FY2025
Employee Benefits Guide

OCTOBER 1, 2024–SEPTEMBER 30, 2025

Information about your benefits

Medical | Dental | Vision | Health Resources | FSA | HSA | Retirement | Life | Disability | Long-Term Care

WE VALUE TRAVIS COUNTY EMPLOYEES,

and we want to help you live your healthiest life — mentally, physically and financially. With a comprehensive and competitive benefits program, we offer a wide range of support and coverage for the care you need.

Take a moment to explore all that's available in this guide. It offers summaries of available benefits, eligibility requirements, costs and contact information. We hope you'll find this guide helpful when you're signing up for medical and other benefits, as well as throughout the year when you have questions or want support.

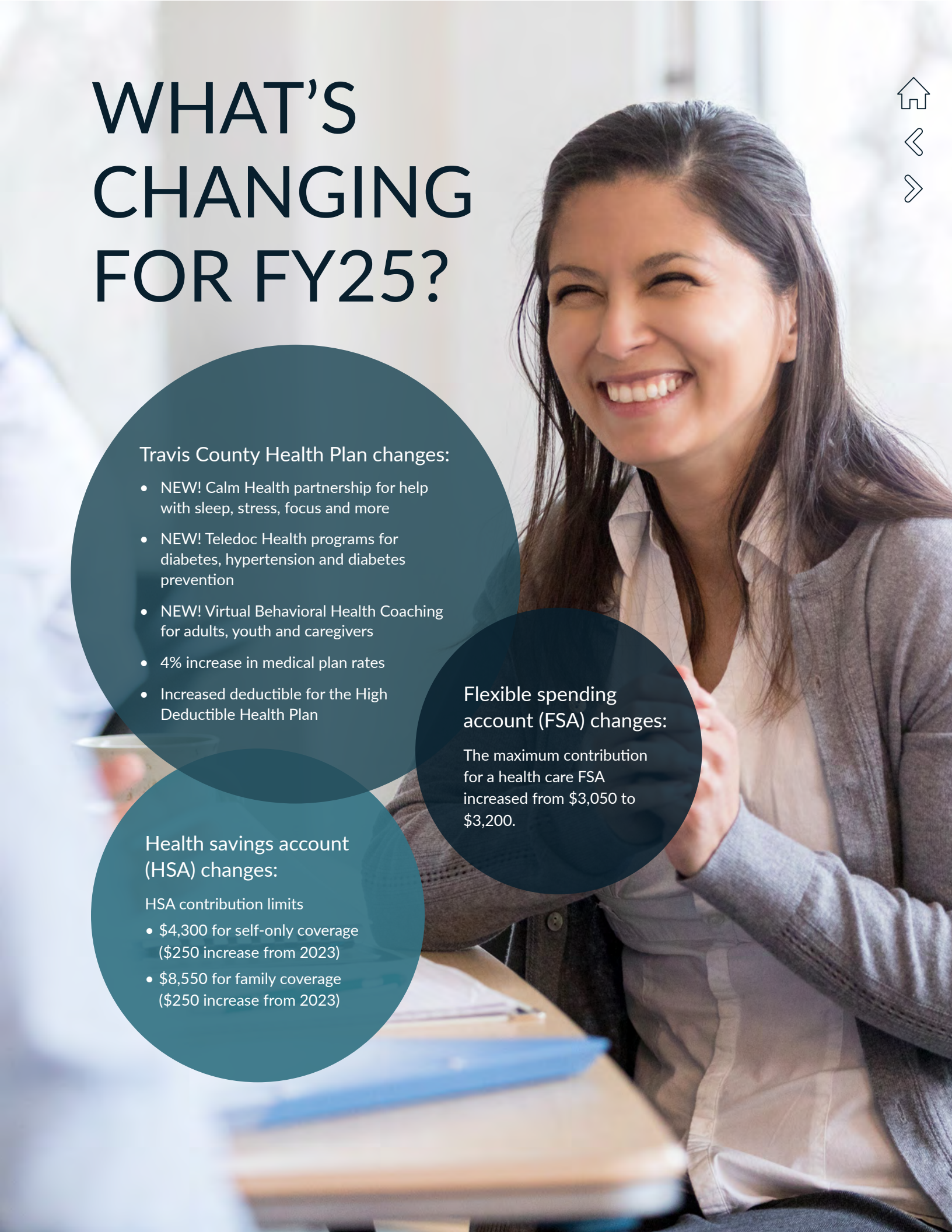
Please keep in mind that Travis County is self-insured, so we ask you to take a proactive approach in understanding these benefits and how to use them. We're doing all we can to manage the long-term cost of health care, and we hope you'll join us.

Sincerely,
Travis County

Note: Every effort has been made to ensure that this information is accurate. It is not intended to replace any legal plan documents, which contain the complete provisions of any benefit. In case of any discrepancy between this guide and the legal plan document, the legal plan document will govern in all cases. You may review the legal plan documents online or by calling the Benefits Office at **1-512-854-0404.**

If benefits change over the course of the fiscal year, this Benefits Guide will be updated in the online version, which you can access on Travis Central.

WHAT'S CHANGING FOR FY25?



Travis County Health Plan changes:

- NEW! Calm Health partnership for help with sleep, stress, focus and more
- NEW! Teledoc Health programs for diabetes, hypertension and diabetes prevention
- NEW! Virtual Behavioral Health Coaching for adults, youth and caregivers
- 4% increase in medical plan rates
- Increased deductible for the High Deductible Health Plan

Flexible spending account (FSA) changes:

The maximum contribution for a health care FSA increased from $3,050 to $3,200.

Health savings account (HSA) changes:

HSA contribution limits

- $4,300 for self-only coverage ($250 increase from 2023)
- $8,550 for family coverage ($250 increase from 2023)


WHAT'S
INSIDE?

BENEFITS CONTACT INFORMATION

Travis County Human Resources Management Department

700 Lavaca Street, Suite 900
Austin, TX 78701

Benefits line:
1-512-854-0404

Fax:
1-512-854-6677

Email:
benefitsteam@traviscountytx.gov

Online:
traviscountytx.gov/human-resources/jobs/benefits

Contact the vendors directly for:
ID cards or claims, benefits or coverage information

HIPAA Compliance and Policy Officer

Phone:
1-512-854-1114

Email:
privacy@traviscountytx.gov

BENEFITS CONTACT INFORMATION

Travis County Health Insurance Plans UnitedHealthcare Group #: 701254	**1-866-649-4873** (members) **1-877-365-7949** (NurseLine) **1-877-237-8576** (retiree billing questions) Website: **myuhc.com**® App: UnitedHealthcare
Travis County Employee Health Clinic	Downtown Clinic: **1-512-854-5509** Airport Blvd. Clinic: **1-512-854-7998** Del Valle Clinic: **1-512-854-1282**
Travis County CARE Program Employee Wellness Program	**1-512-854-CARE** (2273) careprogram@traviscountytx.gov
Pharmacy Benefits Manager OptumRx®	**1-844-265-1719** **1-844-368-8732** (Rx services) **1-855-427-4682** (specialty) Website: **optumrx.com** App: OptumRx
Vision Insurance Davis Vision by MetLife Group #: 242895	**1-833-393-5433** Website: **metlife.com/mybenefits**
Dental Insurance Plans UnitedHealthcare Policy #: 1530869	**1-877-816-3596** Website: **myuhc.com** App: UnitedHealthcare
Basic Life Insurance United Healthcare Group Policy #: 304871	Contact the Benefits Office for claims: **1-512-854-0404**
Employee Assistance Program AllOne Health	24/7 access: **1-888-993-7650** Website: **allonehealth.com/deeroaks** Company code: traviscountytx
Flexible Spending Account (FSA) UnitedHealthcare	**1-866-755-2648** Website: **myuhc.com** App: UnitedHealthcare
Health Savings Account (HSA) Optum Bank®	**1-800-791-9361** Website: **optumbank.com** App: Optum Bank
Supplemental Life, Disability and AD&D New York Life	**1-888-842-4462** Website: **mynylgbs.com**
Texas County & District Retirement System (TCDRS)	**1-800-823-7782** or **1-512-328-8889** Website: **tcdrs.org**
457(b) Deferred Compensation Plan Empower **Empower Representative** Mark Ledson	**1-800-701-8255** Website: **empowermyretirement.com** App: Empower **1-608-640-8746** Mark.ledson@empower.com

ELIGIBILITY AND ENROLLMENT

Employee eligibility

As a Travis County employee, you have access to benefits based on your employment status.

Regular employee

If you are in a regular budgeted position scheduled to work 30 hours or more per week, you are eligible to participate in:

- 457(b) deferred compensation plan
- Basic life and AD&D insurance
- County retirement program through TCDRS (mandatory enrollment)
- Dental insurance
- Dependent life insurance
- Employee assistance program (EAP)
- Flexible spending accounts (medical and dependent care)
- Health savings account and limited flexible spending account — must be enrolled in the High Deductible Health Plan
- Long-term-care insurance
- Personal accident insurance (AD&D)
- Short- and long-term disability
- Supplemental life and AD&D insurance
- Travis County health insurance (includes employee health clinic)
- Travis County wellness program
- Vision insurance

Temporary employee

If you are a temporary employee with an assignment of 6 months or longer or a regular employee scheduled to work less than 30 hours per week, you are eligible to participate in:

- County retirement program through TCDRS (mandatory enrollment)

Temporary employees may be eligible for health, dental and vision benefits if working an average of 30 hours per week or more. Eligibility and enrollment dates will be determined using the measurement, administrative and stability periods in accordance with 26 Code of Federal Regulations Part 54.4980H. Travis County has elected to utilize a 12-month look-back period in determining eligibility and enrollment dates.

Dependent eligibility

Legal or common-law spouse

Defined as a spouse who is legally married to the employee or has filed a Declaration and Registration of Informal Marriage for the State of Texas.

Domestic partner (same or opposite sex)

Defined as a person who shares the same permanent residence and the common necessities of life. A domestic partner or a domestic partner's child is not eligible for COBRA.

Sponsored dependent

Defined for the purposes of this plan as related by blood to the employee (such as over-age dependent child or unmarried parent of employee) and:

- At least 18 years old; and
- Unmarried by either formal marriage or common law; and
- Not related to the employee by marriage; and
- Not employed by Travis County or the employee; and
- Not in active service in the armed forces; and
- Has been living with the employee for at least 6 consecutive months, before applying for coverage; and
- Currently living with the employee; and
- Shares the same permanent residence and the common necessities of life.

A sponsored dependent is not eligible for COBRA. An employee may only cover one adult as a dependent. If a spouse or domestic partner is covered, you cannot cover a sponsored dependent.

Child of employee/spouse/domestic partner

Child includes any of the following:

- A natural child (child of the employee)
- A legally adopted child or a child placed in the home for adoption
- Any other child who is mainly dependent on the employee for care and support and for whom a completed guardianship document has been obtained
- A child for whom the employee/spouse/domestic partner is the legal guardian
- A child for whom the employee/spouse/domestic partner is required by a qualified medical child support order (QMCSO) or court order to provide coverage

Children can be covered from birth through their 26th birthday. Qualifying disabled children are allowed to be covered at any age.

Dependent documentation

Documentation is required to support the eligibility status of new dependents. Any false information may result in loss of coverage for that dependent and may require reimbursement to the plan for any claims paid. The documentation must be presented prior to your first day of coverage. If documentation is not received, the dependent will be dropped. Social Security numbers must be provided for all eligible dependents.

