City of Round Rock

Employee Benefits Guide

2018

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Austin Business Journal's
HEALTHIEST EMPLOYERS
OF CENTRAL TEXAS

Contents

This 2018 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.

Contact Information

aetna

Medical: 855-339-9406

Pharmacy: 888-792-3862

Dental: 877-238-6200

Vision: 877-973-3238

www.aetna.com

rockcare

866-959-9355
www.healthstatinc.com
901 Round Rock Ave., Ste 300-B
Round Rock, Texas 78681

healthstat
building a healthier busine

Nationwide

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

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

DEER OAKS
EAP SERVICES

Texas Legal

512-327-1372
https://texaslegal.org

ABACUS

Accident & Critical Illness Coverage
John Newman: 352.516.4365

Tyler Jarl, Benefits Manager
tjarl@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

LegalShield
Worry Less. Live More.

Jim Holliday
Phone: 512.567.4969

Benefits Summary

The City of Round Rock recognizes that your benefits are an important part of the reason you choose to be employed 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 decisions to make, it is important that you understand the various benefits options that are available to you and your family.

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.

You are encouraged to review all options before making your benefits elections. Only you can determine which benefits are best for you and your family.

Benefits Eligibility: Who is Eligible?

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. 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. 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.

- 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 enroll a dependent in 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. 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 benefits. 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 if 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 you 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.

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.

Aetna Choice Point of Service Plan

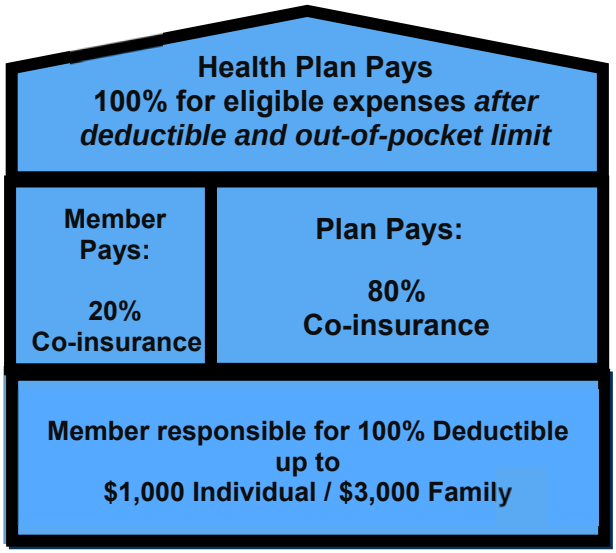
The Point of Service (POS) plan offers in-network and out-of-network benefits. When you need care, you decide whether to go to RockCare, an Aetna in-network doctor, or to an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than 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
$ 5,000 Individual
(Includes $ 1,000 deductible)

$ 14,500 Family
(Includes $ 3,000 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, 2018 through December 31, 2018:

Aetna Choice Medical Rates				
Tier	**Monthly Rate**	**City Portion**	**Employee Portion**	**Per Pay Period**
EE Only	$ 1,140.00	$ 1,000.00	$ 140.00	$ 70.00
EE + Child(ren)	$ 1,350.00	$ 1,000.00	$ 350.00	$ 175.00
EE + Family	$ 1,490.00	$ 1,000.00	$ 490.00	$ 245.00

Note: **Family rate is the same for employee + spouse AND employee + spouse + children**

Unsure if 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	 $ 1,000 $ 3,000	 $ 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	 $5,000 $14,500	 $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
Preventative 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 $300 Copay and deductible	50% after $300 Copay and Deductible
Physician Services for True Emergency (Life-threatening)	80% after $300 Copay and deductible	50% after $300 Copay and Deductible
Services Related to Non-Emergency (Hospital & Physician)	80% after $300 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 and orthopedic appliances	80% after deductible	50% after deductible
Orthotic devices (Only with Diabetes Diagnosis)	80% after deductible	50% after deductible

COST SHARING PROVISIONS	AETNA IN-NETWORK	OUT OF NETWORK
Home Health Care	80% after deductible (120 visits per year)	50% after deductible
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**	50% after deductible, not to exceed $1,500 lifetime benefit	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

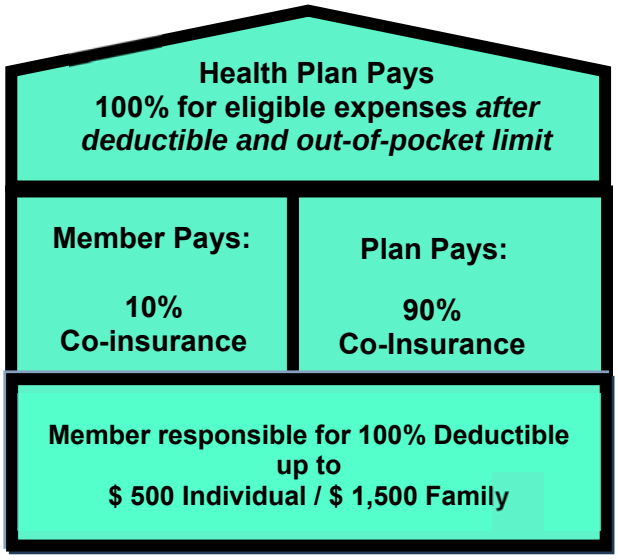
Aetna Whole Health - Seton

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. *Emergency room services are covered in and out of network as outlined in the schedule of benefits.*

