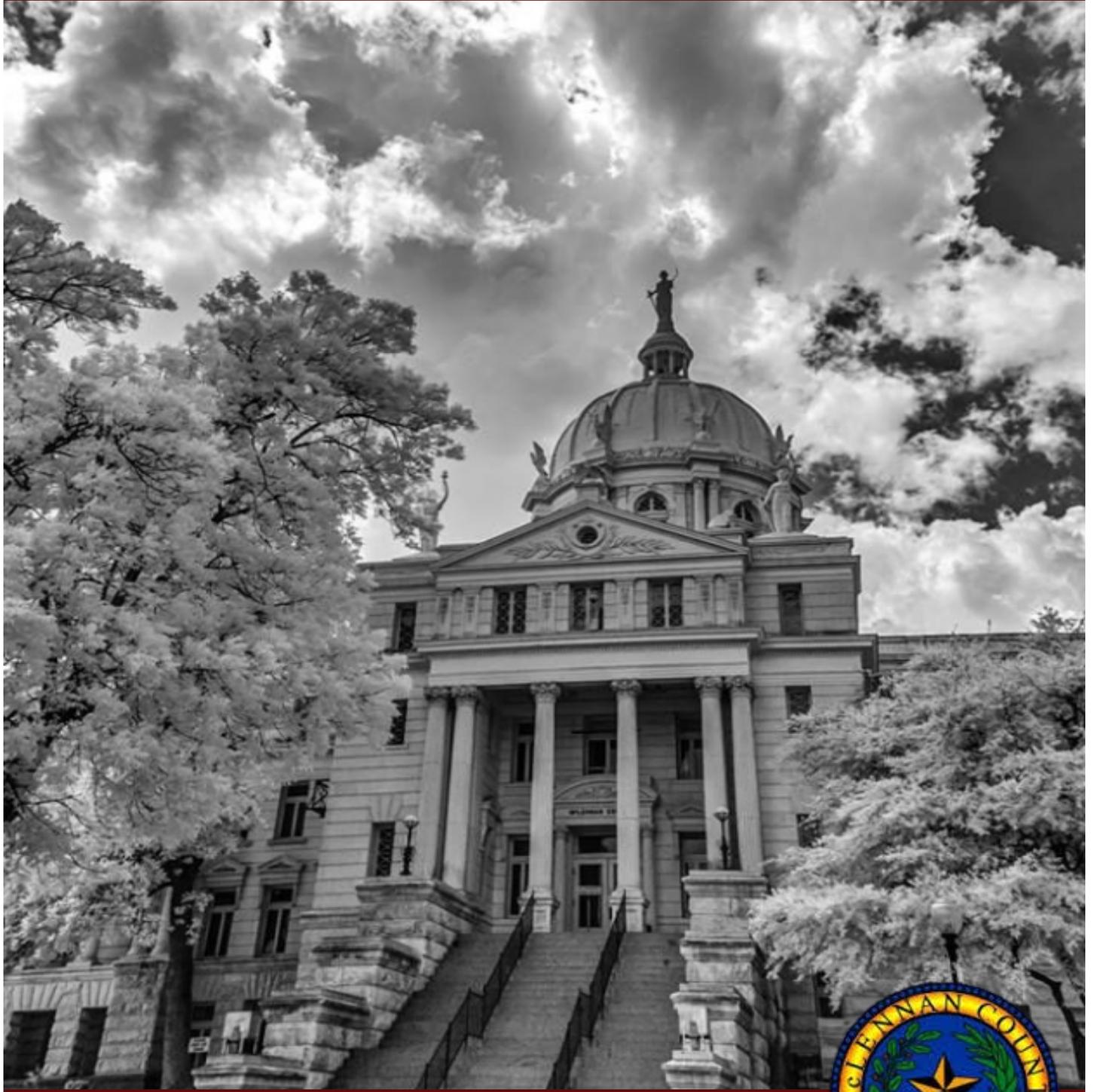


# 2020 McLennan County Benefits Enrollment Guide



# 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](mailto: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 your eligible dependents in specified benefits which include:

- Your legal spouse (a marriage certificate accepted by the US government must be presented at the time of enrollment)
- 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.



## Table of Contents:

- Medical Plan Options, Page 4
- Medical Plan Short Summary, Pages 5 -7
- Vision Plan, Page 11
- Dental Plan, Pages 11 & 12
- Health and Flexible Spending Accounts, and Dependent Care, Pages 13 - 15
- Supplemental Primary Care Plan, Page 16
- Income Protection & Voluntary Benefits, Pages 17 & 18 (Life Insurance Options & AFLAC)
- Employee Assistance Program, Page 19
- Retirement Planning, Page 20 & 21
- Required Health Plan Notices, Pages 22 - 40
- Employee Contributions & Cost Breakdown, Pages 41 & 42
- Contacts & Resources, Page 43

# Enrollment Periods

## New Employees

As a new full-time employee of McLennan County, you become eligible for benefits effective on the 1<sup>st</sup> of the month after 31 calendar days of continuous service. Our benefits plan year runs from January 1<sup>st</sup> through December 31<sup>st</sup>.

## 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. (See Making Changes During the Year/Qualifying Events for information regarding changes during the year.) Open Enrollment is held during the month of November. Elections you make during the open enrollment period will become effective on January 1<sup>st</sup>, 2019 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.) Make your benefit elections by completing the required forms, available at Open Enrollment. 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?

Forms will be available at Open Enrollment or you may consult with your HR Team member to identify which forms will be necessary depending upon the changes or elections you want to make.

