

FY21

Employee Benefits Guide



October 1, 2020 - September 31, 2021

Information about your Benefits:
Medical - Dental - Vision - Life Insurance - Disability - FSA - Wellness

WELCOME TO YOUR TRAVIS COUNTY EMPLOYEE BENEFITS!

As a valued employee of Travis County, your health and wellbeing is important to us. The information provided in this guide will serve as a resource tool for you as you prepare to select the best benefit choices for you and your family. The guide provides summaries of the benefits available, eligibility requirements, costs and contact information.

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 and how to use them. Since Travis County is self-insured, we are doing everything we can to ensure that we are all informed consumers and effectively manage the long term cost of healthcare.

If benefits change over the course of the fiscal year, this Benefits Guide will be updated in the online version which you can access on Travis Central.

Every effort has been made to ensure that this information is accurate. It is not intended to replace any legal plan documents which contain the complete provisions of any benefit. In case of any discrepancy between this guide and the legal plan document, the legal plan document will govern in all cases. An employee may review the legal plan documents online or by calling the Benefits Office at 512.854.0404.

WHAT'S CHANGING FOR FY21?

Travis County Health Plans Changes:

- No change in medical premiums or plan design
- New! Diabetes Health Plan

Travis County Dental, Vision, Life, and Disability Plans Changes:

- 4.5% rate increase for PPO dental plans

Health Savings Account Changes:

- Maximum contributions increased from \$3,550 to \$3,600 for Individual and \$7,100 to \$7,200 for Employee and Dependents
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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
Fax- 512.854.6677
Email- BenefitsTeam@traviscountytexas.gov
Online- <http://traviscentral/hr/benefits>
Contact the vendors directly for:
ID cards, claims, benefits, or coverage information

Travis County Health Insurance Plans

United Healthcare (UHC)
Group #: 701254
866.649.4873 (Members)
877.365.7949 (Nurse Line)
877.237.8576 (Retiree Billing Questions)
www.myuhc.com
App: Health4Me

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

Optum Rx
844.265.1719
844.368.8732 (Rx services)
855.427.4682 (specialty)
www.optumrx.com
App: OptumRx

Vision Insurance

Davis Vision
877.923.2847
Client Code 3632
www.davisvision.com
App: DavisVision

Dental Insurance Plans

Sun Life Financial
Group #: 915209
877.743.1454
www.slservicerresources.com
App: Sun Life Benefit Tools

Basic Life Insurance

United Healthcare
Group Policy #: 304781

Employee Assistance Program

Deer Oaks EAP
866.327.2400
www.deeroakseap.com
Username & Password- traviscountytexas
App: iConnectYou

Flexible Spending Accounts (FSA)

United Healthcare (UHC)
866.649.4873
www.myuhc.com
App: Health4Me

Health Savings Account (HSA)

Optum Health Bank
800.791.9361
www.optumbank.com
App: Optum Bank

Supplemental Life, Disability and AD&D

Cigna
800.362.4462
www.Cigna.com
App: myCigna

Texas County & District Retirement System (TCDRS)

800.823.7782 or 512.328.8889
www.tcdrs.org

Deferred Compensation Plan 457(b)

Empower Retirement
Moody Bank Building
400 W 15th Street # 317
Austin, TX 78701-1641
800.701.8255
www.empower-retirement.com
App: Empower Retirement

Empower Representative

Chara Green 512.831.2942
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 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
- Dependent Life Insurance
- Personal Accident Insurance (AD&D)
- Flexible Spending Accounts (Medical & Dependent Care)
- Health Savings Account and Limited FSA (must be enrolled in HDHP)
- Short & Long Term Disability
- 457(b) Deferred Compensation Plan
- Employee Assistance Plan (EAP)
- Travis County Wellness Program
- 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 eligible to participate in:

- County Retirement Program through TCDRS (mandatory enrollment)

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 or Common-Law Spouse

Defined as a spouse who is legally married to the employee or has filed a Declaration and Registration of an Informal Marriage for the State of Texas.

Domestic Partner (same or opposite sex)

Defined as a person who shares the same permanent residence and the common necessities of life. A domestic partner or a domestic **partner's child is not eligible** for COBRA.

Sponsored Dependent

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

A sponsored dependent is not eligible for COBRA. An employee may only cover one adult as a dependent. If a spouse or domestic partner is covered, you cannot cover a sponsored dependent.

Child of 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.

DEPENDENT DOCUMENTATION

Documentation is required to support the eligibility status of new dependents. Any false information may result in loss of coverage for that dependent and may require reimbursement to the plan for any claims paid. The documentation must be presented prior to your first day of coverage. If documentation is not received, the dependent will be dropped. Social Security numbers must be provided for all eligible dependents.

- 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 Employee and Spouse**
- **Child (legally adopted child of Employee's Domestic Partner): Final order of adoption of child showing Employee'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 Benefit Plan Year begins on October 1st of each year and continues through September 30th of the following year. As an employee you are allowed to make elections and/or changes only during certain enrollment periods. Please review the additional information regarding enrollment periods.

New Hire Enrollment

As a new employee, you will be eligible for benefits the first of the month following 28 days of benefit-eligible employment. New employees will be given an initial enrollment period of 30 days after their hire date to enroll. During this time, employees are allowed to add, delete or change benefit elections. Enrollment is conducted through the Employee Self-Service in the SAP system (SAP ESS).

Open Enrollment

Each year we offer you an opportunity to review your current benefits and make changes for the upcoming plan year. During Open Enrollment you are allowed to add, remove or change your benefits. Open Enrollment is typically conducted in the month of August. The changes you make will be effective October 1st. If you do not make changes, your benefits will rollover. You must re-enroll in Flexible Spending Accounts each year.