Here's how it works:

In Network
Out-of-Pocket Limit
$ 2,500 Individual
(Includes $ 500 deductible)

$ 5,000 Family
(Includes $ 1,500 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, 2018 through December 31, 2018:

Aetna Whole Health - Seton Medical Rates				
Tier	**Monthly Rate**	**City Portion**	**Employee Portion**	**Per Pay Period**
EE Only	$ 1,136.00	$ 1,031.00	$ 105.00	$ 52.50
EE + Child(ren)	$ 1,311.00	$ 1,031.00	$ 280.00	$ 140.00
EE Family	$ 1,441.00	$ 1,031.00	$ 410.00	$ 205.00

Note: **Family rate is the same for employee + spouse AND employee + spouse + children**

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

Go to Aetna.Navigator and enter your provider or facility name and zip code. A pop up box will appear that asks you to choose your Aetna plan. Select (TX) Aetna Whole Health-Seton Health Alliance Plan.

AETNA WHOLE HEALTH – SETON PLAN
MEDICAL SCHEDULE OF BENEFITS

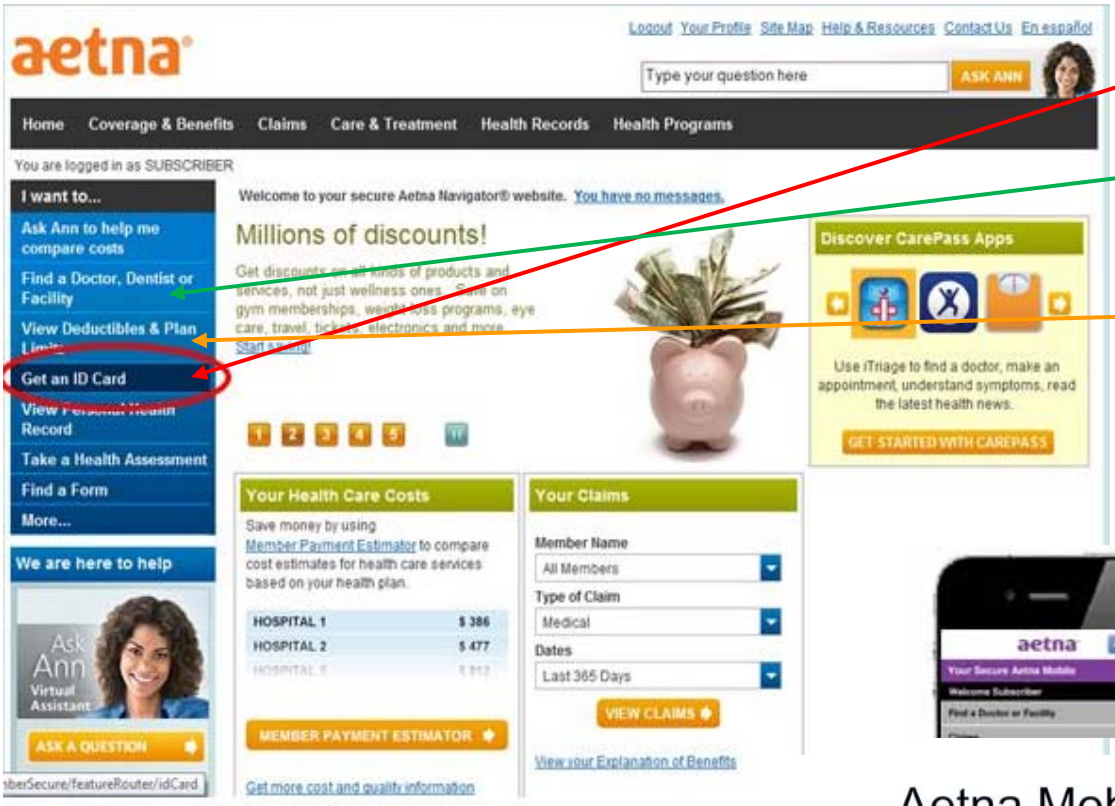
COST SHARING PROVISIONS	AETNA WHOLE HEALTH - SETON (No Out of Network Benefits)
ANNUAL DEDUCTIBLE	
Per Covered Person	$ 500
Per Family (3 individuals must be met to satisfy)	$ 1,500
BENEFIT PERCENTAGE (After Deductible is satisfied)	90%
Primary Care Physician	$25
Specialist Physician	$35
The Office Visit Copayment applies to all services performed in the office, by the same provider, on the same day as the office visit. 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	$2,500
Per Family	$5,000
Physician Services	
Office Setting Charges	$25
Non-Office Setting Charges	$35
Allergy Injections	90% after deductible
Preventative Care	100% - deductible waived
Diabetes Education & Counseling	90% after deductible
Inpatient (Room & Board limited to average semi-private room. Intensive care limited to the UCR.)	90% after deductible
Outpatient	90% after deductible
Hospital Services for True Emergency (Life-threatening)	90% after $300 Copay and deductible
Physician Services for True Emergency (Life-threatening)	90% after $300 Copay and deductible
Services Related to Non-Emergency (Hospital & Physician)	Not Covered
Urgent Care	$35 Copay
Ambulance Services (Ground or Air)	90% after deductible
Outpatient Diagnostic Services (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
Spinal Treatment/Chiropractic Care	100% at Airrosti 90% after Deductible for Others
Durable Medical Equipment, Prosthetic Devices, Orthopedic Appliances	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 through resolution 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, not to exceed $1,500 lifetime benefit
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!