## When and how do I pay my premiums?

Benefit premiums are paid by payroll deduction from your paycheck the month prior to the month of coverage. You can check your deductions by reviewing your pay stub or contacting a member of the HR Team. Monthly premiums are owed in full and are not prorated based on qualifying event effective dates. Example: If a qualifying event date (with the exception of birth/adoption) falls at the end of the month, the monthly premium is owed for the entire month in which the qualifying event occurs. You may experience double premium deductions from your paycheck for multiple pay periods based on the date of the qualifying event.

# 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 associated copay and not the deductible.

## No Out of Network Benefits except for Emergency Care

The Network Health Care Provider shall mean a Health Care Provider who has contracted with the Network to provide treatment or services to Covered Persons under the Plan and to accept Negotiated Rates as payment in full for such treatment and services. Out-of-Network Health Care Providers shall mean a Health Care Provider who has not contracted with the Network to provide treatment or services to a Covered Person under the Plan. Neither plan offers out of network benefits except for emergency care. Refer to the FAQ for information on obtaining referrals for out of network care when appropriate.

## 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 Schedule of Benefits 2020

Effective January 1, 2020	Plan 1 Base Plan	Plan 2 Consumer Driven Health Plan
<b>Calendar Year Deductible</b> <small>(Deductible applies to Out-of-Pocket Maximum and resets to Zero each January 1st)</small>	\$2,000 Individual \$4,000 Family	\$3,500 Individual \$7,000 Family (Embedded)
<b>Calendar Year Out-of-Pocket Maximum</b> <small>(Medical and Prescription Drug Deductibles, Copayments, and Coinsurance amounts apply toward Out-of-Pocket Maximum)</small>	\$5,500 Individual \$11,000 Family	\$3,500 Individual \$7,000 Family (Embedded)
<b>Outpatient Services</b>		
<b>Primary Care Office Visit</b>	\$35 Copay	\$0 Copay after deductible
<b>Specialty Care Office Visit</b>	\$55 Copay	\$0 Copay after deductible
<b>Preventive Services</b> (including lab and x-ray)	No Charge	No Charge
<b>Standard Lab and X-Ray</b> (Routine Office Visit)	No Charge	0% after deductible
<b>Diagnostic/Radiology</b> <small>(Limited to: angiograms, CT scans, MRIs, PET scans, myelography, stress tests, ultrasound)</small>	20% After Deductible	0% after deductible
<b>Outpatient Surgery</b>	20% After Deductible	0% after deductible
<b>Allergy Serum</b>	20 % After Deductible	0% after deductible
<b>Immunizations</b> (Age & Gender Appropriate)	No Charge	No Charge
<b>Eye Exam</b> (1 refraction annually)	\$35 Copay	0% after deductible
<b>Maternity</b> (Pre- and Post- Natal Care)	No Charge	No Charge
<b>Other Outpatient Services</b> <small>(Including other services, treatments, or procedures received at time of visit)</small>	20% after deductible	0% after deductible
<b>Therapeutic Services</b>		
<b>Speech &amp; Hearing (20 Visit Limit)</b>	\$35 Copay	\$0 Copay after deductible
<b>Physical Therapy (20 Visit Limit)</b>	\$35 Copay	\$0 Copay after deductible
<b>Manipulative Therapy Services (20 Visit Limit)</b> <i>(Chiropractic Services/Airrosti)</i>	\$35 Copay	\$0 Copay after deductible
<b>Inpatient Services</b>		
<b>Hospital Room, Semi-private</b>	20 % After Deductible	0% after deductible
<b>Intensive Care Unit</b>	20 % After Deductible	0% after deductible
<b>Other Hospital Services</b>	20 % After Deductible	0% after deductible
<b>Skilled Nursing Facility</b> (requires pre-authorization)	20% After Deductible	0% after deductible

Effective January 1, 2020	Plan 1 Base Plan	Plan 2 Consumer Driven Health Plan
<b>Durable Medical Equipment</b>		
<b>Durable Medical Equipment</b> (includes blood glucose meters, continuous glucose monitoring systems, as applicable)	50% After Deductible	\$0 after deductible
<b>Diabetic Self-Management Training</b>		
<b>Education/Nutrition Counseling</b> (for SWHP ONLINE Self-Management tools –no charge; deductible does not apply)	\$35 Copay	\$0 Copay after deductible
<b>Outpatient - Behavioral Health/Chemical Abuse Services</b>		
<b>Behavioral Health</b>	\$35 Copay	\$0 Copay after deductible
<b>Alcohol and Drug Dependency</b>	\$35 Copay	\$0 Copay after deductible
<b>Inpatient - Behavioral Health/Chemical Abuse Services</b>		
<b>Mental Illness, Serious Mental Illness, Treatment of Chemical Dependency</b>	20% After Deductible	0% after deductible
<b>Alcohol and Drug Dependency</b>	20% After Deductible	0% after deductible
<b>Home Infusion Therapy</b>		
<b>Home Infusion Therapy</b> (requires pre-authorization)	20% After Deductible	0% after deductible
<b>Home Health Services</b>		
<b>Home Health</b> (requires pre-authorization)	\$35 Copay	\$0 Copay after deductible
<b>Hospice</b> (requires pre-authorization)	No Charge	0% after deductible
<b>Emergency Care Services</b>		
<b>Emergency Room: in-network / out-of-network-subject to balance billing</b>	\$250 Copay + 20% After Deductible	0% after deductible
<b>Urgent Care: in-network / out-of-network-subject to balance billing</b>	\$75 Copay	0% after deductible
<b>Ambulance</b>	20% After Deductible	0% after deductible
<b>Prescription Drug (Rx) Coverage On Next Page</b>		