- Spouse (formal ceremony): marriage certificate
- Spouse (common law): copy of filed Declaration and Registration of Informal Marriage
- Domestic partner (same or opposite sex): birth certificate or driver's license and completion of Certificate of Domestic Partnership affidavit form
- Child (natural child of participant): birth certificate
- Child (natural child of participant's spouse): birth certificate and marriage certificate
- Child (natural child of participant's domestic partner): completion of the Certificate of Domestic Partnership and birth certificate
- Child (legal adoption): final order of adoption showing participant as child's parent
- Child (legally adopted child of participant's spouse): final order of adoption showing participant's spouse as child's parent and marriage certificate or Declaration and Registration of Informal Marriage for employee and spouse
- Child (legally adopted child of employee's domestic partner): final order of adoption showing employee's domestic partner as child's parent and completion of Certificate of Domestic Partnership
- Sponsored dependent: birth certificate(s) verifying relationship and age plus completion of online Certificate of Sponsored Dependent
- Child with handicap or disability: supporting medical documentation

Enrollment

The benefits plan year begins October 1 of each year and continues through September 30 of the following year. As an employee, you are allowed to make elections and/or changes only during certain enrollment periods. Please review the additional information regarding enrollment periods.

New-hire enrollment

As a new employee, you will be eligible for benefits on the first of the month following 28 days of benefits-eligible employment. New employees will be given an initial enrollment period of 30 days after their hire date to enroll. During this time, employees are allowed to add, delete or change benefit elections. Enrollment is conducted through Employee Self-Service in the SAP system (SAP ESS).

Open enrollment

Each year we offer you an opportunity to review your current benefits and make changes for the upcoming plan year. During open enrollment, you are allowed to add, remove or change your benefits. Open enrollment is typically conducted in the month of August. The changes you make will be effective October 1. If you do not make changes, your benefits will roll over. You must re-enroll in flexible spending accounts each year.

Benefit changes during the plan year: Qualifying life events

IRS Section 125 guidelines allow you to enroll in a health, dental and/or vision plan and have your premiums adjusted before taxes. The IRS requires that benefits paid with pre-tax contributions stay in effect for the full plan year. Therefore, you cannot change your elections unless you have a qualifying life event (QLE). A complete list of what the IRS considers a qualifying event is listed in your summary plan description (SPD), but in general, it includes:

- Change in your legal marital status: marriage, divorce, annulment or death of spouse
- Change in your dependent's status: birth, adoption, placement for adoption, death or your dependent loses eligibility due to age or marriage
- Change in your employment status or work schedule that affects your benefits eligibility
- Change in your spouse's benefits coverage or eligibility
- Change in permanent residence that may affect the coverage for which you are eligible

Any change in coverage must be consistent with the QLE. You have 30 days from the qualifying event to change your coverage election. If you have a QLE, call the Benefits Office within 30 days to determine if your life event qualifies and provide the necessary documentation to make the change. QLE changes to benefits will have an effective date of the first of the month following the date of the QLE. For changes in eligibility for Medicaid or State CHIP coverage, you have 60 days from the event to notify the Benefits Office.

You may make changes only to your health, dental, vision, dependent life, spouse life and/or flexible spending account(s) benefit elections during the benefit plan year if you experience a QLE. Changes to life insurance beneficiaries and participation in the 457(b) deferred compensation plan may be changed at any time during the year.


HEALTH
PLANS

MEDICAL INSURANCE

Travis County health insurance

Travis County medical coverage helps you maintain your wellbeing through preventive care and access to an extensive network of providers. Medical benefits are administered by UnitedHealthcare. Choose the plan that best matches your needs, and keep in mind that the option you elect will be in place for the entire plan year unless you have a qualifying event. As you consider the best plan for yourself — and your family, if applicable — consider:

- Copay amount
- Deductible amount
- Dependent coverage
- Future expenses (maternity, planned surgery, etc.)
- Out-of-pocket maximum
- Premium costs
- Usage

Here's a brief description of the plans.

Preferred Provider Organization (PPO) Plan	Consumer Choice Plan	High Deductible Health Plan (HDHP)	Exclusive Provider Organization (EPO) Plan *Plan is closed to new enrollments*
In- and out-of-network	**In- and out-of-network**	**In- and out-of-network**	**In-network only**
• Lower out-of-pocket cost for network providers • Copays or deductibles for services • Separate deductible and out-of-pocket maximum for pharmacy	• Low monthly premiums • No premium for employee-only coverage • Plan doesn't pay until deductible has been met (not including preventive care, which is covered 100%) • Deductible does not apply to prescription pharmacy benefits	• Lowest monthly premiums • Plan doesn't pay until deductible has been met (not including preventive care, which is covered 100%) • No separate pharmacy deductible • Includes a health savings account (HSA) that can be used to pay for eligible expenses, and the County contributes to it annually	• Highest monthly premium • Copays for most services including inpatient hospital, office visits and emergency room • Some services have both a copay and a deductible • Covers 100% of charges once the deductible and copay have been met • Separate deductible and out-of-pocket maximum for pharmacy

Monthly premiums

	Employee only	Employee + 1 adult	Employee + 1 child	Employee + children	Employee + adult + child	Employee + adult + children
EPO	$157.00	$734.00	$337.00	$586.00	$1,011.00	$1,275.00
PPO	$33.00	$364.00	$107.00	$252.00	$537.00	$700.00
Consumer Choice	$0.00	$245.00	$33.00	$148.00	$380.00	$514.00
High Deductible	$0.00	$228.00	$18.00	$132.00	$364.00	$495.00

Per-pay-period premiums

	Employee only	Employee + 1 adult	Employee + 1 child	Employee + children	Employee + adult + child	Employee + adult + children
EPO	$78.50	$367.00	$168.50	$293.00	$505.50	$637.50
PPO	$16.50	$182.00	$53.50	$126.00	$268.50	$350.00
Consumer Choice	$0.00	$122.50	$16.50	$74.00	$190.00	$257.00
High Deductible	$0.00	$114.00	$9.00	$66.00	$182.00	$247.50

Imputed income of health plan premiums

Travis County allows employees to enroll and cover a domestic partner, a child of a domestic partner, a grandchild and/or a sponsored adult on their health coverage. Both the employee and Travis County contribute to the cost of premiums for these covered individuals.

While Travis County allows these dependents on the plan, for federal income tax purposes, providing group health care benefits to a non-IRS-qualified dependent is taxable to the employee. This requires Travis County to calculate imputed income for the employee, which reflects the value of the contribution that the employer makes on behalf of these covered person(s). In addition, the payroll deduction contribution that you make to cover your non-IRS-qualified dependent is a post-tax deduction.

For example, if the County contributes $1,378 per month for employee + adult coverage and contributes $814 for employee-only coverage, the imputed income amount for the other adult is $564 per month. This is considered to be the County contribution made for the other adult's coverage. Below are the monthly imputed income amounts.

Covered Dependent	Monthly (EPO, PPO, Consumer)	Per Pay Period (EPO, PPO, Consumer)	Monthly (HDHP)	Per Pay Period (HDHP)
Non-qualified adult *(domestic partner, sponsored adult)*	$587	$293.50	$621	$310.50
Non-qualified child *(child of domestic partner, grandchild)*	$208	$104	$242	$121
Non-qualified children *(2 or more children of domestic partner, grandchildren)*	$514	$257	$548	$274

Plan comparison chart

	PPO Plan	Consumer Choice	High Deductible	EPO Plan *(no new enrollments)*
	In- and out-of-network coverage*	In- and out-of-network coverage*	In- and out-of-network coverage*	In-network only
County annual contribution to health savings account	$0	$0	$500 individual $1,000 family (Amount is reduced based on date of hire for new employees)	$0
Employee annual contribution limit for health savings account	N/A	N/A	$4,300 individual $8,550 family	N/A
Deductible				
In-network	$700 individual $1,750 family	$500 individual $1,250 family	$1,650 individual $3,300 family	$600 per individual
Out-of-network	$2,000 individual $5,000 family	$1,500 individual $3,750 family	$4,500 individual $9,000 family	Not covered
Coinsurance				
In-network	Plan pays 85% Member pays 15%	Plan pays 80% Member pays 20%	Plan pays 90% Member pays 10%	Plan pays 100% Member pays 0%
Out-of-network	Plan pays 60% Member pays 40%	Plan pays 60% Member pays 40%	Plan pays 60% Member pays 40%	Not covered
Medical out-of-pocket maximum				
In-network	$4,500 individual $9,000 family	$3,500 individual $7,000 family	$5,000 individual $6,200 family	$4,500 individual $9,000 family
Out-of-network	$6,000 individual $12,000 family	$10,000 individual Family unlimited	$10,000 individual $20,000 family	Not covered
Preventive services				
In-network	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%
Medical services				
Employee health clinic**	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%	$50 fee per visit; Plan pays 100% after deductible is met	Plan pays 100% Member pays 0%
Physician's office services	$30 per visit — UnitedHealthcare Premium-designated specialist $45 per visit — specialist	Deductible and coinsurance	Deductible and coinsurance	$35 per visit — PCP & UnitedHealthcare Premium-designated specialist $50 per visit — specialist
Urgent care center services	$45 per visit	Deductible and coinsurance	Deductible and coinsurance	$50 per visit
24/7 Virtual Visit through UnitedHealthcare**	$10 copay	Deductible and coinsurance	Deductible and coinsurance	$10 copay
Emergency room	$300 per visit, waived if admitted to hospital	Deductible and coinsurance	Deductible and coinsurance	$300 per visit, waived if admitted to hospital
Ambulance services — emergency only**	$100 copay	Deductible and coinsurance	Deductible and coinsurance	$100 copay
Hospital — inpatient stay	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	$1,250 copay per visit, then deductible

*In-network coverage detailed unless otherwise noted.
**Refer to your plan documents for additional details.

Plan comparison chart, continued

	PPO Plan	Consumer Choice	High Deductible	EPO Plan *(no new enrollments)*
	In- and out-of-network coverage*	In- and out-of-network coverage*	In- and out-of-network coverage*	In-network only
Medical services (continued)				
Outpatient surgery	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	$600 copay per visit, then deductible
Maternity services**	Deductible and coinsurance No copay applies to physician office visits for prenatal care after the first visit	Deductible and coinsurance No copay applies to physician office visits for prenatal care after the first visit	Deductible and coinsurance	$1,250 copay per visit, then deductible No copay applies to physician office visits for prenatal care after the first visit
Mental health services — inpatient, outpatient and intermediate**	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	$1,250 copay, then deductible
Mental health services — office visit	$10 per visit	Deductible and coinsurance	Deductible and coinsurance	$10 per visit
Other services				
Mammograms, colonoscopies and endoscopies	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%	If preventive care: Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%
Acupuncture**	$30 per visit	Deductible and coinsurance	Deductible and coinsurance	$35 per visit
Allergy services in a physician's office**	$30 per visit — PCP $45 per visit — specialist	Deductible and coinsurance	Deductible and coinsurance	$35 per visit — PCP $45 per visit — specialist
Allergy testing	100% covered	100% covered	Deductible and coinsurance	100% covered
Chiropractic services**	$30 per visit	Deductible and coinsurance	Deductible and coinsurance	$35 per visit
Dental services — accident-related only**	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Durable medical equipment**	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%	Deductible and coinsurance	Plan pays 100% Member pays 0%
Eye examinations**	$45 per visit	Deductible and coinsurance	Deductible and coinsurance	$50 per visit
Hearing aid benefit	$1,000 allowance every 3 years	$1,000 allowance every 3 years	Deductible and coinsurance $1,000 allowance every 3 years	$1,000 allowance every 3 years
Home health care services**	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%	Deductible and coinsurance	Plan pays 100% Member pays 0%

Plan comparison chart, continued

	PPO Plan	Consumer Choice	High Deductible	EPO Plan *(no new enrollments)*
	In- and out-of-network coverage*	In- and out-of-network coverage*	In- and out-of-network coverage*	In-network only
Other services (continued)				
Hospice care**	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%	Deductible and coinsurance	Plan pays 100% Member pays 0%
Outpatient diagnostic and therapeutic services — CT scans, PET scans, MRI and nuclear medicine**	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	No charge after deductible is met
Professional fees for surgical and medical services	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	100% covered
Prosthetic devices**	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%	Deductible and coinsurance	Plan pays 100% Member pays 0%
Rehabilitation services — outpatient therapy**	$15 per visit for 15 visits in conjunction with an office visit 16 or more visits: $30 per visit — PCP $45 per visit — specialist	Deductible and coinsurance	Deductible and coinsurance	$15 per visit for 15 visits in conjunction with an office visit 16 or more visits: $35 per visit — PCP $50 per visit — specialist
Skilled nursing facility/ inpatient rehabilitation facility services**	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	$1,250 copay per visit, then deductible
Substance use services — outpatient	$30 per visit	Deductible and coinsurance	Deductible and coinsurance	$35 per visit
Substance use services — inpatient**	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Inpatient: $1,250 copay per visit, then deductible
Transplantation services **	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Inpatient: $1,250 copay per visit, then deductible
Pharmacy out-of-pocket maximum				
In- and out-of-network	$2,500 individual, $5,000 family	$2,500 individual, $5,000 family	Subject to medical out-of-pocket maximum	$2,500 individual, $5,000 family

Certain procedures may require prior authorization. You or your provider should call the number on the back of your ID card to verify.

