A GUIDE TO YOUR BENEFITS 2021

WILLIAMSON COUNTY
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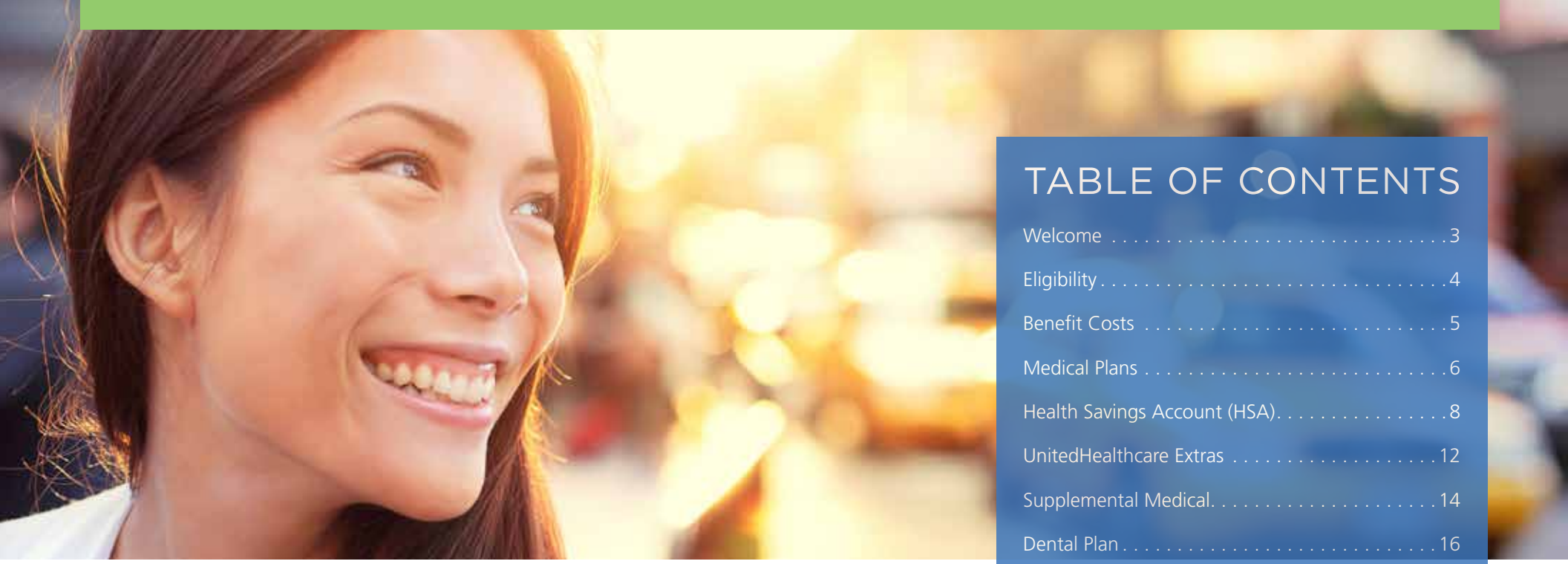

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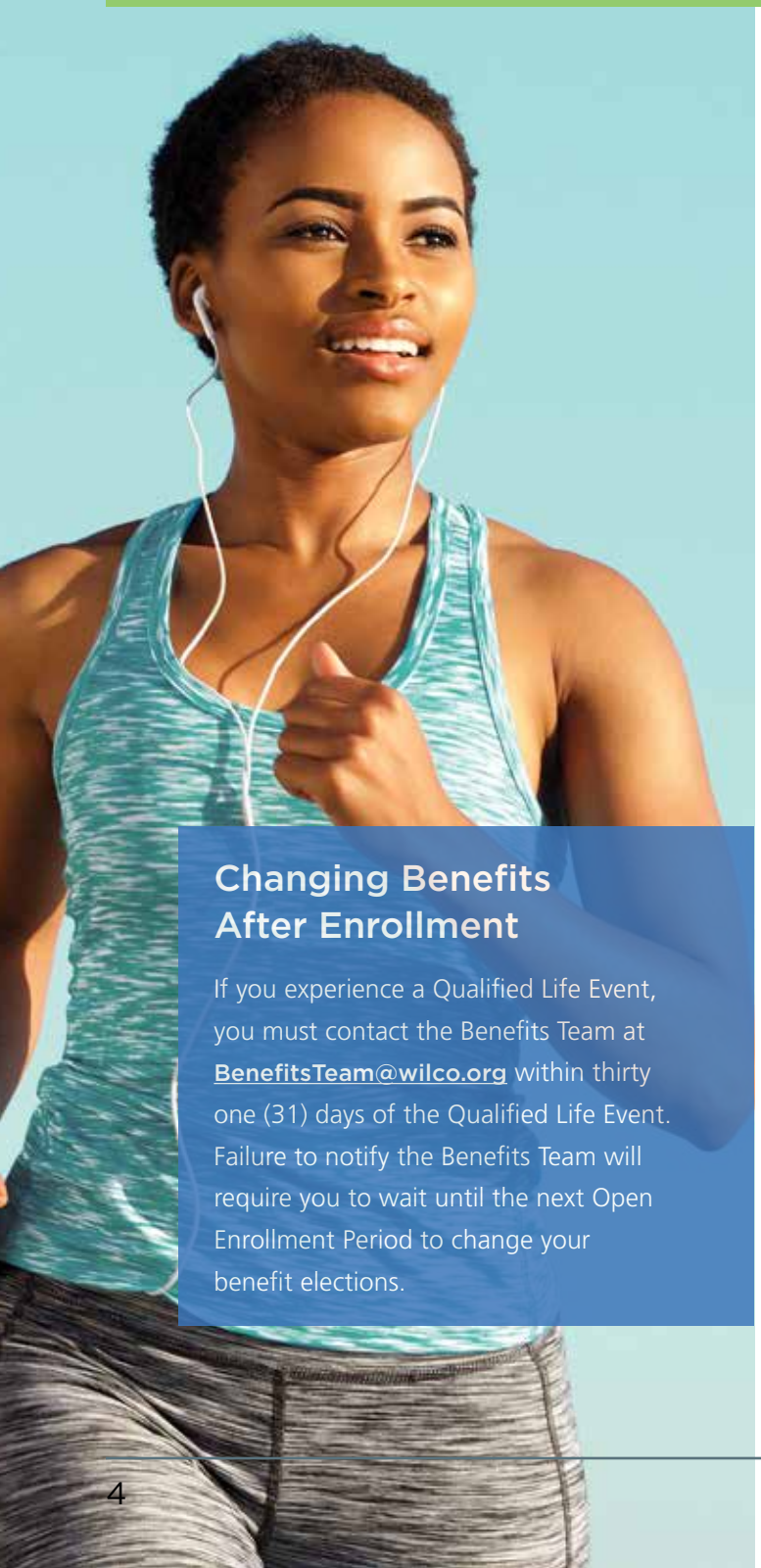
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 33 for more details.

