ROUND ROCK TEXAS

2024

Retiree Benefits Guide

Live Happy | Live Well

Important Contacts

Coverage	Contact	Phone	Website / Email
Medical	UnitedHealthcare	Choice / EPO: 888-787-4112	**www.myuhc.com**
Employee Medical Clinic	RockCare	800-993-8244	RockCare webpage on Employee Net
Pharmacy	UnitedHealthcare	888-290-5416	**www.myuhc.com**
Dental	United Concordia	800-332-0366	**www.unitedconcordia.com**
Vision	Community Eye Care	888-254-4290	**www.cecvision.com**
Retirement	Texas Municipal Retirement System (TMRS)	512-476-7577	**www.TMRS.com**
Employee Assistance Program	Deer Oaks EAP Services	866-327-2400	**www.deeroaks.com** **eap@deeroaks.com**
Teladoc	Teladoc	855-835-2362	**www.teladoc.com**
Human Resources	Tyler Jarl, Benefits Manager	512-341-3143	**tjarl@roundrocktexas.gov**
	Sharon Callis, Benefits/Wellness Specialist	512-671-2701	**scallis@roundrocktexas.gov**

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 pages 22-23 for more details.

Table of Contents

Welcome

Each year, you have the opportunity to choose from a variety of retiree benefits that can make a real difference in your life. You can elect a benefit that's exactly right for your personal situation.

This guide provides a summary of the retiree benefits available to you. Please review it carefully and make your elections before the deadline. All elections you make during Open Enrollment will be effective on January 1, 2024. No changes will be allowed at any other time unless you have a Qualified Life Event (such as a birth, death, divorce, marriage, etc.).

If you have any questions about your benefits choices or about how to enroll, please contact Human Resources so you can be sure to have the benefits you need.

Benefits Staff:

Tyler Jarl, PHR, SHRM-CP
Benefits Manager/FMLA Coordinator
Phone: 512-341-3143
Email: **tjarl@roundrocktexas.gov**

Eligibility

You may enroll your eligible dependents for coverage. This includes the following:

Eligibility in the City of Round Rock Retiree Benefits Coverage will terminate upon your and/or your dependent's eligibility for health coverage with another employer, and/or your and/or your dependent's eligibility for Medicare. It is the responsibility of retirees to inform the City of Round Rock in the event they become eligible for health coverage with another employer. Failure to do so will cause retiree benefits with the City of Round Rock to terminate.

Open Enrollment:

Each year, Open Enrollment provides you an opportunity to modify your benefits. All eligible retirees must enroll online in ESS. Retirees may complete their online enrollment using the computers in the benefits conference room of the City's Human Resources Department (appointment required). Elections made during Open Enrollment become effective January 1 of the following year.

Qualified Life Events

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

If you have a qualified life event change or if you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 30 days of the event by providing documentation to Human Resources. If you do not enroll online within 30 days, you will have to wait until the next Open Enrollment to make new elections.

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

Life Event Enrollment Process

1. Submit a Life Event request in ESS.
2. Provide required documentation to Human Resources.
3. Complete your benefits enrollment in ESS.

If you do not submit a Life Event request, provide your required documentation to Human Resources and complete your enrollment in ESS within 30 days of the Qualifying Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualifying Life Event).

Benefit Costs

The City of Round Rock pays the full cost of many of your benefits. For others, the City of Round Rock and you share the cost.

Benefit	Who Pays
Medical, Prescription	City of Round Rock/You
RockCare	City of Round Rock
Dental	City of Round Rock/You
Vision	City of Round Rock/You
Employee Assistance Program	City of Round Rock

Medical Plans

The City's medical plans all provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs and hospitalization.

Retiree Health Plans Surcharges

- If you were employed by the City of Round Rock for less than 10 years prior to your retirement, there is an additional $100.00 per month retiree responsibility to your medical rate.
- If you were employed by the City of Round Rock for more than 10 and less than 20 years prior to your retirement, there is an additional $50.00 per month retiree responsibility to your medical rate.
- If you were employed by the City of Round Rock for more than 20 years prior to your retirement, there is no additional retiree responsibility to your medical rate.

EPO

UHC — EPO Plan offers in-network benefits only. When you need care, you decide whether to go to RockCare or a UHC in-network doctor. With in-network providers, you generally do not have to file claims. If you receive care from out-of-network providers and/or out-of-network facilities, you will be responsible for all costs billed.