Effective January 1, 2020	Plan 1 Base Plan	Plan 2 Consumer Driven Health Plan
<b>Prescription Drug (Rx) Coverage (Can use any in-network Rx provider)</b>		
<b>Annual Benefit Maximum</b>	Unlimited	Unlimited
<b>Annual Deductible</b>	None	Included with medical deductible
		<i>Note: Copays only apply to preventive drugs as appropriate (deductible does not apply). All non-preventive drugs are subject to the deductible.</i>
<b>Retail Quantity (Up to a 30-day supply)</b>		
<b>Generic</b>	\$15 Copay	\$10 Copay
<b>Preferred Brand</b>	\$35 Copay	\$30 Copay
<b>Non-Preferred</b>	Lesser of \$60 or 50%	Lesser of \$55 or 50%
<b>Non-Formulary</b>	Not Covered	Not Covered
<b>Maintenance Quantity (Up to a 90-day supply) Maintenance quantities must be obtained from a Baylor Scott and White pharmacy</b>		
<b>Generic</b>	\$30 Copay	\$20 Copay
<b>Preferred Brand</b>	\$70 Copay	\$60 Copay
<b>Non-Preferred</b>	Lesser or \$120 or 50%	Lesser or \$110 or 50%
<b>Non-Formulary</b>	Not Covered	Not Covered
<b>Outpatient Specialty Drugs</b>	<b>No Calendar Year Deductible</b>	<b>Calendar Year Deductible Applies</b>
<b>Specialty Tier 1</b>	10% Copay	0% after deductible
<b>Specialty Tier 2</b>	20% Copay	0% after deductible
<b>Specialty Tier 3</b>	30% Copay	0% after deductible
<b>Specialty Tier 4 (This tier has been removed)</b>	Not Covered	Not Covered
<b>Diabetic Supplies (Unlimited Benefit)</b>		
<b>Preferred Diabetic Supplies:</b> test strips, lancets, lancet device, control solution	Tier 1 - \$15 Copay as appropriate	Tier 1 - \$10 Copay as appropriate
<b>Non-Preferred Diabetic Supplies:</b> test strips, lancets, lancet device, control solution	Tier 2- \$35 Copay as appropriate	Tier 2- \$30 Copay as appropriate
<b>Diabetic Syringes and Needles</b>	Tier 1 - \$15 Copay as appropriate	Tier 1 - \$10 Copay as appropriate
<p><b>Certain exclusions may apply. This is not intended to be an all-inclusive description of the health plan. For more information, please refer to the provisions of the Summary Plan Description.</b></p> <p><b>BENEFITS ARE PROVIDED <u>ONLY</u> FOR IN NETWORK PROVIDERS, EXCEPT FOR CERTAIN SITUATIONS INVOLVING EMERGENCY CARE. ACCESSING OUT OF NETWORK PROVIDERS IN NON-EMERGENCY SITUATIONS WITHOUT PRIOR APPROVAL WILL RESULT IN NO BENEFIT PAYMENTS AND THE MEMBERS WILL BEAR FULL FINANCIAL RESPONSIBILITY FOR ALL COSTS INCURRED.</b></p> <p><b>To view a complete list of providers and other plan details, go to <a href="https://mclennan.swhp.org/">https://mclennan.swhp.org/</a>.</b></p> <p><i>Customer Service 800-299-8640.</i></p> <p><i>McLennan County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.</i></p>		

# 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://swhp.org/Portals/0/Files/Forms/Formulary/McLennan-Group-Value-Formulary-2019.pdf>

## What is a deductible and when does it reset?

The deductible is the amount you pay for covered health care services before your insurance plan starts to pay. With a \$1,000 deductible, for example, you pay the first \$1,000 of covered services yourself. Your deductible amount runs through a calendar year meaning the dollar amount accrued resets to zero January 1<sup>st</sup>.

## How do I find a physician in my area?

You can use the website, <https://portal.swhp.org/#/search?networkCode=HMO&hideOptions=true>, 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://portal.swhp.org/#/login>) 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. They 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 with any applicable deductibles or out-of-pocket maximums; however, it is important to plan for routine medical needs. Out-of-network may be subject to balance billing. 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**

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. Coverage may only be provided for an out-of-network provider if there is a qualifying emergency. 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 Scott & White; allowable amounts are generally considered reasonable based on what most providers charge for a particular service in a geographic area. Any charges above the allowable amount will not count toward your deductible or out-of-pocket max.

## **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. With some services from an out-of-network provider, the plan pays 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 80% of an in-network covered charge, you pay 20%.

## Out of Pocket Maximum

The 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. 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. Please also note that preventive services are not applied to your deductible. 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 Benefit



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. NVA only offers In-Network provider benefits; be sure your care provider is within the network. Contact Information: 800-672-7723 or [www.e-nva.com](http://www.e-nva.com)