WELCOME

At Williamson County it's our employees who make the difference in our success. That's why you have the opportunity to choose from a variety of benefits that can make a real difference in your life. We offer a broad range of benefits, including health insurance, dental insurance, vision insurance, life insurance, disability insurance and much more.

You can customize a benefits program that's exactly right for your personal situation. This guide provides a summary of your benefit options. Please review it carefully and make your elections before the deadline.

If you have any questions about your benefits choices or about how to enroll, contact the Benefits Team at **BenefitsTeam@wilco.org**. Then you'll be sure to have the benefits you need for the year ahead.



Changing Benefits After Enrollment

If you experience a Qualified Life Event, you must contact the Benefits Team at BenefitsTeam@wilco.org within thirty one (31) days of the Qualified Life Event. Failure to notify the Benefits Team will require you to wait until the next Open Enrollment Period to change your benefit elections.

ELIGIBILITY

Full-time employees are eligible for benefits. Most of your benefits are effective on the first day of the month following your 60-day waiting period. New employees have twenty (20) days from your date of hire to complete your new hire election in the Benefits Portal.

All full-time employees must complete Open Enrollment elections to continue elected coverage (or change your elected coverage) during the Open Enrollment Period. Benefit elections are completed in the Benefits Portal each benefit plan year. You may also enroll your eligible dependents for coverage. This includes the following:

- Your legal spouse or qualified domestic partner
- Children under the age of 26, regardless of student, dependency or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability, and who are indicated as such on your federal tax return

Qualified Life Events

Generally, you may only change your benefit elections during the Open Enrollment Period. However, since life happens, changes to your benefit elections during the year are allowed for Qualified Life Events.

Below are examples of Qualified Life Events:

QUALIFIED LIFE EVENT		DOCUMENTATION NEEDED
Change in marital status	• Marriage • Divorce/Legal Separation • Death	• Copy of marriage certificate • Copy of divorce decree • Copy of death certificate
Change in number of dependents	• Birth or adoption • Step-child • Death	• Copy of birth certificate or copy of legal adoption papers • Copy of birth certificate plus a copy of the marriage certificate between employee and spouse • Copy of death certificate
Change in employment	• Change in your eligibility status (i.e., full-time to part-time) • Change in spouse's benefits or employment status	• Notification of increase or reduction of hours that changes coverage status • Notification of spouse's employment status that results in a loss or gain of coverage

BENEFIT COSTS

Williamson County pays the full cost of many of your benefits. For others, Williamson County and you share the cost or you pay the full cost. Pretax means the cost comes out of your pay before taxes are deducted. After-tax means your cost comes out of your pay after taxes are deducted. The chart below shows who pays for each benefit and the related tax treatment.

BENEFIT	WHO PAYS	TAX TREATMENT
Medical and Prescription	Williamson County/You	Pretax
Vision	You	Pretax
Dental	You	Pretax
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	Williamson County	N/A
Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance	You	Post-tax
Voluntary Short-Term	You	Post-tax
Voluntary Long-Term Disability	You	Post-tax
Health Savings Account	Williamson County/You	Pretax
Flexible Spending Accounts	You	Pretax
TCDRS Retirement Plan	Williamson County/You	Pretax
457B Deferred Compensation Plan	You	Pretax
Employee Assistance Plan	Williamson County	N/A
Additional Voluntary Benefits	You	Post-tax

MEDICAL PLANS

Our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

Each medical plan offers:

- Comprehensive health care benefits
- In-network preventive care covered at 100%
- Coverage for eligible children up to age 26
- Prescription drug coverage

Key Plan Differences

The key difference between the plans is the amount of money you'll pay each pay period. The plans have different:

- **Network** – Nexus has a smaller network and lower cost share, Choice Plus has a larger network and therefore a higher cost share
- **Annual deductible amount** – the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay
- **Out-of-pocket maximums** – the most you will pay each year for eligible network services including prescriptions
- **Copay and coinsurance** – money you pay toward the cost of covered services

Save when you use in-network providers

In-network providers offer the highest level of benefits and lower out-of-pocket costs.

Medical Plan Comparison

	NEW HEALTH SAVINGS ACCOUNT – HIGH DEDUCTIBLE HEALTH PLAN	TRADITIONAL PLANS UHC NEXUS ACO OA		TRADITIONAL PLANS UHC CHOICE PLUS	
	IN-NETWORK	IN ACO TIER 1	UHC NETWORK NON-TIER 1	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE					
Individual	$3,000	$2,000	$2,000	$2,000	$4,000
Family	$6,000	$4,000	$4,000	$4,000	$8,000
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)					
Individual	$5,500	$5,500	$5,500	$5,500	Unlimited
Family	$11,000	$11,000	$11,000	$11,000	Unlimited
		YOU PAY		YOU PAY	
COINSURANCE					
Physician Office Visit	20%*	$30 copay	50%*	$30 copay	50%*
Specialist Office Visit	20%*	$55 copay	50%*	$55 copay	50%*
Preventive Care	$0**	$0**	$0**	$0**	$0**
Urgent Care	20%*	$45 copay	$45 copay	$45 copay	50%*
Emergency Room	20%*	$400 copay	$400 copay	$400 copay	$400 copay
Inpatient Hospital	20%*	20%*	50%*	20%*	50%*
PHARMACY					
RETAIL RX (UP TO 30-DAY SUPPLY)					
RX Deductible	Deductible / Coinsurance	$0			
Limited Preventive Scripts	$0***	Diabetic Tier 1, Generic & Tier 2, Preferred; Blood Pressure Tier 1, Generic; Cholesterol – Tier 1, Generic****			
Tier 1 - Generic	20%*	35% ($10 Min/$100 Max)			
Tier 2 - Preferred	20%*	35% ($40 Min/$100 Max)			
Tier 3 - Brand	20%*	35% ($75 Min/$100 Max)			
Specialty Pharmacy	20%*	$125			
MAIL ORDER RX (UP TO 90-DAY SUPPLY)					
Tier 1 - Generic	20%*	$20			
Tier 2 - Preferred	20%*	$80			
Tier 3 - Brand	20%*	$100			

*After Deductible
**Only preventive Primary Care Visits or Well Woman Visits, Mammograms and Preventive Colonoscopies are covered at 100%, as the deductible does not apply. Note: Physician must file claim as preventive visit.
***Limited Preventive Scripts – Refer to the Advantage Prescription Drug List and Core Plus Preventive drug list for medications that may be covered at 100%.
****Limited Preventive Scripts covered at 100%. Refer to the Advantage Prescription Drug List for medications that may be covered at 100%. See the detailed PDL for more information in regard to specific details. Updates to the PDL are made in May, September and January.

HEALTH SAVINGS ACCOUNT (HSA)

For the 2021 benefit plan year, Williamson County is excited to introduce a new Health Savings Account (HSA) plan to all eligible full-time employees. This new plan has a High Deductible Health Plan (HDHP) that allows you to participate in a tax-free HSA. This type of plan includes a higher deductible and out-of-pocket maximum than a traditional plan but has a lower cost per pay period. It is designed to give you greater control of your health care dollars.