All elective surgeries will be reviewed for medical necessity.

*In-network coverage detailed unless otherwise noted.
**Refer to your plan documents for additional details.

DENTAL INSURANCE

Travis County offers 4 dental plans administered by UnitedHealthcare. Here's a quick overview of the plans.

Prepaid DHMO Plan	Basic PPO Plan	Preferred PPO Plan	Preventive Only Plan
National Exclusive Network	*National PPO 20*	*National PPO 30*	*National PPO 30*
No coverage for out-of-network providers	**Choose any dentist including specialists**	**Choose any dentist including specialists**	**Choose any dentist**
• No deductible, no copays for most preventive services • Copays for other treatments • Coverage for pre-existing conditions • No annual maximum for services	• PPO options available • Benefits are paid after any applicable deductible has been met, up to the annual maximum • Fees are lower for dentists participating in the PPO • Limited rollover reward amount for unused annual maximum amounts	• PPO options available • Benefits are paid after any applicable deductible has been met, up to the annual maximum • Fees are lower for dentists participating in the PPO • Limited rollover reward amount for unused annual maximum amounts	• Coverage for preventive services only • No deductible • $750 annual maximum • Fees are lower for dentists participating in the PPO

You can find a dental provider in the UnitedHealthcare network by visiting **myuhc.com.** Or call UnitedHealthcare Dental at **1-877-816-3596.**

Dental plan monthly premiums

	Prepaid DHMO Plan	Basic PPO Plan	Preferred PPO Plan	Preventive Only Plan
Employee only	$11.48	$23.18	$36.24	$12.92
Employee + 1 adult	$18.44	$44.10	$72.44	$25.82
Employee + 1 child	$18.44	$44.10	$72.44	$25.82
Employee + 2 or more children	$24.74	$72.62	$113.36	$35.74
Employee + 1 adult + 1 child	$24.74	$72.62	$113.36	$35.74
Employee + 1 adult + 2 or more children	$28.94	$93.54	$149.60	$51.68

Per-pay-period premiums

	Prepaid DHMO Plan	Basic PPO Plan	Preferred PPO Plan	Preventive Only Plan
Employee only	$5.74	$11.59	$18.12	$6.46
Employee + 1 adult	$9.22	$22.05	$36.22	$12.91
Employee + 1 child	$9.22	$22.05	$36.22	$12.91
Employee + 2 or more children	$12.37	$36.31	$56.68	$17.87
Employee + 1 adult + 1 child	$12.37	$36.31	$56.68	$17.87
Employee + 1 adult + 2 or more children	$14.47	$46.77	$74.80	$25.84

Dental plan comparison

	Prepaid DHMO Plan	Basic PPO Plan	Preferred PPO Plan	Preventive Only Plan
Calendar year deductible	$0	$50	$50	$0
Annual maximum	No max	$1,500	$2,000	$750
Carryover	$0	$400	$500	$0
Preventive services: routine oral exams, routine cleanings, fluoride treatment *(frequency limitations)*	100% (no copays)	100% (no deductible)	100% (no deductible)	100% (no deductible)
Restorative services: fillings, all other x-rays, simple extractions	Various copays	Plan pays 80% Member pays 20%	Plan pays 80% Member pays 20%	Not covered
Major services: crowns, bridgework, dentures, oral surgery, extractions, endodontics (root canals), periodontics (treatment of gums), implants	Various copays Implants not covered	Plan pays 50% Member pays 50%	Plan pays 50% Member pays 50%	Not covered
Orthodontia	Various copays	Plan pays 50% up to a $1,000 lifetime max	Plan pays 50% up to a $1,000 lifetime max	Not covered
Out-of-network coverage	None	Contracted rates	90th percentile of UCR	90th percentile of UCR

Your dental plan includes 2 virtual visits per plan year

Connect with a dentist 24/7 on your phone or computer* for care through DialCare. Your plan includes 2 visits at no additional cost to you** in addition to the routine in-person exams included in your plan.

▶ Visit **DialCare** to see available benefits.

*Consultations can be conducted by phone call or video where allowed in each state.
**You may need to pay an out-of-pocket cost for additional visits.

VISION INSURANCE

Even if you have perfect eyesight, it's important to get your vision checked on a regular basis. To ensure that you and your family have access to quality vision care, Travis County offers a comprehensive vision benefit provided by Davis Vision by MetLife. Through their provider network, you will receive a vision examination as well as eyeglasses (lenses and frames) or contact lenses.

Easy benefits access

With Davis Vision by MetLife, you may visit any provider you choose, but you maximize your savings when you visit a network provider. Find one by logging in to **metlife.com/mybenefits** and selecting Find a Provider or by calling **1-833-393-5433.**

In-Network Benefits		**Out-of-Network Benefits** *If you choose an out-of-network provider, you will be reimbursed up to:*
Eye examination	$10 copay	$45
Pair of lenses *(once every plan year)*	Standard single-vision, lined bifocal or trifocal lenses — $25 copay	Single-vision — $40 Bifocal — $60 Trifocal — $80 Lenticular — $100
Additional lens options and coverage *(once every plan year)*	Clear plastic lenses in any single-vision, bifocal, trifocal or lenticular prescription — covered in full *(See next page for additional lens options and coatings)*	
Frames *(once every other plan year)*	Up to $150 retail allowance toward provider-supplied frame plus 20% off cost exceeding the allowance OR Any fashion or designer frame from Davis Vision's exclusive collection (with retail values up to $175) — covered in full OR Any premier frame from Davis Vision's exclusive collection (with retail values up to $225) — covered in full after an additional $25 copay	$50
Contact lenses in lieu of eyeglasses *(once every plan year)*	Up to $150 allowance toward provider-supplied contacts plus 15% off cost exceeding the allowance. Standard and specialty contacts — evaluation, fitting fees and follow-up care OR Davis Vision Collection contact lenses, evaluation, fitting fees and follow-up care — covered in full after $25 copay (up to 4 boxes of disposable lenses) OR Medically necessary with prior approval — covered in full	Elective — $150 Necessary — $225

Additional lenses coverage and copays

- Davis Vision Collection frames: fashion | designer | premier — $0 | $0 | $25
- Tinting of plastic lenses — $0
- Oversize lenses — $0
- Scratch-resistant coating — $0
- Ultraviolet coating — $12
- Anti-reflective coating: standard | premium | ultra — $35 | $48 | $60
- Polycarbonate lenses — $0/$4–$30
- High-index lenses — $55
- Progressive lenses: standard | premium | ultra — $50 | $90 | $140
- Polarized lenses — $75
- Plastic photosensitive lenses — $65
- Scratch protection plan: single-vision | multifocal lenses — $20 | $40

Out-of-network providers

If you visit an out-of-network provider, you will need to send your itemized receipts with the primary insured's unique identification number and the patient's name and date of birth to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Receipts for services and materials purchased on different dates must be submitted at the same time to receive reimbursement. Receipts must be submitted within 12 months of the date of service.

Value-added features

Order contacts through **davisvisioncontacts.com** to save time and money. You'll receive discounts of up to 25% on the provider's usual and customary fees, or 5% on advertised specials, whichever is lower.

Vision plan premiums

Coverage Level	Monthly Premium	Per-Pay-Period Premium
Employee only	$3.92	$1.96
Employee + 1 adult	$7.44	$3.72
Employee + 1 child	$7.44	$3.72
Employee + 2 or more children	$8.24	$4.12
Employee + 1 adult + 1 child	$8.82	$4.41
Employee + 1 adult + 2 or more children	$11.38	$5.69

HEALTH RESOURCES

CLINICAL RESOURCES

NurseLine

Have questions about symptoms you're experiencing? Not sure if and where you should get care? If it's not an emergency, call NurseLine. Available at no cost to you 24 hours a day, NurseLine connects you with an experienced registered nurse who can give you treatment advice, determine if it's necessary to see a doctor, and help you find a doctor or urgent care facility near your home or office.

Call **1-877-365-7949.**

Virtual care

Get care anytime without leaving home using your smartphone or other connected device,* like a tablet or a computer.

- 24/7 Virtual Visits — 24/7 care is available for common non-emergency health issues such as flu, fever, sore throat, pinkeye, migraines and back pain. A doctor can even refill prescriptions, if needed.**

Visit **myuhc.com/virtualcare** or look for virtual visits on the **UnitedHealthcare® app.**

myuhc.com and the UnitedHealthcare app

Register for your personalized website on **myuhc.com** and download the **UnitedHealthcare app** to:

- Compare costs for providers and services
- Check your plan balances, view your claims and access your health plan ID card
- Access wellness programs
- Connect with providers using virtual visits
- View your health savings account (HSA) or flexible spending account (FSA)
- Compare prescription costs and order refills

Download on the App Store

GET IT ON Google Play

Teladoc Health

Get support managing prediabetes or diabetes, high blood pressure or mental health with Teladoc Health. It offers:

- Personalized tools including connected devices to track blood sugar, blood pressure or weight
- Support from a coach who's certified in your health condition
- Live coaching sessions and messaging
- Helpful courses so you can learn more

Visit **teladochealth.com** to get started.

*Data rates may apply.

**Certain prescriptions may not be available, and other restrictions may apply.

Kaia

Dealing with a stiff neck or aching shoulders? Have more severe back pain? Kaia can help you find ways to get relief. The app is available at no extra cost as part of your health plan and includes:

- On-demand pain relief help
- Workouts tailored to you, with some as short as 15 minutes
- Bite-sized lessons to help you recognize where pain is coming from
- 1-on-1 health coaching with certified professionals
- Strengthening exercises including relaxation techniques for pain management
- Real-time feedback while you exercise

Get started at **startkaia.com/uhc.**

Specialist Management Solutions

If you're looking for specialty care or considering a general surgery, Specialist Management Solutions (SMS) can tell you about your options, connect you to a network provider and guide you throughout the whole process. SMS is available for women's health; gastrointestinal care; ear, nose and throat; orthopedics; colonoscopy; and more. If you're dealing with back or other joint pain and considering surgery, the Spine and Joint Solution can help you explore your treatment options, decide where to go, understand costs, and identify possible ways to save money and shorten your recovery time. You may receive an outreach call from an SMS Care Advocate to help you with your needs.

Call **1-866-649-4873** and ask about SMS.

2nd.MD expert medical opinion services

Received a new diagnosis and you'd like a second opinion? Want to talk through your treatment plan options or medications? 2nd.MD connects you with board-certified elite specialists from prestigious health systems like Harvard Medical School and UTHealth (Texas) at no additional cost to you. Get expert advice for yourself or an eligible family member who's dealing with a chronic condition. 2nd.MD can also take on the burden of finding the right specialist, collecting medical records and navigating the health care system, so you can focus on getting the best care possible.

Visit **myuhc.com > Health & Wellness > My Health & Wellness** to get started.

Personal Health Support

If you're managing an ongoing health condition, get personal support from a specially trained registered nurse who can help you manage your condition, understand your treatment options and explore self-care tips.