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



Print Temporary ID Card

Find a Doctor or Facility

Get Your Claims Details

…AND MUCH MORE

Aetna MobileApp

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

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**

FIX PAIN

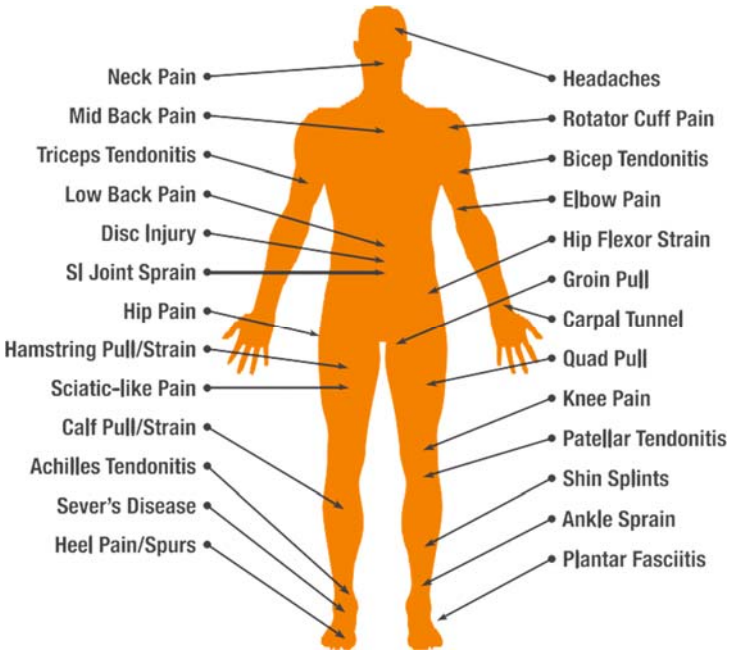
FEEL BETTER IN 3 VISITS

Airrosti is a covered benefit for City of Round Rock employees and dependents enrolled in either Health Plan

Airrosti visits are a $0 Copay

Airrosti providers are experts at diagnosing and rapidly resolving the source of your injury.

Each patient receives one full hour of assessment, diagnosis, treatment, and education designed to eliminate the pain associated with many common conditions, allowing you to quickly and safely return to activity - usually within 3 visits (based on patient-reported outcomes).



Schedule Your Appointment Today!

3.2 visits average to complete injury resolution*

10,000+ SURGERIES AVOIDED

40% THE AVERAGE COST OF OTHER FORMS OF CARE

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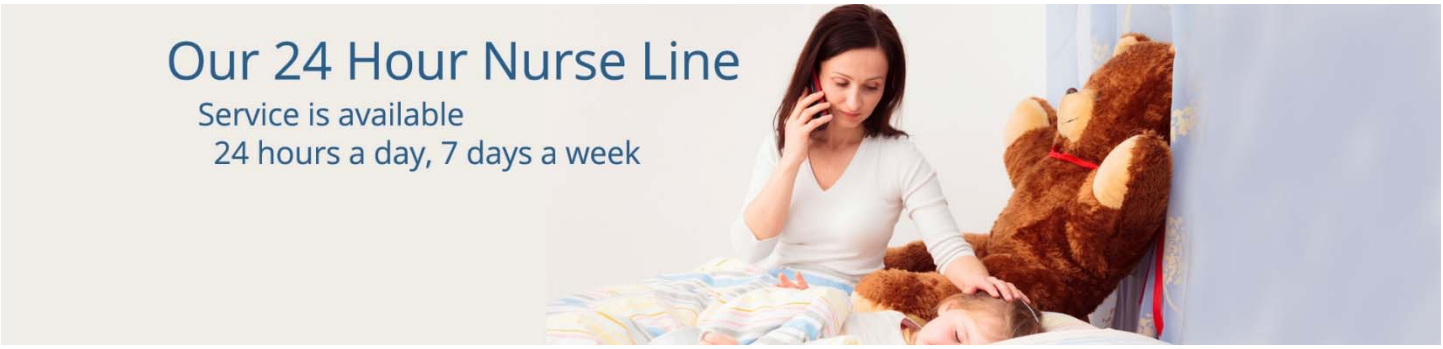
24-HOUR NURSE LINE 1-800-556-1555



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 – log 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.