How a Health Savings Account (HSA) Works

Eligibility
You must be enrolled in the High Deductible Health Plan.

Your Contributions
You contribute on a pretax basis and can change how much you contribute from each paycheck up to the IRS maximum of $3,600 if you enroll only yourself, or $7,200 if you enroll in family coverage. You can make an additional catch-up contribution of $1,000 if you are age 55+.

The Company's Contribution
$500 for employee only coverage.

$500 for employee + family coverage.

Eligible Expenses
Medical, dental, vision and prescription drug expenses incurred by you and your eligible family members. Funds available for reimbursement are limited to the balance in your HSA.

Using Your Account
Use the debit card linked to your HSA to cover eligible expenses or pay for expenses out of your own pocket and save your HSA money for future health care expenses.

Your HSA is always yours – no matter what
One of the best features of an HSA is that any money left in your HSA account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the company or retire, your HSA goes with you and you can continue to pay and save for future eligible health care expenses.

The Triple Tax Advantage

HSAs offer you tax advantages like no other account:

1. You can use your HSA funds to cover qualified medical expenses, plus dental and vision expenses too – tax free.
2. Unused funds grow and can earn interest over time – tax free.
3. You can save your HSA funds to use for your health care when you leave the Company or retire – tax free.

If you like the idea of paying less per paycheck and saving tax-free money for future medical expenses, consider enrolling in the HDHP with HSA.

How a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA) Work Together

Yolanda enrolls herself only in the HDHP with HSA. She chooses to use her HSA to pay for covered services – this reduces her out-of-pocket amount needed to meet her deductible before her health plan begins to pay.

YEAR 1 EXAMPLE	YEAR 2 EXAMPLE
The Company deposits $500 in Yolanda's HSA	The Company deposits $500 in Yolanda's HSA
She contributes $3,100 for a total of $3,600	She contributes $3,100 for a total of $3,600
	$2,900 rolls over from last year for a total of $6,500
She uses her HSA to pay $700 of eligible expenses	She uses her HSA to pay $1,250 of eligible expenses
She has $2,900 in her HSA to roll over to next year	**She has $5,250 in her HSA to roll over to next year**

HSA Plan Highlights

- **In-Network Preventive Care:** The plan pays 100%.
- **Deductible:** You pay 100% for medical care and prescriptions. Once you meet the deductible, coinsurance kicks in.
- **Network:** HSA plan utilizes the Choice Network and does not have Out-of-Network Benefits.
- **Coinsurance:** You and the plan share a percentage of the cost until you meet the out-of-pocket maximum.
- **Out-of-Pocket Maximum*:** Once you reach this, the plan pays 100% of in-network costs for the remainder of the calendar year.

Members enrolled in this plan should refer to the Advantage Prescription Drug List and Core Plus Preventive Drug List for medications covered at 100%. Any medication that is not considered preventive will be subject to the deductible and coinsurance. The Core Plus Preventive Drug list includes a limited selection of blood pressure, cholesterol, diabetic supplies and medications covered at 100%. ***Continuous Glucose Monitors are not covered at 100% under this plan.***

Eligibility

To be eligible to enroll in an HSA:

- You must be covered under a qualifying high-deductible health plan (HDHP) on the first day of the month.
- You have no other health coverage except what is permitted by the IRS.
- You are not enrolled in Medicare, TRICARE or TRICARE for Life.
- You can't be claimed as a dependent on someone else's tax return.
- You haven't received Veterans Affairs (VA) benefits within the past 3 months, except for preventive care.
- You do not have a health care flexible spending account (FSA) or health reimbursement account (HRA). A limited purpose FSA may be permissible.
- Other restrictions and exceptions may also apply. We recommend that you consult a tax, legal or financial advisor.

*If you cover any dependents, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

**Limited Preventive Scripts – Refer to the Advantage Prescription Drug List and Core Plus Preventive drug list for medications that may be covered at 100%.

Is the HSA Right for Me?

After you meet the $3,000 per individual or $6,000 per family deductible, then the plan will have a 20% coinsurance that you are responsible for until you reach the individual $5,500 out-of-pocket maximum and/or the $11,000 per family out-of-pocket maximum.

All out-of-pocket expenses and prescription drug costs count toward your deductible and out-of-pocket maximum.

It is important for you to plan accordingly by preparing a benefit expense budget for anticipated out-of-pocket costs for the 2021 benefit plan year, which could include the following:

BENEFIT SERVICES	CONSIDER	COST
Pharmacy Costs	Deductible applies first, then member will pay the contracted cost for medications	Deductible/Coinsurance
Physician Visits	How many times a year does the member or member's dependents visit Physicians/Specialists	Deductible/Coinsurance
Current Medical Conditions	Does the member have on going medical conditions that require on going treatment	Deductible/Coinsurance
Anticipated Medical Procedures	Are you expecting a newborn, or have an upcoming medical procedure	Deductible/Coinsurance
Urgent Care, Emergency Care	How many times during the previous plan year did you or your family members visit and Urgent Care or Emergency Room	Deductible/Coinsurance
Inpatient Hospital Care	If you are having a medical procedure how many days do anticipate being in a hospital or skilled nursing or rehabilitative hospital setting	Deductible/Coinsurance
Outpatient Surgical Care	Do you or your family members have an outpatient surgery planned	Deductible/Coinsurance

Williamson County Contributions

Williamson County will deposit up to $500 into your HSA based on your effective date, if you enroll in the HDHP plan:

- January 1, 2021: $500
- After January 1, 2021, a prorated deposit will be applied per quarter:
  - First Quarter (January – March): $500*
  - Second Quarter (April – June): $375*
  - Third Quarter (July – September): $250*
  - Fourth Quarter (October – December): $125*

*Deposits are applied on the first pay date in the month according to the effective date of coverage.

Using Your HSA Funds

- Choose the HSA option during open enrollment and complete the on-line application.
- You will receive your HSA welcome kit and Optum Bank debit Mastercard®.
- Activate your account online at **www.myuhc.com** or **www.optumbank.com**.
- Download the Optum Bank app to conveniently manage your HSA.
- To make a payment using your HSA funds, you may use your Optum Bank debit Mastercard, or you may use online bill pay. You can even pay through the Optum Bank mobile app!
- If you pay for qualified expenses out of pocket, you may request a reimbursement via **www.optumbank.com**.

UNITEDHEALTHCARE EXTRAS

There is more to the UnitedHealthcare plans than great coverage. If you enroll in the UHC medical plan, you have access to a variety of wellbeing resources.

myuhc.com

Get the answers you need, when you need them, on **myuhc.com**®, your member website. Personalized service, round-the-clock support and high-tech tools are designed to provide you with a better health care experience.

- View and manage your claims and accounts
- Know your health care costs
- Find the care you need
- Get and stay healthy with innovative wellbeing tools

Rally®

Rally offers personalized recommendations to help you move more, eat better, and feel great. Rally recommends customized Missions, which are simple activities to help improve your diet, fitness, and mood every day. As you make progress, you'll earn Rally Coins, good for a chance to win rewards.