Personal Health Support includes, but is not limited to:

- Asthma
- Birth defects
- Chronic muscle disease, such as multiple sclerosis
- Cystic fibrosis
- Diabetes
- Head injury and spinal cord injury
- Heart disease
- HIV/AIDS
- IV therapy, antibiotics and chemotherapy
- Premature births
- Recent hospital stay
- Respiratory support
- Strokes and cardiac conditions

Call **1-866-649-4873** to get started, or answer the phone if UnitedHealthcare calls.

Cancer Support Program

If you or a covered dependent has been diagnosed with cancer, get support from an experienced cancer nurse. Your nurse will talk you through the emotional challenges of your health journey, answer your questions and guide you to a quality doctor. They may also help you with:

- Learning about and making decisions on treatment, including any clinical trials
- Managing symptoms and side effects
- Getting a second opinion
- Accessing Centers of Excellence (COE)
- Managing prescriptions
- Understanding your benefits
- Making hospice or end-of-life decisions

Call **1-866-649-4873** to get started, or answer the phone if UnitedHealthcare calls.

Diabetes Health Plan

If you've been diagnosed with diabetes, the Diabetes Health Plan can help you get access to affordable care and ongoing support. It features:

- $0 office visits after your deductible has been met for visits related to diabetes
- $0 copays for Tier 1 and Tier 2 diabetes-related medications and supplies

If you have questions or want to enroll in the Diabetes Health Plan program, please contact your UnitedHealthcare Health Engagement Coach, Frances Diep, registered dietitian, at frances.diep@traviscountytx.gov or 512-539-6374.

WELLBEING RESOURCES

Health Coaching

Health Coaching is a free benefit available to all Travis County employees, spouses and dependents over the age of 18. Frances, the health coach, can help you work on health behaviors such as physical activity, eating, prevention/treatment of chronic health conditions and behavioral health. You can schedule a session in person or virtually. Learn more here: **Health Coaching Flyer**

Frances Diep, Registered Dietitian
UnitedHealthcare Health Engagement Coach
1-512-539-6374
frances.diep@traviscountytx.gov
To schedule Health Coaching, visit **calendly.com/frances-diep.**

Travis County CARE Program

Designed just for Travis County employees, retirees and dependents, CARE stands for Checkups, A Healthy Outlook, Regular Exercise and Eating Right. It offers a wide range of resources and tools to help you get and stay healthy, including private and individualized health coaching, on-site employee fitness centers, wellness education and resources, and on-site events. Stay informed by reviewing the monthly CARE Program email newsletter and keeping an eye out for the virtual Wellness Tools mini-series offered throughout the year. It will provide you with updates on tools and resources available to you.

More information about these resources can be found at **traviscentral.traviscountytx.gov/hr/care** or by contacting **CAREprogram@traviscountytx.gov** or **1-512-854-2273.**

FY25 CARE Wellness Topics & Rally Sweepstakes Calendar

The Travis County CARE Program offers monthly education seminars on a variety of wellness topics as well as quarterly Rally Sweepstakes. If you're an employee on the Travis County Health Plan, you can be entered into raffle drawings to win 1 of 10 $25 Visa gift cards each quarter, just for participating. See below for a calendar overview of topics and Rally Sweepstakes activities.

Quarter	Month	Focus Area	Rally Sweepstakes
Q1	October	Women's Health	Health Survey Completion
	November	Diabetes Awareness	
	December	Healthier Holidays	
Q2	January	Preventive Care	Individual Activity Challenge
	February	Heart Health	
	March	National Nutrition Month	
Q3	April	Alcohol & Substance Use	Missions Completion Challenge
	May	Mental Health	
	June	Men's Health	
Q4	July	Summer Safety	Individual Activity Challenge
	August	Immunization Awareness	
	September	Cholesterol Education	

Real Appeal®

Take small steps for lasting change with Real Appeal, an online weight management support available to you and eligible family members at no additional cost.

- Take small steps toward healthier habits. Set achievable nutrition, exercise and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard too.
- Find support along the way. Feel motivated with personalized messages, online group sessions led by coaches and a caring community of members.
- Get a Success Kit delivered right to your door. Make the most of tools and resources including weight and food scales, a portion plate and more. Your Success Kit is delivered after you attend your first live group session.

To enroll, visit **tccare.realappeal.com.**

Rally®

Make hitting your wellbeing goals fun, and earn rewards along the way with Rally. Start with the Rally Health Survey to assess your overall health. Then get personalized recommendations including missions designed to help you improve your fitness, diet and mood. You can compete in challenges against friends or other members — or go for a personal best.

To get started, visit **myuhc.com > Health & Wellness.**

WELLBEING RESOURCES

One Pass Select™

Reach your fitness goals while finding new passions along the way. With One Pass Select, 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 offers affordable access to a nationwide network of fitness centers with gyms near you plus thousands of live and on-demand online fitness classes. All tiers Classic and above also include no-cost subscriptions for grocery and home essentials delivery.

To get started, visit **onepassselect.com.**

Behavioral Health Coaching

If you're living with stress, depression or anxiety, get personalized, virtual support from a coach. Behavioral Health Coaching offers:

- 1-on-1 weekly coaching sessions via video chat
- In-app messaging with your coach
- Courses based on cognitive behavioral therapy

To learn more, go to **myuhc.com** or enroll today at **ableto.com/exploremore.**

Child and Family Behavioral Health Coaching

Sometimes, being a parent can feel joyful. Other times, it can feel like a constant struggle. Maybe getting your kids to talk feels impossible. Perhaps you're worried about their behavior. Or maybe you know they need help, but you're not sure where to look. Child and Family Behavioral Health Coaching from Bend Health can help.

Available at no additional cost to families with children ages 1–17, it offers:

- **Support from an experienced coach** — Coaches are certified or have a master's degree, and they're supervised by licensed practitioners
- **Online coaching sessions** — Get up to four 45-minute confidential sessions per month at no additional cost to you
- **Unlimited messaging** — Talk with your coach between sessions with secure in-app messaging
- **More resources** — Look at educational content anytime, designed to help you better understand what you talk about with your coach
- **Referrals** — If your family needs more support, your coach can offer referrals to therapists and child/adolescent psychiatrists

To learn more, go to **myuhc.com,** or enroll today at **bendhealth.com/coaching.**

Calm Health

You may have heard about or even used the Calm app. Now you have access to its most popular features and much more with Calm Health. Available through your benefits at no additional cost to you, it includes content written by licensed psychologists.

Work toward wellbeing goals like:

- Better sleep
- Building skills to manage stress
- Developing resiliency
- Starting and building a mindfulness habit

It's all self-guided, so you can go at your own pace. Learn more at **myuhc.com.**

Employee assistance program

Your employee assistance program (EAP) is a Travis County funded benefit and is provided by AllOne Health's EAP services, formally known as Deer Oaks. The EAP is designed to help you and your family manage life's challenges. Through this program, you and your family members may access a wide variety of counseling, referral and consultation services to help you deal with personal and work-related issues that may be affecting your job performance or personal wellbeing. Whether you seek short-term counseling, work and life consultation services, legal and financial resources, or assistance with locating child- and eldercare facilities, or you have uncertainty about retirement, AllOne Health is there to assist with these and other requests, 24 hours per day, 7 days per week.

AllOne Health offers a multidisciplinary team of professional counselors and work/life consultants trained to assist with such issues as:

- Child/Elder/Adult Care
- Depression/Anxiety
- Emotional & Psychological Issues
- Family & Marital Problems
- Healthy Lifestyles
- Legal & Financial Difficulties
- Life Changes & Transitions
- Loss & Grief
- Preparing for Retirement
- Stress & Time Management
- Substance Use
- Work/Life Balance

These services are completely confidential and may be easily accessed 24/7 by calling the toll-free Helpline at **1-888-993-7650.** You can also find online tools on the AllOneHealth website. To access them, click "Sign Up" to create an account. Use **traviscountytx** for the "company/student code". Once you create your account, you can access the member portal from any computer, any time of day.

Pharmacy benefits

Optum Rx®

Your prescription drug benefits are administered by Optum Rx, and your medical plan ID card will also include Optum Rx prescription information. Prescriptions for 30 days or less can be filled at any network retail pharmacy. Prescriptions for 90 days can be filled through the Optum Rx mail-order service or at any network retail pharmacy.

To order home delivery, choose the option that's most convenient for you:

- ePrescribe — Your doctor can send an electronic prescription to Optum Rx. Prescriptions for controlled substances, such as opioids, can only be ordered by ePrescribe.
- Online — Visit the website on your member ID card.
- App — Open the Optum Rx app, which you can download from the App Store or Google Play.
- Phone — Call the toll-free number on your member ID card.

If you require a specialty prescription, check out Optum Specialty Pharmacy. It offers:

- Access to your medications at the plan's lowest cost
- 24/7 access to pharmacists
- Clinical and adherence programs
- Medication supplies at no extra cost
- Refill reminders

For more information, visit **specialty.optumrx.com** or call **1-855-427-4682.**

Prescription costs

	EPO and PPO Health Plans		Consumer Choice Health Plan	High Deductible Health Plan
	30-day supply	90-day supply		
Annual pharmacy out-of-pocket maximums (OOPM)	$2,500 individual $5,000 family		$2,500 individual $5,000 family	None — applies to medical OOPMs
Tier 1 — generic	$10	$20	20% coinsurance ($5 min, $35 max)	Deductible and coinsurance
Annual deductible (Tier 2 and 3 only)	$50 individual $125 family	$50 individual $125 family	None	None
Tier 2 — preferred	$35	$70	20% coinsurance ($20 min, $60 max)	Deductible and coinsurance
Tier 3 — non-preferred	$55	$110	20% coinsurance ($40 min, $100 max)	Deductible and coinsurance

Prior authorization — Certain medications require prior authorization from your doctor. You and your doctor will be alerted by your pharmacy when a prior authorization is needed. Prior authorization guidelines are determined on a drug-by-drug basis and may be based on Food and Drug Administration (FDA) and manufacturer guidelines, medical literature, safety, appropriate use and benefit design.

Quantity limits — There may be a limit on the number of units per day, per period or per prescription based on FDA-approved indications and normal monthly usage.

Pay the difference — If you choose a brand-name drug when a generic is available and deemed acceptable by the prescribing physician, you'll pay the difference in cost.

Travis County Employee Health Clinic

Get care right where you work. Travis County has 3 on-site health clinics staffed by physicians and medical care professionals. They're available to employees and dependents who are at least 10 years old and covered by one of the Travis County Health Plans.

Services include:

- Alcohol cessation
- Allergy management (not allergy injections)
- Annual physicals
- Asthma
- Cholesterol/lipid management
- Depression treatment
- Diabetes management
- Health screenings
- High blood pressure management
- Immunizations
- Pregnancy testing
- Tobacco cessation
- Weight management

Visits are by appointment. Limited fast-track appointments for minor illnesses or injuries are available for same-day or next-day visits.

For urgent-care issues or medical questions before and after clinic hours, call the 24-hour UnitedHealthcare NurseLine at **1-877-365-7949.**

Clinic hours

Downtown Clinic

700 Lavaca, 9th Floor, Suite 980

Phone:
1-512-854-5509

Monday–Thursday:
7:30 a.m.–5:30 p.m.
(Closed for lunch 12–1 p.m.)

Friday:
7:30–11:30 a.m.

Airport Blvd. Clinic

5501 Airport Blvd, Suite 201

Phone:
1-512-854-7998

Monday–Tuesday:
7:30 a.m.–5:30 p.m.
(Closed for lunch 12–1 p.m.)

Del Valle Clinic

3518 FM 973 South

Phone:
1-512-854-1282

Wednesday–Thursday:
7:30 a.m.–5:30 p.m.
(Closed for lunch 12–1 p.m.)

Friday:
7:30–11:30 a.m.