Summary of Vision Plan Options	Participating Provider Amounts	Non-Participating Provider	Eye Essential Plan: Participating Provider Coverage Amounts (2 <sup>nd</sup> Pair of Glasses)
<b>Examination (Once Every Plan Year)</b>	Covered 100% After \$10.00 Copay	Reimbursed amount up to \$30.00	Retail less \$10.00
<b>Contact Lens Evaluation/Fitting</b>			Retail less 10%
<b>Lenses: (Once Every Plan Year)</b> 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
<b>Frame (Once Every Two Plan Years)</b>	Retail Allowance Up to \$120.00 (20% discount off balance)*	Up to \$70.00	Retail less 35%
<b>Contact Lenses (Once Every Plan Year; Elective Contact Lenses, but this is in lieu of lenses &amp; frames)</b>	Up to \$105.00 (15% discount (Conventional) or 10% discount (Disposable) off balance)** Medically Necessary - Covered 100%	Up to \$80.00  Medically Necessary - Up to \$210.00	Retail less 15% Retail less 10%
*Does not apply to Wal-Mart / Sam's Club locations or for certain proprietary brands. **Does not apply to Wal-Mart/Sam's Club, Contact Fill (NVA Mail Order) or the following locations: Target, Sears, JC Penney, Boscov's, Pearle, K-Mart, & Macys (prohibited by some manufacturers).			
<b>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:</b>			
\$35.00 Polycarbonate (Single Vision) \$35.00 Polycarbonate (Multi-focal) \$40.00 Standard Anti-Reflective \$65.00 Transitions Single Vision Standard \$70.00 Transitions Multi-focal Standard \$75.00 Polarized		\$12.00 Ultraviolet Coating \$12.00 Solid/Gradient Tint \$10.00 Scratch-Resistant Coating \$50.00 Progressive Lenses Standard \$100.00 Premium Progressive Lenses	

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



# Dental Benefits

## Delta Dental PPO Benefit Highlights

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

<b>Eligibility</b>	Primary enrollee, spouse and eligible dependent children to age 26.
<b>Deductibles</b> Note: The deductibles for the Delta Dental plan reset at the start of the calendar year, January 1st.	Deductibles waived for Diagnostic & Preventive (D&P) and Orthodontics? Yes. \$50.00 per person/\$150.00 per family each plan year.
<b>Maximums</b> D&P counts toward maximum	\$1,000.00 per person each plan year
<b>Waiting Periods</b>	Basic Benefits – None; Major Benefits – 12 Months; Prosthodontics – 12 Months; Orthodontics – 12 Months

<b>Benefits &amp; Covered Services</b>	<b>Delta Dental PPO Dentists**</b>	<b>Non-Delta Dental PPO Dentists**</b>
<b>Diagnostic &amp; Preventive Services (D&amp;P)</b> Exams, cleanings and x-rays	100%	100%
<b>Basic Services</b> Fillings, simple tooth extractions and sealants	80%	80%
<b>Endodontics (root canals)</b>	80%	80%
<b>Periodontics (gum treatment)</b>	80%	80%
<b>Oral Surgery</b>	80%	80%
<b>Major Services</b> Crowns, inlays, onlays and cast restorations	50%	50%
<b>Prosthodontics</b> Bridges and dentures	50%	50%
<b>Orthodontic Benefits</b> Dependent Children	50%	50%
<b>Orthodontic Maximums</b>	\$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 are based on DPO contracted fees for DPO dentists, Premier contracted fees for Premier dentists and 90<sup>th</sup> percentile for non-Delta Dental dentists. Thus, you could pay the difference plus the % of the fee.

<b>Delta Dental Insurance Company</b> 1130 Sanctuary Parkway, Suite 600 Alpharetta, GA 30009	<b>Customer Service:</b> 800-521-2651 or <a href="http://www.deltadentalins.com">www.deltadentalins.com</a> Group # 11252	<b>Claims Address:</b> P.O. Box 1809 Alpharetta, GA 30023-1809
---	--	--

# Health & Flexible Spending Accounts and Dependent Care

**McLennan County offers a Flexible Spending Account and a Health Savings Account. Please note, only employees enrolled in the Base Health Plan can enroll in a Flexible Spending Account and only those eligible employees enrolled in the Consumer Driven Health Plan can contribute to a Health Savings Account.**

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 January 1, 2020 to December 31, 2020. 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 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	\$2,750 maximum per employee
Dependent Care FSA	\$5,000 maximum per household*

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

<p><b>Medical FSA</b></p> <p><b>Eligible Health Care Expenses</b></p> <ul style="list-style-type: none"> <li>• Prescription Medicines and Drugs</li> <li>• Hearing Aids</li> <li>• Orthopedic Goods, Prosthetic Devices</li> <li>• Doctors</li> <li>• Dentists, Orthodontics</li> <li>• Chiropractors</li> <li>• Optometrists, Ophthalmologists, Opticians, Eyeglasses</li> <li>• Over-the-counter Medicines and Drugs (prescription needed)</li> <li>• Chiropodists, Podiatrists</li> <li>• Nursing and Personal Care Facilities</li> <li>• Medical and Dental Laboratories</li> <li>• Medical Services and Health Practitioners</li> <li>• Ambulance Services, Equipment and Supplies</li> </ul> <p><b>Ineligible Health Care Expenses</b></p> <ul style="list-style-type: none"> <li>• Cosmetic expenses such as teeth whitening, and hair removal or hair growth treatments</li> <li>• Massage therapy (unless accompanied with a doctor's note specifying the medical necessity and listing specific diagnosis with length of treatment)</li> <li>• Health club dues</li> <li>• Insurance premiums of any type</li> <li>• Weight loss programs (unless accompanied by doctor's note specifying medical necessity, and listing specific diagnosis with length of treatment)</li> </ul>	<p><b>Dependent Care FSA</b></p> <p><b>Eligible Dependent Care Expenses</b></p> <ul style="list-style-type: none"> <li>• Child care provided at a daycare center or through a private provider</li> <li>• Nanny services with the care of a dependent</li> <li>• Day camps associated with the care of a dependent</li> <li>• Pre-school tuition that is daycare related (price of tuition alone is not eligible)</li> <li>• Annual registration fees for daycare providers</li> <li>• After-hours care that results from working odd hours or overtime</li> <li>• Eldercare</li> </ul> <p><b>Ineligible Dependent Care Expenses</b></p> <ul style="list-style-type: none"> <li>• Costs claimed as a dependent care tax credit on your tax return</li> <li>• Services provided by one of your dependents</li> <li>• Expenses for nighttime babysitting</li> <li>• Your own dependents, under age 19, babysitting</li> <li>• Expenses paid for schooling kindergarten and above</li> </ul> <p><b>USE IT OR LOSE IT</b></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 15<sup>th</sup> at the end of each plan year.)</p>
--	---

### 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 non-qualified 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 can 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 HSA and FSA at the same time. The maximum annual amount that you can contribute to a HSA for 2020 is \$3,550 for individual coverage and \$7,100 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 subject to income taxes or penalties if applicable (Refer to IRS Publication 969).

