, remove or change the following benefits:

- Travis County Health Insurance
- Dental Insurance
- Vision Insurance
- Basic Life and AD&D Insurance
- Supplemental Life and AD&D Insurance
- Supplemental Dependent Life Insurance
- Supplemental Spouse/Domestic Partner Life Insurance
- Personal Accident Insurance
- Long and Short Term Disability
- Flexible Spending Accounts (Medical & Dependent Care)

Changes to life insurance beneficiaries and participation in the 457(b) Deferred Compensation plan may be changed at any time during the year. Open Enrollment for Long Term Care insurance is February 1st of each year and new employees are allowed to enroll in guaranteed issued amounts. Outside of Open Enrollment, employees may enroll in Long Term Care Insurance at any time if an Evidence of Insurability is completed and approved by the carrier.

Adjust Before Taxes (ABT)

IRS Section 125 guidelines allow you to enroll in a Health, Dental, and/or Vision plan and have your premiums Adjusted Before Taxes (ABT). Choosing ABT during your insurance enrollment period means your salary is reduced by an amount equal to the employee contribution for your health, dental and/or vision coverage you have selected and in exchange the County agrees to make these contributions for you. Therefore, your taxable income is decreased by the amount of your contribution for premiums. ABT applies only to contributions for premiums for Health, Dental, and Vision. Domestic partners and sponsored dependent premiums are not eligible for ABT unless they are qualified tax dependents. By choosing ABT, your ability to make certain changes to your benefit elections during the plan year must be in accordance with the IRS Qualifying Life Event guidelines as described in the next section.

Benefit Changes During the Plan Year

The IRS requires that benefits paid with pre-tax contributions stay in effect through the full plan year. Therefore, once made, you cannot change your election unless you have a Qualifying Life Event (QLE). A complete list of what the IRS considers a qualifying event is listed in your SPD, but in general, they include:

- Changes in your marital status: marriage, divorce, annulment, or death of spouse
- Changes in dependent status: birth, adoption, placement for adoption, death, or dependent eligibility status due to age or marriage
- Changes in your employment status or work schedule that affects your benefits eligibility
- Changes in your spouse's benefits coverage or eligibility
- Changes in a permanent residence that result in different available plan options.

Note that any change in coverage must be consistent with the life status change. You have 31 days from the qualifying event to change your coverage election.

The Special Enrollment Rights under HIPAA allows for mid-year enrollment if you decline enrollment now because of other health insurance or group health plan coverage and then you and your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your other coverage). In addition, if you have a new dependent (as a result of marriage, birth, adoption or placement for adoption) you may be able to enroll yourself and your dependents.

You must request special enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you experience a Qualifying Life Event please consult with the Human Resources Management Department within 31 days to determine whether or not the life event you are experiencing qualifies under the regulations for the effective date, for the change and for the documentation required to process the change.

For changes in eligibility of Medicaid or State CHIP coverage, you have 60 days from the event to notify the Human Resources Management Department.

You may only make changes to your Health, Dental, Vision, Dependent Life, Spouse Life and/or Flexible Spending Account(s) benefit elections during the benefit plan year if you experience a Qualified Life Event (QLE).

EMPLOYEE / RETIREE PREMIUMS

Health Plan Premiums

Active Employee **Monthly Premiums**

	Emp only	Emp+1 Adult	Emp+1 Child	Emp+ Children	Emp+adult +Child	Emp+adult +Children
EPO	\$129.00	\$607.00	\$280.00	\$483.00	\$836.00	\$1,055.00
PPO	\$26.00	\$300.00	\$89.00	\$208.00	\$444.00	\$579.00
Consumer Choice	\$0.00	\$202.00	\$28.00	\$122.00	\$315.00	\$426.00

Active Employee **Per Pay-Period Premiums**

	Emp only	Emp+1 Adult	Emp+1 Child	Emp+ Children	Emp+adult +Child	Emp+adult +Children
EPO	\$64.50	\$303.50	\$140.00	\$241.50	\$418.00	\$527.50
PPO	\$13.00	\$150.00	\$44.50	\$104.00	\$222.00	\$289.50
Consumer Choice	\$0.00	\$101.00	\$14.00	\$61.00	\$157.50	\$213.00

Retiree (Under 65) **Monthly Premiums**

	Emp only	Emp+ 1 Adult	Emp + 1 Child	Emp+ Children	Emp+adult +Child	Emp+adult +Children
EPO	\$451.00	\$1019.00	\$592.00	\$803.00	\$1304.00	\$1660.00
PPO	\$270.00	\$620.00	\$337.00	\$457.00	\$831.00	\$1096.00
Consumer Choice	\$152.00	\$434.00	\$195.00	\$287.00	\$620.00	\$855.00

Retiree (Age 65 and Over or Medicare Primary) **Monthly Premiums**

	Emp only	Emp+ 1 Adult	Emp + 1 Child	Emp+ Children	Emp+adult +Child	Emp+adult +Children
EPO	\$186.00	\$326.00	\$291.00	\$457.00	\$489.00	\$653.00
PPO	\$83.00	\$171.00	\$149.00	\$268.00	\$293.00	\$414.00
Consumer Choice	\$48.00	\$122.00	\$101.00	\$208.00	\$231.00	\$337.00
Pharmacy Only Plan	\$39.00	\$80.00				

Imputed Income of Health Plan Premiums

Travis County Health Plan provisions allow County employees to enroll and cover a domestic partner, a child of domestic partner, a grandchild and/or a sponsored adult to their health coverage. Both employees and Travis County contribute to the cost of adding these dependents to the Health Plan.

While the Travis County Health Plan allows these persons on the plan, for federal income tax purposes, providing group health care benefits to a non-IRS-qualified domestic partner, sponsored adult, grandchild and/or child of domestic partner is taxable to the employee, requiring the employer to impute income reflecting the value of the contribution that the employer makes on behalf of these covered person(s). In addition, the payroll deduction contribution that you make to cover your non-IRS-qualified domestic partner, grandchild, sponsored adult and/or your domestic partner's child(ren) is a post-tax deduction.

The Fair Market Value is the amount the County contributes for coverage towards a non-IRS-qualified dependent. For example, if the County contributes \$1,187 per month for Employee + Adult coverage and contributes \$701 for Employee Only coverage then the imputed income amount for the other adult is \$486 per month. This is considered to be the County contribution made for the other adult coverage. Below are the monthly imputed income amounts for Fiscal Year 17.

Covered Dependent	FY17 Monthly Amount	FY17 Per Pay-Period Amount
Non-Qualified Adult (Dom Partner, Sponsored Adult)	\$486.00	\$243.00
Non-Qualified Child (Child of Dom Partner, Grandchild)	\$171.00	\$85.50
Non-Qualified Children (2 or more Children of Dom Partner, Grandchildren)	\$426.00	\$213.00

Dental Plan Premiums

The below premiums are shown on a monthly and per pay period basis and are for both Actives and Retirees.

Monthly Premiums

	Assurant DHMO Plan	Assurant Base PPO Plan	Assurant High PPO Plan
Emp Only Premium	\$11.98	\$20.76	\$32.46
Emp + 1 Adult Premium	\$19.26	\$39.48	\$64.88
Emp + 1 Child Premium	\$19.26	\$39.48	\$64.88
Emp + 2 or more Children Premium	\$25.84	\$65.02	\$101.50
Emp +1 Adult + 1 Child Premium	\$25.84	\$65.02	\$101.50
Emp + 1 Adult + 2 or more Children Premium	\$30.22	\$83.76	\$133.96

Per Pay-Period Premiums

	Assurant DHMO Plan	Assurant Base PPO Plan	Assurant High PPO Plan
Emp Only Premium	\$5.99	\$10.38	\$16.23
Emp + 1 Adult Premium	\$9.63	\$19.74	\$32.44
Emp + 1 Child Premium	\$9.63	\$19.74	\$32.44
Emp + 2 or more Children Premium	\$12.92	\$32.51	\$50.75
Emp +1 Adult + 1 Child Premium	\$12.92	\$32.51	\$50.75
Emp + 1 Adult + 2 or more Children Premium	\$15.11	\$41.88	\$66.98

Vision Premium Rates

The below premiums are shown on a monthly and per pay-period basis and are for both Actives and Retirees.

Coverage Level	Monthly Premium	Per Pay-Period Premium
Emp Only	\$4.26	\$2.13
Emp + 1 Adult	\$8.10	\$4.05
Emp + 1 Child	\$8.10	\$4.05
Emp + 2 or more Children	\$8.96	\$4.48
Emp +1 Adult + 1 Child	\$9.60	\$4.80
Emp + 1 Adult + 2 or more Children	\$12.38	\$6.19

TRAVIS COUNTY HEALTH INSURANCE

Travis County offers all Regular Employees and Retirees a choice of three self-insured Health Insurance Plans. The three plans are administered by United Healthcare and have varying levels of coverage and premium costs. Below are some key terms that will help you understand the coverage levels described in the following sections.

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 accessed. Copays are applied to the plan year out-of-pocket maximum.

Coinsurance - Coinsurance is the percentage of covered expenses paid by you each year after you meet your deductible (20% coinsurance means that you pay 20% of the expenses). Coinsurance amounts paid apply to the out of pocket maximum.

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. The deductible paid amounts apply to the out of pocket maximum.

Open Access - An Open Access plan allows participants to see a Specialist without a referral from their Primary Care Physician. All three Health plan options are considered Open Access.

Please review the following coverage information to determine which plan may offer the best level of coverage for you and your family.

Exclusive Provider Organization – EPO Plan (In–Network Only)

This plan has the highest monthly premium for employees and retirees and covers only in-network services. This plan has copays for most services including inpatient hospital, office visits and emergency room. The plan will cover 100% of charges once the deductible and copay has been made.

Preferred Provider Organization – PPO Plan (In– and Out–of–Network)

This plan offers both in-network and out-of-network coverage. It is important to understand that while you can access care from any doctor, if you use an UHC Choice Plus PPO network doctor your benefit will be much greater and your out-of-pocket will be much less. The in-network deductible is the same as the EPO and Consumer Choice plans. The office visit copays are \$10 less than the EPO plan.

Consumer Choice Plan (In– and Out–of–Network)

This plan has the lowest monthly premiums of the three plans. This plan is different in that all medical services are covered at the deductible and Coinsurance level, including primary care and specialist office visits. The deductible does not apply to prescription pharmacy benefits, which have copays. Members have the option of reducing their out-of-pocket expenses by researching differences in costs by facility or provider. The out-of-pocket maximum on this plan is the same as the EPO and PPO plan.

Do you Know The Right Questions to Ask Your Doctor?