FINANCIAL
RESOURCES

FLEXIBLE SPENDING ACCOUNTS

A flexible spending account (FSA) is an account you set up to pre-fund your anticipated eligible medical and/or dependent care (daycare) expenses. Once you decide how much to contribute, the amount is deducted pre-tax in equal amounts from your paychecks during the plan year. The amount you elect to contribute to the FSA account reduces your taxable income.

Health care FSA

A health care FSA is used to pay for eligible medical, dental and vision expenses that are not covered by your insurance or other plan. These expenses can be incurred by you, your spouse, a qualifying child or any eligible IRS dependent. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate. You and your qualifying spouse and children can use the health care FSA account even if you are not enrolled in Travis County medical insurance.

The FSA card is a convenient reimbursement option that allows UnitedHealthcare to electronically reimburse eligible expenses. When requested, you must send in documentation for transactions that are not a known office visit or prescription copay. Documentation is a statement or bill showing:

- Name of the patient
- Name of the service provider
- Date of service
- Type of service (including prescription name)
- Total amount of service

FSA benefits will end when you terminate employment with the County.

Dependent care FSA

A dependent care FSA is a great way to pay for eligible daycare expenses such as after-school care, babysitting fees, summer camps (not overnight), daycare services, preschool and certain eldercare expenses. Eligible dependents include your qualifying child under 13 or a spouse/tax-dependent relative who is physically or mentally incapable of self-care and lives in your home for more than half the year.

You can request reimbursement from your dependent care FSA as often as you like. However, your approved expenses will not be paid until after the last date of service for which you are requesting reimbursement has passed. The maximum reimbursement you may receive is equal to the current account balance in your dependent care FSA. If your reimbursement request is more than your available balance, the remaining amount will be placed in a pending status. The pending amount will be paid when additional funds are posted to your account.

Limited FSA*

Designed to complement a health savings account, a limited FSA is used to pay only for eligible dental and vision expenses that are not covered by your insurance or other plan. These expenses can be incurred by you, your spouse, a qualifying child or an IRS dependent. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate. You can make using your funds even quicker and more convenient when you use your FSA card.

* Employees must be enrolled in the High Deductible Health Plan with a health savings account to be eligible for a limited FSA.

Examples of how to use your FSA

Example 1: Paying a copay and doctor/dental fees (health care/limited FSA)

Once you enroll in the health care FSA, UnitedHealthcare will send you a health care FSA Mastercard. You can use this at the doctor's office or the pharmacy to pay instantly with FSA funds and avoid waiting for reimbursement. If you use your FSA card, be sure to keep copies of your receipts to substantiate the expense if requested. Or, if you pay by some other method, get a receipt or an explanation of benefits (EOB). You can then submit those payment documents, along with a claim form, to UnitedHealthcare. Within 1 to 3 business days, UnitedHealthcare will process your request and mail your reimbursement check to you or direct-deposit your funds into the account of your choice.

Example 2: Paying for daycare services (dependent care FSA)

Once you have paid for your daycare service, send a completed claim form to UnitedHealthcare, along with documentation showing the following:

- Name and age of the dependent receiving the service
- Cost of the service
- Name and address of the service provider
- Beginning and ending dates of the service
- Social Security or EIN (employer identification number) of the place providing the service

Your request will be processed within 5 business days and either mailed to you or deposited into the account you have chosen.

Annual contribution limits

Health care FSA:

- Minimum annual deposit is $120 for the benefit plan year or $5.00 per pay period
- Maximum annual deposit is $3,200 for the benefit plan year or $133.33 per pay period

Dependent care FSA:

- Minimum annual deposit is $120 for the benefit plan year or $5.00 per pay period
- Maximum contribution depends on your tax filing status. The IRS sets the annual contribution limits for dependent care FSAs. You can contribute up to a maximum of:
  - $2,500 per year, or $104.16 per pay period, if you are married and file a separate tax return
  - $5,000 per year, or $208.33 per pay period, if you are married and file a joint tax return or if you file as single or head of household
  - The lower of your/your spouse's income if either of you earns less than $5,000 a year

FSA Savings Example		
With FSA		Without FSA
$31,000	Annual gross income	$31,000
- $2,500	FSA deposit for recurring expenses	- $0.00
$28,500	Taxable gross income	$31,000
- $6,455	Federal, Social Security taxes*	- $7,021
$22,045	Annual net income	$23,979
- $0.00	Cost of recurring expenses	-$2,500
$22,045	Spendable income	$21,479
By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of $566.		

*Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Example eligible expenses

The following list shows just some of the purchases you can make with a flexible spending account. Only the portion of the medical, dental or vision expense that insurance doesn't pay, and for which are you responsible to pay out of your own pocket, is eligible for reimbursement.

- Coinsurance
- Copays
- Deductibles
- Dental treatment
- Diagnostic items/services
- Durable medical equipment
- Eye exams/glasses/contacts
- Hearing aids
- Immunizations
- Laboratory fees
- Laser eye surgery
- Orthodontia
- Physical therapy
- Prescription drugs
- Stop-smoking program
- X-rays, MRIs, CT scans

For a complete list of eligible expenses or for more information, contact UnitedHealthcare directly at **myuhc.com** or at **1-866-649-4873.**

HEALTH SAVINGS ACCOUNTS

If you have the High Deductible Health Plan, you can enroll in an HSA to pay for qualified expenses, including those of your spouse and/or tax dependents. Contributions to an HSA are tax-free, and withdrawals for qualified expenses are also tax-free. The money is yours to spend this year or save for the future. If you change jobs or retire, you can take the money with you.

- You must be enrolled in the High Deductible Health Plan
- You and your enrolled dependents cannot be claimed on another person's tax return
- You cannot be enrolled in any other health plan
- You cannot be enrolled in Medicare or Tricare
- You and your enrolled dependents cannot be enrolled in a health care FSA
- You must provide a physical address to Optum Health Bank (no P.O. boxes)
- You must be a legal resident of the United States

Once you enroll, Optum Bank will issue a debit card that you can use to pay for qualified expenses. If you use another form of payment, you can reimburse yourself from your HSA. Eligible expenses include doctor office visits, eye exams, prescriptions, laser eye surgery and more. IRS Publication 502 provides a complete list of eligible expenses and can be found on **irs.gov.** There are no receipts to submit for reimbursement; however, you must keep your receipts in case the IRS audits you. Employees can upload and save their receipts on the Optum Bank app or website.

Travis County contributes $500 for employee-only coverage and $1,000 for employee-plus-dependent coverage. The employer contribution is funded annually on January 1. Below is the amount Travis County contributes for new hires. The amount is based on your benefits effective date.

	Jan. 1–March 31	April 1–June 30	July 1–Sept. 30	Oct. 1–Dec. 31
Employee only	$500	$375	$250	$125
Employee + dependent	$1,000	$750	$500	$250

Travis County's contribution will be funded on the debit card up front. An employee can also elect to contribute per pay period or directly to Optum Bank.

HSA contribution limits

Contributions to an HSA are tax-free and can be made through payroll deduction on a pre-tax basis. The money in this account (including interest and investment earnings) grows tax-free as well. As long as the funds are used to pay for qualified expenses, they are also spent tax-free. Per IRS regulations, if funds are used for purposes other than qualified expenses and you are younger than age 65, you will pay federal income tax on the amount withdrawn plus a 20% penalty tax. At age 65, you are no longer eligible to contribute to an HSA. After age 65, the money in your HSA does not have to be used for eligible expenses. An HSA is a great way to save for post-retirement health care needs.

Each year, the IRS places a limit on the amount that can be contributed to the HSA. For 2025, contributions (which include the employer contribution) are limited to the following:

Employee only	Employee + dependent	Catch-up contribution (age 55+)
$4,300	$8,550	$1,000

RETIREMENT PLANNING

Texas County & District Retirement System (TCDRS)

Travis County participates in the Texas County & District Retirement System (TCDRS). The money that funds your plan comes from employee deposits, employer contributions and earnings from investments. Participation in TCDRS is mandatory for qualifying employees. Seven percent of your total pay goes into your TCDRS account every pay period. This money is taken out on a pre-tax basis.

Changes to benefits

The Travis County Commissioner's Court chooses your TCDRS benefits. Every year it reviews Travis County's retirement plan and makes changes, if needed. The Commissioner's Court decides:

- What percentage of your paycheck goes into your TCDRS account
- How much Travis County will match when you retire
- What you must do to be eligible for retirement

How your money grows

Your account earns an annual interest credit of 7%. TCDRS credits this interest to your account each December 31, based on your account balance as of January 1 (see chart below). Over time, the value of your account can increase due to compounding interest — that is, paying interest on interest. Every year you'll get a statement from TCDRS that shows all your deposits for the year as well as how much interest you received. You can also view your current balance online at **tcdrs.org.**

Year	Beginning Balance	Deposits	7% Interest on Dec. 31	Ending Balance
Year 1	$0.00	$2,000.00	$0.00	$2,000.00
Year 2	$2,000.00	$2,000.00	$140.00	$4,140.00
Year 3	$4,140.00	$2,000.00	$289.80	$6,429.80

Vesting

You are considered vested when you have enough service time to be eligible for retirement benefits. To be vested in your plan, you must have 8 years of service credit. Once vested, you may stop working for Travis County and still keep a future retirement benefit. Your personal account will keep earning interest each year until your membership ends. Your membership ends when you withdraw your personal deposits or choose a retirement benefit or upon your death. (If you were a member of TCDRS before 2000, you may be vested with 4 years of service.)

When you can retire

Once you are vested, you are eligible for a retirement benefit when you meet one of the following requirements:

- Age 60 with 8 years of service; or
- Any age with 30 years of service; or
- Rule of 75: Your age plus years of service equals 75

The statement you get from TCDRS every year shows your account balance and the earliest date you will be eligible to receive your retirement benefit. You can also view your statement at **tcdrs.org.**

When you retire

When you retire, you may choose to receive a monthly benefit payment. All payment options pay you for your lifetime. Some of the payment options also provide a monthly benefit for your beneficiary after your death.

Your monthly benefit is based on the amount of money in your account and the matching credits Travis County has agreed to provide. Your current deposits get matching credits in a ratio of 2.25:1, or $2.25 for every $1.00 you are depositing. Travis County also provides monetary credit for time worked before it joined TCDRS (prior service credit). Travis County joined TCDRS in January 1968.

Termination from Travis County

If you terminate from Travis County prior to vesting with TCDRS, you will be eligible to receive back the money you put into the retirement plan. If you are not vested upon termination, you will not be eligible to receive any additional money from Travis County or interest.

Travis County 457(b) deferred compensation plan

Empower Retirement administers the Travis County 457(b) deferred compensation plan. A governmental 457(b) deferred compensation plan is a retirement savings plan that allows eligible employees to save and invest for retirement in both a pre-tax and a post-tax (Roth) plan through voluntary salary contributions. For the pre-tax plan contributions, any earnings on contributions are tax-deferred until money is withdrawn. Then you will pay taxes at your regular tax rate at the time the money is withdrawn. For the Roth plan, since you have contributed to the plan with post-tax fund contributions, any earnings on contributions are not considered to be taxable income when a qualified distribution is taken.

Contribution limits

- Combined maximum limit of 100% ($1 per-pay-period minimum) of your compensation or $22,500, whichever is less, for all retirement contributions; or
- Participants turning age 50 or older may contribute an additional $7,500.

Special 457(b) catch-up contributions, if permitted by the plan, allow a participant for 3 years prior to the normal retirement age (as specified in the plan) to contribute the lesser of:

  - Twice the annual limit ($45,000 in 2024), or
  - The basic annual limit plus the amount of the basic limit not used in prior years (only allowed if not using age 50 or over catch-up contributions)

Contribution limits are set annually by the IRS.

457(b) plan vesting

Vesting refers to the percentage of your account you are entitled to receive upon the occurrence of distributable events. Your contributions and any earning are always 100% vested (including rollovers from previous employers).

