



Your 2015-2016 Benefits Enrollment Guide



Benefits You Can Count On

McLennan County offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family. We also offer many ancillary products to fit your individual needs and ever changing lifestyle.

This guide provides a general overview of your benefit choices and enrollment information to help you select the coverage that is right for you. You can always find additional information about all your benefits by contacting your Human Resources Team.

Office: 254-757-5158

Human.Resources@co.mclennan.tx.us

Eligibility

In order to be eligible for the Health Plan benefits, an employee of McLennan County must average a minimum of 30+ hours per week in a 12 month period.

For voluntary plan options, an employee must be defined as a full time employee of McLennan county. A seasonal, temporary or part time employee would not be eligible to participate in the plan options.

You also have the option to enroll you eligible dependents in specified benefits which include:

- Your spouse (a marriage certificate accepted by the US government)
- Your child(ren) up to age 26, which may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship.
- Your unmarried child(ren) of any age who are incapable of supporting themselves due to a mental or physical disability and who are totally dependent on you.



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Enrollment Periods

New Employees

As a new full-time employee of McLennan County, you become eligible for benefits effective on the 1st of the month after 31 calendar days of continuous service. Our benefits plan year runs from October 1st through September 30th.

Open Enrollment

As a benefits eligible employee, you have the once-a-year opportunity to enroll in or make changes to your benefit elections or eligible dependents during our open enrollment period, unless you experience a qualified event. (See Making Changes During the Year/Qualifying Events for more information.) Open Enrollment is held during the month of August. Elections you make during the open enrollment period will become effective on October 1st, 2015 or once you become eligible for benefits, whichever comes first. (Some products require a more comprehensive eligibility assessment, thus you would not be deducted for the product plan until fully approved.)

How to Enroll

The first step is to review your current benefit elections. One way to check is by reviewing your pay stub or contacting a member of the HR Team. Make your benefit elections by completing the required forms. Once you have made your elections, you will not be able to change them until the next enrollment period unless you have a qualified change in status.

Frequent Enrollment Questions

Where do I find the forms?

Please consult with your HR Team member to identify which forms will be necessary depending upon the changes or elections you want to make.

When are the forms due and where to I return them?

All forms must be turned in by August 31st, or within 31 days of your start date. You may turn your completed forms in during the Open Enrollment Sessions or to the HR Department.

Making Changes During the Year/Qualifying Events

Please choose your benefits carefully. Medical, dental, vision, and flexible spending account contributions are made on a pre-tax basis and per IRS regulations contribution amounts cannot be changed unless you experience a qualified life event. Qualified life events include:

- Marriage, legal separation or divorce
- Death of your spouse
- Birth of a child
- Commencement or termination of adoption proceedings
- Your spouse terminating, obtaining new employment or their open enrollment (that affects eligibility for coverage)
- You or your spouse switching employment status from full-time to part-time or vice versa (that affects eligibility for coverage)
- Significant cost or coverage changes
- Your dependent no longer qualifies as an eligible dependent

Within 31 days* of the event, you need to provide information to the Human Resources team regarding the details about your life event and make desired benefit changes. You will need to submit qualifying event documentation and complete any applicable forms. The HR team will review your request and documentation to determine whether the change you are requesting is allowed. Only benefit changes which are consistent with the qualified life events are permitted.

*Note: 60 days if you, your spouse, or eligible dependent child(ren) loses coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or becomes eligible for state provided premium assistance.

Medical Plan Benefits Options

Providing medical coverage at a reasonable cost is a challenge for all US employers. McLennan County acknowledges that having plan options is helpful to meet our diverse employee medical needs.

Plan 1: Base Health Plan

This plan is based on a classic style where you have a set deductible and copays, and then you pay a % of the overall medical costs once the deductible has been met, if such services are needed, until you have paid the annual Out-of-Pocket Maximum.

Plan 2: Consumer Driven Health Plan

This plan is designed to meet all your medical costs once the deductible has been met. The plan does have a higher deductible value. On this plan you will incur the expense of every medical appointment until the deductible is met, with the exception of preventive care as defined by the Affordable Care Act. Thus, you can expect to pay the entire contracted cost of the physician's office appointment if you are in-network, instead of the copay until you've met the deductible for the plan year. Prescriptions are also subject to the deductible with the EXCEPTION of prescriptions that are considered preventive in nature for a chronic condition. Some of those chronic conditions include diabetes, high blood pressure, elevated cholesterol, asthma and contraceptives. These drug categories would be subject to the associate copay and not the deductible.

Prescription Drug

The prescription drug plan is based upon the Health Plan you select.

Note:

In order to compare the two plan options, we've provided a few details regarding the plan summary. For a full explanation of the benefits plan summary, please contact your HR Team member or refer to <https://mclennan.swhp.org/> or contact customer service at 800-299-8640.



McLennan County Employee Health Plan 2015-2016

<i>Effective Oct. 1, 2015</i>	Plan 1: Base Health Plan	Plan 2: Consumer Driven Health Plan
Annual Deductible (Deductible applies to Out-of-Pocket Max & resets to zero Jan.1 st)	\$1,000 Individual \$2,000 Family	\$3,500 Individual \$7,000 Family (Embedded)
Annual Out-of-Pocket Maximum (Medical & Rx deductible both apply)	\$4,500 Individual \$9,000 Family	\$3,500 Individual \$7,000 Family (Embedded)
<i>Outpatient Services</i>		
Primary Care Office Visit	\$30.00 Copay	\$0.00 Copay After Deductible
Specialty Care Office Visit	\$50.00 Copay	\$0.00 Copay After Deductible
Preventive Services (including lab and x-ray)	No Charge	No Charge
Standard Lab and X-ray	No Charge	0% After Deductible
Diagnostic/Radiology (Limited to: angiograms, CT scans, MRIs, PET scans, myelography, stress tests, ultrasounds)	20% After Deductible	0% After Deductible
Outpatient Surgery	20% After Deductible	0% After Deductible
Allergy Serum	20% After Deductible	0% After Deductible
Immunizations (Age Appropriate)	No Charge	No Charge
Eye Exam (1 Refraction Annually)	\$30.00 Copay	0% After Deductible
Maternity (Pre- and Post-Natal Care)	No Charge	No Charge
Other Outpatient Services (Including other services, treatments, or procedures received at time of visit)	20% After Deductible	0% After Deductible
<i>Outpatient Specialty Drugs (Deductible does not apply)</i>		
Level 1	10% Copay	0% After Deductible
Level 2 (Preferred)	20% Copay	0% After Deductible
Level 3 (Premium Preferred)	20% Copay	0% After Deductible
Level 4 (Non-Preferred)	50% of Charges	0% After Deductible
<i>Inpatient Services</i>		
Hospital Room, Semi-private	20% After Deductible	0% After Deductible
Intensive Care Unit	20% After Deductible	0% After Deductible
Other Hospital Services	20% After Deductible	0% After Deductible
Skilled Nursing Facility (Pre-Certification Required)	20% After Deductible	0% After Deductible (Precertification Required)
<i>Therapeutic Services</i>		
Speech & Hearing	\$30.00 Copay (20 Visit Limit)	\$0.00 Copay After Deductible
Physical Therapy	\$30.00 Copay (20 Visit Limit)	\$0.00 Copay After Deductible
<i>Durable Medical Equipment</i>		
Durable Medical Equipment	50% After Deductible	\$0.00 After Deductible
<i>Diabetic Supplies, Equipment, and Self-Management Training (unlimited benefit) "Deductible Does Not Apply"</i>		
Supplies	50% Copay	Same as DME or RX, as