- 1. What is the test for?*
- 2. How many times have you done this procedure?*
- 3. When will I get the results?*
- 4. Why do I need this treatment?*
- 5. Are there any alternatives?*
- 6. What are the possible complications?*
- 7. Which hospital is best for my needs?*
- 8. How do you spell the name of that drug?*
- 9. Are there any side effects?*
- 10. Will this medicine interact with medicines that I'm already taking?*

For these and other recommended questions please visit

<http://www.ahrq.gov/questionsaretheanswer/questionBuilder.aspx>

Travis County Health Plan Comparison

	EPO Plan <i>In-Network Only</i>	PPO Plan <i>In- and Out-of-Network</i>	Consumer Choice <i>In- and Out-of-Network</i>
Deductible	\$500/individual, each person on the plan is subject to a separate \$500 deductible, up to the out-of-pocket maximum	\$500/ individual \$1,250 Family	\$500/individual \$1,250 Family
Out-of-Network Deductible	Not Covered	\$1,500/ individual \$3,750/family	\$1,500/ individual \$3,750/family
Coinsurance	Plan Pays 100% Member Pays 0%	Plan Pays 85% Member Pays 15%	Plan Pays 80% Member Pays 20%
Out-of-Network Coinsurance	Not Covered	Plan Pays 60% Member Pays 40%	Plan Pays 60% Member Pays 40%
Medical Out-of-Pocket Maximum	\$3,500 Individual \$7,000 Family	\$3,500 Individual \$7,000 Family	\$3,500 Individual \$7,000 Family
Out-of-Network Medical Out-of-Pocket Maximum	Not covered	\$5,000 Individual \$10,000 Family	\$10,000 Individual
Pharmacy Out-of-Pocket Maximum	\$2,500 Individual \$5,000 Family	\$2,500 Individual \$5,000 Family	\$2,500 Individual \$5,000 Family
1. Acupuncture (In Network licensed Acupuncturist only) (limited coverage, consult SPD for complete coverage description)	\$35 per visit - PCP \$50 per visit - Specialist	\$25 per visit - PCP \$40 per visit - Specialist Out-of-Network Deductible & Coinsurance	Deductible & Coinsurance
2. Allergy Services in a Physician's Office (no copay applies to injections or serum)	\$35 per visit - PCP (All Allergists are considered as primary care)	\$25 per visit - PCP (All Allergists are considered as primary care) Out-of-Network Deductible & Coinsurance	Deductible & Coinsurance
3. Ambulance Services – Emergency only Ground transportation or Air Transportation	\$100 Copay	\$100 Copay	Deductible & Coinsurance
4. Chiropractic Services Limit of 3 treatments per visit and 25 visits per calendar year.	\$35 per visit - PCP (All Chiropractors are considered as primary care)	\$25 per visit - PCP (All Chiropractors are considered primary care) Out-of-Network Deductible & Coinsurance	Deductible & Coinsurance
5. Dental Services – Accident related only *Prior notification is required before follow-up treatment begins.	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance

	EPO Plan <i>In-Network Only</i>	PPO Plan <i>In- and Out-of-Network</i>	Consumer Choice <i>In- and Out-of-Network</i>
6. Diabetic Supplies	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0% <u>Out-of-Network</u> Deductible & Coinsurance	Plan Pays 100% Member Pays 0% <u>Out-of-Network</u> Deductible & Coinsurance
7. Durable Medical Equipment *Prior notification is required for retail cost over \$1,000.	*Plan Pays 100% Member Pays 0%	*Plan Pays 100% Member Pays 0% <u>Out-of-Network</u> Deductible & Coinsurance	*Plan Pays 100% Member Pays 0% <u>Out-of-Network</u> Deductible & Coinsurance
8. Emergency Services, applies to both Hospital or Stand-alone ER	\$200 per visit, waived if admitted to hospital	\$200 per visit, waived if admitted to hospital	Deductible & Coinsurance
9. Employee Health Clinic (for ages 10 and over)	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%
10. Eye Examinations Refractive eye examinations are limited to one every calendar year from a Network Provider	\$35 per visit - PCP \$50 per visit - Specialist No benefit for lenses or frames	\$25 per visit - PCP \$40 per visit - Specialist No benefit for lenses or frames <u>Out-of-Network</u> Deductible & Coinsurance	Deductible & Coinsurance No benefit for lenses or frames <u>Out-of-Network</u> Deductible & Coinsurance
11. Hearing Aid Benefit	\$1000 every 3 years	\$1000 every 3 years	\$1000 every 3 years
12. Home Health Care Services provided in the home by an RN, LPN or contracted therapist *Prior notification is required	* Plan Pays 100% Member Pays 0%	* Plan Pays 100% Member Pays 0% <u>Out-of-Network</u> Deductible & Coinsurance	* Plan Pays 100% Member Pays 0% <u>Out-of-Network</u> Deductible & Coinsurance
13. Hospice Care *Prior notification is required	* Plan Pays 100% Member Pays 0%	* Plan Pays 100% Member Pays 0% <u>Out-of-Network</u> Deductible & Coinsurance	* Plan Pays 100% Member Pays 0% <u>Out-of-Network</u> Deductible & Coinsurance
14. Hospital – Inpatient Stay	\$1,000 copay, then Deductible (each hospital visit has a new copay)	Deductible & Coinsurance <u>Out-of-Network</u> Deductible & Coinsurance	Deductible & Coinsurance <u>Out-of-Network</u> Deductible & Coinsurance
15. Maternity Services *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery	Same as 14, 18 & 20 No Copay applies to Physician office visits for prenatal care after the first visit.	Same as 14, 18 & 20 No Copay applies to Physician office visits for prenatal care after the first visit. <u>Out-of-Network</u> Same as 14, 18 & 20	Same as 14, 18 & 20 No Copay applies to Physician office visits for prenatal care after the first visit. <u>Out-of-Network</u> Same as 14, 18 & 20
16. Mental Health Services – Inpatient, Outpatient and Intermediate Must call Care Coordination for authorization prior to receiving Out-of-Network services	\$1,000 copay, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance

	EPO Plan <i>In-Network Only</i>	PPO Plan <i>In- and Out-of-Network</i>	Consumer Choice <i>In- and Out-of-Network</i>
17.Mental Health Services – Office Visits	\$35 per visit	\$25 per visit Out-of-Network Deductible & Coinsurance	Deductible & Coinsurance
18.Outpatient Surgery, Diagnostic and Therapeutic Services			
Outpatient Surgery	\$500 per visit copay	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Diagnostic Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Diagnostic & Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine (requires notification)	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Mammograms, Colonoscopies, and Endoscopies	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%
19.Physician’s Office Services	\$35 per visit – PCP, Virtual Visit or UHC Premium Designated Specialist \$50 per visit - Specialist	\$25 per visit – PCP, Virtual Visits, or UHC Premium Designated Specialist \$40 per visit - Specialist Out-of-Network Deductible & Coinsurance	Deductible & Coinsurance Virtual Visit- \$40 maximum cost
20.Preventive Services	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%
21.Professional Fees for Surgical and Medical Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
22.Prosthetic Devices Prior notification is required for retail cost over \$1,000.	* Plan Pays 100% Member Pays 0%	* Plan Pays 100% Member Pays 0% Out-of-Network Deductible & Coinsurance	* Plan Pays 100% Member Pays 0% Out-of-Network Deductible & Coinsurance
23.Reconstructive Procedures	Same as 14, 17, 18 & 20	Same as 14, 17, 18 & 20	Same as 14, 17, 18 & 20
24.Rehabilitation Services –Outpatient Therapy (physical, speech, and occupational therapy)	\$15 per visit for 15 visits in conjunction with an office visit then for 16 or more visits \$35 per visit - PCP \$50 per visit - Specialist	\$15 per visit for 15 visits in conjunction with an office visit then for 16 or more visits \$25 per visit - PCP \$40 per visit – Specialist Out-of-Network Deductible & Coinsurance	Deductible & Coinsurance Out-of-Network Deductible & Coinsurance

	EPO Plan <i>In-Network Only</i>	PPO Plan <i>In- and Out-of-Network</i>	Consumer Choice <i>In- and Out-of-Network</i>
25.Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Benefits are limited to 60 days per calendar year.	\$1,000 copay per visit, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance
26.Substance Abuse Services - Outpatient	\$35 per visit	\$25 per visit Out-of-Network Deductible & Coinsurance	Deductible & Coinsurance
27.Substance Abuse Services - Inpatient and Intermediate - Network and Non-Network Benefits are limited to 2 series per lifetime. Must call Care Coordination for authorization prior to receiving Out-of-Network services.	\$1,000 copay, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance
28.Transplantation Services See summary plan description for possible limitations and more specific information	\$1,000 copay, then Deductible *Prior notification is required prior to any services	Deductible & Coinsurance *Prior notification is required prior to any services	Deductible & Coinsurance *Prior notification is required prior to any services
29.Urgent Care Center Services	\$50 per visit	\$40 per visit Out-Of-Network Deductible & Coinsurance	Deductible & Coinsurance

Types of Providers considered as Primary Care by Travis County Benefit Plan:

General Practice, Family Practice, Internist, Pediatrics, Internal Medicine, Allergy and Immunology, Obstetrics, Gynecology, Chiropractor, Licensed Professional Counselor, Licensed Clinical Social Worker, Psychologist

***The following procedures require notification of UHC Care Coordination PRIOR to Service**
866-649-4873

- Facility In-patient admissions: including acute hospitalizations, rehabilitation facilities, and skilled nursing facilities
- Home Health Services: All home based services, including Nursing, respiratory therapy, IV Infusion, and Hospice.
- End Stage Renal Disease Services
- Cosmetic Services (If covered by medical plan)
- Dental Services required due to an accident while covered under this plan.
- Durable Medical Equipment (DME) with a retail cost of over \$1,000 whether for purchase or rental
- Transplant Services: Request for Transplant Evaluation
- Inpatient Mental Health and Chemical Dependency (Notification also recommended for Outpatient Mental Health and Chemical Dependence)
- CT Scans, Pet Scans, MRI and some other diagnostic testing
- All elective surgeries will be reviewed for medical necessity

Choosing a Health Plan

When you're choosing a health insurance plan, you'll want to look at more than the premiums and deductibles to evaluate plan options. Take a look at the Coinsurance amount, and then decide which deductible, premium and Coinsurance mix is the best option for you and your family.

There are many factors to consider when choosing a health plan. Think about both your medical and financial needs – from coverage options to monthly premiums, to copays and deductibles. Consider your family situation, your family's anticipated health care needs and available plan options.

It's a good idea to assess your needs and identify your priorities so you know what to look for in a plan. Consider costs, coverage, benefits, doctor flexibility and plan limitations to help you decide which plan is right for you.

Once you know what plan options are available, you can evaluate plan options to determine which one is right for your situation. Review your plan materials – such as brochures, benefit summaries and websites – to find the details that will help you decide. Things to consider may include:

- Affordability (total cost)
- Coverage and benefits
- Access to doctors and hospitals
- Exclusions and limitations
- Health and wellness resources

Did you know that the Patient Protection and Affordable Care Act (PPACA) requires that many Preventive Services be covered at 100%? So how can you make sure you're not over-charged?

1. *Know your Benefits: Make sure that your Doctor's Office is coding your Routine Physical as Preventive Services. The full list of preventive services covered at 100% can be found at <https://www.healthcare.gov/preventive-care-benefits/>*
2. *Always access preventive care at Preferred Providers. The PPACA doesn't require this benefit be extended out-of-network, who charge more for services.*

Pharmacy Benefits

The prescription drug benefits are administered by EnvisionRx Options. Additional information about EnvisionRx Options and your prescription benefit can be found by registering and logging in to your account at www.envisionrx.com. You can also reach their customer service line by calling 800.361.4542.

Your new dual medical/prescription card will be provided by United Health Care and will include the EnvisionRx Options information. Your prescription drug benefit features a formulary drug list. A formulary is a list of preferred medications organized into groups or "Tiers".

Prescriptions for 30 days or less can be filled at any in-network retail pharmacy. Prescriptions for 90 days can be filled through the mail-order service provided by the Costco Mail Order Pharmacy or at any in-network retail pharmacy.

Mail Order and Specialty Medications – EnvisionRx Options has partnered with Costco Mail Order Pharmacy to be your mail order service provider. If you need to start your medication immediately, or do not have a two (2) week minimum supply on hand, request two prescriptions from your physician; one for a short-term supply to fill at a local retail pharmacy and one for a 90-day supply (including refills) that can be submitted to Costco Mail Order Pharmacy.

Costco Mail Order Pharmacy
 215 Deining Circle
 Corona, CA 92880-9911
 1-800-607-6861 phone
 1-800-633-0334 fax
 1-866-443-0060 specialty
www.pharmacy.costco.com

You have 2 options for using this mail-order service.

- 1) Traditional mail order service – where all orders are placed through the mail or by phone.
- 2) Online order service – where orders can be placed online at www.pharmacy.costco.com.

Pharmacy Coverage by Health Plan

Tier	EPO and PPO Health Plan		Consumer Choice Health Plan
	30-day Retail Copay	90-day Retail/Costco Mail Order Copay	30-day and 90-day
Tier 1 Generic	\$10	\$20	20% Coinsurance (\$5 min and \$35 max)
Tier 2 Preferred	\$30	\$60	20% Coinsurance (\$20 min and \$60 max)
Tier 3 Non-Preferred	\$50	\$100	20% Coinsurance (\$40 min and \$100 max)

Prior Authorization – For certain medications, Prior Authorization will be needed from your doctor. You and your doctor will be alerted by your pharmacy when a Prior Authorization is needed. Prior authorization guidelines are determined on a drug-by-drug basis and may be based on FDA and manufacturer guidelines, medical literature, safety, appropriate use and benefit design.

