2017

Employee Benefits Guide

City of Round Rock

Contents

Page 7

Page 11

Page 17

Page 18

Page 19

Page 20

Page 21

Page 23

Page 27

Page 30

Page 31

Page 33

Page 35

Page 35

Page 36

This 2017 Benefits Guide describes, in non-technical language, the essential features of many of the benefit plans sponsored by the City of Round Rock. This Guide has been prepared as a reference only. It is not an official Master Plan Document for the City of Round Rock Health Benefits Plan, which includes dental, vision, life and voluntary benefits. The terms and conditions of coverage under The Plan are determined solely by the Master Plan Document as adopted by the City of Round Rock City Council. If there is any discrepancy between the Plan Document and the information described here, the Plan Document will govern. Participation in the plans does not constitute an employment contract. The City reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time.

Quick Reference

aetna

Medical: 855-281-8858

Pharmacy: 866-612-3852

Dental: 877-238-6200

Vision: 877-973-3238

www.aetna.com

rockcare

866-959-9355

www.healthstatinc.com

healthstat

building a healthier business

Nationwide

Nationwide Insurance
Sarita Null
512-497-1666
nulls2@nationwide.com
www.nrsforu.com

866-EAP-2400
www.deeroaks.com
eap@deeroaks.com

DEER OAKS
EAP SERVICES

Texas Legal

512-327-1372
www.TLPP.com

LegalShield

Worry Less. Live More.

Jim Holliday
Phone: 512.567.4969
http://www.mychoice.us

ABACUS

Accident & Critical Illness Coverage
John Newman: 352.516.4365

Claims Submission
Phone: 800.348.6908
Fax: 888.446.3205
Email: med_claims@aig.com

Jay Light, Benefits Manager
jlight@roundrocktexas.gov
512-341-3143

Sharon Callis, Benefits Specialist
scallis@roundrocktexas.gov
512-671-2701

TMRS

Texas Municipal Retirement System

512-476-7555
www.TMRS.com

Benefits Overview

Austin Healthiest Employer
2015 & 2016

State and Local Government Benefits Association
2014 & 2016 National Runner-up
Exemplary Benefit Design

Employer Healthcare Congress
2016 One of America's Healthiest Employers

The City of Round Rock recognizes that your benefits are an important part of the reason you choose to work here. The City provides a variety of high quality benefits largely paid for by the City or at a reasonable cost to you. Since you have some choices to make, it is important to understand the various programs. That is why this Employee Benefits Guide is being provided for you.

Benefits provided by the City for eligible employees include medical, dental, vision, long term disability, employee assistance plans and life insurance. Employees may also elect to participate in these additional voluntary plans:

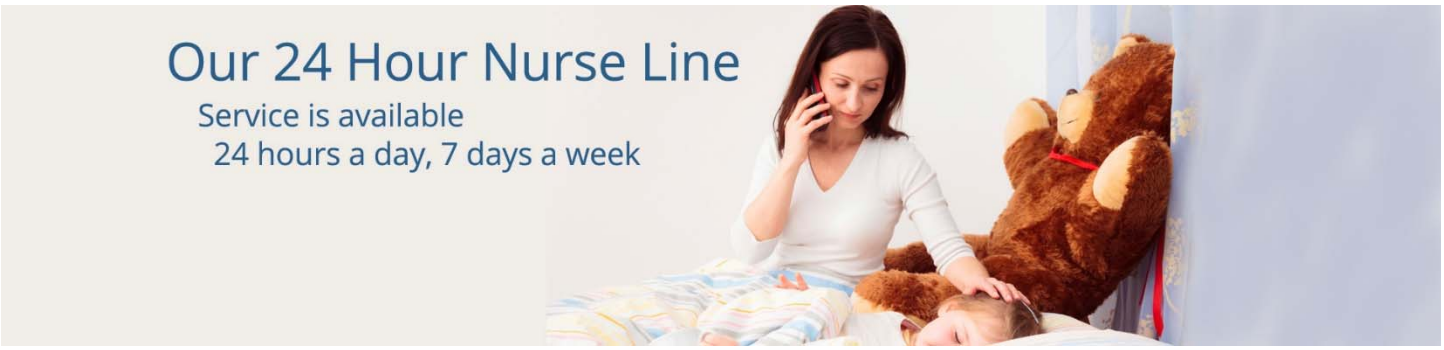
- 457 Deferred Compensation
- Flexible Spending Health Account
- Flexible Spending Dependent Care Account
- Voluntary Life Insurance Plan
- Voluntary Short Term Disability Plan
- Voluntary Accident Plan
- Voluntary Critical Illness Plan
- Texas Legal Protection Plan
- Legal Shield/ID Shield Protection Plan
- Pet Insurance

Benefit Plan	Who Pays
Basic Life and AD&D	*The City of Round Rock*
Long Term Disability	*The City of Round Rock*
Employee Assistance Program	*The City of Round Rock*
Medical	*You and The City*
Prescription Drugs	*You and The City*
Dental	*You and The City*
Vision	*You and The City*
Flexible Spending Accounts	*You*
Voluntary Life and AD&D	*You*
Voluntary Short Term Disability	*You*
Critical Illness and Accident	*You*
Pet Insurance	*You*

The City of Round Rock remains fully committed to providing our employees high quality health care plans. We believe in not only making an impact in our city, but also with our employees.

We encourage you to review all of your options before making your benefits elections. Only you can determine which benefits are best for you and your family. We want you to make informed decisions.

24-HOUR NURSE LINE 1-800-556-1555



A 24-hour nurse line for your health questions

Informed Health® Line

Talk to a registered nurse anytime by calling 1-800-556-1555.

Sometimes your health question can't wait until your doctor's visit. Or even the next morning! With the Informed Health Line, you can speak to a registered nurse about any health issue on your mind – whenever you need to*

- It's toll free.
- You can call as many times as you need at no extra cost.
- Your covered family members can use it, too.

You could save time, money and a trip to the ER

You can turn to the Informed Health Line for helpful health information - instead of an unneeded trip to the ER. That can help you budget your money for when you really need to use it. You'll be able to make smarter health decisions because you have good information – always only a phone call away.

More reasons to use the Informed Health Line

- Get information on a wide range of health and wellness topics.
- Make better health care decisions.
- Find out more about a medical test or procedure.
- Get help preparing for a doctor's visit.

Your online sources for health information

If you like to go online for health information, check out the informed Health Line page on your secure member website. Here's what you can do:

- Send us an email.
- Use our symptom checker.
- Learn about treatment options and health risks.
- Research a medicine and more.

It explains things in terms that are easy to understand. And it's easy to get to – jus long in to www.aetna.com.

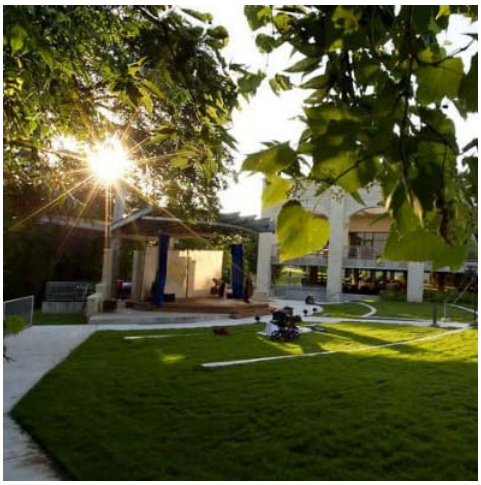
*While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide Information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

Benefits Eligibility

- Who is Eligible?
- Dependent Eligibility
- When Coverage Begins
- Making Changes to Coverage
- Special Enrollment Rules
- Frequently Asked Questions

Who is Eligible?

Eligibility conditions



You are eligible to enroll in the City's benefit plans if you are a regular, full-time employee scheduled to work at least 30 hours per week and has completed the HealthStat Health Risk Assessment requirements. As a regular, full-time employee, you are eligible for benefits on the first day of the month following your date of hire.

Eligible Dependents

You may cover your eligible dependents, including:

- Spouse: Your legally married spouse, including a declared common-law spouse who has completed the HealthStat Health Risk Assessment requirements. Only one spouse may be covered at any time.
- Children: Your biological children, stepchildren, and legally adopted children placed pending adoption who are under 26 years of age. Children over the age of 18 must complete the HealthStat Health Risk Assessment requirements.
- Dependent Grandchildren: Your unmarried grandchild must meet the requirements listed above and must be listed as a dependent (as defined by the Internal Revenue Service) on you or your spouse's federal income tax return. Proof of claiming the dependent may be requested from time to time.
- Disabled Children: To continue coverage for an eligible dependent past the age limit, the child must be covered as a dependent at the time and must also meet the following definitions:
    - A child incapable of earning a living at the time the child would otherwise cease to be a dependent, and depend on you for principal support and maintenance, due to a mental or physical disability.
    - A disabled child continues to be considered an eligible dependent as long as the child remains incapacitated and dependent on you for principal support and maintenance, and you continuously maintain the child's coverage as a dependent under the plan from the time they otherwise would lose dependent status.
    - A dependent child who loses eligibility and later becomes disabled is not eligible to be covered. A disabled child who was not covered as a dependent immediately prior to the time the child would otherwise cease to be a dependent is not eligible to be covered.

Documentation Required

To provide coverage for a dependent under any of the City's benefits programs, you must provide documentation that supports your relationship to the dependent. Social Security Numbers must be provided for all eligible dependents.

Acceptable documents are listed below for the following dependents:

- Spouse: A marriage certificate or declaration of informal (common-law) marriage, which has been recorded as provided by law.
- Child: A certified birth certificate, complimentary hospital birth certificate, Verification of Birth Facts issued by the hospital, or court order establishing legal adoption, guardianship, conservatorship, qualified medical child support order, or be the subject or an Administrative Writ.
- Stepchild: The documentation listed above must also be provided, and a marriage certificate or declaration of informal marriage indicating the marriage of the child's parent and stepparent.
- Dependent Grandchild: The documentation listed above must also be provided, and a marriage certificate or declaration of informal marriage that supports the relationship between you and your grandchild. Additionally, a copy of the income tax return for the preceding year showing the grandchild was claimed as a dependent.
- Disabled Child: Verification of an ongoing total disability including written documentation from a physician verifying an ongoing total disability.
- Qualified Child Pending Adoption: For children already placed in your home, an agreement between you and a licensed child-placing agency or Texas Department of Family and Protective Services, which meets the requirements listed in Dependent Eligibility.