Investment options

A wide array of core investment options is available through your plan. Each option is explained in further detail in your plan's fund sheets. Once you have enrolled, investment option information is also available at **empowermyretirement.com** or by calling **1-800-701-8255.**

In addition to the core investment options, a self-directed brokerage (SDB) account is available. The SDB account allows you to select from numerous investment options for additional fees. The SDB account is intended for knowledgeable investors who acknowledge and understand the risks associated with the investments contained in the SDB account.

Rollovers

Only plan administrator–approved balances from an eligible governmental 457(b), 401(k), 403(b) or 401(a) plan or an individual retirement account (IRA) may be rolled over to the plan. Distributions you receive prior to age 59½ may be subject to the 10% early withdrawal federal tax penalty.

Withdrawals

Qualifying distribution events are as follows:

- Retirement
- Severance of employment (as defined by the Internal Revenue Code provisions)
- Attainment of age 70½ (if allowed by government plan's provisions)
- Death (your beneficiary receives your benefits)
- Unforeseeable emergency (as defined by the Internal Revenue Code and if allowed by your plan's provisions)

Each distribution is subject to ordinary income tax except for an in-service transfer to purchase service credit.

Loans

Your plan allows you to borrow the lesser of $50,000 or 50% of your total vested account balance. The minimum loan amount is $1,000, and you have up to 5 years to repay your loan — up to 10 years if the money is used to purchase your primary residence. There is a $50 origination fee for each loan, plus an ongoing annual $25 fee.

LIFE INSURANCE

Employee basic life and AD&D coverage

All regular employees receive basic life and accidental death and dismemberment (AD&D) coverage in the amount of $50,000 each provided by Travis County at no cost to employees. This coverage is with UnitedHealthcare.

If you are age 70 or older, coverage amount(s) will reduce according to the following schedule:

Age	Insurance amount reduces to
70–74	65% of original amount
75–79	40% of original amount
80–84	25% of original amount
85–89	15% of original amount
90+	10% of original amount

Employee supplemental life and AD&D coverage

You also have the option to elect supplemental life and AD&D coverage from New York Life. Amounts are issued in $25,000 increments only. The overall maximum benefit of life and AD&D coverage you can elect is 4 times your annual salary, rounded to the next higher multiple of $25,000, up to a maximum of $350,000.

Example:

Employee's base salary is $15.00 per hour, and they are scheduled to work 40 hours per week. The maximum amount of supplemental life and AD&D coverage the employee is allowed to elect is $125,000.

$15.00/hour x 2,080 hours/year = **$31,200**

$31,200 annual x 4 = **$124,800**

$124,800 rounded up to the next highest $25,000 = **$125,000**

Guarantee issue

If you enroll during your new-hire enrollment period, you may apply for any amount of life insurance coverage up to the maximum without having to complete an evidence of insurability (EOI) form.

If you and your eligible dependents do not enroll during your new-hire enrollment period, you can apply for coverage only during the open enrollment period or within 30 days of a qualifying life event. EOI is not required during open enrollment if the increase in coverage is by one $25,000 benefit unit for employees or $10,000 for spouses. Any request for coverage higher than one $25,000 benefit unit requires completion of an EOI form and approval from New York Life.

Additional benefits

- Portability/conversion — If you retire, reduce your hours or leave Travis County, you may apply to take this coverage with you according to the terms outlined in the contract. You may be able to convert your term life coverage to an individual life insurance policy.
- Accelerated benefit — If you become terminally ill and are not expected to live more than 12 months, you may request up to 100% of your life insurance amount, without fees or present-value adjustments.

Monthly supplemental life and AD&D rates

(Age as of October 1)	$25,000 coverage	$50,000 coverage	$75,000 coverage	$100,000 coverage	$125,000 coverage
under 30	$1.40	$2.80	$4.20	$5.60	$7.00
30–39	$2.08	$4.16	$6.24	$8.30	$10.38
40–44	$2.98	$5.96	$8.94	$11.90	$14.88
45–49	$4.34	$8.66	$12.98	$17.30	$21.64
50–54	$7.04	$14.06	$21.08	$28.10	$35.14
55–59	$9.74	$19.46	$29.18	$38.90	$48.64
60–64	$15.58	$31.16	$46.74	$62.30	$77.88
65–69	$23.00	$46.00	$69.00	$92.00	$115.00
70+	$40.10	$80.20	$120.30	$160.40	$200.50

(Age as of October 1)	$150,000 coverage	$175,000 coverage	$200,000 coverage	$225,000 coverage	$250,000 coverage
under 30	$8.40	$9.80	$11.20	$12.60	$14.00
30–39	$12.46	$14.54	$16.60	$18.68	$20.76
40–44	$17.86	$20.84	$23.80	$26.78	$29.76
45–49	$25.96	$30.28	$34.60	$38.94	$43.26
50–54	$42.16	$49.18	$56.20	$63.24	$70.26
55–59	$58.36	$68.08	$77.80	$87.54	$97.26
60–64	$93.46	$109.04	$124.60	$140.18	$155.76
65–69	$138.00	$161.00	$184.00	$207.00	$230.00
70+	$240.60	$280.70	$320.80	$360.90	$401.00

(Age as of October 1)	$275,000 coverage	$300,000 coverage	$325,000 coverage	$350,000 coverage
under 30	$15.40	$16.80	$18.20	$19.60
30–39	$22.84	$24.90	$26.98	$29.06
40–44	$32.74	$35.70	$38.68	$41.66
45–49	$47.58	$51.90	$56.24	$60.56
50–54	$77.28	$84.30	$91.34	$98.36
55–59	$106.98	$116.70	$126.44	$136.16
60–64	$171.34	$186.90	$202.48	$218.06
65–69	$253.00	$276.00	$299.00	$322.00
70+	$441.10	$481.20	$521.30	$561.40

Dependent life insurance

In addition to basic and supplemental employee life insurance, employees can elect life insurance coverage for their spouse and/or dependent children. The basic dependent life insurance includes coverage for an employee's spouse and dependent children for one flat rate per month. The cost for coverage listed below is $0.77 per pay period or $1.54 per month.

Spouse/domestic partner	$10,000
Child	$5,000 (age 6 months to 26 years)
Infant	$1,000 (14 days to 6 months)

Spouse/domestic partner supplemental life insurance

If you elect basic dependent life coverage, you have the option to also elect additional spouse/domestic partner supplemental life insurance. The supplemental life insurance can be elected to increase the total amount of coverage for a spouse/domestic partner up to a maximum of $30,000 ($10,000 or $20,000 in addition to the dependent life insurance above). Rates are based on age and coverage amount.

Monthly Amount			**Per-Pay-Period Amount**		
Age of spouse	**$10,000 coverage**	**$20,000 coverage**	**Age of spouse**	**$10,000 coverage**	**$20,000 coverage**
under 30	$0.36	$0.72	under 30	$0.18	$0.36
30–39	$0.64	$1.26	30–39	$0.32	$0.63
40–44	$1.00	$1.98	40–44	$0.50	$0.99
45–49	$1.54	$3.06	45–49	$0.77	$1.53
50–54	$2.62	$5.22	50–54	$1.31	$2.61
55–59	$3.70	$7.38	55–59	$1.85	$3.69
60–64	$6.04	$12.06	60–64	$3.02	$6.03
65–69	$9.00	$18.00	65–69	$4.50	$9.00
70+	$15.84	$31.68	70+	$7.92	$15.84

Personal accident insurance (AD&D)

Personal accident insurance helps protect you against losses due to accidents. A covered accident is a sudden, unforeseeable external event, resulting directly from and independently of all other causes, in a covered injury or covered loss that occurs while coverage is in force. To help survivors of severe accidents adjust to new living circumstances, New York Life will pay benefits according to the chart below.

If, within 365 days of a covered accident, bodily injury results in:	New York Life will pay this % of benefit amount
• Loss of life, or • Total paralysis of upper and lower limbs, or • Loss of any combination of two: hands, feet or eyesight, or • Loss of speech and hearing in both ears	**100%**
• Total paralysis of both upper and lower limbs, or • Total paralysis of both upper and lower limbs on one side of the body, or • Loss of one hand, one foot or sight in one eye, or • Loss of speech, or • Loss of hearing in both ears	**50%**
• Loss of thumb and index finger of the same hand, or • Total paralysis of one upper or one lower limb, or • Loss of all four fingers of the same hand, or • Loss of all toes of the same foot	**25%**
• Coma	**1%**

How much coverage can you buy?

You may select from $25,000 to $500,000 of coverage, in units of $25,000. Your spouse's benefit amount will be 50% of your coverage amount or 60% if you have no dependent children. The maximum benefit amount for your spouse is $300,000. Each of your covered children's benefit amounts will be 10% of yours, or 15% if you have no eligible spouse, up to a maximum benefit amount of $25,000 for each child.

Each family member's coverage is a percentage of the benefit amount you select. It will depend on who your insured family members are at the time of a covered accidental loss. You may need to request changes to your existing coverage if, in the future, you no longer have dependents who qualify for coverage. See rates and coverage amounts below.

	Monthly Amount		Per-Pay-Period Amount	
Benefit Amount	**Employee Only**	**Family Coverage**	**Employee Only**	**Family Coverage**
$25,000	$0.50	$0.88	$0.25	$0.44
$50,000	$1.00	$1.75	$0.50	$0.88
$100,000	$2.00	$3.50	$1.00	$1.88
$150,000	$3.00	$5.25	$1.50	$2.63
$200,000	$4.00	$7.00	$2.00	$3.50
$250,000	$5.00	$8.75	$2.50	$4.38
$300,000	$6.00	$10.50	$3.00	$5.25
$400,000	$8.00	$14.00	$4.00	$7.00
$500,000	$10.00	$17.50	$5.00	$8.75

DISABILITY INSURANCE

Short-term disability

Short-term disability (STD) provides benefits when you are unable to work for a short period of time. Benefits are payable when New York Life determines that you are:

- Unable to perform the material duties of your regular occupation; and
- Unable to earn 80% or more of your covered earnings from working in your regular occupation.

Your paid-time-off accrual balance should be considered when purchasing a short-term-disability policy. Benefits are paid based on a percentage of your weekly earnings, less income from other benefits, which could include workers' compensation, unemployment or other disability plans.

Short-Term-Disability Benefit Highlights	
Policy number	VDT-960952
Benefit level	60% of weekly earnings
Maximum weekly benefit	$1,500
Minimum weekly benefit	$25
Waiting period	14 days illness 14 days accident or injury
Maximum benefit duration	13 weeks

Pre-existing condition limitation

New York Life will not pay benefits for any period of disability caused or contributed to by, or resulting from, a pre-existing condition. A pre-existing condition means any injury or illness for which the employee incurred medical expenses; received medical treatment, care or services including diagnostic measures; or took prescribed drugs or medicines within 3 months before their most recent effective date of insurance. This limitation will not apply to a period of disability that begins after an employee is covered for at least 12 months after their most recent effective date of insurance, or the effective date of any added or increased benefits.

Benefit level and rates

The after-tax premium rate for the coverage is $0.44 per $10 of weekly benefit amount. The chart below shows example monthly premium amounts based on different levels of salary. The benefit level is set based on your salary at initial enrollment or your salary as of October 1 of each year.

Annual Salary	Weekly STD Benefit	Monthly Premium	Per-Pay-Period Premium
$21,666.67	$250.00	$11.00	$5.50
$26,000.00	$300.00	$13.20	$6.60
$34,666.67	$400.00	$17.60	$8.80
$43,333.33	$500.00	$22.00	$11.00
$52,000.00	$600.00	$26.40	$13.20
$60,666.67	$700.00	$30.80	$15.40
$69,333.33	$800.00	$35.20	$17.60
$78,000.00	$900.00	$39.60	$19.80
$86,666.67	$1,000.00	$44.00	$22.00
$95,333.33	$1,100.00	$48.40	$24.20
$104,000.00	$1,200.00	$52.80	$26.40
$112,666.67	$1,300.00	$57.20	$28.60
$121,333.33	$1,400.00	$61.60	$30.80
$130,000.00	$1,500.00	$66.00	$33.00

Long-term disability

Long-term-disability (LTD) coverage provides benefits when you are unable to work for a longer period of time due to a covered illness or injury. Long-term-disability benefits are payable when New York Life determines that:

- You are limited from performing the material and substantial duties of your regular occupation due to your illness or injury; and
- You have a 20% or more loss in your indexed monthly earnings due to the same illness or injury; and
- After benefits have been paid for 24 months, you are disabled when New York Life determines that due to the same illness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience; and
- You have a 40% or more loss in your indexed monthly earnings; and
- You are under the regular care of a physician.