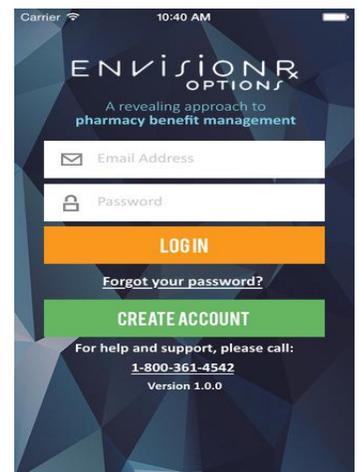
Quantity Limits - There may be a limit on the number of units per day, per period or per prescription based on FDA-approved indications and normal monthly usage.

Pay the Difference - Participants will pay the brand copay and the difference in cost between the brand drug and the corresponding generic drug when a true generic is available and deemed acceptable by the prescribing physician.

Pharmacy Out-of-Pocket Maximum – All three health plans, which include the pharmacy coverage, will have a pharmacy out-of-pocket maximum. The out-of-pocket maximum is \$2,500 per individual or \$5,000 for family. Once a participant reaches this maximum in out-of-pocket expenses, the plan will cover eligible pharmacy costs at 100% for the remainder of the plan year.

Additional Tools and Resources – The EnvisionRx app is a free tool that helps EnvisionRx members conveniently manage their prescription benefits using a secure connection through their mobile device. Features include:

- Digital ID Card that can be used by pharmacists and doctors
- Access to prescription claims information (mail and retail), including days until next refill
- Member profile, including cost information for prescriptions and the ability to identify cost savings opportunities based on member plan design and formulary
- Pharmacy help desk phone numbers
- A secure connection to personal health information, only accessible with user name and password



Travis County Employee Health Clinic

Travis County has three on-site Health Clinics staffed by Physicians and Medical Care Professionals available to Employees, Retirees and Dependents who are at least 10 years old and are covered by one of the Travis County Health Plans.

The mission of the Travis County Employee Health Clinic is to reduce health care costs by partnering with health plan participants and empowering them, through education, prevention, medicine and personal responsibility, to make choices that lead to a healthier lifestyle which reduces the cost of chronic illness and promotes workplace productivity.

Three clinic locations are available to plan participants for physicals, screening, disease management, immunization and fast track appointments. Fast track appointments are available for the same day or next day for minor illnesses or injuries.

Services Offered:

Disease Management and Wellness Programs:

- Diabetes management
- Cholesterol/Lipid management
- High blood pressure management
- Asthma
- Allergy management (not allergy injections)
- Weight management
- Depression treatment
- Tobacco cessation
- Alcohol cessation
- Annual Physical
- Pregnancy Test

Referrals: Chronic pain management will be referred to specialist within the UHC network.

Prescription refills: Requires initial doctor's visit (per protocol). Generic drugs will be prescribed when available.

Work related injuries will receive initial treatment, and then be referred for additional treatment when medically necessary.

For urgent care issues or medical questions before and after clinic hours, you may call the 24 hour United Healthcare Nurse Line at 1.877.365.7949.

Clinic Hours of Operation

Main Clinic

700 Lavaca, 9th Floor, Suite 980

Phone: 512-854-5509

Mon -Thurs 7:30am – 5:30pm

Friday 7:30 am– 11:30am

(closed for lunch 12:00pm – 1:00pm)

Airport Blvd. Clinic

5501 Airport Blvd, Suite 201

Phone: 512-854-7998

Mon - Wed 7:30am – 5:30pm

(closed for lunch 12:00pm – 1:00pm)

Del Valle Clinic

3518 FM 973 South

Phone: 512-854-1282

Thursday 7:30am – 5:30pm

Friday 7:30 am– 11:30am

(closed for lunch 12:00pm –

Travis County CARE Program



TRAVIS COUNTY CARE Program

Travis County Commissioners Court, the Wellness Committee and HRMD are pleased to continue an improved Health and Wellness program for employees, retirees and their dependents.

CARE is an acronym which stands for Checkups, A Healthy Outlook, Regular Exercise and Eating Right. These areas are critical in maintaining overall good health and will be the main focus of program events and activities.

The mission of the CARE program is to inspire, create and maintain a workplace environment that supports healthy lifestyle choices.

The CARE name not only incorporates the focus on health and wellness but also captures the feeling Travis County has towards its employees, retirees and their dependents. Each key focus area addresses prevention and management of current disease states.

Who Can Participate?

CARE Program is available to all employees, retirees, and dependents. UHC programs are available to those covered under the UHC Health Plan.

What the CARE Program Offers:

- A dedicated web page on [TravisCentral](#) specifically for CARE program resources, events and information
- A unique County CARE email address for communicating with CARE program staff careprogram@traviscountytexas.gov
- A unique County CARE phone number to reach CARE program staff – 512.854.CARE (2273)
- Health & Well-being presentations
- Fitness activities and groups
- Nutritional education
- Know your numbers events (biometric screenings)
- Private and individualized health coaching sessions with an on-site health coach
- Case and Disease Management services
- Additional resources for each of the 4 focus areas of CARE
- Annual Needs and Interest Survey

If you have questions or are interested in scheduling a health coaching session please call or email your CARE program contacts.

Alex Hainzinger
Health & Wellness Program Administrator
512.854.CARE

Becky Howell
On-site UHC Health Coach
512.854.5680
becky_howell@uhc.com

United Healthcare Tools and Resources

MyUHC.com

The www.myuhc.com web site offers easy-to-use online tools and information that are both practical and personalized. You can access tools and resources anytime day or night. Here are just some of the things you can do:

- View benefits and eligibility
- Estimate treatment costs
- Chat with a nurse online (if in coverage)
- Set up direct deposit
- View account balances
- View claim documents
- Find a network doctor
- Enroll in online health and wellness programs (if in coverage)
- Combine health care and financial management with Quicken Health Expense TrackerSM
- View health statements
- Virtual Visits with Dr. or Nurse

See what you can do at www.myuhc.com and learn about all the valuable online tools and resources that are both practical and personalized so you can get the most out of your benefits.

Register today:

1. Go to www.myuhc.com and select Register Now.
2. Enter the required information and provide your e-mail address.
3. Accept the delivery message and start receiving your communications online.

NurseLine (877.365.7949)

NurseLine is a team of registered nurses available to answer your health questions 24 hours a day, seven days a week. You can call the NurseLine toll-free or use Live Nurse Chat to get information about complex conditions, providers and managing your condition. NurseLine® and Live Nurse Chat services can help you make smart health care decisions with immediate access to experienced registered nurses. You can:

- Find a doctor, hospital, urgent care center, or emergency room
- Understand treatment options that you can discuss with your doctor
- Seek answers to medication questions
- Locate available resources

To talk to a NurseLine nurse, call **800.846.4678**. Or if you prefer talking to a nurse online, log in to www.myuhc.com to access Live Nurse Chat.

Personal Health Support/Case Management

Personal Health Support is a unique program for individuals who are living with a chronic condition or dealing with complex health care needs. The program provides a high level of support, educational tools, and telephone access to a registered nurse who is assigned to employees and their families. They can tell employees more about the benefits available to them, offer information about a wide range of health issues and direct them to UnitedHealth Premium® and Centers of Excellence network physicians and facilities. The nurse may also discuss and refer to the disease management services. These resources can help individuals better manage chronic conditions such as diabetes and asthma, or other serious illnesses, including cancer.

Personal Health Support includes but is not limited to members with the following conditions or receiving the following treatments:

- Cancer
- IV therapy, antibiotics, and chemotherapy
- Hyper-alimentation
- AIDS
- Premature births
- Birth defects
- Chronic muscle disease, such as Multiple Sclerosis
- Head injury and spinal cord injury
- Strokes and cardiac conditions
- Ventilator dependency
- Respiratory support
- Cystic Fibrosis
- Burn conditions
- Diabetes
- Asthma
- Heart Disease
- Recent hospital stay

myHealthcare Cost Estimator

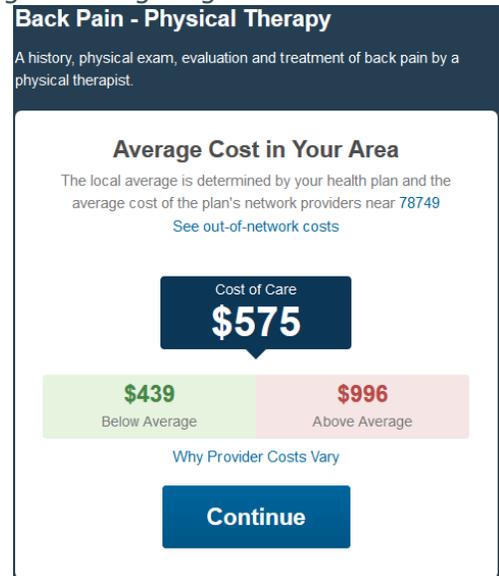
Using your benefit information, myHealthcare Cost Estimator shows you the estimated cost for a treatment or procedure, and how that cost is impacted by your deductible, Coinsurance and out-of-pocket maximum. This means that you'll get an estimate of what you'll be responsible for paying out of your pocket, providing you with useful information for planning and budgeting.

The more you use myHealthcare Cost Estimator, the more you'll see that not all doctors are the same. Depending on what you're looking for, you could see a wide range of estimates for the same procedure or treatment. You can then use this information to help you decide where to get care, or to start a discussion with your doctor.

You can search by condition or treatment with terms such as:

- Back pain
- X-rays
- MRIs
- Bone density study
- Low thyroid

Just search for the condition (e.g., back pain) or treatment (e.g., physical therapy) you would like an estimate for, and we'll show you doctors and locations that offer those services in your area. You'll also be able to learn about your care options, compare estimated costs, see quality and cost efficiency ratings, and even map out where you'll be going. Most importantly, you'll be able to make a more informed decision about what option is best for you.



Health4Me Mobile App

UnitedHealthcare's Health4Me provides instant access to you and your family's critical health information – anytime and anywhere. Whether you want to find physicians near you, check the status of a claim or speak directly with a nurse, Health4Me is your go-to resource for everything related to your health. The Health4Me app is available from the Apple iTunes App Store as a free download for the iPhone. It is also available as a free download in the Android marketplace for Android phones as well as the Google Play store.



- Search for physicians or facilities by location or specialty
- Locate urgent care facilities and ERs
- Store your favorite physicians and facilities with your notes to view in the future
- Skip the phone prompts and have a service representative contact you to answer any questions about claims or benefits
- View and share member health plan ID card information
- View hospital quality information to help make an informed decision about where you go for care
- Contact an experienced registered nurse 24/7 for advice regarding any kind of medical question
- Check status of deductible and out-of-pocket spending
- View, sort and pay claims
- Collect, track and share past and current Personal Health Records
- Estimate costs of common procedures and conditions up front

Rally Health Survey

Rally is a user-friendly digital experience on www.myuhc.com that will engage you in a new way by using technology, gaming and social media to help you understand, learn and support you on your health journey.

With the online Rally Health Survey, personalized Missions, rewards and connections to wearables like Fitbit®, Jawbone® and more, we make it easier for you to get motivated to be healthier. When you sign up for Rally, the first thing you'll learn is your Rally Health Age, which tells you how your body is feeling right now. Then you can start exploring all the great digital tools that may help you make healthier choices based on your life, schedule and needs.

Rally offers a personalized interactive experience:

- Challenges and Communities
- Missions and rewards
- Lifestyle plans
- Intuitive Health Survey

To get started, visit www.myuhc.com and once you are logged in on the home page click on “Rally Health Survey” link or click on the Rally icon.