Benefit Changes during the Plan Year- Qualifying Life Events

IRS Section 125 guidelines allow you to enroll in a Health, Dental and/ or Vision and have your premiums adjusted before taxes. The IRS requires that benefits paid with pre-tax contributions stay in effect the full plan year. Therefore, you cannot change your elections 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:

- Change in your legal marital status: marriage, divorce, annulment, or death of spouse
- Change in your dependent's status: birth, adoption, placement for adoption, death or your dependent loses eligibility due to age or marriage
- Change in your employment status or work schedule that affects your benefits eligibility
- Change **in your spouse's benefits coverage or eligibility**
- Change in a permanent residence that may affect the coverage for which you are eligible for

Any change in coverage must be consistent with the QLE. You have 30 days from the qualifying event to change your coverage election. If you have a QLE, call the Benefits Office within 30 days to determine if your life event qualifies and also the necessary documentation to make the change. For changes in eligibility of Medicaid or State CHIP coverage, you have 60 days from the event to notify the Benefits 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 QLE. Changes to life insurance beneficiaries and participation in the 457(b) Deferred Compensation plan may be changed at any time during the year.

EMPLOYEE HEALTH PLAN PREMIUMS

Monthly Premiums

	Emp only	Emp+1 Adult	Emp+1 Child	Emp+ Children	Emp+adult +Child	Emp+adult +Children
EPO	\$139.00	\$650.00	\$299.00	\$518.00	\$896.00	\$1,129.00
PPO	\$29.00	\$321.00	\$95.00	\$223.00	\$476.00	\$620.00
Consumer Choice	\$0.00	\$217.00	\$30.00	\$131.00	\$337.00	\$456.00
High Deductible	\$0.00	\$202.00	\$17.00	\$116.00	\$324.00	\$438.00

Per Pay-Period Premiums

	Emp only	Emp+1 Adult	Emp+1 Child	Emp+ Children	Emp+adult +Child	Emp+adult +Children
EPO	\$69.50	\$325.00	\$149.50	\$259.00	\$448.00	\$564.50
PPO	\$14.50	\$160.50	\$47.50	\$111.50	\$238.00	\$310.00
Consumer Choice	\$0.00	\$108.50	\$15.00	\$65.50	\$168.50	\$228.00
High Deductible	\$0.00	\$101.00	\$8.50	\$58.00	\$162.00	\$219.00

Imputed Income of Health Plan Premiums

Travis County allows its 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 the employee and Travis County contribute to the cost of premiums for these covered individuals.

While Travis County allows these dependents on the plan, for federal income tax purposes, providing group health care benefits to a non-IRS-qualified dependent is taxable to the employee. This requires Travis County to calculate imputed income for the employee which reflects 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 dependent is a post-tax deduction.

For example, if the County contributes \$1,271 per month for Employee + Adult coverage and contributes \$750 for Employee Only coverage then the imputed income amount for the other adult is \$521 per month. This is considered to be the County contribution made for the other adult coverage. Below are the monthly imputed income amounts.

Covered Dependent	Monthly (EPO, PPO, Consumer)	Per PP (EPO, PPO, Consumer)	Monthly (HDHP)	Per PP (HDHP)
Non-Qualified Adult (Dom Partner, Sponsored Adult)	\$521.00	\$260.50	\$550.00	\$275.00
Non-Qualified Child (Child of Dom Partner, Grandchild)	\$184.00	\$92.00	\$213.00	\$106.50
Non-Qualified Children (2 or more Children of Dom Partner, Grandchildren)	\$456.00	\$228.00	\$485.00	\$242.50

TRAVIS COUNTY HEALTH INSURANCE

Travis County's medical coverage helps you maintain your wellbeing through preventive care and access to an extensive network of providers. Medical benefits are administered by United Healthcare. Choose the plan that best matches your needs and keep in mind that the option you elect will be in place for the entire plan year, unless you have a qualifying event. Here are some items to consider when choosing a health plan:

- Premium costs- Premiums are the amount that is deducted per pay check for the health plan chosen
- Dependent coverage- Premiums are more expensive for dependent coverage
- How do you use the plan? Are you a high utilizer or low utilizer?
- Amount of copays
- Deductible amounts
- Out-of-pocket maximums
- Future expenses (maternity, planned surgery, etc)

Below is a brief description of each health plan offered.

Exclusive Provider Organization EPO Plan (In-Network Only)

This plan has the highest monthly premium for employees and covers only in-network services. This plan has copays for most services including inpatient hospital, office visits and emergency room. Some services have both a copay and a deductible. The plan will cover 100% of charges once the deductible and copay has been made. There is a separate deductible and out-of-pocket maximum for pharmacy on this plan.

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 in-network doctor your benefit will be much greater and your out-of-pocket will be much less. This plan consists of either copays or deductibles for services. There is a separate deductible and out-of-pocket maximum for pharmacy on this plan.

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

This plan has low monthly premiums. This plan is a **“deductible first” plan where you have to pay the deductible before the plan will pay any coinsurance;** this includes primary care and specialist office visits. Preventive care is covered at 100%. The deductible does not apply to prescription pharmacy benefits. The pharmacy on this plan is a percentage of the cost of the medication but includes minimums and maximums. This plan is free for employee only and could be a good choice for employees who rarely use the plan.

High Deductible Health Plan- HDHP (In and Out-of-Network)

This plan has the lowest monthly premiums of the four plans. **This plan is a “deductible first” plan** where you have to pay the deductible first before the plan will pay any coinsurance. Preventive care is covered at 100%. There is not a separate Pharmacy deductible on this plan. This plan includes a Health Savings Account that can be used to pay for eligible expenses. The County contributes to the HSA annually and the account is portable, which means it stays with the employee if they leave Travis County or retire. The HSA also has investment options. This plan is free for employee only and could be a good choice for employees who rarely use the plan.