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, 2018 - December 31, 2018.

Aetna Dental Plan Rates				
Tier	**Monthly Rate**	**City Portion**	**Employee Portion**	**Per Pay Period**
EE Only	$ 46.00	$ 20.00	$ 26.00	$13.00
EE/Child(ren)	$ 61.00	$ 20.00	$ 41.00	$20.50
EE/Spouse	$ 64.00	$ 20.00	$ 44.00	$22.00
EE/Family	$ 93.00	$ 20.00	$ 73.00	$36.50

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, 2018 - December 31, 2018

Aetna Vision Plan Rates				
Tier	**Monthly Rate**	**City Portion**	**Employee Portion**	**Per Pay Period**
EE Only	$ 7.00	$ 6.00	$ 1.00	$ 0.50
EE/Child(ren)	$ 12.70	$ 6.00	$ 6.70	$ 3.35
EE/Spouse	$ 12.00	$ 6.00	$ 6.00	$ 3.00
EE/Family	$ 18.68	$ 6.00	$ 12.68	$ 6.34

VISION BENEFITS

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**** **https://www.eyemedlasik.com/**	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

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSAs) help you save money on health and day care expenses.

Tax Implications

The federal government takes about 30% of each dollar you earn in FICA and income taxes, and you take home the remaining 70% to use for your living expenses. When you use an FSA, you set aside money before it is taxed, so you spend the entire 100% of your earned income on your health and day care expenses.

How Does it Work?

- During Open Enrollment, estimate your expenses for the plan year and enroll in the plan.
- Your annual election amount will be evenly deducted pre-tax from your paycheck throughout the plan year.
- You cannot change your annual election amount after the plan start unless you have a life event. (e.g. birth, death, marriage or divorce).

HOW TO ACCESS YOUR BENEFITS

Swipe your Navia Benefit Card to pay for eligible health care expenses. Funds come directly out of your Health FSA and are paid to the provider. Some swipes require Navia to verify the expense, so hang on to your receipts! If Navia needs to verify, they will send you an email or notification via the smartphone app.

You can also submit Health Care FSA and Dependent Care FSA claims online, through the smartphone app for Android and iPhone, email, fax or mail. Claims are processed within a few days and reimbursements are issued according to the City's reimbursement schedule. Be sure to include documentation that clearly shows the date, type and cost of the service.

VISIT OR CONTACT NAVIA AT:

www.naviabenefits.com

customerservice@naviabenefits.com

(800) 669-3539 | (425) 452-3500

SUBMITTING CLAIMS IS EASY

FlexConnect is a convenient, easy-to-use tool that syncs your medical, dental, and vision insurance claims to your FSA plan to streamline claim submissions from a single platform. Through the FlexConnect portal, you can track spending and receive notifications when there is an out-of-pocket expense that could be reimbursed from your FSA. Log in to your Navia account and click the FlexConnect tile. For additional information, please visit **https://www.naviabenefits.com/participants/resources/flex-connect/**

NAVIA APP

Whether you're at the doctor's office or on vacation, the MyNavia App allows you to manage and access your benefits right from your smartphone. Available for iPhone and Android devices, the MyNavia App is a free-to-download and free-to-use tool for any Navia participant with a Flexible Spending Account (FSA).

Search for "MyNavia" in the Google Play or Apple App Store and download the App.

Pre-tax Solutions:

Health Care FSA

The Health Care FSA (HCFSA) allows you to pay for out-of-pocket medical expenses with tax-free dollars. Think of the HCFSA as a tool to pay for all your regular medical expenses throughout the plan year.

- Expenses for you, your spouse and tax dependents are eligible for reimbursement, regardless of if they are covered on your medical plan.
- The Health Care FSA is a pre-funded benefit. This means you have access to your full annual election amount at any time during the plan year.

Estimating future expenses is an important step as you prepare to enroll in an FSA. The more accurate you are in estimating your expenses the better the plan will work for you!

Common Eligible Expenses

- Prescription Drugs
- Copays and Coinsurance
- Deductibles
- Office Visits
- Dental Work
- Orthodontia
- Glasses
- Contacts
- Chiropractic
- Hearing Aids
- Massage
- Services not covered by insurance

Expenses that are cosmetic in nature are not eligible.

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, 2018). 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 $110.41 per pay period (cannot exceed $2,650 per year)			

Dependent Care FSA

Child care can be one of the single largest expenses for a family with children. A Dependent Care FSA (DCFSA) can be used to pay for your qualified day care expenses with pre-tax dollars which can save you up to $1700 per year!

The DCFSA limit is set by the IRS and is a calendar year limit of $5,000 per household, $2,500 if married and filing separately. If your plan year is not on a calendar year, take extra care in calculating your annual election.