UnitedHealthcare App

The UnitedHealthcare app is available as a free download from the Apple® iTunes® App Store® and the Android® Market. Get instant access to your health information, find a physician near you, check the status of a claim or get advice from a nurse.

Virtual Visits – Medical

Connect with a doctor for non-emergency care right from your mobile device or computer without an appointment. You can even get a prescription sent to your local pharmacy. If you are enrolled in one of the traditional plans, virtual visits are offered at no cost. **If you are enrolled in the HSA plan, you will pay $49 per visit.** Appointments are available 24/7 and take about 15 minutes. Log in to **myuhc.com** to learn more and schedule appointments. Virtual visits are a convenient way to get care for:

- Bladder infection/Urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/headaches
- Pink eye
- Rash

Virtual Visits – Behavioral Health

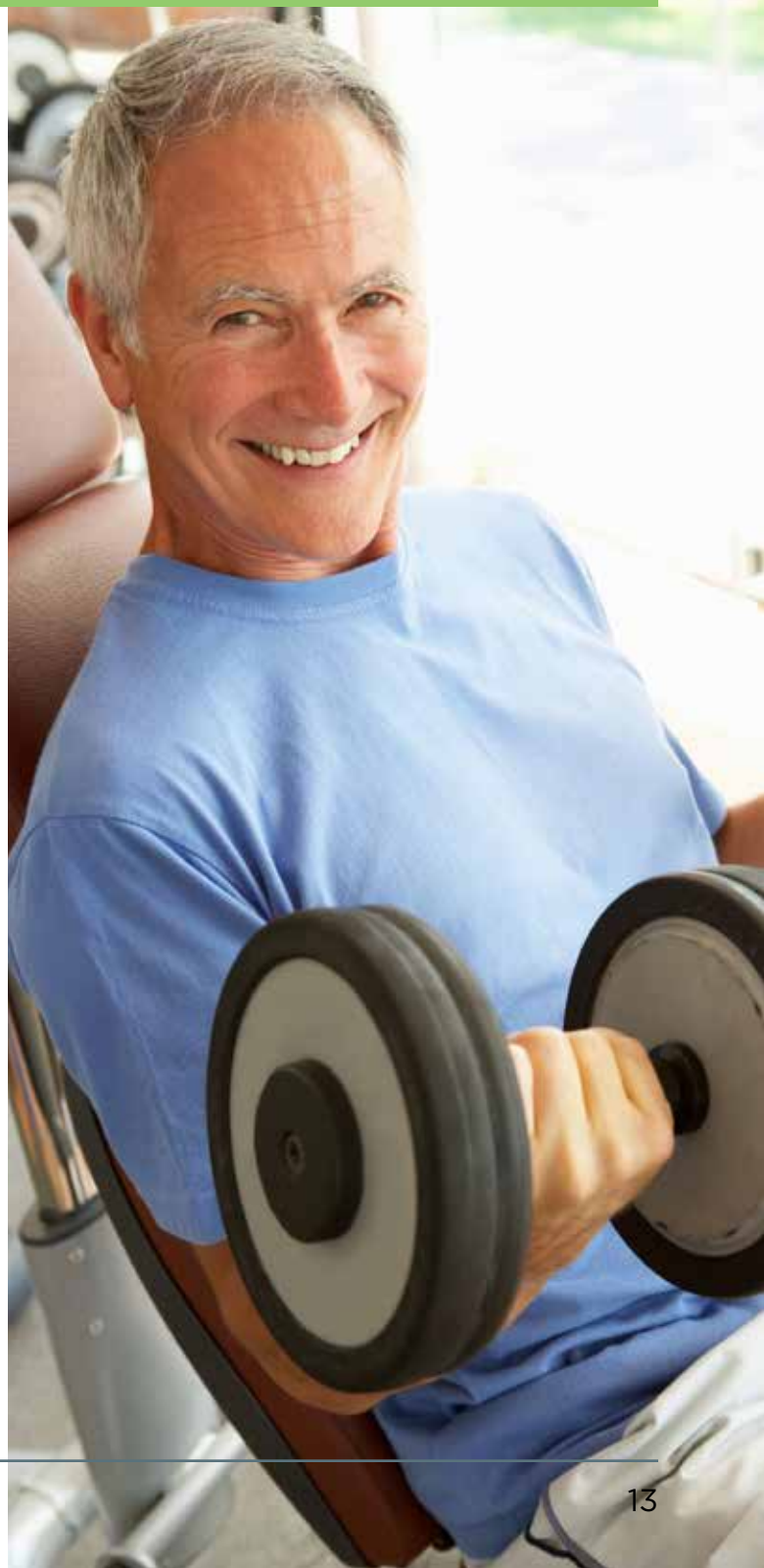
Behavioral health virtual visits provide quick and easy access to behavioral health professionals from your mobile device, tablet or computer. You can connect with a provider from the comfort of home, with convenient appointment times to accommodate busy schedules. They're part of your behavioral health benefit through UnitedHealthcare. **If you are enrolled in one of the traditional plans, the cost is $55 per visit. If you are enrolled in the HSA plan, you will pay 20% after your deductible is met.** Use a behavioral health virtual visit for needs such as depression, anxiety, ADD/ADHD, addiction, mental health disorders and counseling.

UHC – Real Appeal

UHC's Real Appeal™ provides you with a plan for lasting weight loss. If you are enrolled in one of our medical plans, this program is provided to you at no additional cost. Real Appeal includes:

- A personalized transformation coach for an entire year who will guide you through the program, customizing it to fit your needs, personal preferences, goals and medical history.
- Staying accountable to goals is easier than ever with 24/7 online support and the mobile app, where you can access:
    - Customizable food, activity, weight and goal trackers
    - Unlimited digital content including streaming workout videos
    - Success group support which lets you chat with others who are participating in the program
    - Weekly Real Appeal All-Star Show featuring healthy tips from celebrities, athletes and health experts
    - Weekly analysis, feedback and goal reporting
- A Success Kit with all the gadgets you need to kick-start your weight loss and keep you going strong:
    - Personal blender
    - Digital food scale
    - "Perfect" portion plate
    - Resistance band
    - Electronic body weight scale
    - Exercise DVDs

And more delivered to your door after you attend your first group coaching session.



SUPPLEMENTAL MEDICAL

Accident Insurance

Just as it sounds, Accident insurance can help you pay for costs you may incur after an accidental injury. This type of injury includes things such as a car accident, a fall while skiing or even a fall down the stairs at home. This benefit is paid regardless of any other insurance coverage you might have (including your medical coverage).

ELIGIBLE EXPENSES

Emergency Room Visits

Fractures and Dislocations

Hospital Stays

Medical Exams – including major diagnostic exams

Physical Therapy

Transportation and Lodging – if you are away from home when the accident happens

How the Plan Works

Again, these benefits are in addition to any health insurance benefits you may receive. The benefit amount is paid directly to you. You can use this money in any way you like, including deductibles, child care, housecleaning, groceries, utilities or any purpose that can help you meet your personal, financial or household needs.