Initial Enrollment

When you first join the City, you have 31 days to enroll yourself and your dependents and complete the HealthStat Health Risk Assessment requirements for benefits. If you enroll on time, coverage begins the first of the month following your date of hire. If you do not enroll within 31 days of becoming eligible, you will automatically be enrolled in company-sponsored benefits, such as basic life and accidental death insurance, but you will have to wait until the next annual Open Enrollment to enroll in medical insurance or make changes to coverage. You will be able to utilize the Employee Assistance Program (EAP) upon hire.

Open Enrollment

Each year Open Enrollment provides you an opportunity to modify your medical, dental, vision coverage and/or Flexible Spending Account(s). Changes made become effective January 1 of the following year. All eligible employees may enroll online October 1 through October 31. Employees without access to a computer can enroll in benefits using the computers in various City buildings.

Waiving Coverage

If you are a full-time employee declining or dropping medical and/or dental coverage for yourself, you must:

- Provide proof of other insurance coverage for the coverage you are declining or dropping.
- Complete a Benefits Enrollment Form.

If you later decide you want to be covered, you will not be able to enroll for coverage until the next Open Enrollment or within 31 days of a qualifying life event.

Making Changes to Coverage

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment. You are able to make a qualified life event change if you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualified life event change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event by providing documentation to Human Resources. If you do not enroll online within 31 days, you will have to wait until the next Open Enrollment to make new elections.

Qualified status changes include, but are not limited to:

- Change in number of eligible dependents due to birth, adoption, placement for adoption or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes your or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse or your children
- End of the maximum period for COBRA coverage

Special Enrollment Rules

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must enroll within 60 days of the qualified events shown in the "Special Enrollment Rules" above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

In addition to the changes described above, you may enroll yourself and your spouse (with or without the new dependent) in the City health plan following marriage or the adoption, placement for adoption, or birth of a child, as long as you request enrollment within 31 days of the event. You must be enrolled to cover your dependents. If you have a special enrollment event and want to enroll for health coverage, call Human Resources at (512) 218-5490.

Plan Choices

- Medical Plans
- Prescription Drug Coverage
- Mail Order Program
- Dental Plan
- Vision Plan
- Flexible Spending Accounts
- Life Insurance
- Disability Coverage

Medical Plans

The City's medical plans all provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs and hospitalization. You choose the plan that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

Aetna Choice Point of Service Plan

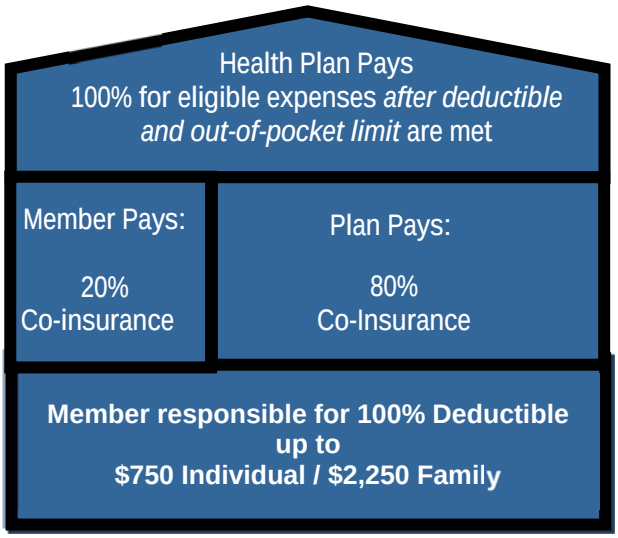
The Point of Service (POS) plan offers in-network and out-of-network benefits. When you need care, you decide whether to go to Rockcare, an Aetna in-network doctor or to an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because Aetna network providers discount their fees. And, with in-network providers, you generally do not have to file claims.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.

Here's how it works:

In Network
Out-of-Pocket Limit
$ 3,000 Individual
(Includes $ 750 deductible)

$ 9,000 Family
(Includes $ 2,250 deductible)



Employee Contributions

Your cost for Medical, Dental and Vision plans in the Benefits Program will be paid on a before-tax basis through your payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions. Below are the contributions in effect January 1, 2017 through December 31, 2017:

Aetna Choice Medical Rates

Tier	Monthly Rate	City Portion	Employee Portion	Per Pay Period
EE Only	$ 920.00	$ 780.00	$ 140.00	$ 70.00
EE + Child(ren)	$ 1,130.00	$ 780.00	$ 350.00	$ 175.00
EE + Family	$ 1,270.00	$ 780.00	$ 490.00	$ 245.00

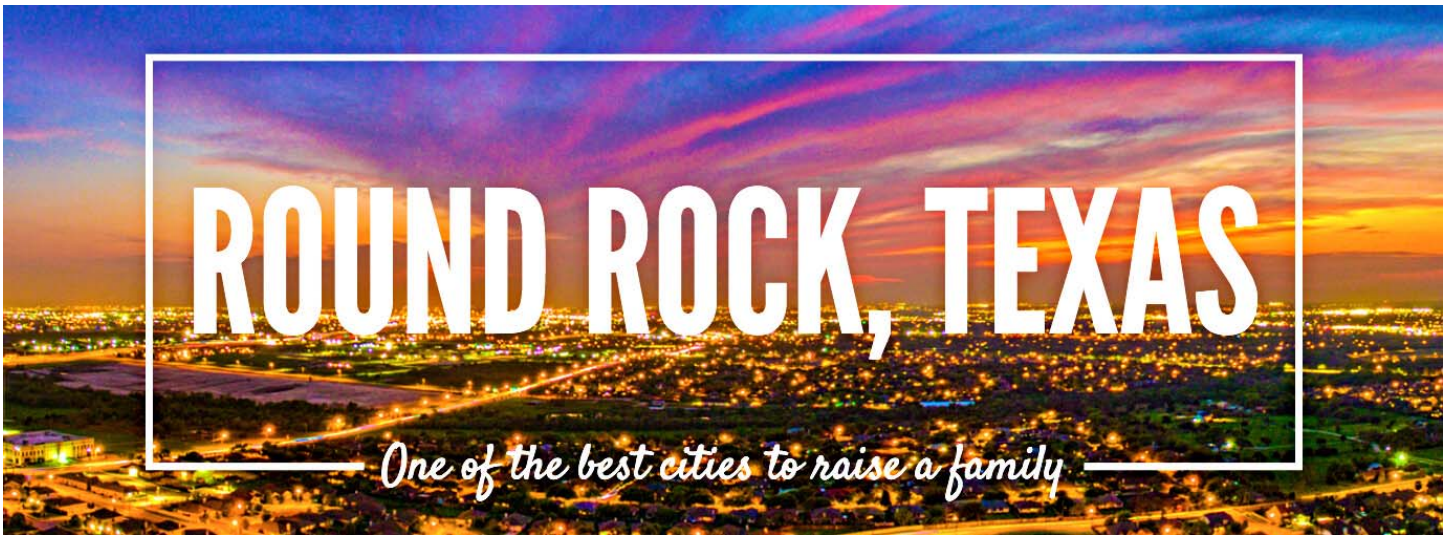
Unsure Doctor Referrals are in the Aetna Network? All of the providers in the Aetna network change frequently. To find out if your doctor participates in the network, go to www.aetna.com and click on "Find a Doc". Be sure to check out the Aexcel Network, where specialist office visits copays are less. Doctors in Aexcel are designated by a "Blue Star".

AETNA CHOICE PLAN
MEDICAL SCHEDULE OF BENEFITS

COST SHARING PROVISIONS	AETNA IN-NETWORK	OUT OF NETWORK
ANNUAL DEDUCTIBLE Per Covered Person Per Family	$ 750 $ 2,250	$ 2,000 $ 6,750
BENEFIT PERCENTAGE (After Deductible is satisfied)	80%	50%
Primary Care Physician	$35	50% after deductible
Specialist Physician	$45	50% after deductible
OUT-OF-POCKET MAXIMUM Per Covered Person Per Family	$3,000 $9,000	$12,000 $36,000
BENEFITS & CONDITIONS		
Office Setting Charges	$35	50% after deductible
Non-Office Setting Charges	$45	50% after deductible
ALLERGY INJECTIONS	80% after deductible	50% after deductible
PREVENTIVE CARE	100% deductible Waived	50% after deductible
DIABETES EDUCATION & COUNSELING	80% after deductible	50% after deductible
Inpatient (Room & Board limited to average semi-private room, Intensive Care limited to the UCR.)	80% after deductible	50% after deductible
Outpatient	80% after deductible	50% after deductible
Hospital Services for True Emergency (Life-threatening)	80% after deductible	Paid at 50% after $225 Copay and Deductible
Physician Services for True Emergency (Life-threatening)	80% after deductible	50% after $225 Copay and Deductible
Services Related to Non-Emergency (Hospital & Physician)	80% after $225 Copay and deductible	Not Covered
URGENT CARE	$50 Copay	50% after deductible
AMBULANCE SERVICES (Ground or Air)	80% after deductible	50% after deductible
OUTPATIENT DIAGNOSTIC SERVICE (CT Scans, PET Scans, MRI and Nuclear Medicine)	80% after deductible	50% after deductible
OUTPATIENT THERAPEUTIC TREATMENTS (Dialysis, Intravenous chemotherapy or other Intravenous Infusion therapy & other treatments not listed)	80% after deductible	50% after deductible
SPINAL TREATMENT/CHIROPRACTIC CARE	100% at Airrosti $45 Copay all others	50% after deductible
DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOPEDIC APPLICANCES	80% after deductible	50% after deductible
ORTHOTIC DEVICES (Only with Diabetes Diagnosis)	80% after deductible	50% after deductible
HOME HEALTH CARE	80% after deductible (120 visits per year)	50% after deductible