### **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
<b>Total Expenses:</b> Prescription drugs - \$150 Routine Physical/Lab tests - \$350	\$500
Paid by preventive care benefit* – no deduction from HSA	\$350
Amount paid from HSA (Justin’s choice)	\$150
<b>HSA Rollover to Year 2</b>	<b>\$850</b>
<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
<b>Total Expenses:</b> Office visits - \$100 Blood work - \$150 Prescription drugs - \$200	\$450
Paid by preventive care benefit* – no deduction from HSA	\$150
Amount paid from HSA (Justin’s choice)	\$300
<b>HSA Rollover to Year 3</b>	<b>\$1,550</b>
<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 \$300 up front in January and an additional \$300 to be paid in \$50 monthly installments beginning midyear 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. New hires with effective dates later than January 1, 2020 can receive HSA contributions from the County in \$50 monthly installments with no upfront bulk contribution.*

**Payroll Process Change: The HSA deductions will be taken on a current basis. The deductions cannot receive the tax credit until after the first of the month the account is established. Taking the deductions on a current basis will insure accurate reporting for W-2 statements.**

# Supplemental Primary Care Plan



**Uncommon Healthcare**  
DIRECT PRIMARY CARE

Uncommon Healthcare is offering **Family Medicine** services for individuals and families in a membership model of practice at 1000 State Hwy 6, Suite 100 in Waco.

## Benefits of Membership in Uncommon Healthcare

Members have their own private physician who provides for all of their primary care needs. They have access to their physician after hours via phone or text for urgent concerns and may schedule telephone or virtual visits-in lieu of in office appointments when appropriate.

Services include: wellness exams (annual, well woman and well child), sports/school/work physicals, care of chronic medical conditions (asthma, high blood pressure, diabetes etc.), treatment of acute illnesses (fever, rashes, sprains etc.), in-office procedures, prompt referrals to specialists when needed and more!

Members are free to select a high deductible health plan (saving thousands annually) with the security of knowing that their primary care needs are provided for.

Convenient location and scheduling with availability of same and next day appointments

NO copays, facility fees, or enrollment fees and no insurance claims are filed for services

**MEMBERSHIP FEE: Adult: \$50/month Child (19 and under): \$30/month**

	Traditional Practice	<b>Uncommon Healthcare DIRECT PRIMARY CARE</b>
<b>Average Wait Time in Office</b>	20-60 minutes	<b>0-3 minutes</b>
<b>Length of Physician Visits</b>	7-10 minutes	<b>30-60 minutes</b>
<b>Telephone and Virtual Visits</b>	No	<b>YES</b>
<b>After-hours Physician Access</b>	Unlikely	<b>YES</b>
<b>Same &amp; Next Day Appointments</b>	Maybe	<b>YES</b>
<b>Average wait for 1<sup>st</sup> Appointment</b>	2-8 weeks	<b>0-5 days</b>
<b>Cosmetic Services</b>	Unlikely	<b>YES, Discounted for Members</b>
<b>Cost Transparency</b>	Marginal	<b>FULL TRANSPARENCY</b>
<b>Cost per Visit (Self Pay)</b>	\$125-\$350	<b>\$0</b>
<b>Copay/Facility Fee per Visit</b>	\$20-\$100	<b>\$0</b>
<b>Procedures (skin biopsy, sutures of minor lacerations, joint injections, excision and destruction of skin lesions)</b>	\$150-\$1000's	<b>INCLUDED in Membership</b>
<b>Lab Tests</b>	\$20-\$500	<b>WHOLESALE PRICING</b>
<b>Imaging Studies</b>	\$75-\$1000's	<b>DISCOUNTED</b>
<b>Wholesale Medications</b>	No	<b>OPTION AVAILABLE</b>

Monthly membership fees for McLennan County employees and dependents may be payroll deducted. Plan coverage can be cancelled at any time during the plan year by notifying the provider and McLennan County HR in writing. The end of coverage will be the last day of the month following notification.

**Note: Joining Uncommon Healthcare does not replace your health insurance plan. Membership fees do not apply to deductibles or out of pocket accumulation.**

# 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. At age 65, 70, 75 and 80 there is a reduction in the amount of insurance coverage. 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 or to review additional plan details, please notify a member of the Human Resources Team.

## 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. Please see the plan policy for specifics.

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	\$.66	\$1.27	\$2.06
Dependent Children	\$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.)								

During annual enrollment, employees and/or spouses who chose not to sign up at initial enrollment are required to provide evidence of insurability for the full amount requested. Employees and/or spouses who enrolled for voluntary life coverage during open enrollment, will be eligible for UP TO \$10,000 of additional coverage without evidence of insurability up to the guarantee issue level. The Counties plan is in \$5,000 increments so the member can either increase the insurability amount by either \$5,000 or \$10,000 as long as the total coverage amount does not exceed \$150,000.