United Healthcare (UHC) Special Programs

Cancer Support Program

The Cancer Support Program provides access to high quality cancer care and helps reduce cancer-related medical expenses. The program addresses:

- Cancer awareness
- Disease and treatment education
- Treatment Decision Support
- Comprehensive cancer case management addressing symptoms and side effects
- Second Opinion Support
- Access to the cancer Centers of Excellence (COE) network
- Patient empowerment
- Clinical coverage review of treatment, prescriptions and clinical trials
- Drug management support
- Administration of benefits (ie. Travel and Lodging)
- Administration of genetic counseling support
- Survivorship support
- End of life/hospice decision making

This comprehensive set of services is provided by a team of specialized cancer nurses, referred to as Cancer Nurse Advocates. They provide needed support to participants throughout cancer treatment and recovery or at end of life, to help them make informed treatment decisions and improve their health care experiences:

- Support and reinforce importance of adherence to their physician's treatment plan
- Help coordinate services between the member and multiple providers, when needed
- Provide information to encourage members' active participation in their care
- Help reduce complications related to the member's cancer diagnosis and treatments through targeted and timely outreach calls

- Ensure member communicates changes in health status to their physician before symptoms escalate
- Ensure members understand when and how to take medications and provide self-care
- Support members in making informed decisions about their care and where they receive it
- Increase awareness and informed choices about hospice and palliative care at end of life
- Assist in coordination of care and benefit issues
- Assist the member and family in accessing Centers of Excellence and the UnitedHealth Premium network

Spine and Joint Solutions

UHC also offers a Spine and Joint Solution, offered as part of your health plan. This program helps people who are considering:

- Spinal fusion surgery
- Spine disc surgery
- Total hip replacement
- Total knee replacement

Once you enroll in the program, you will be working directly with a nurse who will help you get answers so you can make confident decisions. Whether your back, knee or hip pain is new or the result of a chronic condition, UHC will help you find the care that is right for you. The Spine and Joint Solution gives you access to some of the nation's leading orthopedic facilities through UHC's Centers of Excellence (COE) network. By receiving care at one of these facilities, you are more likely to have fewer complications, a shorter recovery time and potentially lower out-of-pocket costs.

Real Appeal

Real Appeal takes an evidence-based approach to support weight loss. The program helps people make small changes necessary for larger long-term health results, based on weight-loss research studies commissioned by the National Institutes of Health. Real Appeal uses a highly interactive weekly internet show, videos and live online coaching to drive small behavior changes week by week over a full year.

Key Program Components:

- Interactive coaching, live over the internet
- Personalization session with a Real Appeal expert
- Weekly group coaching with other participants
- Ongoing one-on-one personalized coaching

Success Kit:

- Program success guide, nutrition guide and fitness guide
- Blender, body weight scale, food scale, workout DVD's, fitness band, pedometer and more

Engaging Entertainment - Highly entertaining and informative online program featuring new, healthy tips from favorite celebs, TV stars, experts and athletes, such as:

- Samantha Harris, former Dancing with the Stars host
- Dr. Ian Smith, former co-host of The Doctors and correspondent for Rachael Ray
- David Jack, recognized sports performance and conditioning coach
- Ellie Krieger, host of the Food Network show, Healthy Appetite with Ellie Krieger

Tools and Tracking

- Web-based participation through web platform or mobile app
- Online or mobile tools to track nutrition and physical activity

Virtual Visits

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy. This program is included as part of your health benefits.

Conditions commonly treated through a virtual visit Doctors can diagnose and treat a wide range of non-emergency medical conditions such as:

- Bladder infection/Urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache

To access virtual visits Log in to www.myuhc.com and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit you will pay your portion of the service costs according to your medical plan on the UHC site, and then you will enter a virtual waiting room. During your visit you will be able to talk to a doctor about your health concerns, symptoms and treatment options.

DENTAL INSURANCE

Travis County offers three voluntary dental plans administered by Assurant Dental to all eligible active employees and retirees. The following information describes the details of each dental plan including the monthly premium information. There are two Preferred Provider Organization (PPO) plans; the Base PPO plan and the High PPO plan, there is also a Dental HMO (DHMO) plan. Both PPO plans utilize the same network of dentists and specialists but reimburse out-of-network providers at different levels and have different annual maximum benefit amounts.

Assurant DHMO Plan

The Assurant Freedom Preferred DHMO Plan is provided by United Dental Care of Texas, Inc. and administered by Union Security Insurance Company. This DHMO dental plan offers benefits through a network of Plan Dentists. When you enroll for benefits, treatments you receive from your selected Plan Dentist will be provided at reduced fees called copays. This plan does not provide coverage for out-of-network providers and requires selection of a primary dentist.

Additional Plan Features

- No Deductibles
- No Waiting Periods
- No copays for most *Preventive* services
- Coverage for Pre-existing Conditions
- Includes Orthodontic copays
- No Claim Forms for Members to File (except Non-Plan Specialty Dentist Services and Emergency Services provided by a Non-Plan Dentist)
- No Referrals Required for Specialty Dentist Services
- No Annual Maximum for Plan Dentist and Plan Specialty Dentist Services

To Enroll in the Assurant DHMO Plan

Select a general dentist from the Directory of Dentists for yourself and every eligible member of your family. Each family member may choose a different Plan Dentist. You must select a Plan Dentist to receive services. Except for certain Specialty Dentist services, all services must be performed by this selected Plan Dentist. You may change your Plan Dentist(s) throughout the Plan Year in accordance with the provisions of the group agreement. However, all services must be performed by a Plan Provider. To select or change your Plan Dentist please contact Assurant at 877.743.1454.

Finding a Provider

You can find a dental provider in the DHMO Dental Series Provider Network by visiting our web site at www.assurantemployeebenefits.com, clicking on the "Find a dentist" link, enter "5451628" in the Group ID field and then select "DHMO/Prepaid Plan - DHMO Dental Series TX". Availability of Plan Dentists and Plan Specialty Dentists varies depending on location.

Assurant Base PPO Plan (Formerly the MAC Plan)

Plan Features Include: Freedom to choose any dentist, including specialists, PPO options available, and Preventive Max Waiver.

How the Plan Works

This dental plan provides a variety of benefits and allows you and your family to use any dentist or specialist you choose. Benefits are paid after any applicable deductible has been met, up to the annual maximum. Claim payments may be made to you or your dentist, whichever you prefer. You may find a DHA provider by visiting the Assurant Employee Benefits web site at www.assurantemployeebenefits.com - Select "Find a dentist" and then enter Group ID "5451628". You can search all providers in the PPO network or you may call customer service at 877.743.1454.

Network and Non-Network Discounts

The Base PPO plan allows employees to have access to the Dental Health Alliance (DHA®) PPO providers and take advantage of their fee discounts. Dentists participating in the DHA® networks have agreed to

discount their usual fees. Treatment is available from dentists who do not participate in DHA®, but their fees are subject to a Maximum Allowable Charge (MAC). The allowable amount for non-participating dentists is based on 45% off the 80th percentile of Usual, Customary and Reasonable (UCR) amount. Patients are responsible for fees in excess of the MAC. There can be significant out-of-pocket expenses if a non-participating dentist is chosen.

Assurant High PPO Plan

Plan Features Include: Freedom to choose any dentist, including specialists, PPO options available, and Preventive Max Waiver.

How the Plan Works

This dental plan provides a variety of benefits and allows you and your family to use any dentist or specialist you choose. Benefits are paid after any applicable deductible has been met, up to the annual maximum. Claim payments may be made to you or your dentist, whichever you prefer. You may find a DHA provider by visiting the Assurant Employee Benefits web site at www.assurantemployeebenefits.com - Select “Find a dentist” and then enter Group ID “5451628”. You can search all providers in the PPO network or you may call customer service at 877.743.1454.

Network and Non-Network Discounts

This dental program offers a PPO (Preferred Provider Organization) through Dental Health Alliance (DHA®) that provides a variety of cost saving features. Although you may visit any dentist you choose, you will receive maximum savings if you visit a DHA® provider. Dentists participating in the DHA® networks have agreed to discount their usual fees. The allowable amount for non-participating dentists is based on the usual and customary. Patients are responsible for fees in excess of usual and customary. This plan provides a better benefit when seeing a non- DHA network provider than the Assurant Base PPO Plan.

Dental Plan Comparison

	Assurant DHMO Plan	Assurant Base PPO Plan	Assurant High PPO Plan
Calendar Year Deductible	\$0	\$50	\$50
Annual Maximum	No max	\$1,500	\$2,000
Preventive services: Routine oral exams, routine cleanings, fluoride treatment (frequency limitations)	100% (no copays)	100% (no deductible)	100% (no deductible)
Restorative services: Fillings, all other x-rays, simple extractions	Various copays	Plan Pays 80% Member Pays 20%	Plan Pays 80% Member Pays 20%
Major services: Crowns, bridgework, dentures, oral surgery, extractions, endodontics (root canals), periodontics (treatment of gums), implants	Various copays *implants not covered	Plan Pays 50% Member Pays 50%	Plan Pays 50% Member Pays 0%
Orthodontia	Various copays	Plan Pays 50% up to a \$1000 lifetime max Member Pays remaining cost	Plan Pays 50% up to a \$1000 lifetime max Member Pays remaining cost
Out-of-Network Coverage	No out-of-network coverage. Must select a network provider.	45% off the 80th percentile of UCR	90th Percentile of UCR

PPO Plan Comparison In- and Out-of-Network

The two PPO dental plans offer the same coverage when receiving services from an in-network provider and both plans use the Assurant Freedom Preferred PPO network. While the coverage is the same for in-network providers, there is a difference in benefit coverage levels when receiving services from an out-of-network provider. The chart below is an example of the allowed amount, insurance coverage amount and member out-of-pocket costs for crown.

	Visit to In-Network PPO Dentist on both the Base and High PPO Plan	Visit to Non-Network Dentist on the Base PPO Plan	Visit to Non-Network Dentist on the High PPO Plan
Provider Normal Charge for Crown	\$1,018	\$1,018	\$1,018
Minus PPO Savings	30%	N/A	N/A
Allowed Amount (in network contracted fee or Out-of-Network Reimbursement)	\$713	\$699*	\$1,018
Allowed Amount Calculation	The negotiated in-network contracted rate	45% off the 80 th percentile of Usual, Customary and Reasonable (UCR)	90 th percentile of Usual, Customary and Reasonable (UCR)
Insurance Pays 50% (Major service)	\$357	\$350	\$509
Member Responsibility (50% of allowed amount)	\$356	\$350	\$509
Balance Bill (Normal Charge - Allowed Amount)	\$0	\$319	\$0
Total Member Out-of-Pocket	\$356	\$668	\$509
Savings from using a network dentist	\$312 or \$153	N/A	N/A

*Savings may differ based on plan design or where deductibles apply. The average retail charge for the crown is based on internal data, 2014.

VISION INSURANCE

Travis County offers a voluntary vision plan administered by Davis Vision to all eligible active employees and retirees. The following information describes the details of the vision plan including the monthly premium information Regular vision care is important to your health whether your vision is 20/20 or you need contacts or glasses.

Through Davis Vision’s provider network, you will receive a comprehensive vision examination, as well as eyeglasses (lenses and frames), or contact lenses in lieu of eyeglasses.

Easy Benefit Access

With Davis Vision, you are able to visit any provider you choose, but you maximize your savings when you visit a network provider.

How to locate a network provider:

- Call the Member Services Team at 800.999.5431
- Log on to the Open Enrollment section of www.davisvision.com and enter Client Code 3632, then click “Find a Provider” to locate a provider near you.
- Once you’ve chosen a network provider, call the provider to schedule your appointment. Let the provider know that you have the Davis Vision plan and give your primary insured’s unique identification number and the patient’s date of birth. While no ID cards are required to obtain services, you may present your Davis Vision ID card at your appointment.