Travis County Health Plan Comparison Chart

	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>	High Deductible <i>In and Out-of-Network</i>
County Annual Contribution to Health Savings Account	\$0	\$0	\$0	\$500 Individual \$1,000 Family (Amount is reduced based on date of hire for new employees)
Employee Annual Contribution Limit for Health Savings Account	N/A	N/A	N/A	\$3,050 Individual \$6,100 Family
Deductible	\$600 per Individual	\$700 Individual \$1,750 Family	\$500 Individual \$1,250 Family	\$1,500 Individual \$3,000 Family
Out-of-Network Deductible	Not Covered	\$2,000 Individual \$5,000 Family	\$1,500 Individual \$3,750 Family	\$4,500 Individual \$9,000 Family
Coinsurance	Plan pays 100% Member pays 0%	Plan pays 85% Member pays 15%	Plan pays 80% Member pays 20%	Plan pays 90% Member pays 10%
Out-of-Network Coinsurance	Not Covered	Plan pays 60% Member pays 40%	Plan pays 60% Member pays 40%	Plan pays 60% Member pays 40%
Medical Out of pocket maximum	\$4,500 Individual \$9,000 Family	\$4,500 Individual \$9,000 Family	\$3,500 Individual \$7,000 Family	\$6,750 Individual \$7,900 Family
Out-of-Network Medical Out of pocket maximum	Not covered	\$6,000 Individual \$12,000 Family	\$6,000 Individual \$12,000 Family	\$13,300 Individual \$26,600 Family
Pharmacy Out of pocket maximum	\$2,500 Individual \$5,000 Family	\$2,500 Individual \$5,000 Family	\$2,500 Individual \$5,000 Family	Subject to Medical Out of pocket Maximum
1. Acupuncture (up to 30 visits)	\$35 per visit - PCP \$50 per visit - Specialist	\$30 per visit - PCP \$45 per visit - Specialist	Deductible & Coinsurance	Deductible & Coinsurance
2. Allergy Services in a Physician's Office (no copay applies to injections or serum)	\$35 per visit - PCP	\$30 per visit - PCP	Deductible & Coinsurance	Deductible & Coinsurance
Allergy Testing	100%	100%		
3. Ambulance Services - Emergency only (Ground or Air Transportation)	\$100 Copay	\$100 Copay	Deductible & Coinsurance	Deductible & Coinsurance
4. Chiropractic Services (Limit of 3 treatments per visit and 25 visits per year)	\$35 per visit - PCP	\$30 per visit - PCP	Deductible & Coinsurance	Deductible & Coinsurance

	EPO Plan	PPO Plan	Consumer Choice	High Deductible
5. Dental Services - Accident related only Prior notification is required before follow-up treatment begins	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
6. Diabetic Supplies	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	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%	Plan Pays 100% Member Pays 0%	Deductible & Coinsurance
8. Emergency Room	\$300 per visit, waived if admitted to hospital	\$300 per visit, waived if admitted to hospital	Deductible & Coinsurance	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%	\$50 Fee per visit, after deductible is met 100%
10. Eye Examinations Limited to one per calendar year	\$35 per visit - PCP \$50 per visit - Specialist	\$30 per visit - PCP \$45 per visit - Specialist	Deductible & Coinsurance	Deductible & Coinsurance
11. Hearing Aid Benefit	\$1,000 every 3 years	\$1,000 every 3 years	\$1,000 every 3 years	Deductible & Coinsurance
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%	Plan Pays 100% Member Pays 0%	Deductible & Coinsurance
13. Hospice Care Prior notification is required	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Deductible & Coinsurance
14. Hospital - Inpatient Stay	\$1,250 copay per visit, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance	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	\$1,250 copay per visit, then Deductible No Copay applies to Physician office visits for prenatal care after the first visit.	Deductible & Coinsurance No Copay applies to Physician office visits for prenatal care after the first visit.	Deductible & Coinsurance No Copay applies to Physician office visits for prenatal care after the first visit.	Deductible & Coinsurance

	EPO Plan	PPO Plan	Consumer Choice	High Deductible
16. Mental Health Services - Inpatient, Outpatient and Intermediate Must call Care Coordination for authorization prior to receiving Out-of-Network services	\$1,250 copay, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
17. Mental Health Services - Office Visit	\$35 per visit	\$30 per visit	Deductible & Coinsurance	Deductible & Coinsurance
18. Outpatient Surgery	\$600 copay per visit, then Deductible	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	Deductible & Coinsurance
Mammograms, Colonoscopies, and Endoscopies	Plan Pays 100% Member Pays 0%	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 & UHC Premium Designated Specialist \$50 per visit - Specialist	\$30 per visit - PCP & UHC Premium Designated Specialist \$45 per visit - Specialist	Deductible & Coinsurance	Deductible & Coinsurance
20. Preventive Services	Plan pays 100% Member pays 0%	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	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%	Plan Pays 100% Member Pays 0%	Deductible & Coinsurance
23. Reconstructive Procedures	Same as 14, 17, 18 & 19	Same as 14, 17, 18 & 19	Deductible & Coinsurance	Deductible & Coinsurance
24. Rehabilitation Services - Outpatient Therapy (physical, speech, and occupational therapy)	\$15 per visit for 15 visits in conjunction with an office visit; 16 or more visits \$35 per visit - PCP \$50 per visit - Specialist	\$15 per visit for 15 visits in conjunction with an office visit; 16 or more visits \$30 per visit - PCP \$45 per visit - Specialist	Deductible & Coinsurance	Deductible & Coinsurance