Here's how it works:	
Health Plan Pays 100% for eligible expenses after both the deductible and out-of-pocket limit have been met.	
Member Pays: 10% Co-insurance In Network Out-of-Pocket Limit $2,500 Individual (Includes $500 deductible) $5,000 Family (Includes $1,500 deductible)	**Plan Pays:** 90% Co-insurance
Member responsible for 100% Deductible up to $500 Individual / $1,500 Family	

Our medical plans with UnitedHealthcare provide 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

Choose the Plan That's Right for You

The key difference between the plans is the amount of money you'll pay each year when you need care.

The plans differ in the following ways:

- **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. Network providers charge you reduced fees but providers outside the plan's network set their own rates, which means you may have to pay the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.

Medical Plans Comparison

This is a summary. Please reference plan documents for full information.

Cost Sharing Provisions	UnitedHealthcare Choice Plus Plan			UnitedHealthcare EPO Plan
	In-Network		Out-of-Network	In-Network
Calendar Year Deductible				
Individual	$1,000		$2,000	$500
Family	$3,000		$6,750	$1,500
Calendar Year Out-of-Pocket Maximum (Includes Deductible)				
Individual	$5,000		$12,000	$2,500
Family	$14,500		$36,000	$5,000
	You Pay			
Coinsurance				
Preventive Care	$0 copay		50%*	$0 copay
Primary Care Physician	$25 copay		50%*	$25 copay
- Children Under Age 19	$0 copay		50%*	$0 copay
Specialist	$45 copay		50%*	$35 copay
UHPD	$25 copay $45 copay	Regular $45 copay	50%*	N/A
Urgent Care	$35 copay		50%*	$35 copay
Allergy Injections	20%*		50%*	10%*
Diabetes Education and Counseling	$45 copay		50%*	$35 copay
Inpatient	20%*		50%*	10%*
Outpatient	20%*		50%*	10%*
Hospital & Physician Services – Emergency	$300 copay + 20%*		$300 copay + 20%*	$300 copay + 10%*
Non Emergency ER Visits	Not covered		Not covered	Not covered
Ambulance Services (Ground & Air)	20%*		50%*	10%*
Outpatient Diagnostic Service (CT scans, PET scans, MRI, nuclear medicine)	20%*		50%*	10%*
Outpatient Therapeutic Treatments (dialysis, intravenous chemotherapy or infusion therapy)	20%*		50%*	10%*
Spinal Treatment / Chiropractic Care	100% at Airrosti $45 copay all others		50%*	100% at Airrosti $35 copay all others
Durable Medical Equipment, Prosthetic Devices, Orthopedic Appliances	20%*		50%*	10%*
Orthotic Devices	20%*		50%*	10%*

* You pay after deductible

	UnitedHealthcare Choice Plus Plan		UnitedHealthcare EPO Plan
	In-Network	Out-of-Network	In-Network
	You Pay		
Cost Sharing Provisions			
Home Health Care	20%* (120 visits per year)	50%*	10%* (120 visits per year)
Hospice Care	20%*	50%*	10%*
Occupational and Speech Therapy	$45 copay (combined 60 visits per year)	50%*	$35 copay (combined 60 visits per year)
Skilled Nursing Facility – Inpatient Rehab Facility (90 days per year maximum)	20%*	50%*	10%*
Organ or Tissue Transplant Services (must be pre-certified)	20%* (must be performed at a Center of Excellence)	Not covered	10%* (prior authorization is required)
Travel and Lodging Benefit	0%* [1]	Not covered	$0* [1]
Outpatient Mental Illness	$45 copay	50%*	$35 copay
Outpatient Substance Abuse	$45 copay	50%*	$35 copay
Outpatient Chemical Dependency	$45 copay	50%*	$35 copay
Inpatient Mental Illness	20%*	50%*	10%*
Inpatient Substance Abuse	20%*	50%*	10%*
Inpatient Chemical Dependency	20%*	50%*	10%*
Hearing Aids	20%* up to $4,000 per calendar year	50%*	10%* up to $4,000 per calendar year
Newborn Inpatient Care	20%*	50%*	10%*
Wig (when prescribed by MD or DO as a result of hair loss)	20%* not to exceed $1,000 per calendar year	20%* not to exceed $1,000 per calendar year	10%*, not to exceed $1,000 per calendar year [2]

* You pay after deductible.

[1] $10,000 maximum benefit; lifetime for travel and lodging payable at 100% at rate of $50 per day for patient or up to $100 per day for patient and one companion.