	In-Network Benefits	Out-of-Network Benefits If you choose an out-of-network provider, you will be reimbursed up to:
Eye Examination	\$10 copay	\$45
Pair of Lenses (once every plan year)	Standard single-vision, lined bifocal, or trifocal lenses after \$25 copay	Single vision \$40 Bifocal \$60 Trifocal \$80 Lenticular \$100
Additional Lens Options and Coverage (once every plan year)	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings)	
Frames (once every other plan year)	Up to \$130 retail allowance toward provider-supplied frame plus 20% off cost exceeding the allowance <i>OR</i> Any Fashion or Designer frame from Davis Vision’s exclusive Collection (with retail values up to \$175), Covered in Full <i>OR</i> Any Premier frame from Davis Vision’s exclusive Collection (with retail values up to \$225), Covered in Full after an additional \$25 copay	\$50
Contact Lenses in Lieu of Eyeglasses (once every plan year)	Up to \$150 allowance toward provider-supplied contacts plus 15% off cost exceeding the allowance. Standard and Specialty Contacts – Evaluation, fitting fees, and follow-up care, \$25 copay applies <i>OR</i> Davis Vision Collection contact lenses, evaluation, fitting fees, and follow-up care, Covered in Full after \$25 copay (Up to 4 boxes of disposable lenses). <i>OR</i> Medically necessary with prior approval, Covered in Full	Elective \$150* Necessary** \$225

Additional Lenses Coverages and Copays

Davis Vision Collection Frames: Fashion Designer Premier	\$0 \$0 \$25
Tinting of Plastic Lenses	\$0
Oversize Lenses	\$0
Scratch-Resistant Coating.....	\$0
Ultraviolet Coating	\$12
Anti-Reflective Coating: Standard Premium Ultra	35 \$48 \$60
Polycarbonate Lenses	\$0/4-\$30
High-Index Lenses	\$55
Progressive Lenses: Standard Premium Ultra	\$50 \$90 \$140
Polarized Lenses	\$75
Plastic Photosensitive Lenses	\$65
Scratch Protection Plan: Single Vision Multifocal Lenses	\$20 \$40

Questions or concerns about your vision options can be addressed by Davis Vision’s Customer Service Center:

Davis Vision Customer Service
800.9995431
Monday – Friday: 7 a.m. to 10 p.m. (Central Time)
Saturday: 8 a.m. to 3 p.m. and Sunday: 11 a.m. to 3 p.m.

If you visit an out-of-network provider, you will need to send your itemized receipts, with the primary-insured’s unique identification number and the patient’s name and date of birth, to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Receipts for services and materials purchased on different dates must be submitted at the same time to receive reimbursement. Receipts must be submitted within 12 months of the date of service.

Important Tip to Remember

Your \$150 contact lens allowance is applied to the contact lens fitting and evaluation fee and the purchase of contact lenses. For example, if the contact lens fitting and/evaluation fee is \$30, you will have \$120 towards the purchase of contact lenses.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document.

Value-Added Features:

- Replacement contacts through www.DavisVisionContacts.com for mail-order contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider’s Usual & Customary fees, or 5% off advertised specials, whichever is lower.

LIFE INSURANCE

Employee Basic Life and AD&D Coverage

All regular employees receive Basic Life and Accidental Death & Dismemberment (AD&D) Coverage in the amount of \$50,000 each. Effective October 1, 2106, the coverage is with United Healthcare and is provided by the County at no cost to employees.

If you are age 70 or over coverage amount(s) will reduce according to the following schedule:

<u>Age:</u>	<u>Insurance Amount Reduces to:</u>
70 - 74	65% of original amount
75 - 79	40% of original amount
80 - 84	25% of original amount
85 - 89	15% of original amount
90 or more	10% of original amount

Additional Benefits:

- Portability/Conversion: If you retire, reduce your hours or leave Travis County, you may apply to take this coverage with you according to the terms outlined in the contract. You may be able to convert your Term life coverage to an individual life insurance policy.
- Accelerated Benefit: If you become terminally ill and are not expected to live more than twelve months, you may request up to 100% of your life insurance amount, without fees or present value adjustments.

Employee Supplemental Life and AD&D Coverage

In addition to the Employee Basic Life and AD&D Coverage provided by the County, you also have the option to elect and purchase Supplemental Life and AD&D Coverage from Cigna. Amounts are issued in **\$25,000 increments only**. The overall maximum benefit of Life and AD&D coverage you can elect is the lesser of 4 x annual earnings rounded to the next higher multiple of \$25,000, up to a maximum of \$250,000.

Example: Employee A's base salary is \$15.00 per hour and is scheduled to work 40 hours per week. The maximum amount of Supplemental Life and AD&D coverage the employee is allowed to elect is \$125,000.

$$\begin{aligned} & \$15.00/\text{hour} \times 2,080 \text{ hours/year} = \$31,200 \text{ annual} \times 4 = \$124,800 \text{ rounded up to the} \\ & \text{next highest } \$25,000 = \mathbf{\$125,000} \end{aligned}$$

Guarantee Issue

If you enroll during your Initial Enrollment period, you may apply for any amount of Life insurance coverage up to the maximum without having to complete an Evidence of Insurability.

If you and your eligible dependents do not enroll during your Initial Enrollment period, you can apply for coverage only during the Open Enrollment period or within 31 days of a Qualifying Life Event. Evidence of Insurability (EOI) is not required during Open Enrollment if the increase in coverage is by one \$25,000 benefit unit. Any request for coverage higher than one \$25,000 benefit unit requires completion of an EOI Form and approval from the carrier.

Monthly Supplemental Life and AD&D Rates:

(Age as of Oct. 1)	Coverage Amount				
	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00	\$125,000.00
under 30	\$1.50	\$3.00	\$4.50	\$6.00	\$7.50
30-39	\$2.25	\$4.50	\$6.75	\$9.00	\$11.25
40-44	\$3.25	\$6.50	\$9.75	\$13.00	\$16.25
45-49	\$4.75	\$9.50	\$14.25	\$19.00	\$23.75
50-54	\$7.75	\$15.50	\$23.25	\$31.00	\$38.75
55-59	\$10.75	\$21.50	\$32.25	\$43.00	\$53.75
60-64	\$17.25	\$34.50	\$51.75	\$69.00	\$86.25
65-69	\$25.50	\$51.00	\$76.50	\$102.00	\$127.50
70+	\$44.50	\$89.00	\$133.50	\$178.00	\$222.50

(Age as of Oct. 1)	Coverage Amount				
	\$150,000.00	\$175,000.00	\$200,000.00	\$225,000.00	\$250,000.00
under 30	\$9.00	\$10.50	\$12.00	\$13.50	\$15.00
30-39	\$13.50	\$15.75	\$18.00	\$20.25	\$22.50
40-44	\$19.50	\$22.75	\$26.00	\$29.25	\$32.50
45-49	\$28.50	\$33.25	\$38.00	\$42.75	\$47.50
50-54	\$46.50	\$54.25	\$62.00	\$69.75	\$77.50
55-59	\$64.50	\$75.25	\$86.00	\$96.75	\$107.50
60-64	\$103.50	\$120.75	\$138.00	\$155.25	\$172.50
65-69	\$153.00	\$178.50	\$204.00	\$229.50	\$255.00
70+	\$267.00	\$311.50	\$356.00	\$400.50	\$445.00

Dependent Life Insurance

In addition to Basic and Supplemental employee life insurance, eligible employees can also elect life insurance coverage for their spouse and/or dependent children. The basic dependent life includes coverage for an employee's spouse and dependent children for one flat rate per month, regardless of the number of children enrolled. The maximum amount of coverage for a dependent child is \$5,000. The coverage amounts and rates are listed below.

Basic Dependent Life:	Spouse/Dom Partner	\$10,000
	Child	\$5,000 (age 6 months to 26 years)
	Infant	\$1,000 (14 days to 6 months)

Basic Dependent Life Rate: \$1.54 per month \$0.77 per pay-period

Spouse/Domestic Partner Supplemental Life Insurance

If you elect and purchase basic dependent life coverage you have the option to also purchase additional Spouse/Domestic Partner supplemental life insurance. The Spouse/Domestic Partner supplemental life insurance can be elected to increase the total amount of coverage for a Spouse/Domestic Partner up to a maximum of \$30,000.

Spouse/Dom Partner Supplemental Life: \$10,000 or \$20,000 (in addition to the basic dep life policy)

Spouse/Domestic Partner Supplemental Life Rates:

Age of Spouse	Monthly Amount		Age of Spouse	Per Pay Period Amount	
	\$10,000	\$20,000		\$10,000	\$20,000
Under 30	\$0.40	\$0.80	Under 30	\$0.20	\$0.40
30-39	\$0.70	\$1.40	30-39	\$0.35	\$0.70
40-44	\$1.10	\$2.20	40-44	\$0.55	\$1.10
45-49	\$1.70	\$3.40	45-49	\$0.85	\$1.70
50-54	\$2.90	\$5.80	50-54	\$1.45	\$2.90
55-59	\$4.10	\$8.20	55-59	\$2.05	\$4.10
60-64	\$6.70	\$13.40	60-64	\$3.35	\$6.70
65-69	\$10.00	\$20.00	65-69	\$5.00	\$10.00
70+	\$17.60	\$35.20	70+	\$8.80	\$17.60

Personal Accident Insurance

If you are a regular employee of Travis County, you are eligible to elect the Cigna Personal Accident Insurance for you and your dependents on the first day of the month following 30 days of employment. You may elect to cover your lawful spouse under age 70, and your dependent children up to age 26.

Benefit Amount	Monthly Amount		Per Pay-Period Amount	
	Employee Only	Family Coverage	Employee Only	Family Coverage
\$25,000	\$0.50	\$0.88	\$0.25	\$0.44
\$50,000	\$1.00	\$1.75	\$0.50	\$0.88
\$100,000	\$2.00	\$3.75	\$1.00	\$1.88
\$150,000	\$3.00	\$5.25	\$1.50	\$2.63
\$200,000	\$4.00	\$7.00	\$2.00	\$3.50
\$250,000	\$5.00	\$8.75	\$2.50	\$4.38
\$300,000	\$6.00	\$10.50	\$3.00	\$5.25
\$400,000	\$8.00	\$14.00	\$4.00	\$7.00
\$500,000	\$10.00	\$17.50	\$5.00	\$8.75

Personal Accident Insurance Benefits

The Personal Accident Insurance helps protect you against losses due to accidents. A covered accident is a sudden, unforeseeable, external event, resulting directly and independently of all other causes, in a covered injury or covered loss that occurs while coverage is in force. To help survivors of severe accidents adjust to new living circumstances, Cigna will pay benefits according to the chart below.

If, within 365 days of a covered accident, bodily injury results in:	We will pay this % of the benefit amount
Loss of life, or Total paralysis of upper and lower limbs, or Loss of any combination of two: hands, feet or eyesight, or Loss of speech and hearing in both ears	100%
Total paralysis of both upper and lower limbs, or Total paralysis of upper and lower limbs on one side of the body, or Loss of one hand, foot, or sight in one eye, or Loss of speech, or Loss of hearing in both ears	50%
Loss of thumb and index finger of the same hand, or Total paralysis of one upper or one lower limb, or Loss of all four fingers of the same hand, or Loss of all toes of the same foot	25%
Coma	1%

How much coverage can you buy?

You may select from \$25,000 to \$500,000 of coverage, in units of \$25,000. Your spouse's benefit amount will be 50% of your coverage amount or 60% if you have no dependent children. The maximum benefit amount for your spouse is \$300,000. Each of your covered children's benefit amounts will be 10% of yours or 15% if you have no eligible spouse, up to a maximum benefit amount of \$25,000 for each child.

Each family member's coverage is a percentage of the benefit amount you select. It will depend on who your insured family members are at the time of a covered accidental loss. You may need to request changes to your existing coverage if, in the future, you no longer have dependents who qualify for coverage. We will refund premium if you do not notify us of this and it is determined at the time of a claim that premium has been overpaid.

Retiree Life Insurance

Employees are eligible to continue life insurance for themselves and covered spouses once they retire. If you enroll upon retirement, the Basic Life benefits are Guarantee Issue and no underwriting approval is required. To purchase coverage listed under "Optional Amount" in the table below you must complete an Evidence of Insurability form and it must be approved by Cigna. Listed below are the coverage options and rates for retirees under age 70 as well as retirees who are age 71 or higher.