## 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

## Short Term Disability, provided by AFLAC

McLennan County offers a Short-Term Disability Aflac policy to you via payroll deduction. This policy is intended to supplement your major medical plan. Short-Term Disability applies if you are prevented from working due to an illness or injury for a short period of time. Short-term disability income insurance is designed to pay you benefits sooner and for a shorter period of time than long-term disability income insurance. There is a waiting period in the short-term policy to receive benefits, please refer to the policy terms for details regarding the waiting period.

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

### Coverage Details:

- 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

# Deer Oaks - Employee Assistance Program

The Deer Oaks Employee Assistance Program (EAP) is a free service provided for you and your dependents by McLennan County. This program offers a wide variety of counseling, referral, and consultation services, which are all designed to assist you and your family in resolving work/life issues in order to live happier, healthier, more balanced lives. Deer Oaks can provide assistance with a variety of different lifestyle needs. These services offer counseling sessions, financial guidance and legal assistance, among other services to help ease some of your daily commitments. All services are completely confidential.

## Eligibility

All employees and their household members/dependents are eligible to access the EAP. This includes retirees and employees who have recently separated from McLennan County (within 6 months of separation). There is no need to be enrolled in the Medical Health Plan to receive this benefit.

## Some of the Available Services Include

<b>The in-person or telephonic counseling and assessment services provide support for:</b>		
Job Related Stress	Child or Adolescent Problems	Dealing w/Divorce Issues
Depression & Anxiety	Anger Management	Problems w/co-workers or supervisors
Family Issues	Domestic Violence	Substance Abuse
Marital Problems	Family Issues	Stress Management

<b>The Work/Life services available to provide support and assistance include:</b>		
Child Daycare Referrals	Babysitters	Preschool & Nursery Schools
Parenting & Adoption Resources	Sick Child Care	Before & After School Care
Back-up & Odd Hour Care	In-Home Care	Special Needs Care & Summer Camps
Residential or Day Camps	Sport Camps	Religious Camps
<b>Part of the Work/Life services offers extensive assistance with Eldercare services including:</b>		
Referrals Elder Adult Day Care	Retirement Communities	Adaptive Transportation Services
Assisted Living Facility Referrals	Elder Substance Abuse Programs	Mental Health Services & Resources
Nursing Home Care Options	Senior Centers	Independent Living Centers
Alzheimer's Support	Volunteer Organizations	Cancer Care Centers
Medicare/Medicaid Resources & Assistance	Community Services	Geriatric Case Management Programs

The Employee Assistance Program also has a financial service, legal service and identity recovery services available. Legal services can assist with creating or updating a living will, family law, bankruptcy, adoption, consumer issues, criminal law, etc. The financial planning services can assist in budgeting, debt consolidation, college planning, vacation planning, retirement planning, etc. These services provide consumer education and financial workshops to assist you in reaching your goals. The identity recovery services assist you with maintaining your credit history integrity and assists in undoing any damage from identity theft.



Call DEER OAKS EAP Services: 1-888-993-7650;  
 E-mail: [eap@deeroaks.com](mailto:eap@deeroaks.com) or go to: [www.deeroaks.com](http://www.deeroaks.com)  
 Username: mctx Password: mctx

# 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 1<sup>st</sup>, 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 visit [www.tcdrs.org](http://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.

## Nationwide - A Voluntary Deferred Compensation 457b Retirement Plan

As part of your employee benefits package, McLennan County offers you the ability to participate in a 457(b) Retirement Savings Plan offered by Nationwide. 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 2020 is \$19,500. 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.

### Loans

Loans are not permitted.

### 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 IRS 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.



# 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](http://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](http://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](http://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](http://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](http://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 –**

<b>ALABAMA – Medicaid</b>	<b>COLORADO – Medicaid</b>
Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a> Phone: 1-855-692-5447	Medicaid Website: <a href="http://www.colorado.gov/">http://www.colorado.gov/</a> Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
<b>ALASKA – Medicaid</b>	
Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a> Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
<b>ARIZONA – CHIP</b>	<b>FLORIDA – Medicaid</b>
Website: <a href="http://www.azahcccs.gov/applicants">http://www.azahcccs.gov/applicants</a> Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: <a href="https://www.flmedicaidprecovery.com/">https://www.flmedicaidprecovery.com/</a> Phone: 1-877-357-3268
	<b>GEORGIA – Medicaid</b>
	Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
<b>IDAHO – Medicaid</b>	<b>MONTANA – Medicaid</b>
Medicaid Website: <a href="http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx">http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx</a> Medicaid Phone: 1-800-926-2588	Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.html">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.html</a> Phone: 1-800-694-30844
<b>INDIANA – Medicaid</b>	<b>NEBRASKA – Medicaid</b>
Website: <a href="http://www.in.gov/fssa">http://www.in.gov/fssa</a> Phone: 1-800-889-9949	Website: <a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a> Phone: 1-800-383-4278
<b>IOWA – Medicaid</b>	<b>NEVADA – Medicaid</b>
Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a> Phone: 1-888-346-9562	Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900
<b>KANSAS – Medicaid</b>	
Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a> Phone: 1-800-792-4884	
<b>KENTUCKY – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> Phone: 1-800-635-2570	Website: <a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">http://www.dhhs.nh.gov/oii/documents/hippapp.pdf</a> Phone: 603-271-5218
<b>LOUISIANA – Medicaid</b>	<b>NEW JERSEY – Medicaid and CHIP</b>
Website: <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a>	Medicaid Website:

Phone: 1-888-695-2447	<a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>
<b>MAINE – Medicaid</b>	Medicaid Phone: 609-631-2392
Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a> Phone: 1-800-977-6740 TTY: 1-800-977-6741	CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
<b>MASSACHUSETTS – Medicaid and CHIP</b>	<b>NEW YORK – Medicaid</b>
Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> Phone: 1-800-462-1120	Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
<b>MINNESOTA – Medicaid</b>	<b>NORTH CAROLINA – Medicaid</b>
Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a> Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a> Phone: 919-855-4100
<b>MISSOURI – Medicaid</b>	<b>NORTH DAKOTA – Medicaid</b>
Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005	Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-800-755-2604
<b>OKLAHOMA – Medicaid and CHIP</b>	<b>UTAH – Medicaid and CHIP</b>
Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	Website: <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a> Phone: 1-866-435-7414
<b>OREGON – Medicaid</b>	<b>VERMONT – Medicaid</b>
Website: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a> <a href="http://www.hijosaludablesoregon.gov">http://www.hijosaludablesoregon.gov</a> Phone: 1-800-699-9075	Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427
<b>PENNSYLVANIA – Medicaid</b>	<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a> Phone: 1-800-692-7462	Medicaid Website: <a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a> Medicaid Phone: 1-800-432-5924  CHIP Website: <a href="http://www.famis.org/">http://www.famis.org/</a> CHIP Phone: 1-866-873-2647

<b>RHODE ISLAND – Medicaid</b>	<b>WASHINGTON – Medicaid</b>
Website: <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a> Phone: 401-462-5300	Website: <a href="http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx">http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx</a> Phone: 1-800-562-3022 ext. 15473
<b>SOUTH CAROLINA – Medicaid</b>	<b>WEST VIRGINIA – Medicaid</b>
Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="http://www.dhhr.wv.gov/bms">http://www.dhhr.wv.gov/bms</a> Phone: 1-877-598-5820, HMS Third Party Liability
<b>SOUTH DAKOTA - Medicaid</b>	<b>WISCONSIN – Medicaid</b>
Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059	Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a> Phone: 1-800-362-3002
<b>TEXAS – Medicaid</b>	<b>WYOMING – Medicaid</b>
Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a> Phone: 1-800-440-0493	Website: <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a> Phone: 307-777-7531

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](http://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](http://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)

January 1, 2020

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](mailto:human.resources@co.mclennan.tx.us) or 214 N. 4<sup>th</sup> 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](mailto:human.resources@co.mclennan.tx.us) or 214 N. 4<sup>th</sup> 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](mailto:human.resources@co.mclennan.tx.us) or 214 N. 4<sup>th</sup> Street, Suite 200, Waco, Texas 76701; or by calling (254)-757-5158.]

## NOTICE CONCERNING NON-DISCRIMINATION

McLennan County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. McLennan County does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

McLennan County:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the McLennan County Human Resources Department.

If you believe that McLennan County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Human Resources Director, 214 N 4<sup>th</sup> Street, Suite 200, Waco, Texas 76701-1366, Phone: 254-757-5158, Fax: 254-757-5073 or via email [Human.Resources@co.mclennan.tx.us](mailto:Human.Resources@co.mclennan.tx.us). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Human Resources Director is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## 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](mailto:human.resources@co.mclennan.tx.us) or 214 N. 4<sup>th</sup> Street, Suite 200, Waco, Texas 76701; or by calling (254)-757-5158.

## **Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)**

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to a Covered Employee's military leave of absence. These requirements apply to medical and dental coverage for the Employee and his or her Dependents.

For leaves of less than 31 days, coverage will continue for the duration of such leave. For leaves of 31 days or more, the Employee may continue Employee and Dependent coverage by paying the required contribution to the Employer, until the earliest of the following: 24 months from the last day of employment with the Employer; the day after the Employee fails to return to work; or the date the Plan is canceled. The Employer may charge the Employee and his or her Dependents up to 102% of the total coverage cost.

If coverage ends during the leave of absence because the Employee does not elect USERRA and the Employee is reemployed by the Employer, coverage for the Employee and his or her Dependents may be reinstated if: (a) the Employee gave the Employer advance written or verbal notice of his or her military service leave; and (b) the duration of all military leaves while the Employee is employed with the Employer does not exceed 5 years. The Employee and his or her Dependents will be subject to only the balance of any waiting period that was not yet satisfied before the leave began. If coverage under this Plan terminates as a result of the Employee's eligibility for military medical and dental coverage and the Employee's order to active duty is canceled before active duty service commences, these reinstatement rights will apply.

## **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.

## **Family and Medical Leave Act (FMLA)**

The Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under the Plan on the same conditions as coverage would have been provided if the Covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under the Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

## **Health Insurance Marketplace Coverage Options and Your Health Coverage**

### **General Information**

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

### **What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2019 for coverage starting as early as January 1, 2020.

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

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

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

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

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

## How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Human Resource Team at [human.resources@co.mclennan.tx.us](mailto:human.resources@co.mclennan.tx.us) or 214 N. 4th Street, Suite 200, Waco, Texas 76701; or by calling (254)-757-5158.

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

\*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

## Affordable Healthcare Act Coverage Requirements

Under the Affordable Healthcare Act (ACA), McLennan County is required to offer health benefits to employees who average at least 30 hours of work per week. The County determines who is eligible for coverage based on the following the three stage administrative procedure outlined by the ACA.

### Measurement Period

This is a time period 12 months in length during which the County looks at an employee's work history to determine whether or not that employee has worked more than 30 hours a week on average. If yes then that employee is considered a full-time equivalent employee.

### Administrative Period

This is the period of time – not more than 90 days during which the County will be doing the measurement, making the determination of whether or not an employee is a full-time employee and notifying them of their status and eligibility.