[2] If medical criteria is met.

	United Healthcare Choice Plus Plan Rates		
	Monthly rate	City Monthly Rate	Retiree Monthly Rate
Retiree Only	$1,499.00	$1,100.00	$399.00
Retiree + Child(ren)	$1,818.00	$1,100.00	$718.00
Retiree + Spouse	$1,898.00	$1,100.00	$798.00
Retiree + Family	$2,296.00	$1,100.00	$1,196.00

	United Healthcare EPO		
	Monthly rate	City Monthly Rate	Retiree Monthly Rate
Retiree Only	$1,477.00	$1,100.00	$377.00
Retiree + Child(ren)	$1,774.00	$1,100.00	$674.00
Retiree + Spouse	$1,854.00	$1,100.00	$754.00
Retiree + Family	$2,247.00	$1,100.00	$1,147.00

Prescription Benefits

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy.

Prescriptions you fill at non-participating pharmacies are generally not covered.

Prescription (Rx) Drug Coverage	
	(Rx) You Pay
Pharmacy	
Retail Rx (up to 30-day supply)	
Tier 1	$0
Tier 2	$30
Tier 3	$50
Retail Rx (up to 90-day supply)	
Tier 1	$0
Tier 2	$90
Tier 3	$150
UHC/Optum Mail Order Rx (up to 90-day supply)	
Tier 1	$0
Tier 2	$90
Tier 3	$150

OptumRx Frequently Asked Questions

Is OptumRx home delivery pharmacy in my plan's network?

Yes, it's part of your plan's pharmacy network.

Once I've enrolled in home delivery, how long will it take to get my medication(s)?

Medications should arrive 2-5 days after the pharmacy receives completed new and refill orders.

Am I able to track my home delivery orders?

Yes. You can track your home delivery orders from your online account or with the app.

What is a long-term medication?

Long-term medications are those you take on a regular basis. They may also be called "maintenance medications." These may be taken for high blood pressure, cholesterol and depression.

Can I use home delivery for any medication?

No. Not all prescriptions may be filled through home delivery. For example, OptumRx home delivery cannot fill prescriptions for certain pain medications like opioids.

You can find out which of your prescriptions can be filled through home delivery by going online or using the app. Or, you can call customer service using the number on your member ID card.

What is ePrescribe?

It's a way for your provider to send electronic prescriptions to OptumRx. It is much faster than paper and faxing prescriptions. Be sure to ask your doctor to ePrescribe when possible. Prescriptions for controlled substances, such as opioids, can only be ordered by ePrescribe. Some exceptions apply.

Can I set up medication reminders?

Yes. Use your online account to set up email, phone or text alerts for when it's time to refill or take your medication.

How does the automatic refill program work?

Go online or use the app to enroll eligible medications. Then, OptumRx home delivery will send your refills when it's time. They will notify you before they ship and they'll use your approved payment method on file. It's that easy.

OptumRx Mail Order Benefit Contact Information:
800-356-3477
www.OptumRx.com

Activate Your myuhc.com Account

Put your health plan at your fingertips and get the most out of your benefits

Your personalized website, **myuhc.com**, features tools designed to help you:

- **Find, price and save on care.** You can save with Virtual Visits* and other tools. You can save an average of 36%* when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status
- **Access claim details**, plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills**, get estimates and compare medication pricing**
- **Check your plan balances**, access financial accounts and more

Activation is Quick

1. Go to **myuhc.com** > **Register Now**
2. Fill out the required fields and create your username/password
3. Enter your contact information and security questions
4. Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates

*Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

**Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

Medical Extras

Airrosti

Airrosti is a health care group that treats the root cause of soft tissue injuries (including strains, sprains, muscle pulls and chronic knee, hip, back or neck pain.) The time Airrosti providers spend with each patient — a full hour of one-on-one care — leads to a more accurate diagnosis and better outcome.

Plus, the highly individualized evaluation and treatment often eliminates unnecessary imaging, injections, pharmaceuticals and other costly procedures.

Here's How it Works:

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

Retirees and their dependents enrolled with the City's medical plans may receive treatment at Airrosti for a $0 copay (not to exceed 20 visits per member per year).

Contact: **www.airrosti.com** or 800-404-6050

RockCare – Provided by CareATC

All retirees and their dependents — age 2 and above — enrolled with the City's medical plans may receive primary care at RockCare at no cost.