Below is an Example

- On his way to work, John was in a car accident.
- He was transported by ground ambulance to the emergency room and admitted to the hospital.
- He had a dislocated hip and spent five days in the hospital.
- He had several physical therapy sessions before returning to work.
- John submitted his accident claim and received $5,850 from his accident insurance coverage.
- He used it towards his deductible, copay and supplemental income for his missed work days.

SAMPLE REIMBURSEMENTS

Ground Ambulance	$300
Emergency Room	$150
X-ray	$50
MRI	$150
Hospital Stay – Admission + 5 days	$2,000
Dislocated Hip	$3,000
Appliances	$100
Physical Therapy (4 sessions)	$100
Total Benefit Paid	$5,850

Please refer to the benefit summary for details of this coverage.

Critical Illness Insurance

Critical illnesses can have a huge impact on your life. A critical illness can keep you from working and can make it difficult to do simple, everyday things. Critical Illness insurance can help reduce your stress — financially and mentally — while you recover from your illness. These illnesses can include, but are not limited to, the following:

SAMPLE OF COVERED CONDITIONS	
Heart Attack	Parkinson's Disease
Multiple Sclerosis	Stroke
Alzheimer's Disease	Major Organ Failure

BENEFIT AMOUNT	
Employee and Spouse	$5,000 – $30,000 in $5,000 increments
Children	$1,000 – $15,000

Please refer to the benefit summary for details of this coverage.

How the Plan Works

Critical Illness insurance pays a fixed one-time benefit amount if you are diagnosed with a covered disease or illness after your coverage effective date. You can use this money for any purpose you like. It can help pay for expenses not covered by your health care plan (such as your deductible or copays), lost income, child care, travel to and from treatment, home health care costs or any of your regular household expenses.

Below is an Example

- Tom suffered a relatively small stroke.
- He was hospitalized for five days.
- He began rehab to get back to where he was physically before the stroke.
- Tom submitted his claim and received a lump-sum payment of $10,000.

DENTAL PLAN

Your dental health is an important part of your overall wellbeing. Dental insurance gives you a reason to smile — it's affordable and may cover preventive care (including regular checkups) as well as fillings, bridges, crowns and other dental services.

When you enroll in the Dental Plan, you may visit any dentist you choose, but in-network providers offer larger discounts and can file your claims for you. If you prefer to see an out-of-network provider, keep in mind, since they are not under a contract, they may charge you for any amount billed in excess of the negotiated discounted rate.

The amount you pay for your coverage is based on who you cover and which plan you choose.

	UHC DENTAL LOW PLAN	UHC DENTAL HIGH PLAN
	IN-NETWORK	IN-NETWORK
CALENDAR YEAR DEDUCTIBLE		
Individual	$50	$50
Family	$150	$150
CALENDAR YEAR OUT-OF-POCKET MAXIMUM		
Per Individual	$750 per individual (Basic and Major Services combined)	$1,500 per individual (Basic and Major Services combined)
	YOU PAY	**YOU PAY**
PREVENTIVE CARE		
Exams, Cleanings, X-rays, Fluoride Treatments	$0	$0
BASIC SERVICES		
Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency Exams	10%	10%
MAJOR PROCEDURES		
Crowns, Inlays/Outlays, Dentures and Bridgework, Repairs	Not covered	35%
ORTHODONTIA		
24-Month Treatment Fee — Additional fees will apply for pre-ortho visits and treatment, records and retention, and banding		
Adults	Not covered	50% up to a lifetime maximum benefit of $2,000 per individual; deductible waived
Children (up to 19th birthday)	Not covered	

VISION PLAN

You may elect vision care coverage, which provides affordable, quality vision care nationwide. Although vision care services and supplies are covered in- and out-of-network, your benefits are generally greater when you use **Spectera** network providers. Your costs are based on the family members you choose to cover.

	UHC VISION PLAN	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	YOU PAY	REIMBURSEMENT
COST		
Exam	$0	Up to $40
Materials	$0	N/A
COVERED SERVICES - LENSES		
Single Lenses	$0	Up to $40
Bifocals	$0	Up to $60
Trifocals	$0	Up to $80
Frames	$250 allowance	Up to $45
COVERED SERVICES - CONTACTS IN LIEU OF FRAMES/LENSES		
Contacts Medically Necessary	$0	Up to $210
Contacts - Elective	$250 allowance*	Up to $250*
BENEFIT FREQUENCY		
Exams	Once per plan year	Once per plan year
Lenses	Once per plan year	Once per plan year
Frames	Once per plan year	Once per plan year
Contacts	Once per plan year	Once per plan year

*Members choose glasses or contacts to receive $250 allowance.

See **www.myuhcvision.com** for discounts.

If you are a participant in a Health Savings Account (HSA), you are not eligible for the Health Care FSA reimbursement account.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using tax-free dollars. **There are two types of FSAs — the Health Care FSA and the Dependent Care FSA:**

Health Care FSA

Used to pay for services not covered by your medical, dental or vision plan such as copays, coinsurance, deductibles, prescription expenses, lab exams and tests, contact lenses and eyeglasses.

Dependent Care FSA

Used to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Health Care FSA to pay for Dependent Care expenses.

HEALTH CARE FSA	VS	DEPENDENT CARE FSA
Contribute up to $2,750 per year, pretax.		Contribute up to $5,000 per year, pretax, or $2,500 if married and filing separate tax returns.
Receive a debit card to pay for eligible medical expenses (funds must be available in your account).		You must submit claims and be reimbursed if you enroll in this FSA; no debit cards are provided.
Eligible expenses include medical copays, coinsurance, deductibles, eyeglasses, over-the-counter medications prescribed by your doctor.		Can only be used to pay for eligible dependent care expenses including day care, after-school programs and elder care programs.
If you do not spend all the money in this FSA by **December 31**, unused dollars will be forfeited per IRS regulations for pretax contributions.		If you do not spend all the money in this FSA by **December 31**, unused dollars will be forfeited per IRS regulations for pretax contributions.
Submit claims up to **March 31** of the following year for expenses from January 1 to December 31.		Submit claims up to **March 31** of the following year for expenses from January 1 to December 31.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

It's important to give some serious thought to what expenses and income needs your dependents would have if something happened to you. To make sure you have financial protection, the Company offers several different types of Life and AD&D insurance.

Basic Life insurance. This coverage is provided at no cost to you, and you are automatically enrolled even if you don't elect medical. If you purchase additional Life insurance for yourself, you may also purchase coverage for your spouse and dependent children.

AD&D is provided as part of your Basic Life coverage and provides you specified benefits for a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that death occurs from an accident, 100% of the AD&D benefit would be payable to your beneficiary(ies).