HEALTHIEST EMPLOYERS

HOSPICE CARE	80% after deductible	50% after deductible
OCCUPATIONAL, SPEECH, AND CARDIAC THERAPY	80% after deductible (Combined 60 Visits per year)	50% after deductible
SKILLED NURSING FACILITY INPATIENT REHAB FACILITY	80% after deductible (90 days per year maximum)	50% after deductible
ORGAN OR TISSUE TRANSPLANT SERVICES (Must be pre-certified)	80% after deductible	50% after deductible
TRAVEL, LODGING AND MEALS BENEFIT	80% after deductible	50% after deductible
OUTPATIENT MENTAL ILLNESS SUBSTANCE ABUSE CHEMICAL DEPENDENCY	$45 Copay per visit $45 Copay per visit $45 Copay per visit	50% after deductible 50% after deductible 50% after deductible
INPATIENT MENTAL ILLNESS SUBSTANCE ABUSE CHEMICAL DEPENDENCY	80% after deductible 80% after deductible 80% after deductible	50% after deductible 50% after deductible 50% after deductible
TMJ (Temporomandibular Joint Dysfunction) Office Settings Non-Office Settings	No Coverage	
HEARING AIDS	80% after deductible up to $4,000 per year	50% after deductible
RADIAL KERATOTOMY LASIK PROCEDURE	No Coverage	No Coverage
NEWBORN INPATIENT CARE	80% after deductible	50% after deductible
WIG (when prescribed by MD or DO as a result of hair loss due to chemotherapy or radiation)	80% after deductible up to $350 per year	No Coverage



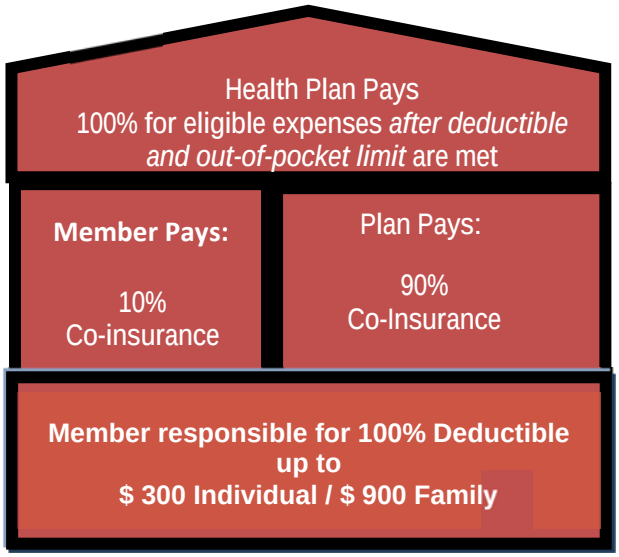
Aetna Whole Health - Seton

The Aetna Whole Health- Seton Plan offers in-network benefits only. When you need care, you decide whether to go to Rockcare or an Aetna in-network doctor. With in-network providers, you generally do not have to file claims. If you receive care from out-of-network providers and/or out –of-network facilities, you will be responsible for all costs billed.

Here how it works:

In Network
Out-of-Pocket Limit
$ 2,000 Individual
(Includes $ 300 deductible)

$ 4,000 Family
(Includes $ 900 deductible)



Employee Contributions

Your cost for Medical, Dental and Vision plans in the Benefits Program will be paid on a before-tax basis through your payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions. Below are the contributions in effect January 1, 2017 through December 31, 2017:

Aetna Whole Health - Seton Medical Rates				
Tier	Monthly Rate	City Portion	Employee Portion	Per Pay Period
EE Only	$ 885.00	$ 780.00	$ 105.00	$ 52.50
EE + Child(ren)	$ 1,060.00	$ 780.00	$ 280.00	$ 140.00
EE Family	$ 1,190.00	$ 780.00	$ 410.00	$ 205.00

To find out if your provider is in-network on the Aetna Whole Health-Seton Plan:

Go to Aetna.com/docfind and enter your provider or facility name and zip code. A pop up box will appear that ask you to choose your Aetna plan. You should select (TX) Aetna Whole Health-Seton Health Alliance Plan.

AETNA WHOLE HEALTH – SETON PLAN
MEDICAL SCHEDULE OF BENEFITS

COST SHARING PROVISIONS	AETNA WHOLE HEALTH - SETON (No Out of Network Benefits)
ANNUAL DEDUCTIBLE Per Covered Person Per Family (3 individuals must be met to satisfy Family Deductible)	 $ 300 $ 900
BENEFIT PERCENTAGE (After Deductible is satisfied)	90%
Primary Care Physician	$25
Specialist Physician	$35
The Office Visit Copayment applies to all services performed in the office, by the same provider, on the same day as the office visit. Copayments do not apply towards the Out-of-Pocket maximum and will continue to apply after satisfaction of the Annual Deductible. No Copayment applies to Physician office visits for prenatal care after the first visit. No Copayment applies when an office visit charge is not assessed and the Deductible and Benefit Percentage will apply. "Primary Care Physician" includes Family Practiced, General Practice, Internal Medicine, Obstetrics/gynecology, Pediatrician, licensed nurse practitioner or Physician Assistant. "Specialist Physician" includes any Physician who is practicing any branch of medicine or medical specialty other than those listed above.	
OUT-OF-POCKET MAXIMUM Per Covered Person Per Family	 $2,000 $4,000
Eligible Expenses in excess of the Out-of-Pocket Maximum will be paid at 1% for the remainder of the Benefit Period. The following expenses do not accrue towards the Out-of-Pocket Maximum. Deductible, Copayments, charges for any non-network provider, charges which exceed benefit maximums, charges paid at a reduced percentage because of non-compliance with Pre-Certification or Pre-Treatment review and the charge or portion of any charges which exceeds Usual, Customary and Reasonable (UCR) guidelines.	
PHYSICIAN SERVICES Office Setting Charges Non-Office Setting Charges	 $25 $35
ALLERGY INJECTIONS	90% after deductible
PREVENTIVE CARE	100% deductible Waived
DIABETES EDUCATION & COUNSELING	90% after deductible
HOSPITAL & OTHER FACILITY SERVICES Inpatient (Room & Board limited to average semi-private room. Intensive Care limited to the UCR.) Outpatient	 90% after deductible 90% after deductible
EMERGENCY ROOM & URGENT CARE SERVICES	
Hospital Services for True Emergency (Life-threatening)	$225 Copayment
Physician Services for True Emergency (Life-threatening)	$225 Copayment
Services Related to Non-Emergency (Hospital & Physician)	Not Covered
URGENT CARE	$35 Copay
AMBULANCE SERVICES (Ground or Air)	90% after deductible
OUTPATIENT DIAGNOSTIC SERVICE (CT Scans, PET Scans, MRI and Nuclear Medicine)	90% after deductible
OUTPATIENT THERAPEUTIC TREATMENTS (Dialysis, Intravenous chemotherapy or other Intravenous Infusion therapy & other treatments not listed)	90% after deductible

HEALTHIEST EMPLOYERS

SPINAL TREATMENT/CHIROPRACTIC CARE	100% at Airrosti 90% after Deductible for Others
DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOPEDIC APPLICANCES	90% after deductible Pre-Notification required when charges exceed $1,000
ORTHOTIC DEVICES (Only with Diabetes Diagnosis)	90% after deductible
HOME HEALTH CARE	100% deductible waived (60 visits per year)
HOSPICE CARE	100% deductible waived
SHORT-TERM REHABILITATIVE THERAPY OUTPATIENT SERVICES	
OCCUPATIONAL, SPEECH, AND CARDIAC THERAPY	$25 Copay (Combined 100 Visits per year)
SKILLED NURSING FACILITY INPATIENT REHAB FACILITY	100% deductible waived (90 days per year maximum)
ORGAN OR TISSUE TRANSPLANT SERVICES (Must be pre-certified)	90% after deductible (Services must be performed at a Preferred Transplant Center)
***Preferred Transplant Center** means a medical facility for which the Plan, either directly or through the Network has obtained special billing discounts for the Covered Person and the Plan and for which the Plan or Network has ascertained based upon objective criteria that the facility and its Physicians have a superior degree of expertise for the transplant services provided, and the facility's positive patient outcomes are significantly high.	
TRAVEL, LODGING AND MEALS BENEFIT	100% after deductible* $10,000 Maximum Benefit per year/lodging and meals payable at 100% at rate of $50 per day for patient or up to $100 per day for patient and one companion
OUTPATIENT MENTAL ILLNESS SUBSTANCE ABUSE CHEMICAL DEPENDENCY	90% after deductible
INPATIENT MENTAL ILLNESS SUBSTANCE ABUSE CHEMICAL DEPENDENCY	90% after deductible 30 visits per year maximum lifetime benefit for substance abuse/chemical dependency 3 treatment episodes which may include Inpatient care, intensive outpatient care, and other follow-up care throughresolution and discharge as approved by the utilization management company. If Pre-certification is not obtained, benefits will be reduced by $250.
TMJ (Temporomandibular Joint Dysfunction) Office Settings Non-Office Settings	 $25 Copay 90% after deductible
HEARING AIDS	90% after deductible
RADIAL KERATOTOMY LASIK PROCEDURE	50% after deductible $1.500 lifetime limit
NEWBORN INPATIENT CARE	90% after deductible
WIG (when prescribed by MD or DO as a result of hair loss due to chemotherapy or radiation)	90% after deductible (1 per lifetime)

Aetna Navigator

A new, improved Aetna Navigator® website is here!

You told us how your Aetna Navigator® secure member website could be even more helpful. We heard what you said!

Aetna Navigator now has a new look with more choices. It also has better features that make it faster and easier for you to:

- Find health information
- Get your claims details
- Print member ID cards
- Find a doctor or facility
- Verify if medication is covered

www.aetna.com

Here are a few of the tools Aetna has to offer for your convenience.

Aetna MobileApp

Access your health records, view claims and find in-network providers all while you are on the go.

Payment Estimator

Use your own plan details to compare costs before you go to the doctor.

Prescription Drug Coverage

If you enroll in the City's medical plan, you will automatically receive prescription drug coverage. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order pharmacy program.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are generally not covered.