Retirees age 70 or less	Basic Amount	Monthly Cost	Optional Amount	Monthly Cost	Total Available	Total Monthly Cost
Retiree Employee Life	\$15,000	\$2.08	\$10,000*	\$4.84	\$25,000	\$6.92
Retiree Spouse Life	\$7,500	\$2.08	\$5,000*	\$4.84	\$12,500	\$6.92

Retirees age 71 or higher	Basic Amount	Monthly Cost	Optional Amount	Monthly Cost	Total Available	Total Monthly Cost
Retiree Employee Life	\$5,000	\$5.90	\$5,000*	\$8.80	\$10,000	\$14.70
			\$10,000*	\$17.60	\$15,000	\$23.50
			\$15,000*	\$26.40	\$20,000	\$32.30
Retiree Spouse Life	\$2,500	\$2.95	\$2,500*	\$4.40	\$5,000	\$7.35
			\$5,000*	\$8.80	\$7,500	\$11.75

**Optional Life requires underwriting and approval from carrier. Complete the Evidence of Insurability form and send to address on form (unless you have already been approved in a prior year).*

FLEXIBLE SPENDING ACCOUNTS (FSA)

If you are in a regular budgeted position scheduled to work 30 hours or more per week you are eligible to enroll for the FSA accounts administered by Total Administrative Services Corporation (TASC). FSA elections may be made during your Initial Enrollment period, during Open Enrollment or within 31 days of an approved Qualified Life Event. A Flexible Spending Account (FSA) is an account you set up to pre-fund your anticipated, eligible medical expenses and/or dependent care expenses that are normally not covered by your insurance. Once you decide how much to contribute to your Medical Expense and/or Dependent Care FSA, the amount is deducted pre-tax in small, equal amounts from your paychecks during the plan year.

Medical Expense FSA (may be used for self or dependent health care expenses)

A Medical Expense FSA is used to pay for eligible medical expenses which aren't covered by your insurance or other plan. These expenses can be incurred by yourself, your spouse, a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate. You can also make using your funds even quicker and more convenient when you use your TASC Card. You and your qualifying spouse and children can use the Medical FSA account even if you are not enrolled in Travis County health insurance.

The TASC Card is a convenient reimbursement option that allows TASC to electronically reimburse eligible expenses under your employer's plan and IRS guidelines. Because it is a payment card, when you use the TASC Card to pay for eligible expenses, funds are electronically deducted from your account. You must send in documentation for certain TASC Card transactions, such as those that are not a known office visit or prescription copay (as outlined in your health plan's Schedule of Benefits). When requested, you must send in documentation for these transactions. Documentation for a card expense is a statement or bill showing:

- Name of the patient
- Date of service
- Total amount of service
- Name of the service provider
- Type of service (including prescription name)

Dependent Care FSA (may be used for day care services for dependent children or adults)

The Dependent Care FSA is a great way to pay for eligible dependent care expenses such as after school care, baby-sitting fees, summer camps (not overnight), daycare services, nursery and preschool. Eligible dependents include your qualifying child under 13, spouse and/or tax dependent relative.

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expenses will not be paid until after the last date of service for which you are requesting reimbursement has passed. Remember that for timely processing of your Dependent Care FSA reimbursement, your payroll contributions must be current.

Examples of how to use your FSA:

Example 1: Paying a copay and doctor/dental fees (Medical Expense FSA)

Once you enroll in the Medical FSA plan, TASC will send you a Medical Expense FSA Mastercard for you to use. You can use this at the Doctor's office or the pharmacy to pay instantly with FSA funds and avoid waiting for reimbursement. If you use your TASC Card be sure to keep copies of your receipts to substantiate the expense if requested. Or if you pay by some other method, after paying your copay get receipt or an Explanation of Benefits (EOB). You can then submit those payment documents, along with a claim form to TASC. Within one to three business days, TASC will process your request and mail your reimbursement check to you or direct deposit your funds into the account of your choice.

Example 2: Paying for daycare services (Dependent Care FSA)

Once you have paid for your child's daycare service, send a completed claim form to TASC, along with documentation showing the following:

- Name, age and grade of the dependent receiving the service
- Cost of the service
- Name and address of the service provider
- Beginning and ending dates of the service

Your request will be processed within five business days and either mailed to you or deposited into the account you have chosen.

Annual Contribution Limits for FY 2017

For Medical Expense FSA:

Minimum Annual Deposit is \$120 for the benefit plan year or \$5.00 per pay period
 Maximum Annual Deposit is \$2,550 for the benefit plan year or \$93.75 per pay period

For Dependent Care FSA:

Minimum Annual Deposit is \$120 for the benefit plan year or \$5.00 per pay period
 The maximum contribution depends on your tax filing status.

- If you are married and filing separately, your maximum annual deposit is \$2,500 or \$104.16 per pay period.
- If you are single and head of household, your maximum annual deposit is \$5,000 or \$208.33 per pay period.
- If you are married and filing jointly, your maximum annual deposit is \$5,000 or \$208.33 per pay period.
- If either you or your spouse earns less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.

FSA Savings Example		
(With FSA)		(Without FSA)
\$31,000	Annual Gross Income	\$31,000
<u>- \$2,500</u>	FSA Deposit for Recurring Expenses	<u>- \$0.00</u>
\$28,500	Taxable Gross Income	\$31,000
<u>- \$ 6,455</u>	Federal, Social Security Taxes	<u>- \$7,021</u>
\$22,045	Annual Net Income	\$23,979
<u>- \$0.00</u>	Cost of Recurring Expenses	<u>- \$2,500</u>
\$22,045	Spendable Income	\$21,479
By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of \$566!		
* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.		

Example Eligible Expenses

These are services/items that are generally known to be incurred/obtained primarily for medical care; in other words, they are services/items that practically no one would incur or obtain unless they had a medical condition that prompted the expenditure. These “primarily medical” services/items are the types of expenses that normally qualify for reimbursement under a Medical Expense FSA. Examples of Eligible Expenses include the following;

Copays	Dental Treatment	Immunizations	Stop-smoking program
Coinsurance	Diagnostic Items/Services	Laboratory Fees	Durable Medical Equip.
Prescription Drugs	Eye exams/Glasses/Contacts	Orthodontia	Laser eye surgery; Lasik
Deductibles	Hearing Aids	Physical Therapy	X-rays; MRI; CT Scans

For a complete list of eligible expenses or for more information, contact TASC directly at <http://www.tasconline.com/mytasc/> or at 800-422-4661.

Changing your FSA Election During the Plan Year

Plan rules allow you to change, start and/or stop your FSA election amount as long as it meets the qualifying event rules as determined by the IRS. Within 31 days of a qualifying event, you must submit a Change in Status (CIS)/Election Form and supporting documentation to Travis County HRMD. Upon the approval of your election change request, your existing FSA(s) elections will be stopped or modified (as appropriate). Visit www.tasconline.com/mytasc/ for information on rules governing periods of coverage and IRS Special Consistency Rules.

FSA Worksheets

Use the worksheets below to determine how much to deposit in your FSA accounts. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

Medical Expense FSA Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles \$ _____

Coinsurance or copays \$ _____

Vision care \$ _____

Dental care \$ _____

Prescription drugs \$ _____

Travel costs for medical care \$ _____

Other eligible expenses \$ _____

ANNUAL TOTAL \$ _____

Dependent Care FSA Worksheet

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Daycare services \$ _____

In-home care/au pair services \$ _____

Nursery and preschool \$ _____

After school care \$ _____

Summer day camps \$ _____

ELDER CARE SERVICES

Daycare center \$ _____

In-home care \$ _____

ANNUAL TOTAL \$ _____

Remember, your total contribution cannot exceed IRS limits for the plan year and calendar year.

DISABILITY

Short Term Disability

Short Term Disability (STD) coverage provides benefits when you are unable to work for a short period of time due to a covered illness or injury. Regular employees are eligible to enroll in the CIGNA Short Term Disability plan during Initial Enrollment or during Open Enrollment.

Short Term Disability benefits are payable when Cigna determines that due to your sickness or injury you are:

- unable to perform the material duties of your Regular Occupation; and
- unable to earn 80% or more of your Covered Earnings from working in your Regular Occupation.

Short Term Disability Benefit Highlights	
Policy Number	VDT-960952
Benefit Level	60% of weekly earnings
Maximum Weekly Benefit	\$1,500
Minimum Weekly Benefit	\$25
Waiting Period	14 days illness 14 days accident or injury
Maximum Benefit Duration	13 weeks

If approved, STD benefits begin after your waiting period, which is generally 14 days from the first day you are first sick, or injured.. Your paid-time off accrual balance should be considered when purchasing a Short Term Disability Policy. Benefits are paid based on a percentage of your weekly earnings less income from other benefits which could include workers' compensation, unemployment or other disability plans.

Pre-Existing Condition Limitation

Cigna will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred medical expenses, received medical treatment, care or services including diagnostic measures, or took prescribed drugs or medicines within 3 months before his or her most recent effective date of insurance.

This limitation will not apply to a period of Disability that begins after an Employee is covered for at least 12 months after his or her most recent effective date of insurance, or the effective date of any added or increased benefits.

Benefit Level and Rates

If you enroll in the Short Term Disability insurance you may be eligible for up to 60% of your weekly income if approved. The after-tax premium rate for the coverage is \$0.030 per month per weekly benefit amount. The chart below shows you example monthly premium amounts based on different levels of salary. The benefit level is set based on your salary at initial enrollment or your salary as of October 1st of each year.

Annual Salary	Weekly STD Benefit	Monthly Premium	Per Pay-period Premium
\$21,666.67	\$250.00	\$7.50	\$3.75
\$26,000.00	\$300.00	\$9.00	\$4.50
\$34,666.67	\$400.00	\$12.00	\$6.00
\$43,333.33	\$500.00	\$15.00	\$7.50
\$52,000.00	\$600.00	\$18.00	\$9.00
\$60,666.67	\$700.00	\$21.00	\$10.50
\$69,333.33	\$800.00	\$24.00	\$12.00
\$78,000.00	\$900.00	\$27.00	\$13.50
\$86,666.67	\$1,000.00	\$30.00	\$15.00
\$95,333.33	\$1,100.00	\$33.00	\$16.50
\$104,000.00	\$1,200.00	\$36.00	\$18.00
\$112,666.67	\$1,300.00	\$39.00	\$19.50
\$121,333.33	\$1,400.00	\$42.00	\$21.00
\$130,000.00	\$1,500.00	\$45.00	\$22.50

Long Term Disability

Long Term Disability (LTD) coverage provides benefits when you are unable to work for a longer period of time due to a covered illness or injury. Regular employees are eligible to enroll in the Cigna Long Term Disability coverage during Initial Enrollment or during Open Enrollment.

Long Term Disability benefits are payable when Cigna determines that due to your sickness or injury:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.
- After benefits have been paid for 24 months, you are disabled when Cigna determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.
- You must be under the regular care of a physician in order to be considered disabled.

Long Term Disability Benefit Highlights	
Policy Number	VDT-960953
Benefit Level	60% of monthly earnings
Maximum Monthly Benefit	\$6,000
Minimum Weekly Benefit	\$25
Waiting Period	90 days
Maximum Benefit Duration	Up to your Social Security Normal Retirement Age

The Waiting Period is the length of time of disability which must be satisfied before you are eligible to receive benefits. Benefits are paid based on a percentage of your monthly earnings less income from other benefits which could include Travis County sick leave, workers' compensation, unemployment or other disability plans

Pre-Existing Condition Limitation

Cigna will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred medical expenses, received medical treatment, care or services including diagnostic measures, or took prescribed drugs or medicines within 6 months before his or her most recent effective date of insurance.

This limitation will not apply to a period of Disability that begins after an Employee has been in Active Service for a continuous period of 12 months during which the Employee has received no medical treatment, care or services in connection with the pre-existing conditions or is covered for at least 24 months after his or her most recent effective date of insurance, or the effective date of any added or increased benefits.

Benefit Level and Rates

If you enroll in the Long Term Disability insurance you are eligible for up to 60% of your monthly income. The premium rate for the coverage is \$0.50 per \$100 of the monthly payroll coverage amount. The chart below shows you example monthly premium amounts based on different levels of coverage. The benefit level is set based on your salary at initial enrollment or your salary as of October 1st of each year.