The waiting period is the length of time for disability that must be satisfied before you are eligible to receive benefits. Benefits are paid based on a percentage of your monthly earnings, less income from other benefits, which could include Travis County sick leave, workers' compensation, unemployment or other disability plans.

Long-Term-Disability Benefit Highlights	
Policy number	VDT-960953
Benefit level	60% of monthly earnings
Maximum monthly benefit	$6,000
Minimum weekly benefit	$100 or 10% of your monthly benefit prior to any reductions for Other Income Benefits, whichever is greater
Waiting period	90 days
Maximum benefit duration	Up to your Social Security normal retirement age

Pre-existing condition limitation

New York Life will not pay benefits for any period of disability caused or contributed to by, or resulting from, a pre-existing condition. A pre-existing condition means any injury or illness for which the employee incurred medical expenses; received medical treatment, care or services including diagnostic measures; or took prescribed drugs or medicines within 6 months before their most recent effective date of insurance.

This limitation will not apply to a period of disability that begins after an employee has been in active service for a continuous period of 12 months during which the employee has received no medical treatment, care or services in connection with the pre-existing conditions or is covered for at least 24 months after their most recent effective date of insurance, or the effective date of any added or increased benefits.

Benefit level and rates

The premium rate for the coverage is $0.60 per $100 of the monthly payroll coverage amount. The chart below shows example monthly premium amounts based on different levels of coverage. The benefit level is set based on your salary at initial enrollment or your salary as of October 1 of each year.

Annual Salary	Monthly LTD Benefit	Monthly Premium	Per-Pay-Period Premium
$20,000.00	$1,000.00	$10.00	$5.00
$30,000.00	$1,500.00	$15.00	$7.50
$40,000.00	$2,000.00	$20.00	$10.00
$50,000.00	$2,500.00	$25.00	$12.50
$60,000.00	$3,000.00	$30.00	$15.00
$70,000.00	$3,500.00	$35.00	$17.50
$80,000.00	$4,000.00	$40.00	$20.00
$90,000.00	$4,500.00	$45.00	$22.50
$100,000.00	$5,000.00	$50.00	$25.00
$120,000.00	$6,000.00	$60.00	$30.00

Reporting a disability claim

When to report a claim

- If your physician has determined you are unable to work due to illness, injury or maternity reasons
- In advance of a planned medical absence, such as prescheduled surgery or maternity leave

How to report a claim

Call New York Life's toll-free number to speak with one of their customer intake representatives, who will walk you through the process. All of the information can be given over the phone by calling **1-888-842-4462.** Or you can access the online claim form through New York Life's website, **mynylgbs.com.** Click on Forms and find the Disability Forms section.

LONG-TERM-CARE INSURANCE

Travis County offers voluntary long-term-care insurance. Employees and their family members are eligible to apply for this coverage at any time during the year. New employees will have one guarantee issue period when coverage is offered with no underwriting requirements. This period will be in February of each year. Other employees and family members will go through an application process that includes a medical underwriting questionnaire. Applications will be medically underwritten and approved or rejected based on medical information submitted.

This is an age-rated indemnity product, so your cost depends on the age you are on the effective date of your coverage. Rates do not increase in most cases once you are approved. Premiums will be direct-billed to the employee, retiree or family member.

Long-Term-Care Available Benefit Options	
Policy number	205655
Term of care	3 years, 6 years or lifetime *(Lifetime term requires underwriting for all applicants)*
Long-term-care facility	Choice of $2,000, $3,000, $4,000, $5,000 or $6,000 per month
Home care	50% of monthly long-term-care facility benefit chosen Choice of professional home and community care (professional licensed care) or total choice home care benefits (licensed and unlicensed caregivers)
Inflation protection	5% simple inflation protection

Please go to **unuminfo.com/countyoftravis/index.aspx** or call UNUM at **1-800-227-4165** for more detailed information.

OTHER BENEFITS

Tuition reimbursement

Travis County offers tuition reimbursement to regular employees who have been continuously employed full-time with Travis County at least 6 months prior to the start of the course and remain continuously employed with Travis County at least 6 months after the end of the course. Elected and appointed officials are not eligible for tuition reimbursement. In order to receive a refund, the course must be taken from an accredited college, university or technical school in the United States and approved by the Human Resources Management department (HRMD). Once an employee receives approval and meets the completion requirement(s) for the course or exam, employees can receive assistance equal to 80% of the tuition (tuition, testing and required fees) up to a $1,000 maximum per semester and $2,000 maximum per fiscal year.

For eligibility, completion requirements and other details, please refer to section 10.020 of the Chapter 10: Travis County Personnel Benefits Guidelines and Procedures Manual.

Longevity pay

For regular employees, longevity pay is based on long-term employment and service to Travis County. For transfer employees, longevity pay is based on long-term employment and service to both the City of Austin and Travis County. Longevity pay is paid to regular and transfer employees for each year completed after 3 years of continuous service on the anniversary of their hire date. On an employee's fourth and subsequent anniversaries, they will receive a lump-sum payment for the previous year. Any employee who terminates employment prior to their anniversary date forfeits longevity pay.

Longevity pay is based on whichever is greater:

- $5 per month for each year of service up to 25 years, or
- A percentage of the employee's annual base pay as follows:
  - For 3 to 5 years of service: .50%
  - For 6 to 9 years of service: .75%
  - For 10 to 15 years of service: 1.00%
  - For 16 to 20 years of service: 1.50%
  - For 21 or more years of service: 2.00%

An employee with more than 25 years of service will be credited for the maximum of 25 years at the higher rate.

Peace officers who are in a law enforcement activity or whose job mandates state peace officer certification accrue up to 25 years of longevity pay. Longevity pay begins after 1 year of certification and is prorated upon separation from the County.

Workers' compensation

The county provides all employees with workers' compensation coverage in accordance with state statutes. All non-POPS regular employees are eligible for salary continuation if they are injured or become ill due to a job-related incident and follow the required reporting procedures up to a maximum of 6 months from the date of injury. If you sustain an injury arising out of, or in the course of, work for the County, you must report such injury to your supervisor and/or the Risk Management department immediately.

Training and development

HRMD Learning and Development offers training that supports core competencies for leadership development. Employees and managers can gain the fundamental knowledge and skills they need to become confident and effective leaders by participating in the new Level Up Leadership Training Program.

Level Up 1: Non-managers — blended learning for non-supervisors including a combination of instructor-led classes and online trainings

Level Up 2: First-line Managers — blended learning for supervisors including a combination of instructor-led classes, a 2-day workshop and online trainings

Level Up 3: Managers / Directors — blended learning for supervisors including a combination of instructor-led classes, a 3-day workshop and online trainings

Level Up 4: Executives / Directors — blended learning for advanced leaders including a combination of instructor-led classes, a 4-day workshop and online trainings

The goal of the Level Up program is to enhance and provide professional development including but not limited to soft skills, management skills, team dysfunctions and the "Leadership Challenge."

Leadership Austin

The purpose of this program is to benefit Travis County and the community by providing an opportunity for employees to participate in leadership training as funds are available and to provide written guidelines for consideration in awarding those funds. This program is separate from tuition reimbursement and does not overlap.

Travis County Leadership Austin is available to all employees who wish to take part, if participating would result in a direct benefit to Travis County. Employees who are interested should submit a request to the Human Resources Management department. See Chapter 110.0191–110.0196 of the Travis County Code: Leadership Training — Funding Guidelines for additional details on the program.

PAID TIME OFF

Vacation time

The County recognizes that employees need time away from work for rest, for relaxation and to attend to personal business that must be conducted during normal office hours. We've established a vacation leave policy based on years of service. Regular employees earn vacation leave each pay period as long as employment continues. Regular part-time employees earn vacation leave on a prorated basis.

Employees must obtain approval from their supervisor before using vacation leave.

Vacation Time Accrual Levels	
0–5 years	4.0 hours per pay period
6–10 years	4.5 hours per pay period
11–15 years	5.0 hours per pay period
16–20 years	5.5 hours per pay period
21+ years	6.0 hours per pay period

The maximum accrual of vacation leave is limited to 400 hours (50 days) for regular full-time employees. Upon separation, a regular full-time employee shall be paid for vacation leave accrued on the basis of their final salary rate. Payment shall not exceed a total of 240 hours (30 days).

Vacation will be granted to employees at the discretion of the elected official/department head or their designee, who will give due consideration to the needs of the office/department and the ability of remaining staff to perform the necessary work. An official County holiday that occurs during an employee's vacation shall not be charged against vacation leave time.

Sick time

Regular employees shall earn sick leave at a rate of 4 hours per pay period, with no accrual maximum. Regular part-time employees shall earn sick leave on a prorated basis.

An elected official/department head, or their designee, should authorize use of accrued sick leave for an employee who is unable to perform their duties because of illness, injury or other temporary disabilities. An employee may use accrued sick leave to care for a member(s) of the employee's immediate family, or a person within the same household with whom the employee shares a significant relationship of mutual caring, or who is incapacitated. An employee must obtain approval from their immediate supervisor prior to attending an appointment for non-emergency dental or medical examinations, for themselves or an immediate family member, scheduled during normal working hours.

An elected official/department head or their designee may ask an employee to provide a doctor's statement to substantiate sick leave requests after an employee has been on sick leave for 3 consecutive workdays or more.

Unscheduled sick leave should be used for emergency situations only. The employee should follow the department's notification procedures when unable to report to work as scheduled.

Upon separation, a regular full-time employee shall be paid for half of their accrued sick leave up to a maximum of 480 hours at their final salary rate with a maximum payment not exceeding 240 hours (30 days).

Personal holiday

All regular full-time employees are eligible for up to 3 paid personal holidays each calendar year. Regular part-time employees shall be granted personal holidays on a prorated basis. Personal holidays are in addition to vacation leave and shall be scheduled at the discretion of the elected official/department head or their designee. Personal holidays shall be requested by the employee and approved by the elected official/department head or their designee. Personal holidays do not accumulate from one calendar year to the next and must be used in the same calendar year in which they were granted.

New employees earn personal holidays based on the month in which they are hired.

January through March	April through June	July through September	October through December
3 personal holidays	2 personal holidays	1 personal holiday	None

A new employee must be employed for 90 calendar days before taking a personal holiday. Reinstated employees will earn personal holidays based on their new-hire date, except that no employee may earn more than 3 personal holidays in one calendar year. Unused personal holidays are not paid at separation. A personal holiday may not be used as the last day of employment.

An employee who is on leave without pay will not accrue vacation leave, sick leave, longevity, merit review service or retirement service.

Holiday pay

Regular full-time and regular part-time employees are allowed the holidays designated, unless required by their supervisor to work. Regular part-time employees receive pay for the holidays on a prorated basis.

Regular non-exempt employees who are required by their supervisor to work on a holiday accrue non-designated holiday time credit on an hour-for-hour basis for scheduled hours worked. This credit may be used at a later date.

Regular non-exempt and exempt aviation employees who are required by their supervisor to work on a holiday receive holiday time pay on an hour-for-hour basis for scheduled hours worked in addition to pay for the hours worked.

Regular non-exempt and exempt aviation employees whose regularly scheduled day off falls on a holiday accrue non-designated holiday time credit on an hour-for-hour basis for scheduled hours. This credit may be used at a later date.

Regular non-exempt employees whose regularly scheduled day off falls on a holiday accrue non-designated holiday time credit on an hour-for-hour basis, for scheduled hours. This credit may be used at a later date. Employees must obtain approval from their supervisor before using non-designated holiday time credit.