Basic Life and AD&D Coverage

COVERAGE LEVEL	COVERAGE AMOUNT
Employee	$20,000
Spouse	$5,000
Child	$2,000

Voluntary Life and AD&D Coverage

Voluntary Life insurance for you, your spouse and children can help protect your family during difficult times. Eligible employees may purchase Voluntary Life and AD&D for themselves and their family.

Voluntary Life Coverage Options

COVERAGE FOR	COVERAGE AVAILABLE
Employee	Increments of $10,000, minimum of $100,000, up to 6 times your basic annual earnings, coverage maximum of $300,000.
Spouse	Increments of $5,000 up to $300,000 – not to exceed 100% of employee coverage.
Child	Birth to 6 months, $1,000; 6 months to age 19, $10,000 (age 26 if full-time student).

Voluntary Life and AD&D Rates

VOLUNTARY LIFE RATES	BI-WEEKLY EMPLOYEE RATE PER $1,000	BI-WEEKLY SPOUSE RATE PER $1,000
AGE	MONTHLY RATES PER $1,000	
<35	$0.043	$0.028
35–39	$0.054	$0.039
40–44	$0.076	$0.061
45–49	$0.109	$0.094
50–54	$0.162	$0.147
55–59	$0.271	$0.256
60–64	$0.300	$0.285
65–69	$0.499	$0.484
70–74	$0.874	N/A
75–79	$3.273	N/A

Employee AD&D Bi-weekly Rate	$0.01
Child Bi-weekly Rate	$0.027

SAMPLE RATE CALCULATION

For example: A 36-year-old employee elects $100,000 of coverage

$$\frac{\$100{,}000}{\text{Elected Benefit Amount}} \div \$1{,}000 = 100 \times \frac{\$0.054}{\text{Rate Above}} = \frac{\$5.40}{\textbf{Your Bi-weekly Cost}}$$

Guaranteed Issue and Evidence of Insurability

Employees and spouses who elect coverage when first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

VOLUNTARY DISABILITY INSURANCE

If you have a serious injury or illness that keeps you from working, how would you pay your bills? Disability insurance replaces a portion of your income when you are unable to work due to a qualified illness or non-work-related injury.

Short-Term Disability (STD)

Pregnancy, a scheduled surgery or an unplanned illness or injury could keep you off the job and without income for an extended period of time. STD can protect part of your paycheck should you become disabled.

STD is 100% employee paid. Elections made during Open Enrollment will be effective January 1, 2021.

COVERAGE	BENEFIT
Short-Term Disability	• 60% of your weekly earnings to a $1,500 per week maximum for 12 weeks • Benefit begins after 7 days of disability per week

AGE RATED PREMIUMS	COST PER $10 (OF BI-WEEKLY COVERED EARNINGS)
Under 30	$0.280
30–34	$0.320
35–39	$0.300
40–44	$0.235
45–49	$0.220
50–54	$0.240
55–59	$0.265
60–64	$0.320
65–69	$0.355
70–74	$0.465
75+	$0.465

SAMPLE RATE CALCULATION

For example: A 36-year-old employee elects $30,000 of coverage

$$\frac{\$30{,}000}{\text{Annual Salary Amount}} \div 52 \text{ weeks} = \frac{\$576.92}{\text{Weekly Salary}} \times \frac{.60}{\text{60\% Benefit}} = \$346.15 \div \$10 \times \frac{\$0.30}{\text{Rate Above}} = \frac{\textbf{\$10.38}}{\textbf{Your Bi-weekly Cost}}$$

Long-Term Disability (LTD)

LTD makes sure you have a portion of your income replaced if you can't work for an extended period of time due to a non-work-related illness or injury. This coverage is coordinated with other benefits you may receive while disabled, such as Social Security and Worker's Compensation. LTD payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever comes first. Certain exclusions and pre-existing condition limitations may apply.

LTD is 100% employee paid. Elections made during Open Enrollment will be effective January 1, 2021.

COVERAGE	BENEFIT
Long-Term Disability	• 60% of your monthly earnings to a $6,000 maximum • Benefit begins after 90 days of disability and payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner

For the first 24 months of a disability, you are considered totally disabled if you are unable to perform the material duties of your regular occupation due to a covered injury or sickness. After 24 months, you are considered disabled if you are unable to perform the material duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

AGE RATED PREMIUMS	COST PER $100 (OF BI-WEEKLY COVERED EARNINGS)
Under 30	$0.055
30–34	$0.070
35–39	$0.097
40–44	$0.139
45–49	$0.218
50–54	$0.297
55–59	$0.324
60–64	$0.347
65–69	$0.398
70+	$0.519

SAMPLE RATE CALCULATION

For example: A 36-year-old employee elects $30,000 of coverage

$$\frac{\$30{,}000}{\text{Annual Salary Amount}} \div 12 \text{ months} = \frac{\$2{,}500}{\text{Monthly Salary}} \div \$100 \times \frac{\$0.97}{\text{Rate Above}} = \frac{\textbf{\$2.43}}{\textbf{Your Bi-weekly Cost}}$$

An Example: How STD and LTD Can Work Together

Let's say you have an accident on the ski slopes and you must be away from work due to your injuries. Here's how your disability benefits would work:

- All accrued Leave Time must be exhausted before STD will begin to pay.
- You may receive STD benefits equal to 60% of your pay, up to $1,500 per week, for 12 weeks.
- If you are out longer than 12 weeks and cannot perform your job, LTD benefits would begin and would replace 60% of your pay, up to a maximum of $6,000 per month. These benefits would continue until you no longer meet the definition of disabled as defined by the insurance company.

After 7 days of sickness or injury approved STD may begin to pay benefits

→

Next 12 weeks
Approved STD replaces 60% of your weekly pay

→

After 12 weeks
LTD begins if approved

PLANNING FOR RETIREMENT

What does retirement look like for you? Maybe you plan to travel the world. Or maybe you'd like to take up some hobbies closer to home. Whatever your goal, it's important to take responsibility for your own finances so you have the income you need in the future.

Retirement savings with the TCDRS Retirement Plan

- 7% is deposited into your account and earns 7% compound interest annually
- You receive a lifetime monthly benefit when you become eligible to retire
- Current employer match is 250%
- You can designate/update beneficiaries at **www.tcdrs.org** if no beneficiary is on file, the benefit is paid to a spouse (if married) or estate
- With four or more years of TCDRS service, your beneficiary is eligible for the Survivor Benefit

Vesting

Vesting occurs after 8 years of service. Once vested, you have a right to a lifetime monthly benefit that will include employer matching when you reach retirement eligibility. Even if you leave your job, you can choose to get a lifetime monthly benefit when you become eligible to retire as long as you haven't taken your money out of your account.

Retirement Eligibility

Your retirement eligibility is based on any of the following combinations:

- Age 60 + 8 years of service
- Your age + your years of service (must be vested) = 75
- Any Age + 30 years of service

Retirement savings with a 457(b) through Nationwide

One of the best ways to ensure a secure retirement is to start saving as early as possible. Williamson County has partnered with Nationwide to offer an optional 457(b) deferred compensation plan to employees.