	EPO Plan	PPO Plan	Consumer Choice	High Deductible
25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 60 days per year)	\$1,250 copay per visit, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
26. Substance Abuse Services - Outpatient	\$35 per visit	\$30 per visit	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.	Inpatient \$1,250 copay per visit, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
28. Transplantation Services See summary plan description for possible limitations and more specific information	Inpatient \$1,250 copay per visit, 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	Deductible & Coinsurance Prior notification is required prior to any services
29. Urgent Care Center Services	\$50 per visit	\$45 per visit	Deductible & Coinsurance	Deductible & Coinsurance
30. Virtual Visit	\$10 copay	\$10 copay	Deductible & Coinsurance	Deductible & Coinsurance

The following procedures require notification of UHC Care Coordination PRIOR to services.
Call 866.649.4873 if you need any of the following:

- 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

United Healthcare Tools and Resources

NurseLine- (877.365.7949)

In non-emergency situations, free help is only a phone call or click away. NurseLine is available 24/7 and allows you to speak with an experienced registered nurse who can give you treatment advice **and determine if it's necessary for you to see a doctor**. The nurse can also help locate a doctor or urgent care facility that is near your home or office. This service is free and may save you a trip to the doctor!

Virtual Visits

A virtual visit lets you see and talk to a doctor from your mobile device or computer immediately with or without an appointment. Most visits take less than 10 minutes and doctors can write a prescription, if needed, that you can pick up at the pharmacy of your choice. During your visit you will be able to talk to a doctor about your symptoms and treatment options. You must have a smart phone, tablet or computer with a camera so that the doctor can see and speak to you. Also available for mental health.

Conditions commonly treated:

- Bladder infection/urinary tract infection
- Cold/flu
- Allergies
- Diarrhea
- Fever
- Pink eye
- Rash
- Sinus problems

Virtual visits are not good for anything that may require a hands on exam or emergencies. Download Doctor on Demand App on your smartphone or tablet to access virtual visits. You may also login to myuhc.com to access virtual visits.

MyUHC.com

The www.myuhc.com web site offers online tools, resources and information that are both practical and personalized. Here are just some of the things you can do:

- View benefits and eligibility
- Estimate treatment costs
- View claim documents
- Find a network doctor
- Enroll in online health and wellness programs

To get the most out of your benefits:

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

Health4Me Mobile App

United HealthCare'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 anything related to your health. Download the Health4Me app from the Apple iTunes App Store and the Google Play store.

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. Getting an estimate of what you will be responsible for paying out of your pocket will provide you with useful information for planning and budgeting.

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

Just search for the condition (e.g., back pain) or treatment (e.g., physical therapy) you would like an estimate for, and the Cost Estimator will show you doctors and locations that offer those services in your area. You will 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 will be able to make an informed decision about what's best for you.**



Real Appeal

Real Appeal takes an evidence-based approach to support weight loss. This program helps people make small changes necessary for long-term health results.

Key Program Components:

- Interactive coaching, live over the internet
- Weekly group coaching
- Ongoing one-on-one personalized coaching
- Program success guide, nutrition and fitness guide
- Blender, body weight scale, food scale, **workout DVD's, fitness band, pedometer** and more
- Web-based participation through web platform or mobile app
- Online or mobile tools to track nutrition and physical activity

To enroll visit www.tccare.realappeal.com

Cancer Support Program

Specialized cancer nurses offer needed support to participants throughout cancer treatment, recovery and at the end of life to assist with treatment decisions and improve health care experience.

Experienced, caring nurses from the program are available to support participants in several ways.

Here are a few:

- Disease and treatment decision/education
- Manage symptoms and side effects
- Second opinion support
- Access to Centers of Excellence (COE)
- Clinical coverage review of treatment, prescriptions and clinical trials
- Drug management support
- Administration of benefits (i.e. Travel and Lodging)
- Survivorship support
- End of life/hospice decision making

Spine and Joint Solutions

This program helps people who are considering:

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

Once you enroll in the program, you will be working directly with a nurse who will help get answers so you can make confident decisions. 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.**

Personal Health Support/Case Management

Personal Health Support is a unique program for individuals who are living with a chronic condition or 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 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:

- 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

Rally Health Survey

With the online Rally Health Survey, personalized Missions, rewards and connections to wearables like Fitbit®, 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.

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

Diabetes Health Plan

The Diabetes Health Plan is a condition-based program with enhanced benefits that may potentially help prevent diabetes and slow its progression. Diabetes Health Plan encourages members to follow evidence-based medicine **guidelines and their doctor's care plan** while

removing financial barriers to care. Employees have \$0 copays or 100% coverage after meeting their deductible for HSA plans for visits related to diabetes, prediabetes and/or high blood pressure and high cholesterol as well as 100% coverage for tier 1 and tier 2 diabetes-related medications and supplies.

Pharmacy Benefits

The prescription drug benefits are administered by OptumRx. Your dual medical/prescription card will be provided by UnitedHealthcare and will include OptumRx prescription information. 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 or at any in-network retail pharmacy. OptumRx is the mail order and Specialty service provider.

Optum Specialty Pharmacy offers:

- Access to your medications at the plans lowest cost
- 24/7 access to pharmacists
- Clinical and adherence programs
- Medication supplies at no extra cost
- Refill Reminders

For more information, visit specialty.optumrx.com or call 855.427.4682

How will I order my prescriptions from OptumRx home delivery?

Once your coverage begins, there are four ways to place a home delivery order:

- By e-prescribe. Your doctor can send an electronic prescription to OptumRx. Prescriptions for controlled substances, such as opioids, can only be ordered by ePrescribe*.
- Go online. Visit the website on your member ID card.
- By mobile app. Open the OptumRx app, which you can download from the Apple® App Store® or Google Play™.
- By phone. Call the toll-free number on your member ID card.