Common Eligible Expenses

- Child Care
- preschool
- Before and after school care
- Day Camps

Expenses for school tuition and overnight camps are not eligible.

Expenses can be for your dependent children 12 and under, and in some cases elder care, and must be enabling you to work, actively look for work or be a full-time student.

Example of savings with a Dependent Care FSA

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, 2018). 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).				= $_____
Maximum deduction is $208.33 per pay period (cannot exceed $5,000 per year)				

Election and Claim Filing Period

Open Enrollment period is a great time to look at your benefits and estimate your out-of-pocket expenses. Be sure to only elect an amount that you know you will use during your plan year. At the end of the plan year you will have a claim filing period to turn in any leftover claims for your benefits.

Carryover

Your plan offers a carryover feature for your health FSA. This feature allows you to roll over up to $500 of unused health FSA funds to the following plan year. You will have 60 days to claim thes rollover funds. Health Care FSA funds in excess of $500 is subject to the Use-or-Lose rule. The carryover feature does not apply to unused daycare FSA funds. Carryover amounts will be credited after your claim filing period.

Navia Benefits Card

Rather than filing a claim and waiting for reimbursement, you can use the debit card to pay your provider directly for qualified health care expenses. The card is accepted at participating merchants using the Inventory Information Approval System (IIAS) and at medical care merchants using the Master-Card® system. Be sure to hang on to your receipts in case Navia needs to see them to verify the expense eligibility. If Navia needs to see a receipt, you will receive an alert on your mobile app and you will also receive an email.

Accessing Your Benefits

Navia wants to make accessing your benefits as simple and efficient as possible.

- Online Account Access: You can order additional debit cards, update bank and address information and see up to date details of your benefits.
- Online Claims Submission: Upload your documentation, complete the online wizard, and voila!, a reimbursement will be on its way within a few days!
- Mobile App: MyNavia allows you to simply snap a photo and submit for reimbursement direct from your mobile device.
- Flexconnect: Sync your various medical, dental and vision benefits with your FSA plan for a quick and easy reimbursement. No need to submit documentation, we'll get it from the insurance carrier! Log in to your Navia account and click the FlexConnect tile. For additional information, please visit **https://www.naviabenefits.com/participants/resources/flex-connect/**

Life Insurance

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.

Supplemental Death Benefit

The City 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.

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**.

Coverage	Increments	Maximum	Guarantee Issue (new hires only)
Employee	$10,000	Lesser of: $300,000 or 5x annual salary	$300,000
Spouse	$5,000	Lesser of: $150,000 or 50% employee volume	$30,000
Children	$10,000	$10,000; employee must elect at least $20,000	$10,000

Evidence of Insurability is required when:

- Spouse election is greater than guarantee issue during new hire period
- Electing coverage (late entrant) during open enrollment
- May increase coverage 1 increment during open enrollment without EOI
- If increasing coverage more than 1 increment during open enrollment, EOI is required

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.

Accident and Critical Illness Plans

Accident Insurance

The Accident Insurance plan provides lump sum cash benefits that are paid tax-free for medical treatment received for accidents, injuries, ambulance services, hospitalization, and accidental death. Coverage is available for employees, spouses, and children. There is also a wellness benefit included with the Accident plan. Annual wellness checks, sports physicals and vaccinations qualify for the $50 wellness benefit per insured, not to exceed 4 covered members per year. Please reference the benefits summary on EmployeeNet for the full schedule of benefits with the Accident plan.

Coverage	Monthly Rate	Semi-Monthly Rate
EE	$19.62	$9.81
EE + Children	$35.30	$17.65
EE + Spouse	$29.40	$14.70
EE + Family	$44.08	$22.04

Critical Illness Insurance

Category	Standard coverage
Vascular	Heart attack, stroke, major organ transplant, bypass
Cancer	Invasive cancer, cancer in situ
Other	End-stage renal failure, advanced Alzheimer's, paralysis

All 3 categories are included; benefit payments are per category

Category	Benefit options	Guarantee issue (new hires)
Employee	$5,000; $10,000; $15,000; $20,000	$10,000
Spouse	$2,500; $5,000, $10,000	$2,500

Spouse's benefit may not exceed 50% of employee's benefit. Rates are based upon non-tobacco and tobacco usage. There are no benefits for children with the Critical Illness plan. If you waive coverage during your new hire period and elect Critical Illness during open enrollment, or want to increase your coverage during open enrollment, you will be required to complete an Evidence of Insurability. Please reference EmployeeNet for the full benefits summary and for rates.

How to File a Claim

Call 866.863.9753 to initiate the filing of your Accident and/or Critical Illness claim. A customer service representative will ask you for the information they need and a questionnaire and claim form will be mailed to you for completion.

Disability Coverage

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 is a voluntary benefit.

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 15 days. This coverage automatically provides you STD benefits that replace up to 60% of your weekly salary for a length of time not to exceed 26 weeks. The monthly rate is $0.341 per $10 of benefit.