You can begin contributing to the plan at any time once you become eligible and make contributions to your account through convenient payroll deductions.

- Increase, decrease or stop deferrals, according to your needs
- No coordination of contributions with other qualified plan types
- Contribute up to the maximum to your 457(b) and a 403(b) or 401(k) account
- Enroll at **http://retirementspecialists.myretirementappt.com/** or by calling 877-677-3678
- No-penalty withdrawals after separation from service, regardless of age

ADDITIONAL BENEFITS

Employee Assistance Program

Deer Oaks EAP is our Employee Assistance Program which provides services for all benefit eligible employees and dependents of Williamson County. Through the EAP, you and your family can receive immediate support and guidance, as well as assessments and referrals for further services. You can contact the EAP 24/7 and the EAP covers up to 6 confidential short-term counseling visits. EAP Services are available to you whether or not you elect other benefit coverages through Williamson County.

EAP Services

The EAP can assist with many different types of problems. Among these are stress, depression, anxiety, work/life balance, substance abuse, marital problems, family or parenting conflicts, grief, violence and unhealthy lifestyles. The EAP can also assist in identifying local resources and providing referral information for:

- Pet Care
- Child/Elder Care facilities
- Maintenance and repair providers
- Financial Issues
- Legal advice consultation
- Community volunteer opportunities

It is important to note that all EAP conversations are voluntary and strictly confidential. In addition, there is never a cost to you when you contact an EAP counselor; Williamson County pays the full cost. However, if you and your counselor determine that additional assistance is needed, you will be referred to the most appropriate and affordable resource available. Although you are responsible for the cost of referrals, these costs are often covered under your medical plan by utilizing an in-network provider.

Sick Leave Pool

To be eligible and to participate in the Sick Leave Pool for the next Benefit Plan Year. You must have one year of employment at the time of Open Enrollment and a minimum of eight hours (max of 40 hours) of sick leave available to donate. Participation is voluntary. The Sick Leave Pool provides eligible employees with sick leave once the employee has exhausted all accrued/banked paid leave while on approved FMLA. Hours will not be granted beyond the end of the FMLA period.

Pet Insurance

Let's not forget about our furry friends! Veterinary Pet Insurance (VPI) helps offset the cost of caring for your pet with more than 6,400 covered medical treatments. VPI covers everything from preventive care to accidents and illness, as well as the costs of x-rays, office visits, medications, surgeries and hospital stays. You can either choose your own vet or use a licensed vet in the VPI network. The cost of coverage depends on your pet's age, species, and the coverage level that you select. This voluntary benefit is not sponsored or endorsed by Williamson County. Enroll by calling 877-263-6008.

FOCUS ON WELLBEING

We are committed to helping you prevent illnesses and achieve wellbeing. Did you know that your medical plans pay 100% of the cost for preventive care? This means you and your dependents receive recommended preventive services like immunizations and screenings at no cost to you.

What Is Preventive Care?

Preventive care includes services that help you stay healthy, including:

- Vaccines that protect your health by preventing diseases and other problems
- Screenings to check for diseases early when they may be easier to treat
- Education and counseling to help you make health decisions

Take Action!

Participating in our Wellbeing Program not only benefits you physically, mentally and emotionally, it also benefits you financially.

Complete the required wellbeing actions to avoid wellbeing surcharges (increased premiums) in the 2022 Benefit Plan Year:

All current employees and spouses who are enrolled in a Williamson County Medical Plan must complete the following wellbeing actions between January 1, 2021 and December 31, 2021 to avoid the wellbeing surcharges (increased medical premiums) that will be applied in the 2022 Benefit Plan Year as noted below:

SURCHARGE (INCREASED MEDICAL PREMIUM)	WELLBEING ACTIONS
$100 Monthly Nicotine Usage Surcharge	• Complete during benefits enrollment through the portal.

$100 Monthly HRA/Wellbeing Exam/Biometric Screening Surcharge	• Complete the Health Questionnaire by logging into myuhc.com through the Rally Program. Both the employee and covered spouse will each complete:
	  • Wellbeing Exam
	  • Biometric Screening
	  • Physician Certification on Medical Form
	Note: New Hires or new Williamson County Medical Plan members must complete these actions within 90 days of their benefit effective date.

EMPLOYEE CONTRIBUTIONS

We Are in This Together

Wilco is self-funded for medical, vision, dental and pharmacy coverage. This means all actual costs of claims and administrative fees are shared between the county and you, the employee. UHC processes claims according to plan provisions.

Costs continue to rise each year due to market trends and increased plan usage and claims. Still, Wilco employee benefit premiums, deductibles and copays remain competitive and are among the lowest in the market. Let's keep it that way!

Although the County pays the majority of the costs, you, as the employee, play an important role. By maintaining a healthy lifestyle and choosing economical resources for your care, you are minimizing rising costs and premiums.

	EMPLOYEE BASE RATE* PER 24 PAY PERIODS	EMPLOYEE BASE RATE* PER MONTH	EMPLOYER MONTHLY CONTRIBUTION	TOTAL MONTHLY MEDICAL COST (EMPLOYEE + EMPLOYER CONTRIBUTION)
HSA MEDICAL PLAN – HIGH DEDUCTIBLE HEALTH PLAN				
Employee Only	$22.00	$44.00	$491.38	$535.38
Employee + Spouse	$88.00	$176.00	$1,277.81	$1,453.81
Employee + Children	$46.12	$92.23	$1,175.86	$1,268.09
Employee + Family	$102.29	$204.58	$1,981.32	$2,185.90
TRADITIONAL PLAN – NEXUS ACO MEDICAL PLAN				
Employee Only	$27.04	$54.08	$540.79	$594.87
Employee + Spouse	$108.16	$216.32	$1,399.03	$1,615.35
Employee + Children	$56.68	$113.36	$1,295.63	$1,408.99
Employee + Family	$113.36	$226.72	$2,202.05	$2,428.77
TRADITIONAL PLAN – CHOICE PLUS MEDICAL PLAN				
Employee Only	$105.56	$211.12	$525.68	$736.80
Employee + Spouse	$175.24	$350.48	$1,578.07	$1,928.55
Employee + Children	$134.68	$269.36	$1,419.47	$1,688.83
Employee + Family	$202.28	$404.56	$2,477.19	$2,881.75
Wellbeing Actions				
FAILURE TO COMPLETE:	**PER PAY PERIOD SURCHARGES****		**MONTHLY SURCHARGES****	
Nicotine User	$50 (Increase)		$100 (Increase)	
Health Risk Assessment, Annual Wellbeing Exam, Biometric Screening	$50 (Increase)		$100 (Increase)	
Dental Rates	**Employee Per 24 Benefit Pay Period**		**Employee Base Rate* Per Month**	
Dental Low Plan				
Employee Only	$17.00		$34.00	
Employee + Spouse	$31.50		$63.00	
Employee + Children	$35.00		$70.00	
Employee + Family	$38.50		$77.00	
Dental High Plan				
Employee Only	$23.50		$47.00	
Employee + Spouse	$43.50		$87.00	
Employee + Children	$47.50		$95.00	
Employee + Family	$53.00		$106.00	
Vision Rates	**Employee Per 24 Benefit Pay Period**		**Employee Base Rate* Per Month**	
Employee Only	$6.35		$12.69	
Employee + Spouse	$12.04		$24.07	
Employee + Children	$14.12		$28.23	
Employee + Family	$19.86		$39.71	