	EPO and PPO Health Plan		Consumer Choice Health Plan	High Deductible Health Plan
	30 Day Supply	90 Day Supply		
Annual Pharmacy Out of Pocket Maximums	\$2,500 Individual \$5,000 Family		\$2,500 Individual \$5,000 Family	None- Applies to Medical OOPM
Tier 1- Generic	\$10	\$20	20% Coinsurance (\$5 min, \$35 max)	Deductible & Coinsurance
Annual Deductible (Tier 2 & 3 Only)	\$50 Individual \$125 Family	\$50 Individual \$125 Family	None	None
Tier 2- Preferred	\$35	\$70	20% Coinsurance (\$20 min, \$60 max)	Deductible & Coinsurance
Tier 3- Non-Preferred	\$55	\$110	20% Coinsurance (\$40 min, \$100 max)	Deductible & Coinsurance

Prior Authorization -Certain medications require prior authorization 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.

Travis County Employee Health Clinic

Travis County has three on-site health clinics staffed by physicians and medical care professionals available to Employees and Dependents who are at least 10 years old and are covered on 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 reduce 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. Limited fast track appointments for minor illnesses or injuries are available for the same day or next day visits.

Services Offered include:

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

Clinic Hours of Operation

Downtown 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- 1pm)

Airport Blvd. Clinic
5501 Airport Blvd, Suite 201
Phone: 512-854-7998
Mon - Tues 7:30am - 5:30pm
(Closed for lunch 12- 1pm)

Del Valle Clinic
3518 FM 973 South
Phone: 512-854-1282
Wed- Thurs 7:30am - 5:30pm
Friday 7:30 am- 11:30am
(Closed for lunch 12- 1pm)

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 877.365.7949.



TRAVIS COUNTY
CARE Program
SMALL STEPS TO BIG CHANGES

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. We encourage you to participate in these activities, use the tools and resources available, win prizes and ultimately enjoy the benefits of good health through CARE.

What the CARE Program Offers:

- A dedicated web page at <http://traviscentral/hr/care> 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
- Onsite events available at various locations
- Onsite Fitness class offerings
- Weight loss challenges
- Nutritional education
- Employee Assistance Program
- Know your numbers events (biometric screenings)
- Private and individualized health coaching sessions with an on-site health coach
- Case and Disease Management services
- Onsite fitness centers and exercise equipment
- Additional resources for each of the 4 focus areas of CARE

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
512.854.2273
careprogram@traviscountytexas.gov

Frances Diep
On-site UHC Health Coach
512.854.5860 - office
512.539.6374 - cell
frances.diep@traviscountytexas.gov

DENTAL INSURANCE

Travis County offers three dental plans administered by Sun Life Financial. The following information describes the details of each dental plan including the monthly premium information. There is a Dental HMO (DHMO) plan and also two Preferred Provider Organization (PPO) plans.

You can find a dental provider in the Sun Life Network by visiting www.slfserviceresources.com, click on the **“Find a dentist” link, enter “915209” in the Group ID field and** then select the appropriate plan- DHMO/Prepaid Plan or PPO Network. Or you may call customer service at 877.743.1454.

Prepaid DHMO Plan

The Prepaid DHMO 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.

Plan features include: No deductible, no copays for most preventive services, coverage for pre-existing conditions, and no annual maximum for services.

Enrolling in the DHMO Plan

Select a general dentist from the Directory of Dentists for yourself and every family member on the dental plan. Each family member may choose a different Plan Dentist. 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.

Freedom Basic 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.

Network and Non-Network Discounts

The Basic 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.

Freedom Preferred PPO Plan

Plan Features Include: Freedom to choose any dentist, including specialists, PPO options available, Preventive Max Waiver and a better benefit for non-DHA providers.

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.

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 Freedom Basic PPO.

Dental Plan Premiums

Monthly Premiums

	Prepaid DHMO Plan	Freedom Basic PPO Plan	Freedom Preferred PPO Plan
Employee Only	\$11.98	\$23.21	\$36.29
Employee + 1 Adult	\$19.26	\$44.14	\$72.54
Employee + 1 Child	\$19.26	\$44.14	\$72.54
Employee + 2 or more Children	\$25.84	\$72.70	\$113.50
Employee +1 Adult + 1 Child	\$25.84	\$72.70	\$113.50
Employee + 1 Adult + 2 or more Children	\$30.22	\$93.65	\$149.79

Per Pay-Period Premiums

	Prepaid DHMO Plan	Freedom Basic PPO Plan	Freedom Preferred PPO Plan
Employee Only	\$5.99	\$11.61	\$18.15
Employee + 1 Adult	\$9.63	\$22.07	\$36.27
Employee + 1 Child	\$9.63	\$22.07	\$36.27
Employee + 2 or more Children	\$12.92	\$36.35	\$56.75
Employee +1 Adult + 1 Child	\$12.92	\$36.35	\$56.75
Employee + 1 Adult + 2 or more Children	\$15.11	\$46.83	\$74.90

Dental Plan Comparison

	DHMO Plan	Freedom Basic PPO	Freedom Preferred PPO
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 50%
Orthodontia	Various copays	Plan Pays 50% up to a \$1,000 lifetime max	Plan Pays 50% up to a \$1,000 lifetime max
Out-of-Network Coverage	None	45% off the 80th percentile of UCR	90th Percentile of UCR

VISION INSURANCE

Even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, Travis County offers a comprehensive vision benefit provided by Davis Vision. Through **Davis Vision’s** provider network, you will receive a 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. You can locate a provider by logging on the www.davisvision.com and select **“Find a Provider”** or by calling 877.923.2847

	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

Out-of-Network Providers

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

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.

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.**

Vision Plan Premiums

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

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 provided by Travis County at no cost to employee. This coverage is with United Healthcare.

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

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 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 four times (4x) your annual salary 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.