If you waive short-term disability coverage during your new hire period and elect to add this benefit during open enrollment, you will be required to complete an Evidence of Insurability, which Aetna will email to you.

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.

Employee Medical Clinic

All employees and their dependents over the age of 5 enrolled in either of the City's medical plans may go to RockCare at **no cost**.

RockCare Services

- Manage Diabetes
- Manage Blood Pressure
- Manage Cholesterol
- Sore Throat
- Allergy Care
- Muscle/Joint Pains
- Lab Work/Tests
- Referral to Specialists
- Bladder Infection
- Prescription Medications
- Sinus Infections
- Headaches

RockCare Hours & Location

Monday	7:00 am	-	4:00 pm
Tuesday	7:00 am	-	4:00 pm
Wednesday	7:00 am	-	4:00 pm
Thursday	7:00 am	-	4:00 pm
Friday	7:00 am	-	2:00 pm

Closed 12:00 p.m. to 1:00 p.m. daily

Walk-in's: Acute/sickness only
7:00 a.m. to 7:45 a.m.
1:00 p.m. to 1:45 p.m.

901 Round Rock Ave.
Suite 300-B
Round Rock, TX 78681

To make an appointment, call 1-866-959-9355

Health Risk Assessments

Health Risk Assessments (HRA's) are available to employees and dependents. 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 TO SCHEDULE AN HRA

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

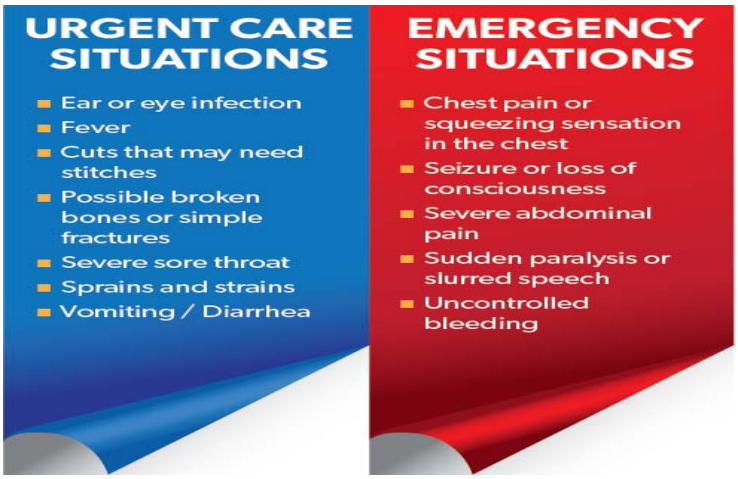
Rockcare will measure your height, weight, blood pressure and provide a fasting blood draw.

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.

Urgent Care and 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.

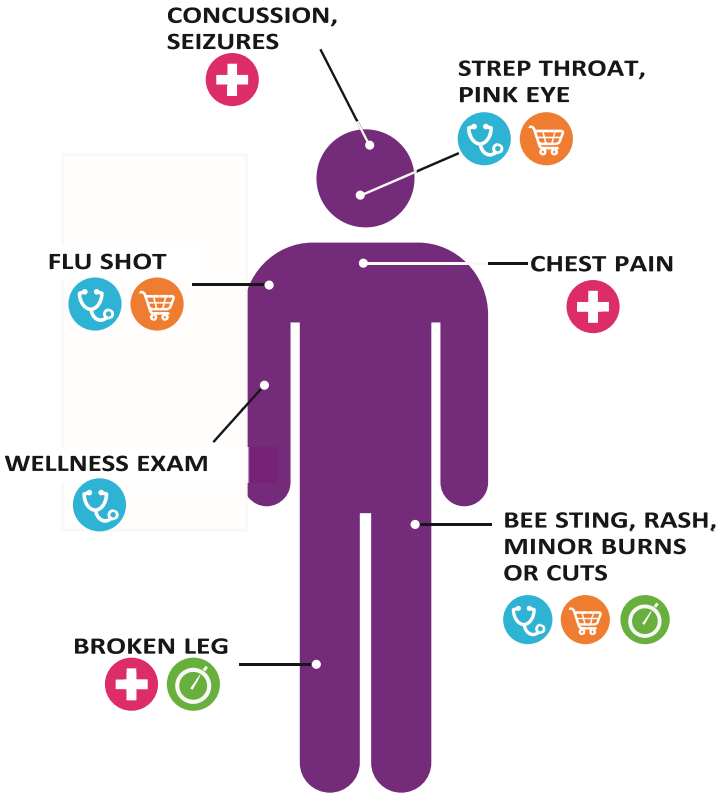


Out of Pocket Cost to You	Where to go	When to go	Examples	Average Cost to the City
$0	rockcare	**For routine care or non-emergency needs during office hours**	**Health Exams, Cold, Flu, sore throats, minor injuries, aches and pains**	**$56**
$35	Austin Regional Clinic medspring urgent care Seton Healthcare Family	**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**

Know where to go

Save time and money by knowing your urgent care options

You never know when you may need medical care.
So it's always good to understand your options.
If your health or life is in serious danger, call 911 or go to the nearest emergency room. But go elsewhere for non-life-threatening events.