		appropriate
Equipment	Same as DME or Rx, as appropriate	Same as DME or RX, as appropriate
Education/Nutrition Counseling	\$30.00 Copay	\$0.00 Copay After Deductible
<i>Outpatient – Mental Health/Chemical Abuse Services</i>		
Serious Mental Illness (requires referral and approval of medical director)	\$30.00 Copay	\$0.00 Copay After Deductible
Alcohol & Drug Dependency	\$30.00 Copay	\$0.00 Copay After Deductible
<i>Inpatient – Mental Health/Chemical Abuse Services</i>		
Serious Mental Illness (requires referral and approval of medical director)	20% After Deductible	0% After Deductible
Alcohol & Drug Dependency	20% After Deductible	0% After Deductible
<i>Home Infusion Therapy (requires authorization)</i>		
Home Infusion Therapy	20%	0% After Deductible
<i>Home Health Services (requires authorization)</i>		
Home Health	\$30.00 Copay	\$0.00 Copay After Deductible
Hospice	No Charge	0% After Deductible
<i>Emergency Care Services</i>		
Emergency Room (in and out of area)	20% After Deductible	0% After Deductible
Urgent Care (in and out of area)	\$50.00 Copay	0% After Deductible
Ambulance	20% After Deductible	0% After Deductible
Prescription Drug Coverage (can use any in-network Rx provider)		
		**Note: Copays only apply to preventive drugs (deductible does not apply) All non-preventive drugs are subject to the deductible.
Annual Benefit Maximum	Unlimited	Unlimited
Annual Deductible	None	Included with medical deductible
<i>Retail Quantity (up to a 30 day supply)</i>		
Generic	\$10.00 Copay	\$10.00 Copay
Preferred Brand	\$30.00 Copay	\$30.00 Copay
Non-Preferred	Lesser of \$55.00 or 50%	Lesser of \$55.00 or 50%
Non-Formulary	Greater of \$55.00 or 50%	Greater of \$55.00 or 50%
<i>Maintenance Quantity (up to a 90 day supply; maintenance quantities must be obtained from a Scott & White Health Plan Pharmacy or Wal-Mart Mail Order)</i>		
Generic	\$20.00 Copay	\$20.00 Copay
Preferred Brand	\$60.00 Copay	\$60.00 Copay
Non-Preferred	Lesser or \$110.00 or 50%	Lesser of \$110.00 or 50%
Non-Formulary	N/A	N/A

Frequently Asked Questions Regarding the Health Plan

What is a formulary drug?

A prescription drug formulary is a comprehensive list of prescription drugs deemed safe and effective with acceptable or superior financial value. The formulary is an evolving process as existing and new drugs are evaluated by the Scott & White Health Plan Pharmacy and Therapeutics Committee (P&T). You can view the McLennan County Employee Health Plan formulary at <https://mclennan.swhp.org/providers/pharmacy-services/prescription-drug-lists>.

How do I find a physician in my area?

You can use the website, <https://mclennan.swhp.org/mclennan-county/find-provider>, to find the health care provider you need, or call Customer Service at 1-800-299-8640. We do not require that you have a Primary Care Physician (PCP), so you can choose anyone from our network at any time.

On the website you will see a symbol with a “+” under the provider’s name. If the symbol is green, that provider is accepting new patients. If the symbol is orange, approval is required by that provider to accept a new patient. The website is updated when notification is received, but sometimes there are delays in notifications. There will always be providers coming in and out of network and new patient acceptance may change periodically.

The network of physicians has recently expanded to include the North Texas Region Hospitals (Fort Worth, Dallas, etc.) In order to identify in-network physicians in this area, please adjust the zip code to one within 100 miles of these city locations. If you enter a McLennan County area zip code, you are limited to a 100 mile radius of Waco and some of these North Texas hospitals are beyond that radius.

Where can I access information about my benefits, plan, claims, EOBs (Explanation of Benefits) or other important information?

My Benefits (<https://swhpah.swhp.org/Logon.jsp>) is available online 24/7 to assist you in verifying member eligibility and benefits, checking claim status and many other options. For further assistance, you can contact Customer Service at 1-800-299-8640.

What should I do if I get a bill that should have been paid by the McLennan County Employee Health Plan?

As soon as you receive the bill, please contact a Claims Representative at 1-800-321-7947. We will research the bill to determine if a payment has already been made and will work with your provider to resolve the situation.

How do I appeal a decision that adversely affects coverage, benefits or my relationship with the organization?

For more information on your appeal rights, please contact Customer Advocacy by calling 1-800-321-7947.

How are injections charged under my plan?

The codes the providers use determines how the benefits pay. If the provider sees the injection as more of a diagnostic procedure then you may be subject to paying deductible and co-insurance.

What kind of coverage will my college-age child have while away at school?

The McLennan County Employee Health Plan will cover any emergency that occurs while away at school; however, it is important to plan for routine medical needs. If your child is attending school within the state and is located near an in-network clinic, your child can receive covered care at the facility. If the student is attending school out of the service area, it may be necessary to consider supplementary coverage for routine medical care or consider using the college health center for his/her routine medical care.

How do I get a referral outside the network when you cannot provide the services that I need?

The provider network is a large multi-specialty network and, in most cases, can meet the majority of your medical needs. If you develop a medical condition that your regular doctor and the network specialists cannot care for, you will need (1) a recommendation from your network provider; and (2) the approval of the Medical Director before any out-of-plan services can be covered. A formal review of your case will then be provided and you will receive a letter outlining clearly what the McLennan County Employee Health Plan will or will not cover with the outside physician.

Health Care Plan Information & Terminology

In-Network Advantage

Consider your health care options highlighted in this guide. Some plans give you the freedom to use any health care provider of your choice. However when you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible for paying the difference between the allowable charges and what the provider charges. Allowable amounts are set by the insurance carrier; allowable amounts are generally considered reasonable based on what most providers charge for a particular service in a geographic area.

Annual Deductible

Your annual deductible is the amount of money you must first pay out-of-pocket before your plan begins paying for services covered by coinsurance. Some services from an out-of-network provider, the plan plays a lower percentage of coinsurance. The deductible starts over every January 1. Refer to your health care plan summaries for more information. In many cases, the deductible does not need to be met for services when a copay applies.

Copayments and Coinsurance

A copayment (copay) is the fixed dollar amount you pay for certain in-network services. In some cases, you may be responsible for coinsurance after the copay is made.

Coinsurance is the percentage of covered expenses shared by the employee and the plan. In some cases, coinsurance is paid after the insured meets a deductible. For example, if the plan pays 60% of an in-network covered charge, you pay 40%.

Out of Pocket Maximum

Some plans feature an out-of-pocket maximum, which limits the amount of coinsurance you will pay for eligible health care expenses. Once you reach that maximum, the plan begins to pay 100% of eligible expenses. There may be separate in-and out-of-network maximums. Due to health care reform, copays and deductibles, including those incurred for prescriptions, will apply to your out-of-pocket maximum accumulation.

Preventive and Non-preventive Services

These are services generally linked to routine wellness exams. Non-preventive services are those that are considered treatment or diagnosis for an illness, injury or other medical condition. There may be limits on how often you can receive preventive care treatments and services. You should ask your health care provider whether your visit is considered routine/preventive or non-preventive care. Examples of preventive are include:

- Annual routine physicals (see plan for guidelines and details)
- Bone-density tests
- Immunizations
- Pelvic exams
- Mammograms
- Pap smears
- Cholesterol screenings
- PSA exams
- Prenatal exams and gestational diabetes tests
- Breastfeeding supplies and counseling
- Screening and counseling for HIV, HPV and domestic violence
- Contraceptive drugs, devices and sterilization (see plan for details)



Vision Benefits

McLennan County offers you vision coverage through NVA (National Vision Administrators, LLC.). NVA offers a comprehensive vision care plan to you and your eligible family members. Benefits include eye exams plus assistance with contact lens fittings, glasses, frames or contacts. NVA only offers In-Network provider benefits, so please be sure your care provider is within the network.