### Stability Period

Once the County has determined and notified the employee of their full-time status, employees will be considered full-time for a stability period, which can be no less than the measurement period. At the end of the stability period, you may again measure the employee's status.

## General Notice of Cobra Continuation Coverage Rights

### Continuation Coverage Rights Under Cobra

You're getting this notice because you recently gained coverage under a McLennan County Employee Health Plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Read this notice carefully to help understand your COBRA rights. Keep in mind that when you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are

covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For additional and more complete information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

## What Is Cobra Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

### Employee

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because either of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

### Spouse

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation which later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

### Dependent children

Your dependent children (including any child born to or placed for adoption with you during the period of COBRA coverage who is properly enrolled in the Plan and any child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

## Retiree Coverage

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

## When Is Cobra Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the Company; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B or both)

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: McLennan County Human Resources. The Plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

## How Is Cobra Coverage Provided?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage.

- When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.
- When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Also, when the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

### **Disability Extension**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

### **Second Qualifying Event Extension**

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

### **Are There Other Coverage Options Besides Cobra?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

## If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

## Keep Your Plan Informed Of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## Plan Contact Information

McLennan County Employee Health Plan; McLennan County Human Resources Department  
214 North 4th Street, Suite 200  
Waco, Texas 76710  
254-757-5158

## Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. As a plan participant, you are entitled to a comprehensive description of your rights and obligations under the McLennan County Employee Health Plan.

Your plan offers health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available:

- A Summary Plan Description (SPD)
- A Summary of Benefits & Coverage (SBC)

The SBC summarizes important information about any health coverage option in a standard format, to help you compare across options. In order to ensure that you fully understand the benefits available to you and your obligations as a plan participant, it is imperative that you familiarize yourself with the information contained within the SPD.

The SPD & SBC are provided to you on the McLennan County Intranet under Human Resources, or on the S&W website <https://mclennan.swhp.org/>. If you would like to receive a paper copy of these documents, please contact Human Resources and one will be provided to you free of charge.

# 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
<b>Medical Coverage</b> (McLennan County contributes \$563.05 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
<b>Medical Coverage</b> (McLennan County contributes \$519.51 to the total cost of the plans' monthly premium; in addition, the County contributes a total of \$600 into the HSA- Health Savings Account by providing \$300 upfront in January and \$50 monthly beginning midyear. An exception exists for new hires.)			
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
<b>Dental Coverage</b>			
Delta Dental	PPO	Employee Only	\$25.70
		Employee + 1 Dependent	\$43.71
		Employee + 2 or More Dependents	\$64.84
<b>Vision Coverage</b>			
NVA	Vision	Employee Only	\$4.41
		Employee + Spouse	\$7.94
		Employee + Child(ren)	\$7.94
		Employee + Family	\$11.48
<b>Life &amp; Disability Coverage</b>			
Dearborn National	Term Life (Group Plan)	Employee Only - \$10,000 Coverage until the age 65	<i>Paid by McLennan County</i>
Dearborn National	Voluntary Term Life or Long Term Life (Group Plan)	Employee + Eligible Unlimited Dependents	Employee – Paid Based on Elections
Dearborn National	Long Term Disability	Employee Only	Employee – Paid Based on Salary & Age

<b>CARRIER</b>	<b>COVERAGE</b>	<b>CATEGORY</b>	<b>MONTHLY COST</b>
<b>Retirement Plan &amp; 457(b) Plans</b>			
TCDRS	Savings Plan	Employee Only	5% of Annual Salary + Ability to earn the County Contribution Amount
Nationwide	457(b) Plans	Employee Only	Employee – Paid (Based on the amount you want to contribute within IRS guidelines)
<b>Health Care &amp; Dependent Care</b>			
Health Savings Account (HSA)	Only with Health Plan 2: Consumer Driven Health Plan	Depends on Coverage Selected for the Health Plan (see HSA plan details for exceptions)	McLennan County Contributes \$300 upfront in January and \$50 monthly beginning midyear to the HSA-Health Savings Account 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
<b>Voluntary Insurance by AFLAC</b>			
Short Term Disability (STD)	Voluntary Supplemental Insurance Plan	Consult with AFLAC Representative	Employee - Paid

The information in this Benefit 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.



# 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	<a href="https://mclennan.swhp.org/">https://mclennan.swhp.org/</a>
Vision	#13170001	NVA	800-672-7723	<a href="http://www.e-nva.com">www.e-nva.com</a>
Dental	#11252	Delta Dental	800-521-2651	<a href="http://www.deltadentalins.com/enrollees">www.deltadentalins.com/enrollees</a>
Primary Care Alternative		Uncommon Healthcare	254-339-1360	<a href="http://www.uncommonhealthcare.com">www.uncommonhealthcare.com</a>
Life & Disability	#GAE60023	Dearborn National	800-348-4512	<a href="http://www.dearbornnational.com">http://www.dearbornnational.com</a>
EAP Services		Deer Oaks	888-993-7650 <a href="mailto:eap@deeroaks.com">eap@deeroaks.com</a>	<a href="http://www.deeroaks.com">www.deeroaks.com</a>
Retirement	#254	TCDRS	800-823-7782	<a href="http://www.tcdrs.org">www.tcdrs.org</a>
Deferred Compensation	Entity #0036265001	Nationwide	877-677-3678	<a href="http://www.NRSforU.com">www.NRSforU.com</a>
Health Care & Dependent Care Accounts		McLennan County Auditor's Office	254-757-5156	
Voluntary Insurance by AFLAC		AFLAC Representative Tim Davis	254-791-3825 <a href="mailto:tim@mytbaonline.com">tim@mytbaonline.com</a>	