Annual Salary	Monthly LTD Benefit	Monthly Premium	Per pay-Period Premium
\$20,000.00	\$1,000.00	\$8.33	\$4.17
\$30,000.00	\$1,500.00	\$12.50	\$6.25
\$40,000.00	\$2,000.00	\$16.67	\$8.33
\$50,000.00	\$2,500.00	\$20.83	\$10.42
\$60,000.00	\$3,000.00	\$25.00	\$12.50
\$70,000.00	\$3,500.00	\$29.17	\$14.58
\$80,000.00	\$4,000.00	\$33.33	\$16.67
\$90,000.00	\$4,500.00	\$37.50	\$18.75
\$100,000.00	\$5,000.00	\$41.67	\$20.83
\$120,000.00	\$6,000.00	\$50.00	\$25.00

Reporting a Disability Claim

When to report a claim

- If your physician has determined you are unable to work due to illness, injury or for maternity reasons
- In advance of a planned medical absence, such as prescheduled surgery or an expected maternity leave

How to report a claim

Call Cigna's toll-free number to speak with one of their Customer Intake Representatives who will walk you through the process. All of the information can be taken over the phone. Just dial:

1-800-36-Cigna or 1-800-362-4462

Or, if you prefer, you can access the online claim form through Cigna's website, www.cigna.com. To submit a life, accident or waiver claim through Cigna.com click on **Forms** and find the **Disability/Accident/Life Forms** Section.

LONG TERM CARE INSURANCE

Travis County offers voluntary Long Term Care insurance. Employees and retirees and their family members are eligible to apply for this coverage at *any* time during the year. New Employees will have one guarantee issue period when coverage is offered to them with no underwriting requirements. This period will be in February of each year. Other employees, retirees and family members will go through an application process that includes medical underwriting questionnaire and submit for approval. Applications will be medically underwritten and approved or rejected based on medical information submitted. This is an age rated indemnity product, so your cost depends on the age you are at effective date of your coverage. Rates do not increase in most cases once you are approved. Premiums will be direct billed to employee, retiree or family member. Policy Number **205655** UNUM Life Insurance Co. of America

Long Term Care Available Benefit Options	
Term of Care	3 years, 6 years or Lifetime* (lifetime term requires underwriting for all applicants)
Long Term Care Facility Benefit	Choice of \$2000, \$3000, \$4,000, \$5000, or \$6000 per month
Home Care Benefit	50% of monthly long term care facility benefit chosen. Choice of Professional Home and Community Care (professional licensed care) or Total Choice Home Care benefits (licensed and unlicensed caregivers).
Inflation Protection Benefit	5% Simple inflation protection

Please go to <https://w3.unum.com/enroll/countyoftravis/index.aspx> or <http://traviscentral/> for more detailed information on this important benefit. UNUM may be reached directly at 1-800-227-4165.

RETIREMENT

Texas County and District Retirement System (TCDRS)

Travis County participates in the Texas County and District Retirement System. The money that funds your plan comes from employee deposits, employer contributions and earnings from investments. Your participation in TCDRS is **mandatory** for qualifying employees.

Changes to Benefits

The Travis County Commissioner's Court chooses your TCDRS benefits. Every year it reviews your employer's retirement plan and makes changes, if needed. It decides:

- What percentage of your paycheck goes into your TCDRS account
- How much Travis County will match when you retire
- What you must do to be eligible for retirement

Your Deposits

Each paycheck, 7% of your total pay goes into your TCDRS account. This money is taken out of your paycheck on a pre-tax basis.

How Your Money Grows

Your account earns an annual interest credit of 7%. TCDRS credits this interest to your account each December 31, based on your account balance as of January 1 (Chart 1 below). Over time, the value of your account can increase a great deal because of compounding interest— that is, paying interest on interest. Every year you'll get a statement from TCDRS that shows all your deposits for the year as well as how much interest you received. You can also view your current balance online at www.tcdrs.org.

Year	Beginning Balance	Deposits	7% Interest on December 31	Ending Balance
Year 1	\$0.00	\$2,000.00	\$0.00	\$2,000.00
Year 2	\$2,000.00	\$2,000.00	\$140.00	\$4,140.00
Year 3	\$4,140.00	\$2,000.00	\$289.80	6,429.80

Vesting

You are considered "vested" when you have earned enough service time to be eligible for retirement once you reach the age requirement. To be vested in your plan, you must have 8 years of service credit. Once vested, you may stop working for your current employer and still keep your right to a future retirement benefit. Your personal account will keep earning interest each year until your membership ends. Your membership ends when you withdraw your personal deposits or choose a retirement benefit, or upon your death. (If you were a member of TCDRS before 2000, you may be vested with 4 years of service.)

When You Can Retire

Once you are vested, you are eligible for a retirement benefit when you meet one of the following requirements:

- At age 60 with 8 years of Service; or
- At any age with 30 years of Service; or
- You age plus your years of Service equals 75 (also called the rule of 75)

The statement you get from TCDRS every year shows your account balance and the earliest date you will be eligible to retire. You can also view your statement online at www.tcdrs.org. If you have more than one TCDRS account, please visit our Web site or call Member Services for more information about managing multiple accounts.

When You Retire

When you retire, you may choose to receive a monthly benefit payment. All payment options pay you for your lifetime. Some of the payment options also provide a monthly benefit for your beneficiary after your death.

Your monthly benefit is based on the amount of money in your account and the matching credits your employer has agreed to provide. Your current deposits get matching credits in a ratio of 2.25:1, or \$2.25 for every \$1.00 you are depositing. (Travis County may change its matching credits in the future so your current ratio may not apply to all of your future deposits.) Travis County also provides monetary credit for time worked before it joined TCDRS (prior service credit). Travis County joined TCDRS in January 1968.

Termination from Travis County

If you terminate from Travis County prior to vesting with TCDRS, you will be eligible to receive back your monies you put into the Retirement Plan. If you are not vested upon termination you will not be eligible to receive any additional monies from Travis County or interest.

Other Benefits

Please contact TCDRS directly at 800.823.7782 for more information on other benefits that may be available in certain situations.

Travis County 457(b) Deferred Compensation Plan

About the 457(b) Deferred Compensation Plan

Empower Retirement (formerly Great-West Retirement Services) administers the Travis County 457(b) Deferred Compensation Plan. A governmental 457(b) Deferred Compensation Plan is a retirement savings plan that allows eligible employees to save and invest for retirement in both a pre-tax and post-tax (Roth) plan through a voluntary salary contribution. For the pre-tax plan contributions and any earnings on contributions are tax-deferred until money is withdrawn. Then you will pay taxes at your regular tax rate at the time the money is withdrawn. For the Roth plan, since you have contributed to the plan with post-tax funds contributions and any earnings on contributions are not considered to be taxable income when withdrawn. All regular Travis County employees may contribute to the Plan. Temporary employees are not eligible to participate.

2016 Contribution Limits

- Combined maximum limit of 100% (\$1 per pay-period minimum) of your compensation or \$18,000, whichever is less for all retirement contributions, or;
- Participants turning age 50 or older in 2016 may contribute an additional \$6,000.
- Special 457(b) catch-up contributions, if permitted by the plan, allow a participant for 3 years prior to the normal retirement age (as specified in the plan) to contribute the lesser of:
 - Twice the annual limit (\$36,000 in 2016), or
 - The basic annual limit plus the amount of the basic limit not used in prior years (only allowed if not using age 50 or over catch-up contributions)

Contribution limits are set annually by the IRS. 2017 contribution limits were not available at the time of publication.

457(b) Plan Vesting

Vesting refers to the percentage of your account you are entitled to receive upon the occurrence of distributable events. Your contributions and any earnings are always 100% vested (including rollovers from previous employers).

Investment Options

A wide array of core investment options is available through your Plan. Each option is explained in further detail in your Plan's fund sheets. Once you have enrolled, investment option information is also available through the Web site at www.empower-retirement.com or toll free at 800-701-8255.

In addition to the core investment options, a Self-Directed Brokerage (SDB) account is available. The SDB account allows you to select from numerous investment options for additional fees. The SDB account is intended for knowledgeable investors who acknowledge and understand the risks associated with the investments contained in the SDB account.

Rollovers

Only Plan Administrator approved balances from an eligible governmental 457(b), 401(k), 403(b) or 401(a) plan or an Individual Retirement Account (IRA) may be rolled over to the Plan. Distributions you receive prior to age 59½ may be subject to the 10% early withdrawal federal tax penalty.

Withdrawals

Qualifying distribution events are as follows:

- Retirement
- Severance of employment (as defined by the Internal Revenue Code provisions)
- Attainment of age 70½ (If allowed by Government Plan's provisions)
- Death (your beneficiary receives your benefits)
- Unforeseeable emergency (as defined by the Internal Revenue Code and if allowed by your Plan's provisions)

Each distribution is subject to ordinary income tax except for an in-service transfer to purchase service credit.

Loans

Your Plan allows you to borrow the lesser of \$50,000 or 50% of your total vested account balance. The minimum loan amount is \$1,000 and you have up to 5 years to repay your loan — up to 10 years if the money is used to purchase your primary residence. There is a \$50 origination fee for each loan, plus an ongoing annual \$25 fee.

How Can I Get More Information?

Visit the Empower Retirement website at www.empower-retirement.com or call KeyTalk® toll-free at 800.701.8255 for more information. The Web site provides information regarding your Plan, as well as financial education information, financial calculators and other tools to help you manage your account.

PAID TIME-OFF BENEFITS

It is the intent of the county to provide all regular employees with a competitive benefit package. The Commissioners Court will determine the level of benefits that will be provided based on the financial resources of the County. Employee benefits are subject to change on an annual basis by order of Commissioners Court through the budgetary process.

Vacation Time

The County recognizes that employees need time away from work for rest, relaxation, and to attend to personal business that must be conducted during normal office hours, therefore, the County has established a vacation leave policy. Employees must obtain approval from their supervisor, before using vacation leave. Regular employees shall earn vacation leave each pay period as long as employment continues. Regular part-time employees shall earn vacation leave on a prorated basis.

The maximum accrual of vacation leave is limited to 240 hours (30 days) for regular full-time employees, except for law enforcement officers, who have no limit on accrual. Upon separation, a regular full-time employee shall be paid for vacation leave accrued on the basis of their final salary rate. Payment shall not exceed a total of 160 hours (20 days).

Vacation Time Accrual Levels	
0 - 5 years	4.0 hours per pay period
6 - 10 years	4.5 hours per pay period
11 - 15 years	5.0 hours per pay period
16 - 20 years	5.5 hours per pay period
21 + years	6.0 hours per pay period

Vacation will be granted to employees at the discretion of the elected official/department head or their designee who will give due consideration to the needs of the office/department and the ability of remaining staff to perform the necessary work. An official county holiday which occurs during an employee's vacation shall not be charged against vacation leave time.

Sick Leave

Regular employees shall earn sick leave at a rate of 4 hours per pay period, with no accrual maximum. Regular part-time employees shall earn sick leave on a pro-rated basis.

An elected official/department head, or his/her designee, should authorize use of accrued sick leave for an employee who is unable to perform his/her duties because of illness, injury, or other temporary disabilities. An employee may use accrued sick leave to care for a member(s) of the employee's immediate family, or a person(s) within the same household with whom the employee shares a significant relationship of mutual caring, who are ill or incapacitated. An employee must obtain approval from his/her immediate supervisor prior to attending an appointment for non-emergency dental or medical examinations, for himself or an immediate family member, scheduled during normal working hours.

An elected official/department head, or his/her designee, may ask an employee to provide a doctor's statement to substantiate sick leave requests after an employee has been on sick leave for three (3) consecutive work days or more.

Unscheduled sick leave usage should be used for emergency situations only. The employee should follow the department's notification procedures when unable to report to work as scheduled.

Upon separation, a regular full-time employee shall be paid for one-half of his/her accrued sick leave up to a maximum of 480 hours at his/her final salary rate. Separation sick leave payment shall not exceed a total of 240 hours (30 days).

Personal Holiday

All regular full-time employees are eligible for up to three (3) paid personal holidays each calendar year if approved on an annual basis by the Commissioners Court. Regular part-time employees shall be granted personal holidays on a prorated basis.

Personal holidays are in addition to vacation leave and shall be scheduled at the discretion of the elected official/department head, or his/her designee. Personal holidays shall be requested by the employee and approved by the elected official/department head or his/her designee. Personal holidays do not accumulate from one calendar year to the next and must be used in the same calendar year in which they were granted.