FY25 Travis County Approved Holidays	
Veterans Day	November 11, 2024
Thanksgiving Day	November 28, 2024
Day after Thanksgiving	November 29, 2024
Christmas Holiday	December 24 & December 25, 2024
New Year's Day	January 1, 2025
Martin Luther King Jr. Day	January 20, 2025
Presidents' Day	February 17, 2025
Memorial Day	May 26, 2025
Juneteenth	June 19, 2025
Independence Day	July 4, 2025
Labor Day	September 1, 2025

If an employee is requesting leave, the employee must use non-designated holiday time credit before using vacation leave unless the employee is subject to losing vacation leave if it is not taken within the following 3 months. It is the employee's responsibility to request the appropriate type of leave. Non-designated holiday time credit accrues until it is used or until an employee separates from the County. Upon separation, non-exempt employees are not paid for more than 16 hours of unused non-designated holiday credit. Unused non-designated holiday credit is paid at their final salary rate.

Catastrophic sick leave pool

Commissioners Court approved the implementation of a catastrophic sick leave (CSL) policy. This policy allows employees to donate hours to a "pool." Enrollment is concurrent with the open enrollment period each year. The hours in the pool can be used by employees who have exhausted all of their paid time off due to a catastrophic illness.

Who is eligible to donate time to the CSL pool?

Travis County employees must:

- Be regular, full-time employees; and
- Have worked full-time with Travis County for 12 consecutive months; and
- Voluntarily donate a minimum of 8 hours of leave (maximum of 40 hours) during open enrollment. Donation may include sick and/or vacation leave.

At separation, employees may donate up to 80 hours of any combination of sick and/or vacation leave.

Who is eligible to use CSL time from the pool?

- An employee donates a minimum of 8 hours or more to the CSL pool every other year during open enrollment to be eligible October 1 to September 30.
- An employee must be absent from work for 7 consecutive work days as a result of their own catastrophic injury or illness or that of an immediate family member.
- An employee must submit the request for CSL with appropriate medical documentation to the CSL administrator for consideration for approval.

What qualifies as a catastrophic injury or illness?

The CSL policy provides the following definition in Section 110.0372:

(2) Catastrophic Illness or Injury. A catastrophic illness or injury is defined as a severe condition or combination of conditions affecting the mental or physical health of the individual that has resulted in a life-threatening condition and/or has a major impact on life functions. Such life functions shall include, but are not limited to, the loss of physical senses, the loss of physiological processes or the loss of limb. Leave taken on an intermittent basis that does not require the employee to be absent from work for a period of at least 7 days does not qualify. A health care provider, as defined below, must certify the catastrophic condition. The catastrophic illness or injury must:

(A) Be present for a minimum of 7 consecutive calendar days, and

(B) Require continuous or ongoing medical treatment or rehabilitation by a health care provider for an extended time, and

C) Be characterized by the sudden onset of symptoms, which can be life threatening, or can cause significant or serious impairment or disability, and

(D) Be incurable or so serious as to significantly interfere with the ability of the employee or an immediate family member to perform with reasonable continuity the material duties of their job for 30 consecutive days or longer, and includes complications that require one or more of the following:

(i) Hospital care like inpatient care in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to that care, or

(ii) Supervision due to an incapacity for a permanent or long-term condition for which treatment may not be effective, like a severe stroke or heart attack or the terminal stages of a disease, or

(iii) Multiple treatments by a health care provider for a non-chronic condition when the treatments result in an absence from work, such as chemotherapy or radiation for cancer or therapy for organ transplant, but

(iv) Does not include conditions like elective surgery, a broken limb, cold or flu or allergy, or some routine types of surgery, such as orthopedic or appendectomy with minor or no complications.

Paid parental leave

Paid Parental Leave policy will provide 12 weeks of paid leave in a 12-month period to be used for the care or bonding of a new child due to the birth, adoption, foster-to-adopt or a court-ordered kinship after May 3, 2022. PPL hours are prorated for part-time eligible employees. Eligible employees are Regular employees and Special Project employees who have been employed by the County for at least 182 consecutive days on the date when the Parental Event occurs. More information on Paid Parental leave as well as the policy can be found on Travis Central.

REQUIRED NOTICES

Premium assistance under Medicaid and CHIP

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **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 at **1-877-543-7669** or visit **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 **askebsa.dol.gov** or call **1-866-444-3272.**

If you live in Texas, you may be eligible for assistance paying your employer's health plan premiums. The following list of states is current as of January 31, 2024. Contact your state for more information on eligibility.

TEXAS — Medicaid

Website: **hhs.texas.gov/services/health/medicaid-chip**

Phone number: **1-800-440-0493**

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Newborns Act disclosure

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for a mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymphedema.

In addition, the plan may not:

- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the health care provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance and copays consistent with other coverage provided by the plan.

Continuation coverage rights under COBRA

Introduction

You are receiving 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 gross misconduct.

If you are the spouse of an employee, you will 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 their 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.

When is COBRA continuation 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; and
- The employee's entitlement 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:

Travis County Human Resources Management Department
c/o Benefits Division
P.O. Box 1748
Austin, TX 78767

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 COBRA 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.

Flexible spending account or medical reimbursement account

If you are participating in the company's flexible spending account or medical reimbursement account at the time of your termination or reduction of hours, you may also have the right to continue participation under COBRA based on the following parameters:

- You will be allowed to continue coverage for the remainder of the current plan year if you have a balance remaining in your account at the time of your termination or reduction in hours; and
- You will not be able to receive reimbursements in excess of your original election amount in the account; and
- You make monthly payments in the same amount as your regular payroll deductions while you were an active employee.

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 **healthcare.gov.**

If you have questions:

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

If you have any questions about your rights to COBRA continuation coverage, contact:

UnitedHealthcare
Customer Care Center
P.O. Box 221709
Louisville, KY 40252

uhcservices.com
Toll free: **1-877-237-8576**
Email: **cobra_kyoperations@uhc.com**

Health Insurance Portability and Accountability Act (HIPAA) Notice

Travis County 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. Travis County maintains electronic health records and will not use or disclose your health information except as described in this notice. Please review it carefully.

Our uses and disclosures

We may use and share your information as we:

- Address workers' compensation, law enforcement and other government requests
- Bill for your services
- Comply with the law
- Do research
- Help with public health and safety issues
- Remind you of appointments for care
- Respond to lawsuits and legal actions
- Respond to organ and tissue donation requests
- Run our organization
- Treat you
- Work with a medical examiner or funeral director

Your rights

You have the right to:

- Ask us to limit the information we share
- Choose someone to act for you
- Correct your paper or electronic medical record
- File a complaint if you believe your privacy rights have been violated
- Get a copy of this privacy notice
- Get a copy of your paper or electronic medical record
- Get a list of those with whom we've shared your information
- Request confidential communication

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Your choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care

Our uses and disclosures details

We typically use or share your health information in the following ways:

- Treat you — We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization — We can use and share your health information to operate programs that provide health care services to you, improve your care and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- Bill for your services — We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research.

We must meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner or funeral director when an individual passes away.

Address workers' compensation, law enforcement and other government requests

We can use or share health information about you:

- For workers' compensation claims — for law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law — for special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your rights details

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you when you submit a written request.
- We will provide a copy or a summary of your health information within 15 days of your request if we maintain it in an electronic format. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address and we will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for 6 years prior to the date you ask, whom we shared it with and why. We will include all the disclosures except those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide 1 accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you think your rights are violated

- You may complain if you think we have violated your rights by contacting the Privacy Officer at the email address and telephone number provided for the HIPAA Compliance and Policy Officer on page 6.
- You can also file a complaint with the U.S. Dept. of Health and Human Services (HHS) Office for Civil Rights (OCR) by sending a letter to 200 Independence Avenue, SW, Washington, DC, 20201, or by calling the HHS hotline: **1-877-696-6775.** You will not be retaliated against for filing a complaint.

Your choices details

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- In these cases, you have both the right and the choice to tell us to:
  - Share information with your family, close friends or others involved in your care
  - Share information in a disaster relief situation
  - Include your information in a hospital directory
- If you are not able to tell us your preference — for example, if you are unconscious — we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In cases where sharing of psychotherapy notes is allowed, we will not share them unless you give us written permission.

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

NOTES

NOTES

The information provided through 2nd.MD does not constitute medical advice and does not diagnose, treat or prescribe treatment of medical conditions. All information provided in connection with 2nd.MD is for informational purposes only and does not create a physician-patient treatment relationship. Information provided through 2nd.MD does not substitute medical diagnosis or treatment from your treating physician, and you should discuss the information provided with your treating physician before making any decisions. The 2nd.MD service is subject to change. Coverage exclusions and limitations may apply.

Kaia provides information and support as part of your health plan. It does not provide medical advice or other health services and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Members are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. Kaia is not an insurance program and may be discontinued at any time. This program and its components may not be available in all states or for all group sizes and are subject to change. Coverage exclusions and limitations may apply.

Cancer Support Program is a program, not insurance. Availability may vary on a location-by-location basis and is subject to change with written notice. UnitedHealthcare does not guarantee availability of programs in all service areas, and provider participation may vary. Certain items may be excluded from coverage, and other requirements or restrictions may apply. Please check with your UnitedHealthcare representative.

Diabetes Health Plan is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult with an appropriate health care professional to determine what may be right for you. If your provider determines that a health action is not medically appropriate for you, you may qualify for a different way to earn the incentive. Please have your provider complete the Provider information section of the Health Actions Notification Form. Contact us at 1-866-944-9001, TTY 711, 8 a.m.–8 p.m. ET, Monday–Friday if you have any questions. Recommended health actions may be covered by your benefit plan. Be sure to check your benefit plan for specific coverage details.

Disease Management programs and services may vary on a location-by-location basis and are subject to change with written notice. UnitedHealthcare does not guarantee availability of programs in all service areas, and provider participation may vary. Certain items may be excluded from coverage, and other requirements or restrictions may apply. If you select a new provider or are assigned to a provider who does not participate in the Disease Management program, your participation in the program will be terminated. Self-Funded or Self-Insured Plans (ASO) covered persons may have an additional premium cost. Please check with your employer.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

Rally Health® provides health and wellbeing information and support as part of your health plan. It does not provide medical advice or other health services and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the Health Survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Real Appeal is a voluntary weight management program that is offered to eligible members at no additional cost as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Results, if any, may vary. Any items/tools that are provided may be taxable, and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

24/7 Virtual Visits is a service available with a provider via video, or audio-only where permitted under state law. It is not an insurance product 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.

The UnitedHealthcare plan with Health Savings Account (HSA) is a qualifying High Deductible Health Plan (HDHP) that is designed to comply with IRS requirements so eligible enrollees may open a health savings account (HSA) with a bank of their choice or through Optum Bank, Member FDIC. The HSA refers only and specifically to the health savings account that is provided in conjunction with a particular bank, such as Optum Bank, and not to the associated HDHP.

Health savings accounts (HSAs) are individual accounts offered by Optum Bank and are subject to eligibility and restrictions, including but not limited to restrictions on distributions for qualified medical expenses set forth in section 213(d) of the Internal Revenue Code. State taxes may apply. Fees may reduce earnings on account. This communication is not intended as legal or tax advice. Please contact a competent legal or tax professional for personal advice on eligibility, tax treatment and restrictions. Federal and state laws and regulations are subject to change.

One Pass Select is a voluntary program featuring a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable.

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.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

TRAVIS COUNTY HUMAN RESOURCES MANAGEMENT DEPARTMENT

700 Lavaca Street, Suite 900
Austin, TX 78701

Benefits line:
1-512-854-0404

Fax:
1-512-854-6677

Email:
benefitsteam@traviscountytx.gov

Online:
traviscountytx.gov/human-resources/jobs/benefits

Contact the vendors directly for:
ID cards or claims, benefits or coverage information