*Base Rates are full discounted rate
**Surcharges will apply for failure to complete wellbeing actions

IMPORTANT NOTICES

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)	
Williamson County	**74-6000978**	
5. Employer address	6. Employer phone number	
100 Wilco Way Suite HR 101	**512-943-1533**	
7. City	8. State	9. ZIP code
Georgetown	**Texas**	**78626**
10. Who can we contact about employee health coverage at this job?		
Shelley M. Loughrey, PHR, Director of Benefits Administration		
11. Phone number (if different from above)	12. E-mail address	
	sloughrey@wilco.org	

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

As your employer, we offer a health plan to all Full-time employees.

Eligible employees are:

Employees that are full time and work regularly scheduled 30+ hours per week

With respect to dependents, we do offer coverage.

Eligible dependents are:

- **Spouses**
- **Children up the age of 26**
- **Grandchildren (which legal guardianship and/or financial support is provided)**

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

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

Important Notices

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

Notice of HIPPAA Privacy Practice

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

WILLIAMSON COUNTY'S PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by the The Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 9/23/2014.

The Plan often needs access to your protected health information to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Williamson County requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

PROTECTED HEALTH INFORMATION

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Williamson County for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases, are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. If we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Human Resources Department
Williamson County
100 Wilco Way HR101
Georgetown, TX 78626
512-943-1533

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Medicare Part D Notice

Important Notice from Williamson 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 Williamson 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. **Williamson County has determined that the prescription drug coverage offered by Williamson County 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 Williamson County coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Williamson County coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Williamson 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 through Williamson County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare Prescription drug coverage:

- Visit **www.medicare.gov.**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of "Medicare & You"
- handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty

Date: 9/1/2020
Name of Entity/Sender: Williamson County
Contact/Office: HR Benefits Team
Address: 100 Wilco Way HR101
Georgetown, TX 78626

Phone Number: 512-943-1604

General Notice of COBRA Continuation

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What Is COBRA Continuation Coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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

When Is COBRA Coverage Available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: HR Benefits Team

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact the HR Benefits Team or your medical plan administrator 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 Williamson County your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled.

This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov or** call **1-866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2018. Contact your State for further information on eligibility.

To see if any more states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, ext. 6156

Important Notices

State	Website/E-mail	Phone
Alabama (Medicaid)	http://www.myalhipp.com	1-855-692-5447
Alaska (Medicaid)	Premium Payment Program: http://myakhipp.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx E-mail: CustomerService@MyAKHIPP.com	1-866-251-4861
Arkansas (Medicaid)	http://myarhipp.com/	1-855-692-7447
Colorado (Medicaid and CHP+)	Medicaid: https://www.healthfirstcolorado.com/ CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus	Medicaid: 1-800-221-3943 CHP+: 1-800-359-1991 State Relay 711
Florida (Medicaid)	http://www.flmedicaidtplrecovery.com/hipp/	1-877-357-3268
Georgia (Medicaid)	http://dch.georgia.gov/medicaid (click on Health Insurance Premium Payment (HIPP))	404-656-4507
Indiana (Medicaid)	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/hip/ All other Medicaid: http://www.indianamedicaid.com	1-877-438-4479 1-800-403-0864
Iowa (Medicaid)	http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-888-346-9562
Kansas (Medicaid)	http://www.kdheks.gov/hcf/	1-785-296-3512
Kentucky (Medicaid)	http://chfs.ky.gov/dms/default.htm	1-800-635-2570
Louisiana (Medicaid)	http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	1-888-695-2447
Maine (Medicaid)	http://www.maine.gov/dhhs/ofi/public-assistance/index.html	1-800-442-6003 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	http://www.mass.gov/eohhs/gov/departments/masshealth/	1-800-862-4840
Minnesota (Medicaid)	http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	1-800-657-3739
Missouri (Medicaid)	https://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska (Medicaid)	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada (Medicaid)	https://dhcfp.nv.gov/	1-800-992-0900
New Hampshire (Medicaid)	https://www.dhhs.nh.gov/ombp/nhhpp/	603-271-5218 Hotline: 1-888-901-4999
New Jersey (Medicaid and CHIP)	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 609-631-2392 CHIP: 1-800-701-0710
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://dma.ncdhhs.gov/	919-855-4100

State	Website/E-mail	Phone
North Dakota (Medicaid)	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania (Medicaid)	http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm	1-800-692-7462
Rhode Island (Medicaid)	http://www.eohhs.ri.gov/	1-855-697-4347
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	http://gethipptexas.com/	1-800-440-0493
Utah (Medicaid and CHIP)	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1-877-543-7669
Vermont (Medicaid)	http://www.greenmountaincare.org/	1-800-250-8427
Virginia (Medicaid and CHIP)	Medicaid: http://www.coverva.org/programs_premium_assistance.cfm CHIP: http://www.coverva.org/programs_premium_assistance.cfm	Medicaid: 1-800-432-5924 CHIP: 1-855-242-8282
Washington (Medicaid)	http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program	1-800-562-3022, Ext. 15473
West Virginia (Medicaid)	http://mywvhipp.com/	1-855-699-8447
Wisconsin (Medicaid and CHIP)	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	1-800-362-3002
Wyoming (Medicaid)	https://wyequalitycare.acs-inc.com/	307-777-7531

IMPORTANT CONTACTS

COVERAGE	CONTACT	PHONE	WEBSITE
Medical	UnitedHealthcare Group #911463 Network: UHC Nexus ACO OA and Choice Plus/HSA	UHC Nexus ACO OA: 888-331-3408 Choice Plus/HSA: 844-234-1211	www.myuhc.com
Dental	UnitedHealthcare Group #911463 Network: UHC National PPO 30	Nexus ACO OA: 888-331-3408 Choice Plus: 844-234-1211	www.myuhc.com
Vision	UnitedHealthcare Group #911463	800-638-3120	www.myuhcvision.com
Flexible Spending Accounts	UnitedHealthcare	866-755-2648	www.welcometouhc.com/fsa
Life and AD&D	Symetra Group #01-016850-000	800-796-3872	www.symetra.com
Disability	Symetra Group #01-016850-000	800-796-3872	www.symetra.com
457(b) Retirement	Nationwide	Sarita Null: 512-497-1666	http://retirementspecialists.myretirementappt.com/
Pet Insurance	Nationwide	877-738-7874	www.PetsNationwide.com

WILLIAMSON COUNTY
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This brochure highlights the main features of the Williamson County Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Williamson County reserves the right to change or discontinue its employee benefits plans at any time.