Summary of Vision Plan Options	Participating Provider Amounts	Non-Participating Provider	EyeEssential Plan: Participating Provider Coverage Amounts (2 nd Pair of Glasses)
Examination (Once Every Plan Year)	Covered 100% After \$10.00 Copay	Reimbursed amount up to \$30.00	Retail less \$10.00
Contact Lens Evaluation/Fitting			Retail less 10%
Lenses: (Once Every Plan Year) Single Vision Bifocal Trifocal Lenticular	Standard Glass or Plastic Covered 100% After \$25.00 Copay	Up to \$25.00 Up to \$35.00 Up to \$45.00 Up to \$80.00	Glass or Plastic \$35.00 \$55.00 \$70.00 \$70.00
Frame (Once Every Two Plan Years)	Retail Allowance	Up to \$70.00	Retail less 35%
Contact Lenses (Once Every Plan Year; Elective Contact Lenses, but this is in lieu of lenses & frames) Conventional Disposable	Up to \$105.00 (20% of discount off balance) Medically Necessary - Covered 100%	Up to \$80.00 Medically Necessary - Up to \$210.00	Retail less 15% Retail less 10%

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- \$12.00 Solit/Gradient Tint
- \$75.00 Polarized
- \$15.00 Standard Scratch-Resistant Coating
- \$12.00 Ultraviolet Coating
- \$45.00 Standard Anti-Reflective
- \$50.00 Progressive Lenses Standard
- \$65.00 Transitions Single Vision Standard
- \$70.00 Transitions Multi-focal Standard
- \$35.00 Polycarbonate (Single Vision)
- \$35.00 Polycarbonate (Multi-focal)

Contact Information: 800-672-7723 or www.e-nva.com.

Note: Members are entitled to significant discounts and free initial consultations with all in-network providers regarding LASIK procedures.



Dental Benefits

Dental coverage is key to your overall health and wellness. McLennan County offers you dental coverage through 3 different plan options.

Health League Providers

Health League is a fee based dental program. Health League has established an agreed upon rate schedule with in-network dentists so you know your costs up front. For a complete list of the fee schedules, please call or visit the website: 866-270-6012 or <https://www.healthleague.net/feeschedule.php>

QCD of America

QCD is a managed cost program offering a large selection of highly qualified private practice dental professionals.

The QCD discount program will allow you to save **up to 60% on the total cost**. If you select QCD you will gain these additional advantages: no claim forms; deductibles or coverage maximums; immediate coverage for all pre-existing conditions; orthodontics (braces) for children and adults; coverage if eligible for children up to age 26.

Sample Dental Procedure with QCD	Fee Paid With QCD of America	National Average Dental Fees	Savings with WCD of America
Oral Exam	\$9.00	\$35.00	74%
Full Mouth X-Ray	\$28.00	\$77.00	64%
Teeth Cleaning	\$24.00	\$54.00	56%
Amalgam (1 Surface)	\$28.00	\$79.00	65%
Simple Extraction	\$36.00	\$80.00	55%
Root Canal (1 Canal)	\$185.00	\$387.00	52%
Porcelain w/Metal Crown (lab fees additional)	\$350.00	\$652.00	46%
Complete Upper or Lower Denture	\$400.00	\$770.00	48%

Delta Dental PPO Benefit Highlights – deltadentalins.com

Delta Dental is a Dental Provider Organization plan, which covers expenses that are indicated below:

- Preventive and diagnostic services like routine exams and cleanings, fluoride treatments, topical sealants, space maintainers and X-rays
- Basic services such as amalgam fillings, root canals, oral surgery (extractions) and periodontics
- Major services such as acrylic/fold/porcelain crowns, bridgework/dentures and composite resin fillings

Eligibility	Primary enrollee, spouse and eligible dependent children to age 26.	
Deductibles Deductibles waived for Diagnostic & Preventive (D&P) and Orthodontics?	\$50.00 per person/\$150.00 per family each plan year. Yes.	
Maximums D&P counts toward maximum	\$1,000.00 per person each plan year Yes	
Waiting Periods	Basic Benefits – None; Major Benefits – 12 Months; Prosthodontics – 12 Months; Orthodontics – 12 Months	
Benefits & Covered Services *Services	Delta Dental PPO Dentists**	Non-Delta Dental PPO Dentists**
Diagnostic & Preventive Services (D&P) Exams, cleanings and x-rays	100%	100%
Basic Services Fillings, simple tooth extractions and sealants	80%	80%
Endodontics (root canals) Covered Under Basic Services	80%	80%
Periodontics (gum treatment) Covered Under Basic Services	80%	80%
Oral Surgery Covered Under Basic Services	80%	80%
Major Services Crowns, inlays, onlays and cast restorations	50%	50%
Prosthodontics Bridges and dentures	50%	50%
Orthodontic Benefits Dependent Children	50%	50%
Orthodontic Maximums	\$1,000 Lifetime	\$1,000 Lifetime
Notes: *Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees. **Reimbursements is based on DPO contracted fees for DPO dentists, Premier contracted fees for Premier dentists and 90 th percentile for non-Delta Dental dentists. Thus, you could pay the difference plus the % of the fee.		
Delta Dental Insurance Company 1130 Sanctuary Parkway, Suite 600 Alpharetta, GA 30009	Customer Service: 800-521-2651 or www.deltadentalins.com Group # 11252	Claims Address: P.O. Box 1809 Alpharetta, GA 30023-1809

Health Care and Dependent Care

McLennan County provides you the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through Flexible Spending Accounts. You must enroll/re-enroll in the plan to participate for the plan year October 1, 2015 to September 30, 2016. You can save approximately 25 percent of each dollar spent on these expenses when you participate in a FSA, depending on your tax bracket.

A health care FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. A dependent care FSA is used to reimburse expenses related to care of eligible dependents while you and your spouse work.

Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income tax, Social Security taxes, or state and local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period. If you do not use the money you contributed it will not be refunded to you or carried forward to a future plan year. This is the use-it-or-lose-it rule.

The maximum that you can contribute to the Health Care Flexible Spending account is set by your employer.

The maximum that you can contribute to the Dependent Care Flexible Spending Account is \$5,000 if you are a single employee or married filing jointly, or \$2,500 if you are married and filing separately.

The following example shows how you can save money with a flexible spending account.

Bob and Jane's combined gross income is \$30,000. They have two children and file their income taxes jointly. Since Bob and Jane expect to spend \$2,000 in adult orthodontia and \$3,300 for day care next plan year, they decide to direct a total of \$5,300 into their FSAs.

	Without FSAs	With FSAs
Gross income:	\$30,000	\$30,000
FSA contributions:	0	-5,000
Gross income:	30,000	25,000
Estimated taxes:		
Federal	-2,550*	-1,776*
State	-900**	-750**
FICA	-2,295	-1,913
After-tax earnings:	24,255	20,314
Eligible out-of-pocket		
Medical and dependent care expenses:	-5,000	0
Remaining spendable income:	\$19,255	\$20,561
Spendable income increase:		\$1,306

*Assumes standard deductions and four exemptions.

**Varies, assume 3percent.

The example above is for illustrative purposes only. Every situation varies and we recommend that you consult a tax advisor for all tax advice

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) help you save money by allowing you to pay for certain types of health care and dependent care expenses on a pre-tax basis. You decide how much money to put aside each pay period to cover these expenses up to the maximum. This amount is then deducted from your pay before taxes and deposited into your FSA.