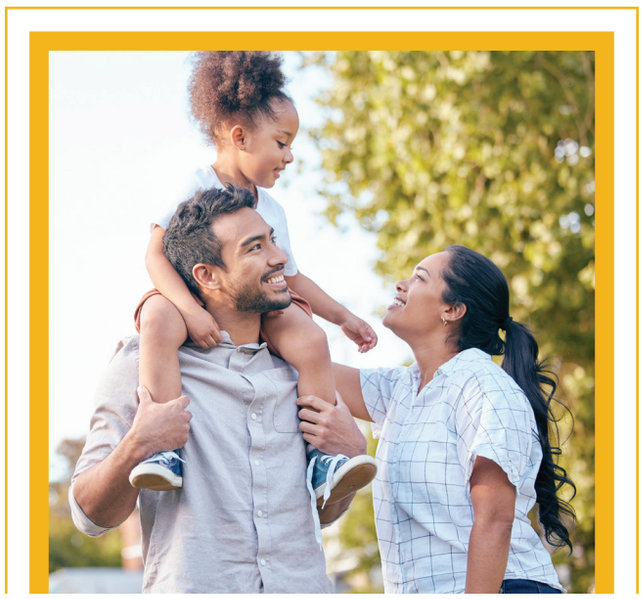
RockCare Services

- Abdominal pain/ cramps
- Allergies
- Animal/insect bites
- Asthma
- Backache
- Blood pressure issues
- Bronchitis
- Cold and flu symptoms
- Dizziness
- Eye infection/ irritation
- Headaches/ migraines
- Laryngitis
- Poison ivy/oak
- Respiratory infection
- Sinusitis
- Sore throat
- Sprains/strains
- Strep

RockCare Hours

- Monday – Thursday: 7:00 a.m. – 4:00 p.m.
- Friday: 7:00 a.m. – 3:00 p.m.
- Saturday and Sunday: Closed

Note: RockCare is closed from 12:00 p.m. – 1:00 p.m. Monday – Thursday



Walk-ins: Acute/Sickness Only

- Monday – Friday: 7:00 a.m. – 7:45 a.m.
- Monday – Friday: 1:00 p.m. – 1:45 p.m.

Location

901 Round Rock Ave., Suite 300, Round Rock, TX 78681. To make an appointment, call the scheduling line at 800-993-8244, or schedule an appointment through the CareATC mobile app or through your CareATC online patient portal.

How to Access the CareATC Mobile App

Securely activate your account by downloading the CareATC app or visiting **www.careatc.com/activate**.

4 Easy Steps:

1. **Tell Us About Yourself** – Provide personal details. It is important you double check that this matches your employer records.
2. **Verify Your Identity** – Complete a short verification quiz.
3. **Create Your Account** – Set up your username and password.
4. **Set Up Your Recovery Options** – Provide a phone number and/or email address to recover login information.

Know Where to Go

Save Time and Money by Knowing Your Options When Rockcare is Closed.

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

Where to Go and What To Go For	
Convenience Care Clinic	Sprains, strains, bites, rashes, burns, cuts, healthy lifestyle screening, strep throat, pink eye, flu shot
Primary Care Doctor's Office	Wellness exam, sprains, strains, bites, rashes, burns, cuts, healthy lifestyle screening, strep throat, pink eye, flu shot
Urgent Care Center	Broken bones, sprains, strains, bites, rashes, burns, cuts
Emergency Room	Concussions, seizures, chest pain, broken bones

Tip: Make sure any Urgent Care Center you visit is in-network. This helps you save the most money.

Austin Regional Clinic Round Rock

940 Hesters Crossing, Round Rock, TX 78681 Phone: 512-244-9024 Fax: 512-218-3704

Clinic Hours

Monday – Friday: 7:15 p.m. – 5:00 p.m.

After-Hours Clinic: Monday – Friday: 5:00 p.m. – 9:00 p.m.

Saturday and Sunday: 8:00 a.m. – 5:00 p.m., or according to demand

Seton Express Care

Primary Care copayment. Staffed with doctors and advanced practitioners, and in-network with both health plans. Open 7 days a week and walk-ins welcome.

Clinic Hours

Monday - Friday: 7 a.m. – 7 p.m.
Saturday - Sunday: 10 a.m. – 4 p.m.