Retail (30-day Supply)	Amount You Pay
Generic:	Free
Preferred Brand:	$30
Non-Preferred Brand:	$50

Mail Order Program

For people who take medicine regularly for chronic conditions, prescription drug costs can be expensive. Mail order service can help. Aetna Rx Home Delivery® fills prescriptions for millions of members who take medications for arthritis, asthma, diabetes, high cholesterol, high blood pressure and other chronic conditions.

Advantages:

- Convenient, consistent care – Instead of monthly trips to the pharmacy, you can get medications shipped directly to your home.
- Great supplies, lower copayments. Instead of a 30-day supply, you get a 90-day supply, with your doctor's approval. And, depending on the medication, you may pay less for that larger amount than for three smaller fills at a retail pharmacy.
- Generic mail order prescriptions are FREE!

ORDERING REFILLS IS EASY – Choose one of these ways

1. Online: You go online to order refills, track the status of an order, and more. Just visit **www.aetna.com** and log into Aetna Navigator. Or go directly to **www.aetnanavigator.com**.
2. By Phone: Call Rx Member Services toll free at (888) RX- AETNA (1-888-792-3862). Have your member ID number, your prescription number, and your credit card number ready.
3. By Mail: Complete the reorder form that you received with your last order and mail it back with your payment. The reorder form will also tell you when you can place your next refill order.

Mail Order (90-day Supply)	Amount You Pay
Generic:	Free
Preferred Brand:	$50
Non-Preferred Brand:	$90

AIRROSTI

Airrosti Visits are $0 Copay

For City of Round Rock employees and dependents on the Aetna Health Plan.

99.8% OF PATIENTS WOULD RECOMMEND AIRROSTI TO FRIENDS & FAMILY

OUR PATIENTS REPORT MORE THAN **2900** SURGERIES PREVENTED

3.1 AVERAGE NUMBER OF VISITS TO COMPLETE INJURY RESOLUTION

Airrosti Round Rock Locations

(22 Austin Area Locations)

Dr. Ashley Welch
thopaedic Associates of Central Texas
4112 Links Lane, STE 101
Round Rock, TX 78664

Dr. Benjamin Renfro
Orthopaedic Associates of Central Texas
4112 Links Lane, STE 101
Round Rock, TX 78664

Dr. Robert Reass
Great Oaks Family Practice
15930 South Great Oaks Dr., STE A-200
Round Rock, TX 78681

Common Injuries and Conditions

Back Pain, Neck Pain, Headaches, Triceps Tendonitis, Disc Injury, SI Joint Sprain, Hip Pain, Hamstring Pull/Strain, Sciatic-like Pain, Calf Pull/Strain, Achilles Tendonitis, Sever's Disease, Heel Pain/Spurs, Rotator Cuff Pain, Bicep Tendonitis, Elbow Pain, Hip Flexor Strain, Groin Pull, Carpal Tunnel, Quad Pull, Knee Pain, Patellar Tendonitis, Shin Splints, Ankle Sprain, Plantar Fasciitis

(800) 404-6050 | www.Airrosti.com

Dental Plan

The City's Dental Plan is administered through Aetna and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings and orthodontia for children.

Dental Preferred Provider Organization (PPO) Plan

The Dental PPO allows you the freedom to visit any dentist, without referrals, for all of your dental care. If you receive care from one of Aetna's preferred dentists, you'll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher and you may need to file your own claims. Your medical ID card is your proof of eligibility for the dental plan.

For a list of Aetna's preferred dentists, go to **www.aetna.com**.

Employee Dental Contributions and Plan Features

Your cost for Medical, Dental and Vision plans in the Benefits Program will be paid on a **before-tax basis** through your payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions.

Below are the premiums that are in effect January 1, 2017 - December 31, 2017.

Aetna Dental Plan Rates				
Tier	Monthly Rate	City Portion	Employee Portion	Per Pay Period
EE Only	$ 40.00	$ 20.00	$ 20.00	$10.00
EE/Child(ren)	$ 54.00	$ 20.00	$ 34.00	$17.00
EE/Spouse	$ 56.00	$ 20.00	$ 36.00	$18.00
EE/Family	$ 82.00	$ 20.00	$ 62.00	$31.00

Dental Plan Feature	Cost
Annual Deductible Individual Family	 $ 50 $ 150
Annual Benefit Maximum	$1,500
Preventive Services (Exams, routine cleanings, fluoride treatments, space maintainers)	100% (no deductible)
Basic Services (X-rays, fillings, sealants, denture repairs)	80% after deductible
Major Services (Crowns, inlays, onlays, bridges, dentures)	50% after deductible
Orthodontia	50% after $50 deductible, up to a lifetime maximum of $1,500 (children to age 20 only)

Vision Plan

The City's basic Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through Aetna.

Vision Coverage

The vision plan offers in-network and out-of-network benefits. When you need care, you decide whether to go to an Aetna in-network provider or to an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network doctors and facilities because Aetna network providers discount their fees. And, with in-network providers, you generally do not have to file claims. If you choose to receive care from an out-of-network provider, the plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses. To find a vision network provider, go to www.aetna.com.

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear. So be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Employee Contributions

*Your cost for Medical, Dental and Vision plans in the Benefits Program will be paid on a **before-tax basis** through your payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions.*

Below are the premiums that are in effect January 1, 2017 - December 31, 2017

Aetna Vision Plan Rates				
TIER	RATE	CITY PAYS	MONTHLY DEDUCTION	PER PAY PERIOD
EE Only	$ 5.77	$ 5.77	$ 0.00	$ 0.00
EE/Child(ren)	$ 10.97	$ 6.00	$ 4.97	$ 2.49
EE/Spouse	$ 11.55	$ 6.00	$ 5.55	$ 2.78
EE/Family	$ 16.98	$ 6.00	$ 10.98	$ 5.49

VISION SCHEDULE

eyemed

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Comprehensive Exam Lenses (including contact lenses)* Frames	1 Every Rolling 12 Months 1 Every Rolling 12 Months 1 Every Rolling 12 Months	
Routine Eye Exam Benefit	$10 Copay	Up to $ 25 Reimbursement
Exam Options:(Fit & Follow Up) Standard Contact Lens Premium Contact Lens	Member pays discounted fee Member pays discounted fee	Not Covered Not Covered
Frames (Any available frame at provider location)	$130 Plan Allowance. Member pays 80% of balance over $130	Up to $ 65 Reimbursement
Standard Plastic Lenses: Single Vision Bifocal Trifocal Lenticular Standard Progressive Lens Premium Progressive Lens	 $10 Copay $10 Copay $10 Copay $10 Copay Member Pays $ 85 $ 120 Plan Allowance. Member Pays $ 85 (Member pays 80% over $120 Plan Allowance	 Up to $15 Reimbursement Up to $ 30 Reimbursement Up to $ 60 Reimbursement Up to $ 60 Reimbursement Up to $ 30 Reimbursement Up to $ 30 Reimbursement
Lens Options: UV Treatment Tint (solid & gradient) Standard Plastic Scratch Coating Standard Polycarbonate – Adults Standard Polycarbonate –Kids >13 Standard Anti-Reflective Coating Polarized	 Member Pays $15 Member Pays $15 Member Pays $15 Member Pays $40 Member Pays $40 Member Pays $45 Member Pays 80% of Retail	 Not Covered Not Covered Up to $ 15 Reimbursement Not Covered Up to $ 15 Reimbursement Not Covered Not Covered
Contact Lenses	Contact Lenses Reimbursement Includes Materials Only	
Conventional Disposable Medically Necessary	Member pays 85% over $130 Member pays 100% over $130 $0 Copay	Up to $ 90 Reimbursement Up to $ 90 Reimbursement $ 200 Reimbursement
Laser Vision Correction Lasik or PRK from US Laser Network**	15% off retail price or 5% off promotional price	Not Covered
Second Pair Discount	Member can receive up to 40% off additional pairs of eyeglasses. Additional discounts are available on contact lens purchases. Use of this program is unlimited.	Not Covered

HEALTHIEST EMPLOYERS

Flexible Spending Accounts (FSA)

The City allows you to contribute to one or both flexible spending accounts, which allow you to save taxes on certain out-of-pocket health care and dependent care expenses. The FSAs are administered by Aetna.

How the FSAs Work

The City offers two types of FSAs:

- Health Care FSA
- Dependent Care FSA
-

If you elect to contribute to one or both of the FSAs, you choose an annual amount to be taken from each of your paychecks and deposited into your account throughout the year. Your contributions are taken out of your paycheck before you pay taxes, so you save money. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year.

With both accounts, the IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the "use it or lose it" rule.

Important FSA Considerations

- Any money left in your FSAs at the end of the plan year may not be rolled over to pay for future expenses in another plan year. Any unused funds will be forfeited, per IRS rules.
- For the Dependent Care FSA, you may only be reimbursed up to the amount in your account at the time you file a claim. If your eligible expenses are greater than the amount in your account, the unreimbursed amount will carry over and be reimbursed after your next deposit. (For the Health Care FSA, you can be reimbursed up to the full amount you have elected to contribute for the year—even if you have not yet contributed that much to your account.)
- The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other. You also cannot transfer funds between the two accounts.
- If you use the Dependent Care FSA, you must provide your caregiver's Social Security number or tax ID when you file a claim for reimbursement.

Health Care FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses that are not covered by another health plan. Examples include, but are not limited to:

- Medical or dental deductibles
- Office visit copays
- Coinsurance amounts
- Amounts you pay for prescription drugs
- Amounts you pay for certain over-the-counter items
- Eyeglasses, contacts and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by the dental plan

NOTE: ***YOU MUST COMPLETE A NEW FSA REIMBURSEMENT FORM AND RE-ENROLL EACH OPEN ENROLLMENT TO CONTINUE YOUR FLEXIBLE SPENDING ACCOUNT.***

FSA Annual Contribution Amount

You can contribute $250 up to a maximum of $2,500 per year to the Health Care FSA.