ACCOUNT	ANNUAL CONTRIBUTION
Medical FSA	\$2,500 maximum per employee
Dependent Care FSA	\$5000 maximum per household*

*If you are married, filing income taxes separately from your spouse: maximum is \$2,500

<p>Medical FSA</p> <p>Eligible Health Care Expenses</p> <ul style="list-style-type: none"> • Prescription Medicines and Drugs • Hearing Aids • Orthopedic Goods, Prosthetic Devices • Doctors • Dentists, Orthodontics • Chiropractors • Optometrists, Ophthalmologists, Opticians, Eyeglasses • Over-the-counter Medicines and Drugs (prescription needed) • Chiropractors, Podiatrists • Nursing and Personal Care Facilities • Medical and Dental Laboratories • Medical Services and Health Practitioners • Ambulance Services, Equipment and Supplies <p>Ineligible Health Care Expenses</p> <ul style="list-style-type: none"> • Cosmetic expenses such as teeth whitening, and hair removal or hair growth treatments • Massage therapy (unless accompanied with a doctor's note specifying the medical necessity and listing specific diagnosis with length of treatment) • Health club dues • Insurance premiums of any type • Weight loss programs (unless accompanied by doctor's note specifying medical necessity, and listing specific diagnosis with length of treatment) 	<p>Dependent Care FSA</p> <p>Eligible Dependent Care Expenses</p> <ul style="list-style-type: none"> • Child care provided at a daycare center or through a private provider • Nanny services with the care of a dependent • Day camps associated with the care of a dependent • Pre-school tuition that is daycare related (price of tuition alone is not eligible) • Annual registration fees for daycare providers • After-hours care that results from working odd hours or overtime • Eldercare <p>Ineligible Dependent Care Expenses</p> <ul style="list-style-type: none"> • Costs claimed as a dependent care tax credit on your tax return • Services provided by one of your dependents • Expenses for nighttime babysitting • Your own dependents, under age 19, babysitting • Expenses paid for schooling kindergarten and above <p>USE IT OR LOSE IT</p> <p>If you do not spend all the money in your Flexible Spending Accounts (or "FSAs") during the year, IRS regulations require that you forfeit any remaining balance. We recommend filing reimbursement for your expenses within 30 days of the date of receipt. (If you are unable to complete your claim for reimbursement, you will be required to do so by the end of the Grace Period. The Grace Period ends on December 15th at the end of each plan year.)</p>
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Claims Submission Process:

Once you incur the expense, you will need to complete some paperwork and turn in your receipts to the Auditor's office for reimbursement. Please contact the Auditor's office for further instructions on this process.

Health Savings Accounts (HSA)

Another account available to fund your out-of-pocket expenses is a Health Savings Account (HSA). If you participate in the Consumer Driven Health Plan (CDHP) and do not have other health plan coverage*, you can set money aside in a Health Savings Account (HSA) before taxes are deducted to pay for eligible medical, dental and vision expenses. An HSA is similar to a flexible spending account in that you are eligible to pay for health care expenses with pre-tax dollars. There are several advantages of an HSA. For instance, money in an HSA can be invested much like 401(k) funds are invested.

As per IRS regulations you cannot participate in both a HAS and FSA at the same time. The maximum annual amount that you can contribute to a HSA is \$3,350 in 2016 for individual coverage and \$6,750 in 2016 for family coverage. Additionally, if you are age 55 or older, you may make an additional annual “catch-up” contribution of \$1,000.

Unused money in an HSA account is not forfeited at the end of the year and is carried forward. Also, your HSA account is yours to keep which means that you can take it with you if you change jobs or retire. If you have any money remaining in your HSA after your retirement, you may withdraw the money as cash.

HSA Example:

Justin is a healthy 28-year-old single man who is active and in good health. He contributes \$1,000 each year to his HSA. His plan’s annual deductible is \$3,000 for individual coverage. If Justin uses his HSA to pay for covered services, this will reduce his out-of-pocket amount needed to meet his deductible before traditional health coverage begins. Here is a look at the first two years of Justin’s HSA plan, assuming the use of in-network providers.

Year 1

HSA - \$1,000 contribution	\$1,000
<u>Total Expenses:</u>	
Prescription drugs - \$150	\$500
Routine Physical/Lab tests - \$350	
Paid by preventive care benefit* – no deduction from HSA	\$350
Amount paid from HSA (Justin’s choice)	\$150
HSA Rollover to Year 2	\$850
<i>Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.</i>	

Year 2

HSA Balance: \$850 from Year 1, plus \$1,000 contribution for Year 2	\$1,850
<u>Total Expenses:</u>	
Office visits - \$100	\$450
Blood work - \$150	
Prescription drugs - \$200	
Paid by preventive care benefit* – no deduction from HSA	\$150
Amount paid from HSA (Justin’s choice)	\$300
HSA Rollover to Year 3	\$1,550
<i>Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.</i>	

Notes: In addition to your personal contribution elections, McLennan County has chosen to contribute \$43.50 to your account if you choose to participate in the High Deductible Health Plan.*You may contribute, if you have another health plan, only if the other health plan is also a qualifying high deductible health plan.

Income Protection & Voluntary Benefits

Life Insurance Employer Paid – Dearborn National

McLennan County pays for and provides eligible employees with \$10,000 of life insurance and \$10,000 of accidental death & dismemberment insurance payable to the beneficiary of your choice. You may change your beneficiary at any time. You do not have to wait until open enrollment to change your beneficiary. To change your beneficiary outside of the open enrollment period, please notify a member of the Human Resources Team.

Please see the plan policy for specifics.

Voluntary Life Insurance Employee Paid

Dearborn National

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Dearborn National Life Insurance Company's Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on.

Eligibility	All eligible, active full time employees
Group Term Life Benefit Employee	\$5,000 increments to \$500,000
Guarantee Issue Amount Employee	\$150,000 (when initially eligible for life insurance)
Group Term Life Benefit Spouse	\$5,000 - \$125,000 in increments of \$5,000, not to exceed 100% of the employee benefit amount
Guarantee Issue Amount Spouse	\$30,000 (when initially eligible for life insurance)
Group Term Life Benefit Child(ren)	Age 6 months to 26 years- \$5,000 or \$10,000
Age Reduction Schedule	Life and AD&D benefits reduce to 65% of the original amount at age 65 and further reduces to 40% of the original amount at age 70, further reduces to 30% of the original amount upon age 75, and further reduces to 20% of the original amount at age 80.
Accelerated Death Benefit (ADB)	Upon the employee's request, this benefit pays a lump sum up to 75% of the employee's life insurance, if diagnosed with a terminal illness and has a life expectancy of 12 months or less. Minimum: \$7,500. Maximum \$250,000. The amount of group term life insurance otherwise payable upon the employee's death will be reduced by the ADB.

Monthly Cost for Each \$1,000 of Employee & Spouse Life Insurance Coverage

Age	<34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74+
Life	\$0.04	\$0.08	\$0.10	\$0.15	\$0.23	\$0.43	\$0.66	\$1.27	\$2.06
Dependent Children	<i>\$1.00 a month for \$5,000 of coverage for each child; \$2.00 a month for \$10,000 of coverage for each child (The cost doesn't change regardless of the number of children in the family.)</i>								

$$\frac{\text{Amount of Coverage Desired}}{\text{Rate for Your Age}} \times \text{Rate for Your Age} = \text{Monthly Total Premium}$$

Voluntary Long-Term Disability – Dearborn National

All eligible employees have the ability to purchase long-term disability income benefits via payroll deduction through Dearborn National Insurance. In the event you become disabled from a non- work-related injury or sickness, disability income benefits are provided as a source of income.