Common Conditions Treated

- Fevers, colds and flu
- Sore throats
- Sprains and strains
- Minor cuts
- Minor breaks
- UTIs
- Rashes

Seton Services

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

Round Rock Location

Seton Family of Doctors at Round Rock 201 University Oaks Blvd., Suite 1260 Round Rock, TX 78665

512-324-4780 | **seton.net/expresscare** – for more information and locations

Convenience Care Clinics — $0 Copay

A Convenience Care Clinic is a walk-in facility, or part of a facility or retail store, that provides care for minor conditions that need attention right away but are not emergency medical conditions, such as a cold, strep throat, or a minor allergic reaction. These facilities may also provide basic preventive care services such as health screenings or vaccinations.

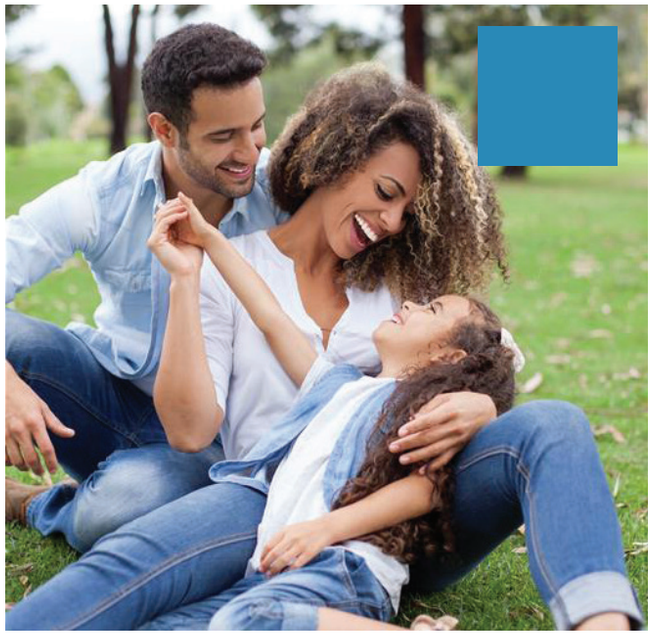
Examples of contracted Convenience Care Clinics are:

- MinuteClinic
- Walmart

United Healthcare Gym Pass

With One Pass Select, we're on a mission to make fitness engaging for everyone. Find a routine that's right for you whether you work out at home or at the gym. Choose a membership tier that fits your lifestyle and provides everything you need for whole body health in one easy, affordable plan. You and your eligible family members (18+) can get started with One Pass Select on January 1, 2024.

- $29/ month, Classic Plan
- $64/ month, Standard Plan
- $99/ month, Premium Plan
- $144/ month, Elite Plan



Teladoc Telemedicine

On-Demand Care with Teladoc is a great option when RockCare is closed and as an alternative to urgent care and emergency room visits. It provides you and your enrolled dependents (no age limitations) access 24/7/365 to U.S. board-certified doctors to receive the treatment you need in an easy and timely manner. In addition, you have the ability to send your visit results to RockCare or your primary care physician.

Convenient

Speak with a provider with or without an appointment. Save time by connecting to care via computer, tablet or mobile device. Available in all 50 states. Just call 800-835-2362.

Affordable

On average, the cost of an urgent care visit may be two times more expensive, and an ER visit may be eight times more, depending on insurance.* Teladoc is in-network with medical plans and has a $25 copay.

High-Quality Care

Non-emergency medical health conditions evaluated by video by an experienced provider. Prescriptions can be sent directly to your pharmacy.

General Medical Consult

What can I use it for?*

Virtual providers are available without an appointment. Members can receive treatment within minutes for non-emergency, acute general medical needs including but not limited to the following. Visit **Teladoc.com** for a complete list.**

Here is a small sample of things Teladoc doctors have treated:		
Flu	Nasal Congestion	Backache
Cough	Sore Throat	Rash/Poison Ivy
Sinus Problems	Sinusitis	Bug Bites
Pink Eye	Seasonal Allergies	Food Poisoning
Bronchitis	Cold	Sunburn
Upper Respiratory Infection	Arthritis	Headaches/migraines

*Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan.

Visit with a doctor 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a doctor by phone or video[1] through **myuhc.com**® or the UnitedHealthcare® app.