A Note Regarding FSA use for Over-the-Counter Medications

You must have a doctor's prescription to use the Health Care FSA to reimburse yourself for certain over-the-counter medications. Examples of medications that require you to submit a doctor's prescription include:

- Acid controllers, digestive aids and stomach remedies
- Allergy and sinus medicines
- Anti-itch and insect bite remedies
- Cold sore remedies
- Cold, cough and flu drugs
- Pain relief medications
- Respiratory treatments
- Sleep aids and sedatives

How the FSA Debit Card Works

If you enroll in the Health Care FSA, you will receive one debit card in the mail.

You can use your debit card at certain places to pay for eligible expenses up-front, such as prescription drugs and office visit copays, without having to pay with cash and wait for a reimbursement. If you use your debit card at a health care provider's office or at a vendor that has the software in place to track eligible FSA expenses, you will not be required to submit a receipt. **However, for most debit card transactions, you will need to submit your receipts as substantiation of your expense, so it's important to keep them.**

If you choose not to use your debit card, you can always pay for your eligible expense and file a claim for reimbursement.

Example of Savings with a Health Care FSA

Sample Healthcare Expenses	Cost Without an FSA	Cost With an FSA	Your Estimated Savings*
Doctor Copay	$35.00	$24.50	$10.50
Specialist Copay	$45.00	$31.50	$13.50
Monthly Diabetic Supplies	$100.00	$70.00	$30.00
Monthly Orthodontic Payment	$125.00	$87.50	$37.50
Eyeglasses	$300.00	$210.00	$90.00
Laser Eye Surgery	$2,500.00	$1,750.00	$750.00

*based on the 10% tax bracket

Health Care Flexible Spending Account Worksheet

Use the following worksheet to estimate out of pocket expenses for the year (January 1 to December 31, 2017). Some common Flexible Spending Health Care expenses are listed below or go to www.irs.gov.

	Employee	+ Dependents	= Total
Prescription Copays	You save money by using generic drugs. Review your maintenance and prescribed over-the-counter prescriptions to see if you are choosing the most economical option.		
Medications (including prescribed over-the-counter prescriptions)	$_____	+ $_____	= $_____
Doctor Visit Copays	$_____	+ $_____	= $_____
Scheduled	$_____	+ $_____	= $_____
Non-Scheduled	$_____	+ $_____	= $_____
Medical Procedures	Some examples of eligible expenses include laser eye surgery, outpatient surgery, hospital copays, coinsurance, hospital stays and lab work.		
Procedures	$_____	+ $_____	= $_____
Dental Care Costs	Examples include orthodontia, root canals, fillings, night guards, splints, etc.		
Routine Dental Expenses	$_____	+ $_____	= $_____
Specialized Procedures	$_____	+ $_____	= $_____
Orthodontia	$_____	+ $_____	= $_____
Vision Care Costs	$_____	+ $_____	= $_____
Estimated annual total of out-of-pocket health care expenses:			$
Divide total by 24 payroll deductions. (New employees divide by the remaining number of calendar year pay periods, after your hire date).			÷ 24
Estimated contribution per pay period. (This is the amount you enter into the Health Care block during online open enrollment).			= $_____
Maximum deduction is $104 per pay period (cannot exceed $2,496)			

Dependent Care FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be:
  - Employed, or
  - A full-time student at least five months during the plan year, or
  - Mentally or physically disabled and unable to provide care for himself or herself

Eligible Dependent Care Expenses

Generally, you may use the money in your Dependent Care FSA for care of:

- Your children under age 13 whom you claim as a dependent for tax purposes
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).

Some typical expenses that are eligible for reimbursement under the plan are:

- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- Day camps
- After-school care

For a complete list of eligible expenses, visit www.irs.gov.

FSA Annual Contribution Amount

You can contribute $250 to $5,000 per year to the Dependent Care FSA.

Example of savings with a Dependent Care FSA

*Based on 15% tax bracket

Sample Dependent Care Expenses	Cost Without A FSA	Cost With A FSA	Your Estimated Out-of-Pocket Savings*
Daycare for Child Under Age 13	$5,000	$3,500	$1,500
Before/After School Care	$4,000	$2,800	$1,200
Summer Camp	$2,400	$1,680	$720
Disabled/Elder Adult Daycare	$5,000	$3,500	$1,500

Dependent Care Flexible Spending Account Worksheet

Use the following worksheet to estimate out of pocket expenses for the year (January 1 to December 31, 2017). Some common Flexible Spending Dependent Care expenses are listed below or go to www.irs.gov.

Activity/Age	Monthly Costs	Number of Months	Number of Children	Total Costs
Day Care – 6 years and under, still not in first grade	$_____	X _____ Months	X _____ Children	= $_____
Before School Childcare – children up to age 13	$_____	X _____ Months	X _____ Children	= $_____
After School Childcare – children up to age 13	$_____	X _____ Months	X _____ Children	= $_____
Summer are or Day Camp – children up to age 13	$_____	X _____ Months	X _____ Children	= $_____
Estimated annual total of out-of-pocket dependent care expenses:				$_____
Divide total by 24 payroll deductions. (For new hires divide by the remaining number of calendar year pay periods, after your hire date).				÷ 24
Estimated contribution per pay period. (This is the amount you enter into the Dependent Care block during online open enrollment).				= $_____

Life Insurance

VOLUNTARY BENEFITS

Basic Life Insurance

The City of Round Rock automatically provides Basic Life and Accidental Death and Dismemberment (AD&D) Insurance for all eligible employees at no cost. Basic Life Insurance and Accidental Death and Dismemberment equal to your annual base earnings up to a maximum of $100,000. The benefit is paid to your beneficiaries in the event of your death.

Annual base earnings include your base salary. Interest is not included.

Supplemental Death Benefit

The City still provides a Supplemental Death Benefit in the retirement program. If you die while employed by the City, Texas Municipal Retirement System (TMRS) will pay your beneficiary or estate a benefit approximately equal to your current annual salary. You are automatically enrolled, with no cost to you, for the Supplemental Death Benefit when you enroll with TMRS. The benefit is paid to your beneficiaries or estate in the event of your death.

Life Insurance Coverage IRS Rules

If your Basic Life Insurance coverage is more than $50,000, your income taxes may be affected. IRS regulations require that the value of life insurance benefits over $50,000 be reported as "imputed income" on your W-2, which is non-cash income you receive from an employer-provided benefit. This is a very nominal fee and depending on your age will be between $1.00 and $4.99 annually.

Optional Life Insurance

In addition, you may also purchase Optional Life Insurance for yourself, your spouse and your children. However, you may only elect coverage for your dependents if you enroll in Optional Life coverage for yourself. You pay for the cost of Optional Life Insurance on an after-tax basis through payroll deductions. Optional Life and AD&D insurance will be taken from your paycheck on a post-tax basis.

Beneficiary Designation

You must designate a beneficiary for your Supplemental Death benefit when you enroll with TMRS. Your beneficiary is the person(s) who will receive the benefits from your Supplemental Life Benefit in the event of your death. You can change your beneficiaries at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your life insurance benefits will go to a probate court.

Additionally, you must designate a beneficiary for your city paid basic life insurance, wages and any reimbursements owed to you by the City of Round Rock at the time of your death. You may do so by completing the Beneficiary Designation Form available on EmployeeNet or at the Human Resources Office.

Disability Coverage

VOLUNTARY BENEFITS

The City provides long term disability coverage at no cost to employees. Disability coverage works to keep all or part of your paycheck coming if you cannot work because of illness, injury or pregnancy. Short term disability can be elected by the employee at the employee's expense.

Short-Term Disability

Short-term disability (STD) benefit is available to all eligible employees. If you enroll in STD, you may be eligible for STD benefits if you remain totally disabled and unable to work for more than 8 days. This coverage automatically provides you STD benefits that replace up to 60% of your weekly salary for a length of time that you choose (either 15 weeks or 25 weeks).

Long-Term Disability

If you remain totally disabled and unable to work for more than 180 days, you may be eligible for Long-Term Disability (LTD) benefits. The City automatically provides you LTD benefits that replace up to 60% of your base pay, up to a maximum of $5,000 per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

When Are You Disabled?

To be considered totally disabled and eligible for LTD benefits, you must be approved by the insurance carrier and seeing a doctor regularly for treatment. In addition:

- Your doctor must certify that you are not able to do your job at the City, and;
- You must have lost 20% or more of your pre-disability income due to your illness or injury.

HEALTHIEST EMPLOYERS

Other Benefits

- Employee Medical Clinic
- Money Saving Tips
- Legal Protection Plan
- Retirement
- Employee Assistance Plan (EAP)
- Education Assistance
- Clay Madsen Recreation Center
- City Pools
- Library Card

Employee Medical Clinic

rockcare

The most important thing you can do for yourself and your family is to stay healthy. Our RockCare clinic will help you meet your goals and is FREE to employees and their eligible dependents covered by Round Rock's health plans. The center is staffed with a Nurse Practitioner and Medical Assistants. The clinic is located at 901 Round Rock Ave, Suite 300-B in Round Rock.

Walk ins are welcome from 7-8 am daily. Except for work related injuries, **appointments are required for the remaining clinic hours.** Please notify the scheduling line if you are unable to keep your scheduled appointment. This will allow for another patient to be seen during that time.

To make an appointment, call 1-866-959-9355 during the hours below:

DAY	TIME		
Monday	6 am	-	4 pm
Tuesday	6 am	-	7 pm
Wednesday	6 am	-	7 pm
Thursday	6 am	-	7 pm
Friday	6 am	-	7 pm
Saturday	7 am	-	12 pm

Medical Clinic Services

- Manage Diabetes
- Manage Blood Pressure
- Manage Cholesterol
- Sore Throat
- Allergy Care
- Muscle/Joint Pains
- Blood Work/Lab Tests
- Referral to Specialist
- Bladder Infection
- Prescriptions for Medications
- Sinus Infections
- Headaches
- Occupational Medicine
- MUCH MORE!

healthstat
inspiring healthy change

HEALTHIEST EMPLOYERS

Health Risk Assessments

Health RISK assessment

healthstat rockcare

To be covered under the City of Round Rock Health Care Plan, employees, retirees and eligible dependents over the age of 18 must complete a Health Risk Assessment (HRA). This assessment helps you as well as the provider understand your current health. The HRA identifies potential health risks that Healthstat, through our medical clinic can help you manage. This is truly a unique benefit to everyone on the health plan. Having Rockcare provides convenient access to the resources that you need to be engaged in your health. Rockcare offers the tools necessary to maintain your health, prevent further issues and to get you healthier. There is NO COST to employees, retirees and/or eligible dependents (between the ages of 5 through 26) covered under our health plan and all health information is kept strictly confidential between you and Healthstat.