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

Guarantee Issue

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

If you and your eligible dependents do not enroll during your New Hire Enrollment period, you can apply for coverage only during the Open Enrollment period or within 30 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 Cigna.

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.

Monthly Supplemental Life and AD&D Rates

(Age as of Oct. 1)	\$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)	\$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, employees can 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. The cost for coverage listed below is \$0.77 per pay period or \$1.54 per month.

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)

Spouse/Domestic Partner Supplemental Life Insurance

If you elect basic dependent life coverage you have the option to also elect additional Spouse/Domestic Partner supplemental life insurance. The 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 (\$10,000 or \$20,000 in addition to the Dependent Life Insurance above). Rates are based on age and coverage amount, see below.

Monthly Amount			Per Pay Period Amount		
Age of Spouse	\$10,000	\$20,000	Age of Spouse	\$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 (AD&D)

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:	Cigna will pay this % of 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. See rates and coverage amounts below.

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

FLEXIBLE SPENDING ACCOUNTS (FSA)

A Flexible Spending Account (FSA) is an account you set up to pre-fund your anticipated, eligible medical expenses and/or dependent care (daycare) expenses that are normally not covered by your insurance. Once you decide how much to contribute to your Healthcare and/or Dependent Care FSA, the amount is deducted pre-tax in equal amounts from your paychecks during the plan year. The amount you elect to contribute to the FSA account reduces your taxable income.

Healthcare FSA

A Healthcare FSA is used to pay for eligible medical, dental and vision expenses which are not covered by your insurance or other plan. These expenses can be incurred by yourself, your spouse, a qualifying child or any eligible IRS dependent. 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 FSA Card. You and your qualifying spouse and children can use the Healthcare FSA account even if you are not enrolled in Travis County health insurance.

The FSA Card is a convenient reimbursement option that allows United Healthcare to electronically reimburse **eligible expenses under your employer's plan** and IRS guidelines. Because it is a payment card, when you use the FSA Card to pay for eligible expenses, funds are electronically deducted from your account. You must send in documentation for certain FSA Card transactions, such as those that are not a known office visit or prescription copay. 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

The Dependent Care FSA is a great way to pay for eligible day care expenses such as after school care, baby-sitting fees, summer camps (not overnight), daycare services, nursery, preschool, and certain elder care expenses. Eligible dependents include your qualifying child under 13, spouse and/or tax dependent relative who is physically or mentally incapable of self-care and lives in your home for more than half the year.

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. The maximum reimbursement you may receive is equal to the current account balance in your Dependent Care FSA. If your reimbursement request is more than your available balance, the remaining amount will be placed in a pending status. The pending amount will be paid when additional funds are posted to your account.

Limited FSA (MUST BE ENROLLED IN THE HIGH DEDUCTIBLE HEALTH PLAN)

Designed to complement a Health Savings Account, a Limited FSA is used to pay only for eligible dental and vision expenses which are not covered by your insurance or other plan. These expenses can be incurred by yourself, your spouse, a qualifying child or IRS dependent. 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 FSA Card.

** Employees MUST be enrolled in the High Deductible Health Plan with a Health Savings Account in order to be eligible for a Limited FSA.

Examples of how to use your FSA:

Example 1: Paying a copay and doctor/dental fees (Healthcare/Limited FSA)

Once you enroll in the Healthcare FSA plan, United Healthcare will send you a Healthcare 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 FSA 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 United Healthcare. Within one to three business days, United Healthcare 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 United Healthcare, along with documentation showing the following:

- Name and age of the dependent receiving the service
- Cost of the service
- Name and address of the service provider
- Beginning and ending dates of the service
- Social Security or Tax (EIN) number of the place providing 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 Healthcare FSA:

Minimum Annual Deposit is \$120 for the benefit plan year or \$5.00 per pay period

Maximum Annual Deposit is \$2,750 for the benefit plan year or \$114.50 per pay period

For Dependent Care FSA:

Minimum Annual Deposit is \$120 for the benefit plan year or \$5.00 per pay period

Maximum contribution depends on your tax filing status. The IRS sets the annual contribution limits for Dependent Care FSAs. You can contribute to up to a maximum of:

- \$2,500 per year if you are married and file a separate tax return, or \$104.16 per pay period
- \$5,000 per year if you are married and file a joint tax return or if you file as single or head of household 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
- \$2,500	FSA Deposit for Recurring Expenses	- \$0.00
\$28,500	Taxable Gross Income	\$31,000
- \$6,455	Federal, Social Security Taxes	- \$7,021
\$22,045	Annual Net Income	\$23,979
- \$0.00	Cost of Recurring Expenses	- \$2,500
\$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 \$566.00!

* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Example Eligible Expenses

These are expenses that are generally known to be used primarily for medical care. Only the portion of the **medical, dental or vision expense which insurance doesn't pay, and for which are you responsible** to pay out of your pocket are eligible for reimbursement. Some examples of Eligible Expenses include:

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 United Healthcare directly at <http://www.myuhc.com> or at 866.649.4873.

HEALTH SAVINGS ACCOUNT (HSA)

Your HSA can be used for qualified expenses, including those of your spouse and/or tax dependents. You own and administer your HSA. Contributions to an HSA are tax free and withdrawals for qualified expenses are also tax free. The money in this account rolls over from year to year if you do not spend it. This account is also portable, which means it stays with you if you leave employment or retire.

Once enrolled in this account, Optum Bank will issue a debit card, giving you direct access to your account. When you have a qualified expense, you can use your debit card to pay. If you use your credit card or other form of payment to pay for your eligible expenses, **you can reimburse yourself from your HSA. Eligible expenses include doctors' office visits, eye exams, prescriptions, laser eye surgery and more.** IRS Publication 502 provides a complete list of eligible expenses and can be found on www.irs.gov. There are no receipts to submit for reimbursement, however you would need to keep your receipts in case the IRS audits you. Employees are able to upload and save their receipts on the Optum App or website.