A convenient and faster way to get care

Doctors can treat a wide range of health conditions—including many of the same conditions as an emergency room(ER)or urgent care—and may even prescribe medications,[2]if needed.**With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is $25.**

Consider 24/7 Virtual Visits for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$25 copay

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit

Get started

Sign in at **myuhc.com/virtualvisits** | Call **1-855-615-8335**
Download the UnitedHealthcare app

United Healthcare

When accessing virtual visits either through myuhc.com or the UHC app, you will be brought directly to the 24/7 Optum Virtual Care page. If you would like to access Teladoc, Doctor on Demand or AmWell - please scroll down on that page to the FAQ section at the bottom. From there, open the question 'Are other virtual visit provider groups supported?'. You will then see the links to the three other virtual visit provider options.

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

United Concordia Dental Plan

Taking care of your oral health is not a luxury, it is a necessity to long-term optimal health. When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill.

	DPPO PLAN
	In-Network
Calendar Year Deductible	
Individual	$50
Family	$150
Calendar Year Out-of-Pocket Maximum	
Per Individual	$1,500
	You Pay
Preventive Care	
Exams, Cleanings, X-rays, Fluoride Treatments	$0
Basic Services	
Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency Exams	20%*
Major Procedures	
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	50%*
Orthodontia	
24-Month Treatment Fee — Additional fees will apply for pre-ortho visits and treatment, records and retention, and banding	
Adults	50% after $50 deductible, up to a lifetime maximum benefit of $1,500 per individual
Children	

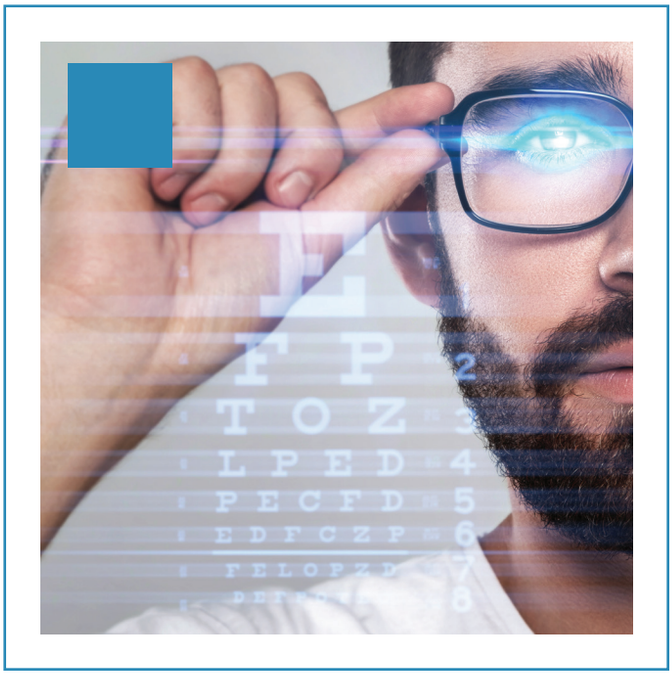
Dental Plan Rates	
Tier	Retiree Monthly Rate
Retiree Only	$37.00
Retiree + Children	$58.00
Retiree + Spouse	$62.00
Retiree + Family	$92.00

Community Eye Care Vision Plan

You may elect vision care coverage, which provides affordable, quality vision care nationwide. Vision care services and supplies are covered in-network and out-of-network, but your benefits are greater when you use in-network providers.