Eligibility	All eligible, active full time employees
Group LTD Benefit Percentage	60%
Maximum Monthly Benefit	\$5,000
Minimum Monthly Benefit	\$100 or 10% of gross monthly earnings, whichever is greater
Elimination Period/Waiting Period Before Benefits Begin	90 days
Survivor Benefit	If the employee passes away after being disabled and receiving long-term disability benefits for 6 consecutive months, Dearborn National will pay the employee’s beneficiary a lump sum benefit equal to three months of disability benefits.
Pre-Existing Condition Limitation	12/24 - A pre-existing condition means a sickness or injury for which an employee received treatment within 12 months prior to the effective date. Any disability contributed to or caused by a pre-existing condition within the first 24 months of the effective date will not be covered.
Mental Disorder Limitation	24 months

Monthly Cost for Voluntary Long Term Disability											
Age	<24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Disability	\$.0013	\$.0021	\$.0035	\$.0050	\$.0071	\$.0104	\$.125	\$.163	\$.0109	\$.0083	\$.0089

TEXAS LIFE Insurance Company

Texas Life offers a voluntary portable, permanent life insurance product for you and your family. This voluntary universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium costs. You may also apply for insurance on your spouse, minor children, even your minor grandchildren. Please consult with our Texas Life agent, Tim Provence, of Provence & Associates Insurance for more detailed information.

Please request the plan summary for the most accurate details, the below is a very concise description of features:

- High Death Benefit (significant life insurance should you die prematurely)
- Minimal Cash Value
- Long Guarantees (death benefit to age 121)
- Refund of Premium (offers you a 10 years’ premium, should you surrender the policy if the premium you pay when you buy the policy ever increases, pending conditions)
- Accelerated Death Benefit Rider (Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92% of the death benefit, minus \$150 administrative fee while you are still alive to assist with costs incurred)

Employee's Whole Life Product Features

Employee's Whole Life (EWL) is whole life insurance issued by New York Life Insurance Company. It is available for purchase only through payroll deduction. EWL offers a guaranteed death benefit and guaranteed cash values. It is a participating policy, that is to say, EWL is eligible for dividends if and when they are declared by New York Life.

Simplified Issue

EWL is available for Simplified Issue underwriting to groups of employees of any size. The minimum participation requirement is 5 paid policies on the lives of eligible employees or dependents (spouses, children and grand children). A completed application is all that is necessary for approval. Physical exams are usually not required.

Employee Eligibility

On the Simplified Issue basis, EWL will be offered to all employees who are:

- age 16 to 70, and
- are actively-at-work (30 hours per week) on a full time basis;
- employed for at least 6 months prior to enrollment.

Family Eligibility

EWL will also be offered to eligible employees' dependents. EWL SI will be available on the spouse, children, and grandchildren of eligible employees. The simplified issue questions must be completed on the applications for the spouse, children, and grandchildren.

Coverage Limits

The maximum face amounts are as follows:

Insured	Issue Ages	Maximum Coverage
Employee	16 - 70	\$150,000
Spouse	16 - 70	\$50,000
Children / Grandchildren	15 days – 25 years	\$25,000

For companies that have 5,000 or more employees we will allow the employee up to \$200,000 in Simplified Issue insurance coverage.

Level Premiums

Premiums for EWL are level and guaranteed not to increase. The minimum face amount is \$5,000 subject to a minimum premium of \$15 per month (\$5 per month for children and grandchildren). The maximum face amount for the employee is \$150,000. The maximum face amount for an employee's spouse is \$50,000 and for the employee's child / grandchild is \$25,000.

² Spouses applying for coverage over \$25,000 or of ages 56-70 must sign the application and necessary documentation acknowledging coverage election.

Voluntary Insurance Offered by AFLAC

McLennan County offers a number of Aflac policies to you via payroll deduction. The purpose of these policies is to allow you to customize your coverage based on your lifestyle or your family history. They are not intended to replace your group medical and pharmacy coverage. These policies are intended to supplement your major medical plan. The benefits are payable directly to the member and not medical providers.

The Aflac benefits are paid directly to the policy holder and most claims are paid in 3 days or less. The Aflac policies are also fully portable which means you can take the policies with you if you leave employment with McLennan County.

Personal Accident Indemnity Plan Highlights (Two Levels of Coverage)

- Payment per ER Visit
- Daily payment for Hospital Stays
- Accident Follow and Physical Therapy payment
- Payment for Injuries sustained in an Accident
- Ambulance and Transportation Benefits
- Life Insurance
- Dismemberment Insurance
- Wellness Benefit

Hospital Advantage (Two Levels of Coverage)

- Payment per ER Visit
- Initial and Daily payment for Hospital Stays
- Office Visit Reimbursement
- Diagnostic Testing payment
- Surgical Procedure payment
- Intensive Care payment

Critical Care and Recovery (Heart Attack/Stroke) Highlights (Two Levels of Coverage)

- Covers 6 Different Events
- Payment for Initial and Subsequent Occurrences
- Hospitalization Benefits
- Ambulance and Travel Benefits
- Follow-up Visit

Cancer Plan Highlights (Four Levels of Coverage)

- Pays benefits for the Initial Diagnosis of Cancer – amount increase each year
- Daily payment for Hospital Stays
- Surgical Procedure payment
- Intensive Care payment
- Second Opinion reimbursement
- “Dreaded Disease” Rider – covers 27 other less common illnesses
- Travel Reimbursement

Short Term Disability

- Covers 55-60% of your Pre-Disability Earnings
- You choose how soon you want benefits to begin
- May be used in conjunction with other coverages you may have
- You choose how long it pays for a qualified disability – 90, 180, 365 or 730 days

Have You Ever?

- Needed your Will prepared or updated
- Been overcharged for a repair or paid an unfair bill
- Had trouble with a warranty or defective product
- Signed a contract
- Received a moving traffic violation
- Had concerns regarding child support
- Worried about being a victim of Identity theft
- Been concerned about your child's identity
- Lost your wallet
- Worried about entering personal information on-line
- Feared the security of your medical information
- Been pursued by a collection agency

What is LegalShield?

LegalShield was founded in 1972, with the mission to make equal justice under law a reality for all North Americans. The 3.5 million individuals enrolled as LegalShield members throughout the United States and Canada can talk to a lawyer on any personal legal matter, no matter how trivial or traumatic, all without worrying about high hourly costs. LegalShield has provided identity theft protection since 2003 with Kroll Advisory Solutions, the world's leading company in ID Theft consulting and restoration. We have safeguarded over 1 million members, provided more than 200,000 identity consultations, and helped restore nearly 10,000 individual identities.

The LegalShield[®] Membership Includes:

- Legal Advice - personal legal issues
- Letters/calls made on your behalf
- Contracts & documents reviewed (up to 15 pages)
- Residential Loan Document Assistance
- Attorneys prepare your Will, your Living Will and your Health Care Power of Attorney
- Moving Traffic Violations (available 15 days after enrollment)
- Trial Defense including Pre-Trial & Trial
- Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)
- IRS Audit Assistance
- 25% Preferred Member Discount (Bankruptcy, Criminal Charges, Other Matters, etc.)
- 24/7 Emergency Access for covered situations

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under age 18 for whom the member is legal guardian; never married, dependent children up to age 26 if a full-time college student; and physically or mentally disabled dependent children.

The IDShieldSM Membership Includes:

Full Service Restoration

Complete identity recovery services by Kroll Licensed Private Investigators and our \$5 million service guarantee ensure that if your identity is stolen, it will be restored to its pre-theft status.