An employee shall earn personal holidays for the calendar year in which the employee begins employment based on the month in which he/she begins work as shown below:

January- March	3 personal holidays
April- June	2 personal holidays
July - September	1 personal holidays
October-December	none

A new employee must be employed for 90 calendar days before taking a personal holiday. Reinstated employees will earn personal holidays based on their new hire date, except that no employee may earn more than 3 personal holidays in one calendar year. Unused personal holidays are not paid at separation. A personal holiday may not be used as the last day of employment.

An employee who is on leave without pay will not accrue Vacation leave, Sick leave, Longevity, Merit review service, or Retirement service.

Travis County will not extend any employee benefits to an employee while he/she remains on leave without pay except as required by law. The employee may choose to make arrangements with the county auditor to pay both the employee and the employer portions of benefit premiums in order to maintain health and insurance coverage during the leave.

Holiday Pay

Regular full-time and regular part-time employees are allowed the holidays designated by the official action of the Commissioners Court, unless required by their supervisor to work. Regular part-time employees receive pay for the holidays on a pro-rated basis.

FY 17 Travis County Approved Holidays	
Veteran's Day	Friday, November 11, 2016
Thanksgiving Day	Thursday, November 24, 2016
Day after Thanksgiving	Friday, November 25, 2016
Christmas Eve (observed)	Friday, December 23, 2016
Day after Christmas	Monday, December 26, 2016
New Year's Day (observed)	Monday, January 2, 2017
Martin Luther King, Jr. Day	Monday, January 16, 2017
President's Day	Monday, February 20, 2017
Memorial Day	Monday, May 29, 2017
Independence Day	Tuesday, July 4, 2017
Labor Day	Monday, September 4, 2017

Regular non-exempt employees who are required by their supervisor to work on a holiday accrue non-designated holiday time credit on an hour for hour basis for scheduled hours worked. This credit may be used at a later date.

- Regular non-exempt and exempt aviation employees who are required by their supervisor to work on a holiday receive holiday time pay on an hour for hour basis for scheduled hours worked in addition to pay for the hours worked.
- Regular non-exempt and exempt aviation employees whose regularly scheduled day off falls on a holiday accrues non-designated holiday time credit on an hour for hour basis for scheduled hours. This credit may be used at a later date.

Regular non-exempt employees whose regularly scheduled day off falls on a holiday accrues non-designated holiday time credit on an hour for hour basis for scheduled hours. This credit may be used at a later date. Employees must obtain approval from their supervisor before using non-designated holiday time credit.

If an employee is requesting leave, the employee must use non-designated holiday time credit before using vacation leave unless the employee is subject to losing vacation leave if it is not taken within the following three months. It is the employee's responsibility to request the appropriate type of leave. Non-designated holiday time credit accrues until it is used or until an employee separates from the County. Upon separation, non-exempt employees are not paid for more than 16 hours of unused non-designated holiday credit. Unused non-designated holiday credit is paid at his/her final salary rate.

Catastrophic Sick Leave Pool

Commissioners Court approved the implementation of a Catastrophic Sick Leave (CSL) Policy. This policy allows employees to donate hours to a "Pool". The enrollment is concurrent with the Open Enrollment period each year. The hours in the pool can then be used by those employees who have donated and exhaust all of their paid time off due to a catastrophic illness.

Who is eligible to donate time to the CSL Pool?

Travis County Employees must:

1. Be a Regular Fulltime employee with Travis County; and
2. Have worked full time with Travis County for 12 consecutive months; and
3. Voluntarily donate a minimum of 8 hours of leave (maximum of 40 hours) during Open Enrollment.
 - a. Donation may be sick leave and/or vacation leave (in 8 hour increments)
 - b. Must have a remaining balance of 40 hours (sick + vacation) after donation

At separation, employees may donate up to 80 hours of any combination of sick and/or vacation leave.

Who is eligible to use CSL time from the Pool?

1. An employee donates a minimum of 8 hours (or more in 8 hour increments) to the CLS Pool each year during Open Enrollment to be eligible from October 1 – September 30.
2. An employee must be absent from work seven consecutive work days as a result of their own catastrophic injury or illness or that of an immediate family member (See 10.076 (a) (7) for immediate family member), and
3. An employee must submit the request for CSL with appropriate medical documentation to the CSL Administrator for consideration for approval.

What qualifies as a catastrophic injury or illness?

The CLS Policy provides the following definition in Section 10.372:

- (2) Catastrophic Illness or Injury. A catastrophic illness or injury is a serious debilitating illness, injury, impairment, or physical or mental condition that is present for a minimum of seven consecutive calendar days, and that involves:
 - (A) A period of illness or injury or treatment connected with inpatient care (e.g., an overnight stay) in a hospital, hospice, or residential medical care facility; or
 - (B) A period of illness or injury requiring absence from work of seven or more consecutive work days, and that also involves continuing treatment by (or under the supervision of) a licensed health care provider; or
 - (C) A period of illness or injury that is long-term due to a condition for which treatment may be ineffective (e.g., stroke, terminal disease, etc.); or
 - (D) An absence of at least seven (7) consecutive work days to receive multiple treatments (including any period of recovery there from) either for restorative surgery after an accident or other injury, or for a prolonged condition, i.e., cancer or kidney disease.

OTHER BENEFITS

Employee Assistance Program

Deer Oaks EAP sponsors Travis County's Employee Assistance Program (EAP). The EAP is a program offering free and confidential short-term counseling and referral services to Travis County employees and their families. Employees are eligible to use the EAP on their first day of employment with the County. The EAP is a resource for personal, work-related, financial and even legal assistance. Employees can access services through Deer Oaks by calling the toll free number at 866.327.2400 anytime, 24 hours a day, and 365 days a year.

You will speak confidentially with one of the Deer Oaks intake and referral counselors who can help set up an appointment with an EAP counselor, schedule a free 30-minute legal or financial consultation or gather referrals and resources on a variety of work/life topics.

It is the policy of Deer Oaks to assure strict confidentiality in the handling of employee's identities and personal information associated with the use of the EAP.

Deer Oaks EAP can help you with:

- Job performance
- Marital difficulties
- Family issues
- Communication skills
- Managing depression and anxiety
- Alcohol / Substance Abuse
- Child and elder care resources
- Parenting support
- Anger management
- Legal and financial issues
- Grief and bereavement
- Smoking cessation
- Weight loss
- Time management
- Stress management
- Personal concerns
- Career management
- Self-improvement plans

Additional resources and contact information can be found on their web site at www.deeroaks.com. To log in to the site for the online newsletters, work/life resource locators, the savings center and others use "traviscountytx" as the user name and password.

Tuition Reimbursement

Travis County offers Tuition Reimbursement to its regular employees, who have been continuously employed full-time with Travis County at least six months prior to the start of the course and remain continuously employed with Travis County at least six months after the end of the course. Elected and Appointed Officials are not eligible for Tuition Reimbursement. In order to receive a refund, the course must be taken from an accredited college, university, or technical school in the United States and approved by the Human Resources Management Department. Once an employee receives approval and meets the completion requirement(s) for the course or exam, employees can receive assistance equal to 80% of the tuition (tuition, testing and required fees) up to a \$1,000 maximum per semester, and \$2,000 maximum per fiscal year.

For eligibility, completion requirements and other details please refer to section 10.020 of the "Chapter 10: Travis County Personnel Benefits Guidelines and Procedures Manual."

Longevity Pay

For regular employees, longevity pay is based on long-term employment and service to Travis County. For transfer employees, longevity pay is based on long-term employment and service to both the City of Austin and the Travis County. Longevity Pay is paid to regular and transfer employees for each year completed after three years of continuous service on the anniversary of their hire date. On an employee's fourth and subsequent anniversaries, he or she will receive a lump sum payment for the previous year. Any employee who terminates employment prior to his or either her anniversary date forfeits longevity pay.

Longevity pay is based whichever is greater, either

- On five dollars per month for each year of service up to 25 years, or
- On a percentage of the employee's annual base pay as follows:
 - For three to five years of service: .50%
 - For six to nine years of service: .75%
 - For 10 to 15 years of service: 1.00%
 - For 16 to 20 years of service: 1.5%
 - For 21 or more years of service: 2.00%
- An employee with more than 25 years of service will be credited for the maximum of 25 years at the higher rate.
- Peace officers who are in a law enforcement activity, whose job mandates state peace officer certification accrue up to 25 years of longevity pay. Longevity pay begins after one year of certification and is prorated upon separation from the county.

Worker's Compensation

The county provides all employees with Workers' Compensation coverage in accordance with state statute. A salary continuation program has been provided by the Commissioner's Court through the budget process. All non-POPS regular employees are eligible for salary continuation if they are injured or become ill due to a job-related incident and follow the required reporting procedures up to a maximum of six (6) months from the date of injury. If you sustain an injury arising out of, or in the course of work, you must report such injury to your supervisor and/or the Risk Management Department immediately.

Training & Development

Management Development

HRMD offers training that supports the "core competencies" that have been approved by the Commissioner's Court. Approval of the "core competencies" established the Court's expectations and a baseline for required knowledge and skills for individuals who supervise people. Gain the fundamental knowledge and skills you need to become a confident and effective manager by participating in world-class training that is guaranteed to enhance your people management skills.

Earn a Management Certificate of Achievement by completing all eight classes as part of the Performance Management initiative.

- Conflict Resolution Alternatives
- EAP Orientation for Supervisors
- Effective Discipline for Performance and Behavior
- FLSA (Fair Labor Standards Act)
- FMLA / ADA
- Harassment Prevention for Supervisors
- Key Principles of Effective Performance Management
- Workers Compensation

Leadership Austin

The purpose of this program is to benefit Travis County and the community by providing an opportunity for county employees to participate in leadership training as funds are available and to provide written guidelines for consideration in awarding of those funds. This program is separate from the Tuition Reimbursement and does not overlap.

Travis County Leadership program is available to all employees who wish to take part in Leadership Training which would result in direct benefit to Travis County. Employees or their department should submit a Memorandum of Request to the Human Resources Management Department.

See Chapter 16 of the Travis County Code: Leadership Training-Funding Guidelines for additional details on the program.

REQUIRED NOTICES

Premium Assistance under Medicaid and CHIP

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877.KIDSNOW (877.543.7669)** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **866.444.EBSA (3272)**.

If you live in Texas, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility.

TEXAS - Medicaid

Website: www.gethipptexas.com

Phone: 800.440.0493

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Newborns Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours).

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for a mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
 - Surgery/reconstruction of the other breast to produce a symmetrical appearance;
 - Prostheses; and
 - Treatment for physical complications during all stages of mastectomy, including lymph edemas.
- In addition, the plan may not:
- Interfere with a participant's rights under the plan to avoid these requirements; or
 - Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and copays consistent with other coverage provided by the plan.

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. For more 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 it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 of the following qualifying events:

- 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 of the following qualifying events:

- 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 continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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 to:

Travis County Human Resources Management Department
c/o Benefits Division
PO Box 1748
Austin, TX 78767

How is COBRA continuation 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of

coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

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

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Flexible Spending Account or Medical Reimbursement Account: If you are participating in the company's Flexible Spending Account or Medical Reimbursement Account at the time of your termination or reduction of hours, you may also have the right to continue participation under COBRA based on the following parameters:

1. You will be allowed to continue coverage for the remainder of the current plan year if you have a balance remaining in your account at the time of your termination or reduction in hours;
2. You will not be able to receive reimbursements in excess of your original election amount in the account; and
3. You make monthly payments in the same amount as your regular payroll deductions while you were an active employee.

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 the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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

If you have any questions about your rights to COBRA continuation coverage, you should contact:

UnitedHealthcare
P.O. Box 221709
Louisville, KY 40252
www.uhcservices.com
Plan contact information

Customer Care Center
Toll Free: 877.237.8576
email: cobra_kyoperations@uhc.com

Health Insurance Portability and Accountability Act (HIPAA) Notice

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws.

Special Enrollments: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "30 days" after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Travis County Human Resources Department at 512.854.9165.



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone’s health or safety
-

Do research

- We can use or share your information for health research.
-

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
-

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
 - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
-

Address workers’ compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers’ compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
-

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of this Notice: August 1, 2016
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