Travis County's contribution will be funded on the debit card up front. An employee can also elect to contribute per pay period. The per pay period amount will be funded on your HSA per pay period. Employees are also able to contribute funds directly to Optum Bank.

To be eligible for the HSA, you must meet the requirements below which are determined by the IRS.

- You must be enrolled in the High Deductible Health Plan
- You and your enrolled dependents cannot be claimed **on another person's tax return**
- You cannot be enrolled in any other health plan
- You cannot be enrolled in Medicare or Tricare
- You and your enrolled dependents cannot be enrolled in a Healthcare FSA
- You must provide a physical address to Optum Health Bank (no P.O boxes)
- You must be a legal resident of the United States

HSA Contribution Limits

Contributions to an HSA are tax-free and can be made through payroll deduction on a pre-tax basis. The money in this account (including interest and investment earnings) grows tax-free as well. As long as the funds are used to pay for qualified expenses, they are also spent tax-free. Per IRS regulations, if funds are used for purposes other than qualified expenses and you are younger than age 65, you will pay federal income tax on the amount withdrawn plus a 20% penalty tax. At age 65, you are no longer eligible to contribute to a HSA. After age 65, the money in your HSA does not have to be used for eligible expenses. An HSA is a great way to save for post-retirement healthcare needs.

Travis County contributes \$500 for employee only coverage and \$1,000 for employee plus dependent coverage. The employer contribution is funded annually on January 1st. Below is the amount Travis County contributes for new hires. The amount is based on your benefits effective date.

Benefits Effective Date	Jan 1- March 31	April 1- June 30	July 1- Sept 30	Oct 1- Dec 31
Employee Only	\$500	\$375	\$250	\$125
Employee + Dependent	\$1,000	\$750	\$500	\$250

Each year, the IRS places a limit on the maximum amount that can be contributed to the HSA. For 2021, contributions (which include the employer contribution) are limited to the following:

Employee Only	\$3,600
Employee + Dependent	\$7,200
Catch-Up Contribution (Age 55+)	\$1,000

DISABILITY

Short Term Disability

Short Term Disability (STD) provides benefits when you are unable to work for a short period of time. Short Term Disability benefits are payable when Cigna determines that 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.

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.

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

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 illness 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

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	\$12.25	\$6.13
\$26,000.00	\$300.00	\$14.70	\$7.35
\$34,666.67	\$400.00	\$19.60	\$9.80
\$43,333.33	\$500.00	\$24.50	\$12.25
\$52,000.00	\$600.00	\$29.40	\$14.70
\$60,666.67	\$700.00	\$34.30	\$17.15
\$69,333.33	\$800.00	\$39.20	\$19.60
\$78,000.00	\$900.00	\$44.10	\$22.05
\$86,666.67	\$1,000.00	\$49.00	\$24.50
\$95,333.33	\$1,100.00	\$53.90	\$26.95
\$104,000.00	\$1,200.00	\$58.80	\$29.40
\$112,666.67	\$1,300.00	\$63.70	\$31.85
\$121,333.33	\$1,400.00	\$68.60	\$34.30
\$130,000.00	\$1,500.00	\$73.50	\$36.75

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. Long Term Disability benefits are payable when Cigna determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your illness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same illness or injury
- After benefits have been paid for 24 months, you are disabled when Cigna determines that due to the same illness 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.

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.

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

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 illness 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

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	\$10.33	\$5.17
\$30,000.00	\$1,500.00	\$15.50	\$7.75
\$40,000.00	\$2,000.00	\$20.67	\$10.33
\$50,000.00	\$2,500.00	\$25.83	\$12.92
\$60,000.00	\$3,000.00	\$31.00	\$15.50
\$70,000.00	\$3,500.00	\$36.17	\$18.08
\$80,000.00	\$4,000.00	\$41.33	\$20.67
\$90,000.00	\$4,500.00	\$46.50	\$23.25
\$100,000.00	\$5,000.00	\$51.67	\$25.83
\$120,000.00	\$6,000.00	\$62.00	\$31.00

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 pre-scheduled surgery or 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 by calling 800.362.4462. Or you can access the online claim form through Cigna's website, www.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 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 with no underwriting requirements. This period will be in February of each year. Other employees and family members will go through an application process that includes a medical underwriting questionnaire. Applications will be medically underwritten and approved or rejected based on medical information submitted. This benefit has a separate Open Enrollment which is conducted in February.

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.

Long Term Care Available Benefit Options	
Policy Number	205655
Term of Care	3 years, 6 years or Lifetime* (lifetime term requires underwriting for all applicants)
Long Term Care Facility	Choice of \$2,000, \$3,000, \$4,000, \$5,000, or \$6,000 per month
Home Care	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	5% Simple inflation protection

Please go to www.unuminfo.com/countyoftravis/index.aspx or call UNUM at 800.227.4165 for more detailed information.

RETIREMENT

Texas County and District Retirement System (TCDRS)

Travis County participates in the Texas County and District Retirement System (TCDRS). 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. 7% of your total pay goes into your TCDRS account every pay period. This money is taken out on a pre-tax basis.

Changes to Benefits

The Travis County Commissioner’s Court chooses your TCDRS benefits. Every year it reviews Travis County’s retirement plan and makes changes, if needed. The Commissioner’s Court 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

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 due to 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 enough service time to be eligible for retirement. To be vested in your plan, you must have 8 years of service credit. Once vested, you may stop working for Travis County and still keep 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:

- Age 60 with 8 years of Service; or
- Any age with 30 years of Service; or
- Rule of 75- your age plus years of Service equals 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.

When You Retire

When you retire, you may choose to receive a monthly benefit payment. All payment options pay you for 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 Travis County 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 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.