HOW DO I PARTICIPATE?

HOW DO I PARTICIPATE?

The first step is to schedule your Health Risk Assessment (HRA) at the Rockcare Clinic. To schedule, call 866-959-9355.

Rockcare will measure your height, weight, blood pressure and provide a fasting blood draw.

This means NO FOOD up to 8 HOURS BEFORE YOUR APPOINTMENT TIME. Rockcare measure total cholesterol, HDL, LDL, triglycerides and glucose. Please drink plenty of water, and take regular medications with water.

Hours of Operation

Monday - Thursday		Friday
7:00 am - 12:00 pm	1:00 pm - 4:00 pm	7:00 am – 2:00 pm

CLOSED FOR LUNCH MONDAY THROUGH THURSDAY 12:00 PM TO 1:00 PM

HEALTHIEST EMPLOYERS

WHAT WILL I RECEIVE?

After your Health Risk Assessment, you will receive a Healthy Life Profile in the mail:
Healthy Life Profile: This document shows the results of the health risks we tested for during your screening. It will also show if any of the results pose a health risk. Your overall score will determine the frequency in which you should visit the clinic to help you either maintain or lower your current health risks.

healthstat

Healthy Life Profile Report

Monday, September 19, 2011

JOHN SMITH
123 Main Street
Charlotte, NC 28217

Thank you for participating in the recent Health Risk Appraisal (HRA). This report is intended to help you understand your health risk score and to recommend a clinic visit schedule that will help you either maintain or lower your current risks. The results of your most recent Health Risk Assessment are presented in the table below. If any of your test results place you in a High-Risk category, your score is highlighted in red.

The Results of Your Health Screening

Your most recent results are shown in the first column.
If you have had more than one HRA, your past results are in the right columns.

Screening Test Name	8/22/2009	3/8/2008
Systolic Blood Pressure	156	215
Diastolic Blood Pressure	90	135
Blood Glucose	124	93
Triglycerides	97	141
Total Cholesterol	198	212
HDL Cholesterol ("good cholesterol")	47	52
LDL Cholesterol ("bad cholesterol")	132	132
Body Mass Index	36.5	35.9
PSA – Prostate Specific Antigen (Males Only)	0.7	0.7
Diabetes Status	No	No
Tobacco Use	Yes	Yes
Last Physical Exam	> 2 years	1 -2 years

Please refer to the Health Risk Guidelines on page 2 of this report

If your score is marked TNP, the test was not performed. A TNP result occurs when 1.) the test is not offered as part of the assessment, 2.) the value may be out of range or 3.) cannot be calculated.

Your Overall Risk Score is ***6***

Low Health Risk	Moderate Health Risk	High Health Risk
0	*1 2 3*	*4 5 6 7 8 9 10+*

Money Saving Tips

Urgent Care vs. Emergent Care

There is often confusion regarding whether to use an Urgent Care Center. Many urgent care centers are operated by hospitals and often provide emergency care treatment, also known as emergent care. **These facilities are as expensive as using an emergency room even though they are advertised as an urgent care center.**

Below are examples of conditions that are treated at an urgent care facility compared to those treated in an emergency room. Also provided are examples of urgent care facilities and emergent care facilities so you will know the difference and choose wisely.

URGENT CARE SITUATIONS	EMERGENCY SITUATIONS
Ear or eye infection	Chest pain or squeezing sensation in the chest
Fever	Seizure or loss of consciousness
Cuts that may need stitches	Severe abdominal pain
Possible broken bones or simple fractures	Sudden paralysis or slurred speech
Severe sore throat	Uncontrolled bleeding
Sprains and strains	
Vomiting / Diarrhea	

Austin Regional Clinic

After-hour clinics

BaylorScott&White Health

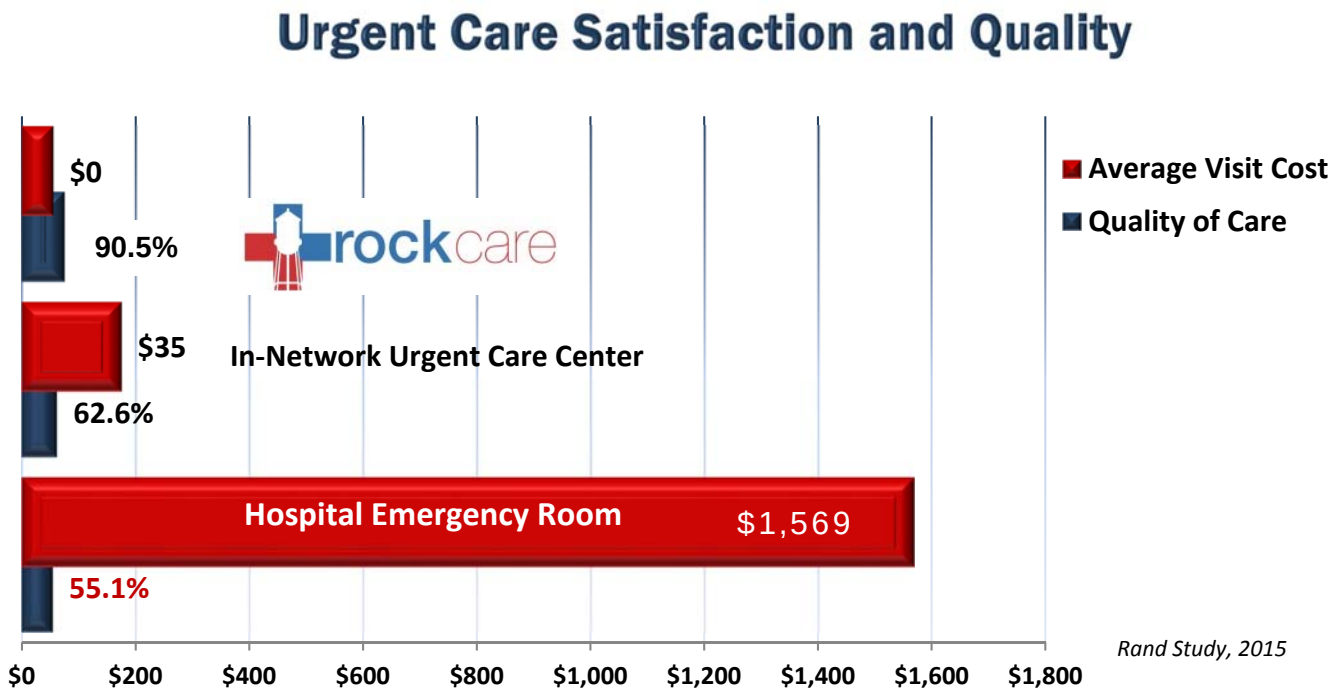
St David's HealthCare

medspring urgent care

NextCare Urgent Care

Be a Wise Consumer

Should I go to the Doctor, Walk-In Clinic, Urgent Care or Emergency Room?



Out of Pocket Cost to You

Out of Pocket Cost to You	Where to go	When to go	Examples	Average Cost to the City
$0	rockcare	For routine care or non-emergency needs during office hours	Health Exams, Cold, Flu, sore throats, minor injuries, aches and pains	$56
$35	Austin Regional Clinic medspring urgent care NextCare Urgent Care	For non-emergency needs when your doctor's office is closed or if you can't use an in-network clinic and you need immediate medical attention	Simple bone breaks, cuts, burns, ear infections, sprains and minor injuries	$176
$950	Baylor Scott & White Health St. David's HealthCare	Use the ER if you have serious symptoms or a life-threatening emergency	Severe bleeding, chest pains, broken bones and poisoning	$1,569

Legal Protection Plans

Membership grants a member access to a host of legal benefits that are available and renew each year. You will have the opportunity to solve your legal matters at a reduced rate, without reducing the level of service. This service also covers wills and estate planning.

Retirement

The City values you as an employee. As part of your compensation, the City provides retirement benefits. Over the years, the City has made a significant investment in providing retirement benefits to employees, so it is important that you understand how your retirement benefits work. Several programs are available to help you prepare for your retirement. These programs include mandatory participation in retirement systems and City contributions to Social Security on your behalf. For more information about your defined benefit retirement plan, contact your retirement system.

Texas Municipal Retirement System (TMRS)

The City's retirement program is with TMRS. Full-time employees contribute a mandatory 7% of their salary. The City contributes a ratio of 2:1 to the employee's fund after the employee has become vested (five years) AND retires (after 20 years of service OR at age 60 with five years of service). The retirement fund earns interest. The City also participates in Social Security. A Supplemental Death Benefit is also provided by TMRS at one times your annual salary.

457 Deferred Compensation Plans

Employees are offered the opportunity to save more toward retirement than the mandatory 7% with TMRS. Under Section 457 of the Internal Revenue Code, employees may defer up to the maximum allowed depending upon their age. Participation is handled through payroll deduction so taxes are reduced each pay period. An employee may join the 457 plan anytime during the year.

Advantages

Reduce current income taxes while boosting retirement savings.
Earnings accumulate tax-deferred.
Portability. An employee can move savings to another governmental 457 plan, IRS or qualified plan.

Withdrawals

An employee may withdraw assets under certain conditions. Additionally, it's necessary to complete the appropriate paperwork available at Human Resources or Nationwide at the number indicated in the Vendor Directory.