Privacy Monitoring

Monitoring your name, SSN, date of birth, email address (up to 10), phone numbers (up to 10), driver license & passport numbers, and medical ID numbers (up to 10) provides you with comprehensive identity protection service that leaves nothing to chance.

Security Monitoring

SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle.

Consultation

Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.

IDShield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 8 dependents.

Payroll Deduction Amount	LegalShield	IDShield	Combined
INDIVIDUAL	\$16.95 monthly	\$8.95 monthly	\$25.90 monthly
FAMILY	\$18.95 monthly	\$18.95 monthly	\$33.90 monthly

This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See a plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions. An individual rate is available for those enrollees who are not married, do not have a domestic partner and do not have minor children or dependents. No family benefits are available to individual plan members. Ask your Independent Associate for details.

Retirement Planning

Texas County & District Retirement System (TCDRS)

Every employee, unless hired for a temporary position, MUST participate in the County's retirement system, TCERS.

As of January 1st, 2014, employees contribute 5% of his/her annual salary and McLennan County matches \$2.50 for every dollar saved by you, the employee. The amount you place into the account for savings will grow at an annual, compounded rate of 7%. To inquire about this wonderful benefit contact: 1-800-823-7782 or www.tcdrs.org.

As an employee, you must complete 8 years of service to be vested, which means when you become eligible to retire, you can draw a monthly annuity for your life and possibly a beneficiary's life. The County's portion is not put into your account until you apply for retirement. To get your 8 years for vesting, it can include time from other entities such as ERS, JRS, TRS, TMRS, COAERS and possibly up to 60 months of military service.

3 Ways to Meet Retirement Eligibility

- Age 60 with 8 years of service
- The Rule of 75 - Age plus service time equals 75
- 30 years of service at any age

Withdrawing Your Money

- If you leave employment with McLennan County, you can withdraw your money upon separation. However, if you want to receive the County's portion of the contribution, you must complete 8 years of service and meet the retirement eligibility requirements.
- If you retire with 8 years of service and choose to withdraw the lump sum of your funds in the account, you will no longer receive the County's contribution. You must elect a monthly annuity disbursement to gain the County's contribution.

Separating Service (If you leave your job)

Advantages of Keeping Your Money in the TCERS Account

- Your money will still earn 7% interest, tax deferred.
- If you are already vested, you can retire at age 60 (or older) and choose a monthly benefit that includes the County's matching contribution.
- Even if you aren't already vested, you may want to keep your money in TCERS in case you go to work for another employer that participated in the TCERS or one of the other Texas proportionate retirement systems. That way you could get the County's or employer's matching once you become eligible to meet the retirement eligibility requirements.

Disadvantages if You Withdraw Your Money Prior to Retirement Eligibility

- You will have to pay the taxes on the money when you withdraw it. The IRS requires TCERS to withhold 20% of your money for federal income taxes, and you still have to report the withdrawal when you file your income taxes.
- If you are younger than 59 ½, you may have to pay the IRS a 10% penalty for withdrawing your money, in addition to the federal income taxes.
- You don't get the County's/Employer's matching when you withdraw the account. You only get your personal deposits plus the interest gained, minus the 20% we have to withhold for taxes.

Voluntary Deferred Compensation: 457 Retirement Plans

As part of your employee benefits package, McLennan County offers you the ability to participate in a 457(b) Retirement Savings Plan. Deferred compensation plans offer supplemental retirement savings. With inflation, increases in health care, the need for long term care or assisted living, creates the need for supplemental retirement savings to ensure you have enough money to live on once you reach retirement age. You have the ability to determine when, where and how much you invest. Deferred comp allows you to defer your money each pay period before it is taxed. In a deferred compensation plan you can elect whether to invest in stocks, bonds, short-term investments or a combination (Mutual Funds). Every investment has a risk level associated with it, which can impact the potential for growth. Keep in mind, the higher the risk the higher the potential loss of the value. The key is to plan realistically, invest as much as you can, adjust as necessary based on life changes, stay in the plan (the longer you invest the better your long term return) and monitor/manage your investment elections regularly to refresh your strategy in order to stay up to date with your retirement goals. Each plan offers a variety of funding options which are listed in the plan details.

The IRS limits the amount you can contribute each calendar year. The federal general limit for 2015 is \$18,000.00. A special catch-up contribution may also be available to you in the three years immediately preceding normal retirement age under the plan. This catch-up contribution and the age 50 and older catch-up contribution may not both be used for the same year. Elective contributions generally may not exceed 100% of your compensation.

Rollovers

If you have a 457(b) retirement plan account with your current employer or through a different provider, and your plan permits, you may be able to consolidate those assets into one of the plan choices below.

Loans

Loans are not permitted at this time.

Withdrawals

Since your plan is designed primarily to help you save for retirement, the IRS has placed restrictions on when money may be withdrawn from your plan account before you retire. You may withdraw money from your plan account under the following circumstances:

- Normal Retirement Age (generally, 70 ½ for 457(b) plans)
- Termination of Employment
- Disability
- Death
- Unforeseeable Emergency (Subject to IRC requirements)

Always consult your tax advisor or investment professional about the income tax consequences of any withdrawals. Ordinary federal income taxes generally apply (unless distributed from Roth accounts qualifying for tax-free distributions). State income taxes may also apply. Withdrawals prior to age 70 ½ are generally prohibited unless you are severed from employment, disabled or have an unforeseeable emergency.

Your Deferred Compensation Plan Choices:

- **Nationwide**
- **MetLife**
- **Valic**

Required Health Plan Notices

Medicare Part D Creditable Coverage Notice

Important Notice from McLennan County 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 McLennan County 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. McLennan County has determined that the prescription drug coverage offered by the McLennan County Health 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 McLennan County coverage will not be affected if you are an active employee.

If you do decide to join a Medicare drug plan and drop your current McLennan County coverage, be aware that you and your dependents will be able to get this coverage back if you are an active employee.

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 McLennan County 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 McLennan County 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 and 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).

CHIPRA/CHIP Notice

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidprecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	MONTANA – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.html Phone: 1-800-694-30844
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392
MAINE – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY: 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijosaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

<p align="center">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462</p>	<p align="center">VIRGINIA – Medicaid and CHIP</p> <p>Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924</p> <p>CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647</p>
<p align="center">RHODE ISLAND – Medicaid</p> <p>Website: www.ohhs.ri.gov Phone: 401-462-5300</p>	<p align="center">WASHINGTON – Medicaid</p> <p>Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473</p>
<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: http://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">WEST VIRGINIA – Medicaid</p> <p>Website: http://www.dhr.wv.gov/bms Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p align="center">WISCONSIN – Medicaid</p> <p>Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493</p>	<p align="center">WYOMING – Medicaid</p> <p>Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531</p>

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Notice of Privacy Practices

HIPAA Notice of Privacy Practices

HIPAA privacy rules require that health plans, or their insurers, distributes a notice to participants explaining their privacy rights as group health plan participants at least every three years. HIPAA also requires that plans give the notice

to new participants and to redistribute the notice if it is revised. Sending the following notice annually fulfills the requirement and might be easier than remembering to send it every three years.

Note: In 2013, HIPAA protections were expanded in important ways, including significant changes to the notice used to explain HIPAA rules governing the group health plan

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

**McLennan County's Health Plan (The Plan)
October 1, 2015**

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights with respect to your Protected Health Information ("PHI"), including the right to know how your PHI may be used by a group health plan.

This Notice of Privacy Practices ("Notice") covers the following group health plan.