Where to go	What to go for
Emergency room	Concussions, seizures Chest pain Broken bones
Urgent care center	Broken bones Sprains, strains Bites, rashes, burns, cuts
Primary care doctor's office	Wellness exam Sprains, strains Bites, rashes, burns, cuts Healthy lifestyle screening Strep throat, pink eye Flu shot
Retail walk-in clinic	Sprains, strains Bites, rashes, burns, cuts Healthy lifestyle screening Strep throat, pink eye Flu shot

Tip: Make sure any urgent care center you visit is in network. This helps you save the most money.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

This message is for informational purposes only, is not medical advice and is not intended to be a substitute for proper medical care provided by a physician.

Open 7 Days a Week.
M-F 7 a.m. – 9 p.m.,
Sat 10 a.m. – 4 p.m.,
Sun 1-7 p.m.

Walk-ins welcome.

Lower Cost than Urgent Care or ER Care.
Physician copay/
deductible for office visit.

Staffed with doctors and advanced practitioners.

Walk in or go to Seton.net/ExpressCare to find available treatment times.

Seton Family of Doctors at Round Rock
201 University Oaks Blvd, Ste 1260
Round Rock, TX 78665
512-324-4780

Our Services

- Minor illness and injury treatment
- Vaccinations and immunizations
- Physicals and wellness exams
- Onsite x-rays
- Onsite lab testing
- Bilingual providers

Common Conditions We Treat:

- Fever, cold and suspected flu
- Sore throat
- Sprains and strains
- Minor cuts
- Minor breaks (splinting)
- Suspected urinary tract infection
- Skin rash

Seton Healthcare Family

Legal Protection Plans

Membership in Texas Legal and/or LegalShield 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. Please reference EmployeeNet for full benefits summaries and rate information.

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. 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.

2018 DEFERRED COMPENSATION LIMITS	
Standard Deferral	**$ 18,500**
Age 50+ Catch-up	**$ 6,000***
Special 457 Catch-up to	**$ 36,500***

*Participants who have not contributed the maximum under IRS law in previous years may contribute an amount less or equal to the maximum limit (essentially, up to double the maximum) in the three years prior to the individual's normal retirement age.