Contribution Limits for Eligible 457(b) Deferred Compensation Plans	
Annual Contribution Limit	In 2017 and thereafter, annual cost of living adjustments may occur. This limit includes both employee and other contributions.
	2017 Annual Maximum $ 18,000
457(b) Special Catch-up Provision	The 457(b) Special Catch-up provision permits increased annual contributions on behalf of a participant. It allows you to make up, or "catch up", for prior years in which you may not have contributed the maximum amount to your employer's 457(b) plan.
	2017 Annual Maximum $ 24,000
Age 50+ Catch-up Provision	If you are at least age 50, and currently participate in a governmental 457(b) plan, you are eligible to contribute an additional amount over the annual contribution limit. However, you cannot use both the Special Catch-up provision and the Age 50+ Catch-up provision in the same year. You must use whichever is greater.
	2017 Annual Maximum $ 24,000
Roth 457	A Roth 457 Deferred Compensation plan may be another good choice if the potential for tax-free income in the future is more important than a tax deduction now.
	2017 Annual Maximum $ 24,000

Employee Assistance Program

Be a Winner
In the Game of Life

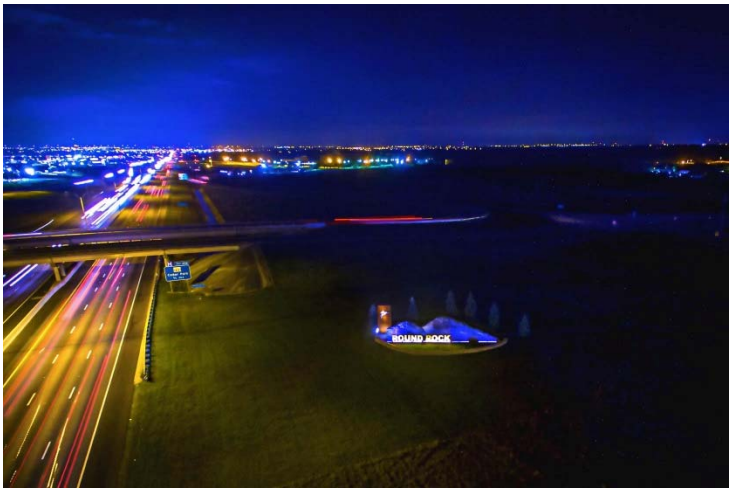
Your EAP is just a click away....

DEER OAKS

Education Assistance

This benefit is to provide financial assistance to employees who are seeking education for career and/or job related development and who are taking for-credit courses through an academic institution. Regular full-time employees with six or more months of service may be eligible for education assistance. The City provides up to $2,000 in education assistance per fiscal year to eligible employees. These funds are allocated on a first-come, first-served basis. Classes must be offered by an accredited school or university and must have the opportunity to be taken for a grade.

Clay Madsen Recreation Center



The City provides all employees the opportunity to choose either a free individual Clay Madsen Recreation Center (CMRC) membership or a discounted family membership. Only immediate family members are eligible to be covered under the discounted family membership. The CMRC is a fully equipped recreation facility with an indoor pool.

Employee & Family Pool Pass (Seasonal Benefit)

The City provides all employees an Employee & Family Pool pass for recreation swimming. This pass provides free admittance to all City pools for employees and their immediate family members.

Round Rock Public Library Card

All City employees receive a free Round Rock Public Library Card regardless of City residence. Employees interested in obtaining a library card should complete an application at the Library.

Frequently Asked Questions

Eligibility Questions

Q. If I am not sure how to access my benefits or who to call, where should I begin?
A. If you need assistance with any of the benefits offered by the City of Round Rock, call Employee Benefits at *512-671-2701 and ask to speak with a Benefits representative.*

Q. How do I enroll my newborn in my medical plan?
A. Go to Employee Self Service within 31 days of your child's birth to initiate a life event, even if you have other children enrolled. You must provide a certified birth certificate, the complimentary birth certificate, or a Verification of Birth Facts issued by the hospital. Complete a Benefits Enrollment Form and enroll online in the Employee Self Service.

Q. My daughter is graduating from college next week, and will turn 21 next month. Do I have to drop her from my insurance?
A. No. Your dependents may continue coverage until age 26, as long as they meet the eligibility requirements.

Q. How do I add or remove my spouse from my benefits?
A. Go to Employee Self Service within 31 days to initiate a life event of your marriage or of your domestic divorce. You must provide a Divorce Decree or marriage certificate.

Q. I am resigning my position from the City of Round Rock, how can I continue my coverage?
A. COBRA is offered to you and your covered dependents when coverage has ended. You will receive a COBRA information letter after your separation. For more information, call Employee Benefits at 512-671-2701.

Q. Can I cover my grandchild?
A. *You can if you claim the grandchild on your income tax return. You must provide a copy of the preceding year's income tax return and a birth certificate.*

Benefits Questions

Q. I just signed up for benefits. When can I expect to receive my ID cards?
A. You should receive your ID cards within two to three weeks of enrolling or making changes to your benefits. You can go to Aetna Navigator and print temporary ID cards. The City cannot order ID cards for you.

Q. If I need to see a doctor or have a prescription filled prior to receiving my ID card, what should I do?
A. *You can go to the employee medical clinic, Rockcare at no cost to you. If you go to another provider, you will need to pay for the services out-of-pocket, then submit a claim form and your receipt to Aetna. You will receive reimbursement for these expenses, minus the required copay if you visited an in-network provider.*

Q. Can I make changes to my benefits during the year?
A. Yes, within 31 days of a qualifying life event, such as birth of a child, marriage/divorce, loss of other coverage, or when you or your dependents receive coverage from another insurance company.

Q. If I am called for military duty, what steps should I take concerning my benefits?
A. Call Employee Benefits at 512-671-2701 to discuss your options.

Q. I will be out on leave without pay. What should I do to make sure that my benefits continue?
A. Call the Employee Benefits Division at 512-671-2701 to discuss your options and make arrangements to pay your benefit premiums if required.

Required Health Coverage Notices For Your Files

This brochure contains legal notices that are required to be distributed to participants in group health plans sponsored by the City of Round Rock.

The notices included in this brochure are:

- Notice of Privacy Practices that explains how the City of Round Rock group health plans protect your personal medical information.
- Medicare Part D Notice that provides information about how your current prescription drug coverage under the City of Round Rock healthcare plans is affected—and your options for coverage—when you become eligible for Medicare.
- COBRA Rights Notice that explains when you and your family may be able to temporarily continue coverage under the City of Round Rock health plans if coverage would otherwise end for you.
- Newborn & Mothers Health Protection Notice that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.
- Women's Health and Cancer Rights Act that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.
- Notice of Special Enrollment Rights
- New Health Insurance Marketplace Coverage Options and Your Health Coverage that explains key parts of the health care law that took effect in 2014.

Group Health Plan Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Duties

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this notice but reserve the right to change the terms of the notice and to make the new notice provisions effective for all protected health information we maintain. If we change the terms of the notice, we will provide you with a copy of the revised notice by letter and posting. This notice will remain in effect until replaced or amended. Detailed large claim health information received from healthcare vendors will only be viewed by individuals in the following positions: Benefits manager, Human Resources Director, Benefits Specialist, and the City Attorney assigned to Human Resources. These employees have a legitimate business need to view this information in order to consider alternate health insurance funding options for the city.

Your Protected Information

In order to conduct operations, our designated agents or we, collect, create and/or use different types of information. This may include information about you such as your name, address, age, health status, medical or psychological conditions, and information about dependents. Some of this information may qualify as *protected health information*. Our use or disclosure of *protected health information* may be restricted or limited by law. *Protected health information* means individually identifiable health information that is transmitted by electronic media, maintained in electronic or computer format, or transmitted or maintained in any other form or medium. *Protected health information* does not include certain educational or employment records.

Permitted Uses and Disclosures of Your Protected Information

For Payment – Our designated agents or we may use and disclose information about you in managing your healthcare. This may include such functions as premium payment activities, reimbursing healthcare providers for services, determining eligibility or coverage of an individual, performing coordination of benefits, adjudicating claims, healthcare data processing including claims management, collection activities, obtaining payments under a reinsurance contract, medical necessity reviews, and/or utilization review activities.

For Healthcare Operations – Our designated agents or we may use and disclose information about you for healthcare operations. This may include information about you needed to review the quality of care and services you receive, to provide case management or care coordination services, provide treatment alternatives or other health-related benefits and services, and/or to perform audits, ratings, and forecasts (as limited by HIPAA standards).

For Treatment – Our designated agents or we may use and disclose information about you for treatment purposes. This may include information about you needed for the provision, coordination, or management of healthcare and related services.

As Permitted or Required by Law – **Information about you may be used or disclosed to regulatory agencies, for administrative or judicial proceedings, for health oversight activities, to law enforcement officials when required to comply with a court order or subpoena, and/or as authorized by and to the extent necessary to comply with workers' compensation laws.**

Public Health Activities – Information about you may be used or disclosed to a public health authority for the purposes of preventing or controlling disease, injury or disability, reporting child abuse or neglect, and/or to assist the Food and Drug Administration in tracking products and defects/problems as well as enabling product recalls and conducting post marketing activities. Information about you may also be used or

disclosed if we reasonably believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Abuse, Neglect or Domestic Violence – To the extent required or authorized by law, or with your consent, protected information about you may be disclosed to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect, or domestic violence.
In the Event of Death – In the event of your death, our designated agents or we may disclose your protected information to coroners, medical examiners and/or funeral directors as necessary to carry out their duties.

Organ Transplant – Our agents or we may use or disclose your protected information to organ procurement organizations or related entities for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research Purposes -- Our agents or we may use or disclose your protected information for research provided we first obtain an authorization or waiver from you and representations from the researcher limiting the uses and protecting the privacy of your information.

Correctional Institutions – Our agents or we may use or disclose your protected information to a correctional/custodial institution or appropriate law enforcement official if you are an inmate and the disclosure is necessary for your healthcare and the health and safety of you, other inmates, officers or institution employees.

Business Associates – Where it is necessary to help carry out our healthcare function, we may disclose your information to a business associate and/or allow the business associate to create or receive protected health information on our behalf. In most situations, we must first obtain satisfactory written assurances that the business associate will appropriately safeguard the information. No such assurances are required, however, where disclosure is made to your healthcare provider for treatment purposes.

Minimum Disclosure Required – When using, disclosing or requesting your information, we are normally required to make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. This limitation does not apply in situations involving disclosures to you or made pursuant to your authorization, to a healthcare provider for treatment, to the Secretary of Health and Human Services for HIPAA compliance and enforcement purposes, or as otherwise required by law.