Travis County 457(b) Deferred Compensation Plan

Empower Retirement 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 voluntary salary contributions. 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 fund contributions, and any earnings on contributions, are not considered to be taxable income when withdrawn.

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 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 2019), 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.

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.

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. Employees have access to up to 5 free sessions per year.

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.deeroakseap.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. 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 for the County, you must report such injury to your supervisor and/or the Risk Management Department immediately.

Training & Development

HRMD offers training that supports core competencies for leadership development. Employees and Managers can gain the fundamental knowledge and skills they need to become a confident and effective leader by participating in the Leadership Education and Development (LEAD) training.

LEAD Program I. Basics of Leadership 1-day workshop for non-supervisors

LEAD Program II. New Supervisor Academy 3-day workshop for new supervisors

LEAD Program III. 9 course curriculum with a final exam for current supervisors and managers

- Expectations and Accountability
- Hiring Right
- Communicating Effectively
- Conflict Resolution
- Essentials of Budgeting
- Harassment Prevention for Supervisors
- Conflict Management
- Coaching and Managing for Performance
- Reasonable Suspicion

LEAD Program IV. Executive Leadership Academy

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 Austin program is available to all employees who wish to take part in Leadership Training which would result in direct benefit to Travis County. Employees who are interested should submit a request to the Human Resources Management Department.

See Chapter 110.0191 - 110.0196 of the Travis County Code: Leadership Training-Funding Guidelines for additional details on the program.

PAID TIME-OFF BENEFITS

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 400 hours (50 days) for regular full-time employees. 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 240 hours (30 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 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 their immediate supervisor prior to attending an appointment for non-emergency dental or medical examinations, for themselves 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 (1/2) of their accrued sick leave up to a maximum of 480 hours at their final salary rate with a maximum payment not exceeding 240 hours (30 days).

Personal Holiday

All regular full-time employees are eligible for up to three (3) paid personal holidays each calendar year. 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 their designee. Personal holidays shall be requested by the employee and approved by the elected official/department head or their 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.

New employees earn personal holidays based on the month in which they are hired. See chart below.

January through March	3 personal holidays
April through June	2 personal holidays
July through September	1 personal holiday
October through 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.

Holiday Pay

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

FY21 Travis County Approved Holidays	
Veteran's Day	November 11, 2020
Thanksgiving Day	November 26, 2020
Day after Thanksgiving	November 27, 2020
Christmas Eve (observed)	December 24, 2020
Christmas Day	December 25, 2020
New Year's Day (observed)	January 1, 2021
Martin Luther King, Jr. Day	January 18, 2021
President's Day	February 15, 2021
Memorial Day	May 31, 2021
Independence Day	July 5, 2021
Labor Day	September 6, 2021

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 be used by employees who have exhausted 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, Full time employee; 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. Donation may be sick and/or vacation leave.

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 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, 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 110.0372:

(2) Catastrophic Illness or Injury. A catastrophic illness or injury is defined as a severe condition or combination of conditions affective the mental or physical health of the individual which has resulted in a life threatening condition and/or has a major impact on life functions. Such life functions shall include, but are not limited to, the loss of physical senses, the loss of physiological processes, or the loss of limb. Leave taken on an intermittent basis which does not require the employee to be absent from work for a period of at least seven days does not qualify. A health care provider, as defined below, must certify the catastrophic condition. The catastrophic illness or injury must:

- (A) Be present for a minimum of seven consecutive calendar days, and
- (B) Require continuous or on-going medical treatment or rehabilitation by a health care provider for an extended time, and
- (C) Be characterized by the sudden onset of symptoms which can be life threatening, or can cause significant or serious impairment or disability, and
- (D) Be incurable or so serious as to significantly interfere with the ability of the employee or an immediate family member to perform with reasonable continuity the material duties of his or her job for 30 consecutive days or longer, and includes complications that requires one or more of the following:
 - (i) hospital care like inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to that care, or
 - (ii) supervision due to an incapacity for a permanent or long term condition for which treatment may not be effective, like a severe stroke or heart attack or the terminal stages of a disease, or
 - (iii) multiple treatments by a health care provider for a non-chronic condition when the treatments results in an absence from work, such as chemotherapy or radiation for cancer or therapy for organ transplant, but
 - (iv) does not include conditions like elective surgery, a broken limb, cold or flu or allergy, some routine types of surgery, such as orthopedic, appendectomy with minor or no complications.

REQUIRED NOTICES

Premium Assistance under Medicaid and 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 877.543.7669 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 866.444.3272.

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 July 1, 2018. 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
866.444.3272

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:

United Healthcare
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



Sara Krause
Privacy Officer
Phone: (512) 854-9766 or ext. 49766
Email: privacy@traviscountytx.gov

Travis County Notice of Privacy Practices

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. Travis County maintains electronic health records and will not use or disclose your health information except as described in this notice. Please review it carefully.

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Bill for your services
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- **Address workers' compensation, law enforcement, and other government requests**
- Respond to lawsuits and legal actions

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief

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.

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.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of **those with whom we've shared your information**
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

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.

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 health plan to coordinate payment for your health care.

Administer your plan

We may disclose your health information to our health plan administrator.

Example: We contract with a third party to administer the health plan, and they need information to enroll you and to pay claims.

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

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

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.

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 an electronic or paper copy of your health and claims records

- You can ask to see or get an electronic or paper copy of your health and claims records and other health information we have about you when you submit a written request. Ask us how to do this.
- We will provide a copy or a summary of your health information, within 15 days of your request if we maintain it in an electronic format. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is 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.**

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 the Privacy Officer at the email address and telephone number provided on the top of 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 your care
- Share information in a disaster relief situation

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.

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, in our office, and on our web site.