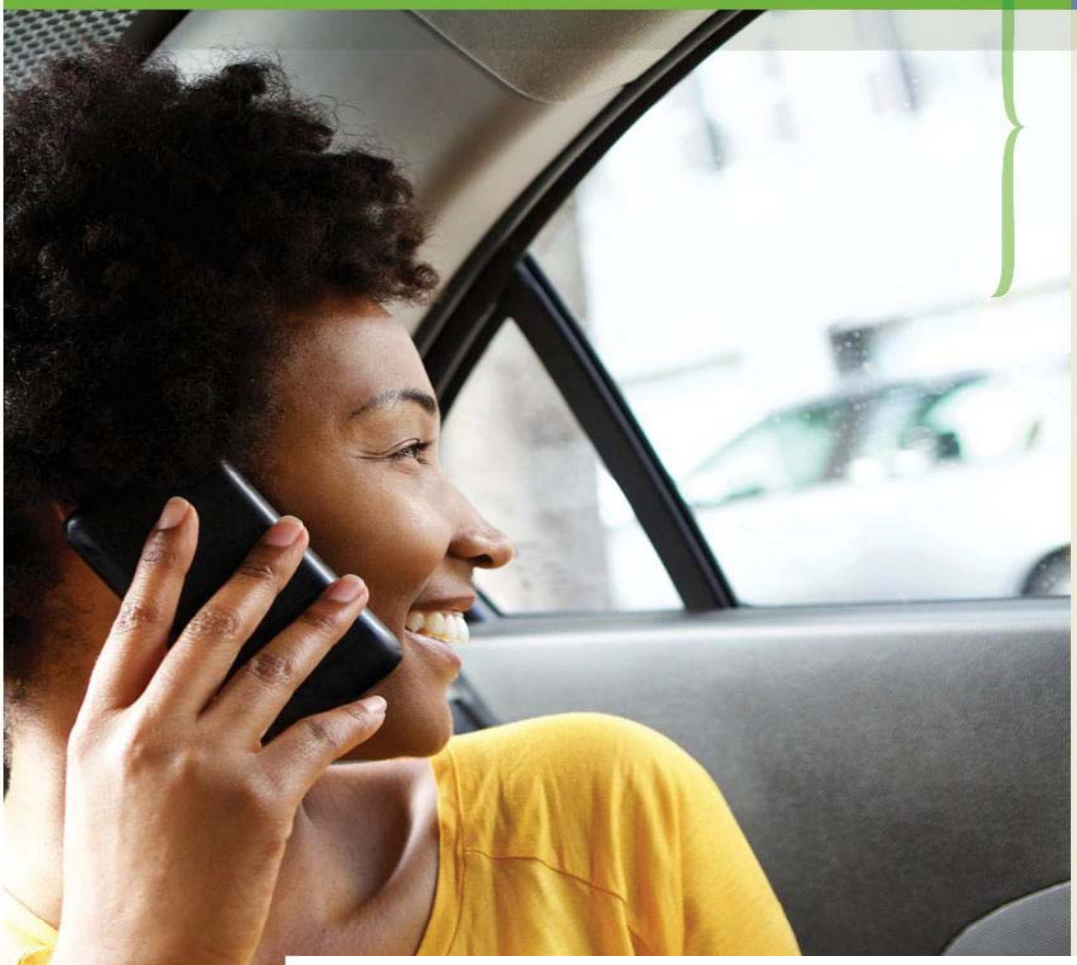
Withdrawals

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.

Employee Assistance Program

Instant Support

ICONNECTIONYOU: YOUR EAP ON THE GO



FEATURES:

- Access your EAP at the click of a button.
- Calls, instant messaging (IM), short message service,(SMS), video, and articles
- Answered 24 hours a day, 365 days a year
- Members can connect with experts instantly or make arrangements for a later appointment
- Accessible by iOS and Android devices
- Browse our self-help resources with a few swipes on the phone

iConnectYou is an app that instantly connects you with professionals for instant support and help finding resources for you and your family.

To access iConnectYou, download the app from the App Store (iPhone) or Google Play (Android) and register using the iCY passcode below. For additional information, you may access your EAP's website following the details listed below.

ICONNECTYOU PASSCODE: 52291
TOLL FREE: 1-866-327-2400
WEBSITE: www.deeroakseap.com
WEBSITE USERNAME/PASSWORD: roundrocktexas

DEER OAKS EAP SERVICES

Education Assistance

Financial assistance is available 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 must 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 the Human Resources Department at *512-218-5490 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 (ESS) 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. Enroll online in ESS once you receive notification that your life event is approved.

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. Enroll online in ESS once you receive notification that your life event is approved.

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 512-341-3143.

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. Enroll online in ESS once you receive notification that your life event is approved.

Q. If I am called for military duty, what steps should I take concerning my benefits?
*A. C*all the Human Resources Department at *512-218-5490 and ask to speak with a Benefits representative.*

Q. I will be out on leave without pay. What should I do to make sure that my benefits continue?

*A. C*all the Human Resources Department at *512-218-5490 and ask to speak with a Benefits representative.*

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.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

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 tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often 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 your employer, please check your summary plan description or contact Tyler Jarl at tjarl@roundrocktexas.gov

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 any health coverage offered by your employer. 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.

1. Company Name: The City of Round Rock		2. Employer Identification Number: 74-6017485
3. Employer address 231 E Main Street, Ste 100		4. Employer phone number 512-281-5490
5. City Round Rock	6. State TX	7. ZIP code 78664
8. Who can we contact about employee health coverage at this job? Tyler Jarl		
9. Phone number (if different from above)	10. E-mail address tjarl@roundrocktexas.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to: All employees. Eligible employees are full time employees working at least 30 hours per week.

With respect to dependents: We do offer coverage. Eligible dependents are: Your legal spouse, a child under the limiting age shown in your schedule of coverage, a child of your child who is your dependent for federal income tax purposes at the time application for coverage of the child is made, and any other child included as an eligible dependent under the plan.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

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

Medicare Prescription Drug Notice

Important Notice from The 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 the City of Round Rock plan 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 decide to join a Medicare drug plan, your current City of Round Rock coverage will be affected. If you do decide to join a Medicare drug plan and drop your current City of Round Rock coverage, be aware that you and your dependents may not be able to get this coverage back.

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.

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 "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).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

January 1, 2018
The City of Round Rock
Tyler Jarl
231 E Main Street
Round Rock, TX 78664
512-341-3143 – tjarl@roundrocktexas.gov

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 days after the qualifying event occurs. You must provide this notice to Human Resources.

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

January 1, 2018
The City of Round Rock
Tyler Jarl
231 E Main Street
Round Rock, TX 78664
512-341-3143 – tjarl@roundrocktexas.gov

Other Notices

Notice of Special Enrollment Rights

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in the City of Round Rock's medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 31 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in the City's medical coverage as long as you request enrollment by contacting the benefits manager no more than 31 days after the marriage, birth, adoption or placement for adoption. For more information, contact the City of Round Rock's Human Resources Department.

60-Day Special Enrollment Period

In addition to the qualifying events listed in the enrollment guide and this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact Human Resources or your medical plan administrator.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as

applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information which is maintained by and for the plan for enrollment, payment, claims, and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources.

Expanded Coverage for Women's Preventive Care

Under the Affordable Care Act, the City of Round Rock provides female plan participants with expanded access to recommended preventive services, including contraceptives, without cost sharing. Additional women's preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening

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ROUND ROCK TEXAS
HUMAN RESOURCES