Authorization – Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke, in writing, any such authorization unless we have taken action in reliance on your authorization or it was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy.

To Employer –**Our designated agents or we may disclose your information to your employer to conduct an evaluation relating to medical surveillance of the workplace, to evaluate whether you have a work-related illness, to record such illness or injury as required by law. Prior to disclosing this information to your employer, we must give you written notice at the time the healthcare is provided or, if the healthcare is provided at the work site, prominently post the notice at that location.**

Informational Contact – We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to Plan Sponsor – **We may disclose protected information to the Plan Sponsor only in the form of de-identified summary information and to record enrollments and dis-enrollments**

Your Rights

Under the regulations you will have the right to:

- Send us a written request to see or get a copy of the protected health information that we have about you.
- Request an amendment to your personal information that you believe is incomplete or inaccurate. The request must be in writing and provide a reason to support the proposed amendment.

- Request in writing additional restrictions on uses or disclosures of your protected health information to carry out treatment, payment, or healthcare operations. However, we are not required to agree to these requests.
- Receive an accounting of our disclosures of your protected health information in writing, except when those disclosures are made for treatment, payment or healthcare operations, or when the law otherwise restricts the accounting.
- Receive a paper copy of this notice upon request.
- You cannot be forced to waive your rights established by the privacy regulations.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address. **(Applies to Healthcare Provider**)
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address, if communication to your home could endanger you. **(Applies to Health Plan)**

Complaints

If you believe your HIPAA privacy rights have been violated, you have the right to file a complaint with either the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Washington, D.C. 20201, or Jay Light, City of Round Rock, Benefits Manager, 231 E. Main Street, Round Rock, Texas, 78664, (512) 341-3143. The complaint must be in writing, either on paper or electronically, name the person that is the subject of the complaint and describe the acts or omissions believed to be in violation of your rights. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing a complaint.

Further Information

If you need further information, please contact our HIPAA Compliance Officer, Human Resources, 231 East Main Street, Round Rock, Texas, 78664, Phone: (512) 218-5490.

From this day forward "Our Duties" of the Notice of Individual Privacy Rights will include the following:

Detailed large claim health information received from healthcare vendors will only be viewed by individuals in the following positions: Benefits Manager, Human Resources Director, Benefits Specialist, and the City Attorney assigned to Human Resources. These employees have a legitimate business need to view this information in order to consider alternate health insurance funding options for the city.

Medicare Part D Notice

Important Notice from City of Round Rock about Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Round Rock has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

- If you are an active employee and you decide to enroll in a Medicare prescription drug plan and drop your City of Round Rock Health Plan prescription drug coverage, you and your dependents may not be able to re-enroll in the City of Round Rock Health Plan coverage until the next annual enrollment period.
- If you are a retiree and you decide to enroll in a Medicare prescription drug plan and drop your City of Round Rock Health Plan prescription drug coverage, you and your dependents will not be able to re-enroll in the City of Round Rock Health Plan coverage in the future.

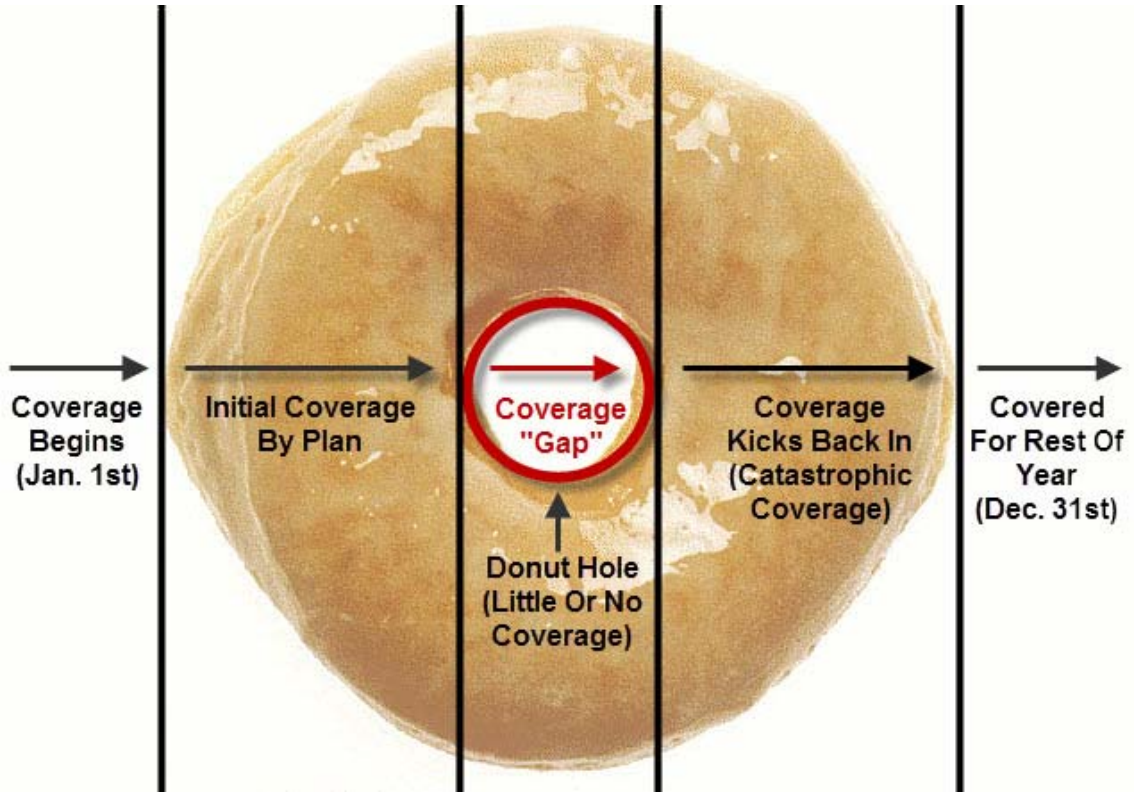
When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?

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

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

What is the Donut Hole?

The "Donut Hole" is an analogy used to explain the coverage gap in Medicare Part D drug plans. On Part D drug plans, the plan itself will help pay for your prescription Medications until you have reached a certain limit ($2,840 in 2011), and from this point on, you will have to pay the total cost of the medications out-of-pocket until you reach the maximum out-of-pocket cost limit ($4,550 in 2011). This gap of $1,710 ($4,550 - $2,840) is what you would have to pay; which is the full cost of your medications while you are in the "donut hole". After you reach the coverage gap limit ($4,550 in 2011) then you will enter what is called "catastrophic coverage" in which you will have the greatest amount of drug coverage until then end of the calendar year. To learn more about the donut hole, view the following link: Medicare Donut Hole. Below is also a picture diagram of how and why it is called the "donut hole"...



For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Round Rock changes. You also may request a copy of this notice at any time.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Round Rock changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

Name of Entity/Sender: City of Round Rock
Contact Position/Office: Jay Light, Benefits Manager
Address: 231 East Main St., Suite 100 Round Rock, TX 78664
Phone Number: (512) 341-3143

Keep this notice.

If you enroll in a Medicare-approved plan that offers prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

COBRA Rights Notice

You're getting 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're the spouse of an employee, you'll 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of Round Rock, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. 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;
- Commencement of a proceeding in bankruptcy with respect to the employer;] or
- 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 after the qualifying event occurs. You must provide this notice to: City of Round Rock

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 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.

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

Date: January 1, 2017
Name of Entity/Sender: The City of Round Rock
Contact/Office: Human Resources Department, Benefits Division
Address: 231 East Main Street, Round Rock, TX 78664
Phone Number: 512.218.5490

The Arts Are Growing In
Round Rock!

health care marketplace New Health Insurance Marketplace

PART A: General Information

The Health Insurance Marketplace is a new way to purchase health insurance in the United States. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer, the City of Round Rock.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

No. Regular full-time employees will not experience savings because the City pays the entire premium for the PPO and the majority of the HMO premium. Part-time employees may realize savings by going to the Marketplace.

Temporary employees hired by the City of Round Rock are not eligible for City-provided medical coverage. Temporary employees and their dependents can purchase health insurance through the Health Insurance Marketplace, designed to provide affordable health insurance.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. The City of Round Rock offers coverage that meets government standards. If you are in a regular budgeted position and work full-time you will not be eligible for a tax credit at the Marketplace.

If you are in a regular budgeted position working part-time, and the premium you would pay for the City's lowest cost medical plan (Employee Only) is more than 9.5 percent of your household income for the year, you may be eligible for a tax credit at the Marketplace. If you are a temporary employee, and therefore not eligible for medical coverage under a City medical plan, you are eligible for medical coverage through the Marketplace and may also qualify for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by the City of Round Rock, then you may lose the City's contribution (if any) to the employer-offered coverage. Also, the City's contribution as well as your employee contribution to City offered coverage is usually excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by the City of Round Rock, review this guide or contact the City of Round Rock at 512-218-5490.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about health coverage offered by the City of Round Rock. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name: City of Round Rock

4. Employer Identification Number: 74-6017485

5. Employer address: 231 E. Main Street

6. Employer phone number: 512-218-5490

7. City: Round Rock **8. State:** Texas **9. ZIP code:** 78664

10. Who can we contact about employee health coverage at this job? Human Resources Department, Employee Benefits

11. Phone number: 512-218-5490 **12. Email address:** HR@roundrocktexas.gov

13. Is the employee currently eligible for coverage offered by the employer, or will the employee be eligible in the next 3 months?

☑ Yes, (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard?

☑ Yes (Go to question 15) ☐ No (Stop and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the Employer has wellness programs, provide the premium that he employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $0 for Wellness Plan

b. How often? ☐ **Weekly** ☐**Every 2 weeks** ☑**Twice a month** ☐**Monthly** ☐**Quarterly** ☐**Yearly**

Basic Health Care Coverage Information

As your employer, the City of Round Rock offers a health plan to all employees in regular budgeted positions. Temporary employees are not eligible for coverage under a City medical plan.

The City of Round Rock offers dependent coverage to eligible dependents. Eligible dependents (spouse, domestic partner, children, and dependent grandchildren) are detailed in this guide.

The City's coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefits costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(ii) of the Internal Revenue Code of 1986)