1. McLennan County's Medical and Pharmacy Plans
2. McLennan County's Flexible Spending Account Plan

The Plan is required by law to maintain the privacy of your PHI and to provide this Notice to you pursuant to HIPAA. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, health care operations, or for any other purposes that are permitted or required by law. This Notice also provides you with the following important information:

- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan's Privacy Officer and/or to the Secretary of the Office of Civil Rights of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

PHI is health information (including genetic information) in any form (oral, written, electronic) that:

- Is created or received by or on behalf of the Plan;
- Relates to your past, present or future physical or mental condition, or the provision of health care services to you, or the payment for those health care services; and
- Identifies you or from which there is a reasonable basis to believe the information can be used to identify you.

Health information your employer receives during the course of performing non-Plan functions is not PHI. For example, health information you submit to your employer to document a leave of absence under the Family and Medical Leave Act is not PHI.

Section 1. Uses and Disclosures of Your PHI

Under HIPAA, the Plan may use or disclose your PHI under certain circumstances without your consent, authorization or opportunity to agree or object. Such uses and disclosures fall within the categories described below. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

General Uses and Disclosures

Treatment. The Plan may use and/or disclose your PHI to help you obtain treatment and/or services from providers. Treatment includes the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist. The Plan may also disclose information about your prior prescriptions to a pharmacist to determine if any medicines contraindicate a pending prescription.

Payment. The Plan may use and/or disclose your PHI in order to determine your eligibility for benefits, to facilitate payment of your health claims and to determine benefit responsibility. Payment includes, but is not limited to billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. The Plan may also disclose your PHI to another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate payment of benefits.

Health Care Operations. The Plan may use and/or disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, underwriting, premium and other activities relating to Plan coverage. It also includes cost management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general Plan administrative activities. For example, the Plan may use your PHI in connection with submitting claims for stop-loss coverage. The Plan may also use your PHI to refer you to a disease management program, project future costs or audit the accuracy of its claims processing functions. However, the Plan is prohibited from using or disclosing PHI that is an individual's genetic information for underwriting purposes.

Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide such services, the Business Associates will receive, create, maintain, use and/or disclose your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide pharmacy benefit management services. However, Business Associates will receive, create, maintain, use and/or disclose your PHI on behalf of the Plan only after they have entered into a Business Associate agreement with the Plan and agree in writing to protect your PHI against inappropriate use or disclosure and to require that their subcontractors and agents do the same.

Plan Sponsor. For purposes of administering the Plan, the Plan may disclose your PHI to certain employees of **Scott & White and McLennan County**. However, these employees will only use or disclose such information as necessary to perform administration functions for the Plan or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Required By Law. The Plan may disclose your PHI when required to do so by federal, state or local law. For example, the Plan may disclose your PHI when required by public health disclosure laws.

Health or Safety. The Plan may disclose and/or use your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of another individual or the public. Under these circumstances, any disclosure will be made only to the person or entity able to help prevent the threat.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI without your consent, authorization or opportunity to agree or object. Note that not every permissible use or

disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

Public Health Activities. The Plan may disclose your PHI when permitted for purposes of public health actions, including when necessary to report child abuse or neglect or domestic violence, to report reactions to drugs or problems with products or devices, and to notify individuals about a product recall. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Health Oversight. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. Oversight activities can include civil, administrative or criminal actions, audits and inspections, licensure or disciplinary actions (for example, to investigate complaints against providers); other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); compliance with civil rights laws and the health care system in general.

Lawsuits, Judicial and Administrative Proceedings. If you are involved in a lawsuit or similar proceeding, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process by another individual involved in the dispute, provided certain conditions are met. One of these conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

Law Enforcement. The Plan may disclose your PHI when required for law enforcement purposes, including for the purposes of identifying or locating a suspect, fugitive, material witness or missing person.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

Workers' Compensation. The Plan may release your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

National Security and Intelligence. The Plan may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Military and Veterans. If you are a member of the armed forces, the Plan may disclose your PHI as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donations. If you are an organ donor, the Plan may disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Research. The Plan may disclose your PHI for research when the individual identifiers have been removed or when the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosure to Secretary

The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to Family Members and Personal Representatives

The Plan may disclose your PHI to family members, other relatives and your close personal friends but only to the extent that it is directly relevant to such individual's involvement with a coverage, eligibility or payment matter relating to your care, unless you have requested and the Plan has agreed not to disclose your PHI to such individual. The Plan will disclose your PHI to an individual authorized by you, or to an individual designated as your personal representative, provided the Plan has received the appropriate authorization and/or supporting documents. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

However, the Plan will not disclose information to an individual, including your personal representative, if it has a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person or treating such person as your personal representative could endanger you; and
- In the exercise of professional judgment, it is not in your best interest to disclose the PHI.

This also applies to personal representatives of minors.

Authorization

Any uses or disclosures of your PHI not described above will be made only with your written authorization. Most disclosures involving psychotherapy notes will require your written authorization. In addition, the Plan generally cannot use your PHI for marketing purposes or engage in the sale of your PHI without your written authorization. You may revoke your written authorization at any time, so long as the revocation is in writing. Once the Plan receives your authorization, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2. RIGHTS OF INDIVIDUALS

You have the following rights with respect to your PHI:

Right to Request Restrictions on PHI Uses and Disclosures. You may request in writing that the Plan restrict or limit its uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to limit disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. For example, you could request that the Plan not use or disclose specific information about a specific medical procedure you had. However, the Plan is not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. The Plan will not ask you the reason for your request, which must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests to receive communications of PHI by alternative means if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

Right to Inspect and Copy PHI. You have a right of access to inspect and obtain a copy of your PHI (including electronic PHI) contained in the Plan's "designated record set," for as long as the PHI is maintained by the Plan in a designated record set. If you request a copy of the information, the Plan may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

“Designated Record Set” includes the medical records and billing records about an individual maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about the individual. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

If your request is granted, the requested information will be provided to you within 30 days after the receipt of your request in the form and format requested, if it is readily producible in such form and format, or if not, in a readable hard copy form (or a readable electronic form and format in the case of PHI maintained in designated records sets electronically) or such other form and format as agreed upon by you and the Plan. If the Plan is unable to comply with request within the 30-day deadline, a one-time 30-day extension is permissible. In such case, you will receive notification of the need for an extension within the initial 30-day period.

Please note that your right does not apply to psychotherapy notes or information compiled in reasonable anticipation of a legal proceeding. The Plan may deny your request to inspect and copy your PHI in very limited circumstances. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. If you believe that the PHI the Plan has about you is incorrect or incomplete, you have the right to request in writing that the Plan amend your PHI or a record contained in a designated record set for as long as the PHI is maintained by the Plan in the designated record set. The Plan has 60 days after the request is made to act on the request. However, a single 30-day extension is allowed if the Plan is unable to comply with the deadline.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask for the amendment of information that: (1) is not part of the medical information kept by or for the Plan; (2) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information that you would be permitted to inspect or copy; or (4) is already accurate and complete. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.

The Right to Receive an Accounting of PHI Disclosures. You have the right to receive a list of disclosures of your PHI that have been made by the Plan on or after April 14, 2003 (or January 1, 2011 in the case of disclosures of your PHI from electronic health records maintained by the Plan, if any) over a period of up to six years (three years in the case of disclosures from an electronic health record) prior to the date of your request. Certain disclosures are not required to be included in such accounting of disclosures, including but not limited to disclosures made by the Plan (1) for treatment, payment or health care operations (unless the disclosure is made from an electronic health record), or (2) in accordance with your authorization. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request. You have the right to receive a paper copy of this Notice even if you have agreed to receive this Notice electronically.

To exercise any of your HIPAA rights described above, you or your personal representative must contact the HIPAA Privacy Officer in writing at human.resources@co.mclennan.tx.us or 214 N. 4th Street, Suite 200, Waco, Texas 76701; or by calling (254)-757-5158. You or your personal representative may be required to complete a form required by the Plan in connection with your specific request.