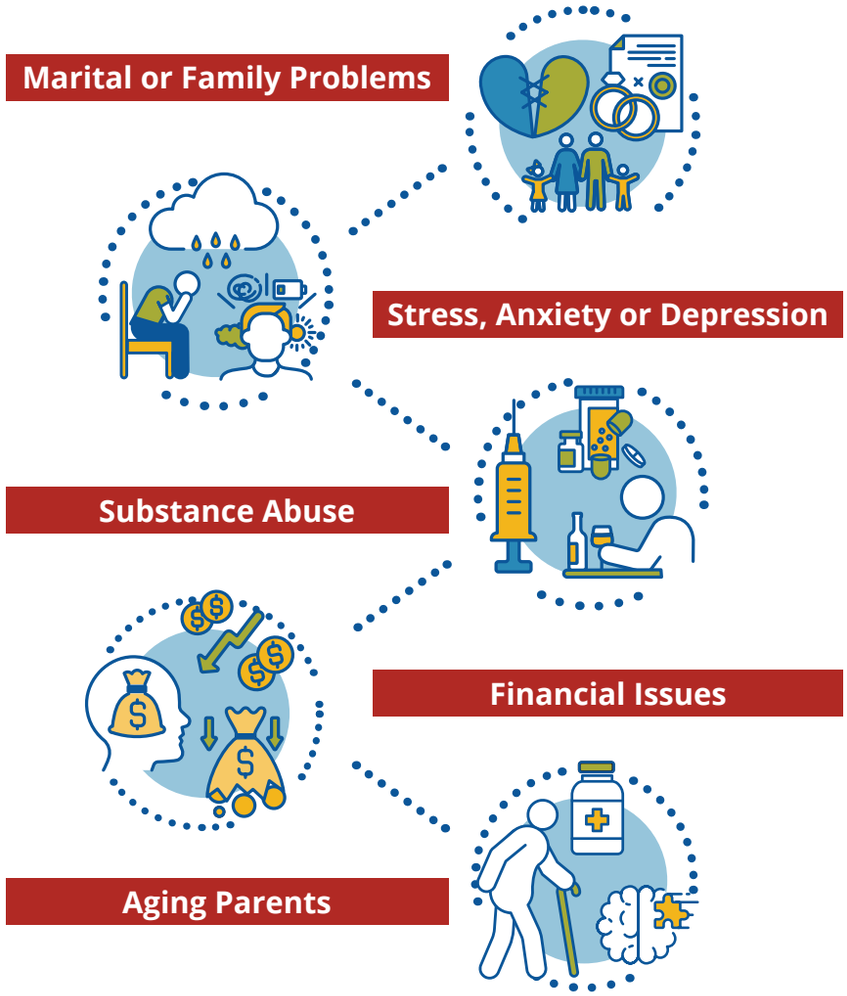
Benefits Summary			
	In-Network Provider	Visionworks	Out-of-Network Provider
	You Pay	**You Pay**	**You Pay (Reimbursement Only)**
Cost			
Routine Eye Exam Benefit	$10 copay	$0 copay	Up to $50
Eyewear Allowance ($225 allowance for eyewear)	$10 copay	$0 copay	Up to $191.25 (85% of the eyewear allowance)
Contact Lens Fitting, Re-fit or Evaluation	$10 copay	$0 copay	Up to $48
Benefit Frequency			
Comprehensive Exam	Once every calendar year for each		
Lenses (including contact lenses)			
Frames			
Second Pair Discount			

Community Eye Care Vision Plan Rates	
Tier	Retiree Monthly Rate
Retiree	$5.86
Retiree + Spouse	$9.96
Retiree + Child	$10.54
Family	$15.62



Employee Assistance Program

Everyone may need a little help from time to time. That's why we offer you and your eligible family members access to licensed counselors through our Employee Assistance Program (EAP).



Through the EAP, you and your family can receive immediate support and guidance, as well as assessments and referrals for further services.
Note - the EAP is not available for children under age 7.

It's important to note that all EAP conversations are voluntary and strictly confidential. In addition, there's never a cost to you when you contact an EAP counselor; the City pays the full cost. You have a benefit of 6 covered sessions per issue per year. However, if you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your medical plan.

iConnectYou: Your EAP on the Go

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

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

iConnectYou Passcode: 52291
Toll Free: 866-327-2400
Website: www.deeroakseap.com
Website Username/Password: roundrocktexas

Important Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Tyler Jarl at **tjarl@roundrocktexas.gov**.

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

PART B: Information About Health Coverage Offered by Your Employer

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

Employer Name	City of Round Rock
Employer Identification Number (EIN)	74-6017485
Employer address	231 E Main Street, Ste 100 Round Rock, TX 78664
Employer phone number	512-218-5490
Who can we contact about employee health coverage at this job?	Tyler Jarl
Phone number (if different from above)	512-341-3143
Email address	**tjarl@roundrocktexas.gov**

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

- As your employer, we offer a health plan to: All employees. Eligible employees are full time employees working at least 30 hours per week.
- With respect to dependents: We do offer coverage. Eligible dependents are: Your legal spouse, a child under the limiting age shown in your schedule of coverage, a child of your child who is your dependent for federal income tax purposes at the time application for coverage of the child is made, and any other child included as an eligible dependent under the plan.

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

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

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

City of Round Rock Notice of Privacy Practices

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

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the City of Round Rock (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 January 1, 2024.