Section 3. THE PLAN'S DUTIES

Notice of Privacy Practices. The Plan is required by law to provide individuals covered under the Plan with notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. In the event of any material change to this Notice, a revised version of this Notice will be distributed to all individuals covered under the Plan within 60 days of the effective date of such change **by first-class U.S. mail** or with other Plan communications.

Breach Notification. The Plan has a legal duty to notify you following the discovery of a breach involving your unsecured PHI.

Minimum Necessary Standard. *When using or disclosing PHI, the Plan will use and/or disclose only the minimum amount of PHI necessary to accomplish the intended purposes of the use or disclosure. However, the minimum necessary standard will not apply in the following situations:*

- Disclosure to or requests by a health care provider for treatment;
- Uses or disclosures made to you; and
- Uses or disclosures that are required by law.

Section 4. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the HIPAA Privacy Officer in writing at human.resources@co.mclennan.tx.us or 214 N. 4th Street, Suite 200, Waco, Texas 76701; or by calling (254)-757-5158.

You will not be penalized or in any other way retaliated against for filing a complaint with the Office for Civil Rights or with the Plan.

Section 5. ADDITIONAL INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact [the HIPAA Privacy Officer in writing at human.resources@co.mclennan.tx.us or 214 N. 4th Street, Suite 200, Waco, Texas 76701; or by calling (254)-757-5158.]

Notice of Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- All stages 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

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact the plan administrator at 800-299-6840.

Patient Protection Disclosure

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

The McLennan County Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Scott & White.

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from the McLennan County Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Scott & White.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have *60 days* from the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event *and* provide the employer plan with timely notice of the event and your enrollment request.

To request special enrollment or obtain more information, contact the Human Resource Team at human.resources@co.mclennan.tx.us or 214 N. 4th Street, Suite 200, Waco, Texas 76701; or by calling (254)-757-5158.

Newborn's and Mothers' Disclosure Notice

MATERNITY BENEFITS

Under Federal and state law you have certain rights and protections regarding your Maternity benefits under the Plan.

Under federal law known as the **"Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act)** group health plans and health insurance issuers generally may 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 section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Under Texas law, if your Plan provides benefits for obstetrical services your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and Copayments that are no less favorable than for physical illness generally.



Employee Contributions

Your benefit contributions are automatically payroll deducted each pay period. The amounts listed below are reflected as a monthly cost, not the per payroll deduction value.

CARRIER	COVERAGE	CATEGORY	MONTHLY COST
Medical Coverage (McLennan County contributes \$510.04 to the total cost of the plans' monthly premium.)			
Plan 1: Base Health Plan	HMO	Employee Only	\$28.09
		Employee + Spouse	\$555.72
		Employee + Child(ren)	\$284.97
		Employee + Family	\$779.18
Medical Coverage (McLennan County contributes \$466.50 to the total cost of the plans' monthly premium and \$43.54 to the HSA- Health Savings Account monthly)			
Plan 2: Consumer Driven Health Plan	HMO	Employee Only	<i>Paid by McLennan County</i>
		Employee + Spouse	\$457.40
		Employee + Child(ren)	\$222.69
		Employee + Family	\$651.13
Dental Coverage			
Delta Dental	PPO	Employee Only	\$25.70
		Employee + 1 Dependent	\$43.71
		Employee + 2 or More Dependents	\$64.84
Health League	Fee Based Dental Plan	Employee + Unlimited Eligible Dependents	\$12.00
QCD	Discount Dental Plan	Employee Only	\$0.00
		Employee + Child(ren)	\$8.00
		Employee + Family	\$12.00
Vision Coverage			
NVA	Vision	Employee Only	\$4.41
		Employee + Spouse	\$7.94
		Employee + Child(ren)	\$7.94
		Employee + Family	\$11.48
Life & Disability Coverage			
Dearborn National	Term Life (Group Plan)	Employee Only - \$10,000 Coverage until the age 64	<i>Paid by McLennan County</i>
Dearborn National	Voluntary Term Life or Long	Employee + Eligible	Employee – Paid

	Term Life (Group Plan)	Unlimited Dependents	Based on Elections
Dearborn National	Long Term Disability	Employee Only	Employee – Paid Based on Salary & Age
Texas Life	Voluntary Portable Life	Employee + Eligible Unlimited Dependents	Employee – Paid Based on Elections
New York Life	Voluntary Whole Life	Employee + Eligible Unlimited Dependents	Employee – Paid Based on Elections
Legal Plan			
LegalShield	Legal	Individual	\$16.95
		Family	\$18.95
ID Shield	Legal	Individual	\$8.95
		Family	\$18.95
Combination LegalShield/ID Shield	Legal	Individual	\$25.90
		Family	\$33.90
Retirement Plan & 457(b) Plans			
TCDRS	Savings Plan	Employee Only	5% of Annual Salary + Ability to earn the County Contribution Amount
Nationwide MetLife Valic	457(b) Plans	Employee Only	Employee – Paid (Based on the amount you want to contribute within IRS guidelines)
Health Care & Dependent Care			
Health Savings Account (HSA)	Only with Health Plan 2: Consumer Driven Health Plan	Depends on Coverage Selected for the Health Plan	McLennan County Contributes \$43.54 + Employee – Paid Amount per IRS
Flexible Spending Account (FSA)	Health Care or Dependent Care	You determine the amount you want to defer up to the IRS annual allotment	Employee - Paid
Voluntary Insurance by AFLAC			
Short Term Disability (STD)	Voluntary Supplemental Insurance Plan	Consult with AFLAC Representative	Employee - Paid
Personal Accident Indemnity	Voluntary Supplemental Insurance Plan	Consult with AFLAC Representative	Employee – Paid
Hospital Advantage	Voluntary Supplemental Insurance Plan	Consult with AFLAC Representative	Employee – Paid
Critical Care & Recovery	Voluntary Supplemental Insurance Plan	Consult with AFLAC Representative	Employee – Paid
Cancer Plan	Voluntary Supplemental Insurance Plan	Consult with AFLAC Representative	Employee – Paid





References & Resources

Benefit Provider	Group Number	Whom To Call	Phone Number	Website
Medical Self Insured Plan		Administered by Scott & White Health Plan	800-299-8640	https://mclennan.swhp.org/
Vision	8044 0000 01	NVA	800-672-7723	www.e-nva.com
Dental	11252	Delta Dental PPO	800-521-2651	www.deltadentalins.com/enrollees
	MCLENNCO12	Health League – Jennifer Jung	254-227-5180 or 866-270-6012	www.healthleague.net
	DISD	QCD of America	972-726-0444 or 800-229-0304	www.qcdofamerica.com
Life & Disability	GAE60023	Dearborn National	866-895-4894	http://www.dearbornnational.com/
	SM1304	Texas Life – Tim Provence	254-772-9260 254-722-7097 timprovence@aol.com	
		New York Life – Duane Sivik	512-948-8005 dsivik@ft.newyorklife.com	
Legal	McLennan County	LegalShield	254-772-7797 billgarner@hotmail.com	www.billgarner.com
Retirement & Deferred Comp	254	TCDRS	800-823-7782	www.tcdrs.org
	Entity #0036265001	Nationwide	877-677-3678	www.NRSforU.com
	Plan# 1014831-01	MetLife	800-543-2520	www.ml.com
	63718	Valic	877-246-4523	www.valic.com
Health Care & Dependent Care Accounts		McLennan County Auditor's Office	254-757-5156	
Voluntary Insurance by AFLAC		AFLAC Representative Tim Davis	254-791-8221 tim@mytbaonline.com	

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.