The Plan often needs access to your protected health information in order 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. City of Round Rock 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 in order 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 in order 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 in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order 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, in order 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, in order 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 City of Round Rock 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. In the event that 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:

City of Round Rock

Tyler Jarl

231 E Main Street, Ste. 100

Round Rock, TX 78664

512-341-3143 – **tjarl@roundrocktexas.gov**

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

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Round Rock and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

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

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

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

For more information about Medicare Prescription drug coverage:

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

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

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

October 1, 2023
City of Round Rock
Tyler Jarl
231 E Main Street, Ste. 100
Round Rock, TX 78664
512-341-3143 — **tjarl@roundrocktexas.gov**

COBRA Rights Notice

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

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

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

What Is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

When Is COBRA Coverage Available?

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

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

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

How Is COBRA Continuation Coverage Provided?

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

behalf of their children.

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

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

Disability Extension of 18-Month Period of Continuation Coverage

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

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

October 1, 2023
City of Round Rock
Tyler Jarl
231 E Main Street, Ste. 100
Round Rock, TX 78664
512-341-3143 – **tjarl@roundrocktexas.gov**

Other Notices

Expanded Coverage for Women's Preventive Care

Under the Affordable Care Act, City of Round Rock provides female plan participants with expanded access to recommended in-network preventive services, including contraceptives, without cost sharing.

Additional women's preventive services that will be covered without cost sharing requirements include:

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

For a description of what these items include, visit **https://www.healthcare.gov/preventive-care-women/**.

60-Day Special Enrollment Period

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

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

Notice of Special Enrollment Rights

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

Newborn & Mothers Health Protection Notice

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

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

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 Human Resources or your medical plan administrator.

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 OKCIC, 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 on the following page, 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, dial **1-877-KIDS NOW**, or visit **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 a state listed below, you may be eligible for assistance paying your employer health plan premiums. The list of states is current as of July 31, 2023. Contact your State for further information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

60-Day Special Enrollment Period	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
California (Medicaid)	**http://dhcs.ca.gov/hipp** **hipp@dhcs.ca.gov**	916-445-8322
Colorado (Medicaid and CHIP)	Medicaid: **https://www.healthfirstcolorado.com/** CHIP: **https://www.colorado.gov/pacific/hcpf/child-health-plan-plus** HIBI: **https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program**	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711
Florida (Medicaid)	**https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**	1-877-357-3268
Georgia (Medicaid)	**https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**	678-564-1162 ext. 2131
Indiana (Medicaid)	Healthy Indiana Plan for low-income adults 19-64: **http://www.in.gov/fssa/hip/** All other Medicaid: **https://www.in.gov/medicaid**	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	Medicaid: **https://dhs.iowa.gov/ime/members** CHIP: **http://dhs.iowa.gov/Hawki** HIPP: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	**https://www.kancare.ks.gov/**	1-800-792-4884
Kentucky (Medicaid and CHIP)	Medicaid: **https://chfs.ky.gov** KI-HIPP: **https://chfs.ky.gov/agencies/dms/members/Pages/kihipp.apsx** KI-HIPP E-mail: **KIHIPP.PROGRAM@ky.gov** KCHIP: **https://kidshealth.ky.gov/Pages/index.aspx**	1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	**www.medicaid.la.gov** **www.ldh.la.gov/lahipp**	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	**https://www.maine.gov/dhhs/ofi/applications-forms**	Enroll: 1-800-442-6003 Private HIP: 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	**https://www.mass.gov/info-details/masshealth-premium-assistance-pa**	1-800-862-4840

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://medicaid.ncdhhs.gov/**	919-855-4100
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)	**https://www.dhs.pa.gov/providers/providers/pages/medical/HIPP-program.aspx**	1-800-692-7462
Rhode Island (Medicaid and CHIP)	**http://www.eohhs.ri.gov/**	1-855-697-4347 or 401-462-0311 (Direct RIte)
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)	**https://www.coverva.org/en/famis-select** **https://www.coverva.org/en/hipp**	1-800-432-5924
Washington (Medicaid)	**https://www.hca.wa.gov/**	1-800-562-3022
West Virginia (Medicaid)	**http://mywvhipp.com/**	1-855-699-8447
Wisconsin (Medicaid and CHIP)	**https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**	1-800-362-3002
Wyoming (Medicaid)	**https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**	1-800-251-1269
Minnesota (Medicaid)	**https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**	1-800-657-3739
Missouri (Medicaid)	**http://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)	**http://dhcfp.nv.gov/**	1-800-992-0900
New Hampshire (Medicaid)	**https://www.dhhs.nh.gov/oii/hipp.htm**	603-271-5218 or 1-800-852-3345, ext. 5218

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