AEDC
2024 Benefits Guide

CITY OF
AMARILLO®
OPEN SPACES ★ ENDLESS OPPORTUNITIES

This guide highlights the main features of many of the benefit plans sponsored by the City of Amarillo. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. The City reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. If you would like a copy of the Summary Plan Descriptions (SPDs), please contact the City of Amarillo Benefits Office at 1-806-378-4235.

Table of Contents

BENEFIT CONTACTS 2
BENEFITS OVERVIEW 3
MEDICAL PREMIUMS 4
DENTAL PREMIUMS 4
VISION PREMIUMS 4
MEDICAL PLANS 5
PRESCRIPTION DRUG PLAN 9
DENTAL PLANS 11
VISION PLAN 13
LIFE INSURANCE 15
VOLUNTARY LONG-TERM DISABILITY (LTD) 16
FLEXIBLE SPENDING ACCOUNTS (FSAS) 17
PENSION BENEFITS 18
OTHER RETIREMENT PLANS 19
OTHER BENEFITS/INFORMATION 19
FUTURE RETIREE BENEFITS 22
HEALTH COVERAGE NOTICES 23
HIPPA NOTICE OF PRIVACY PRACTICES 24
MEDICARE PART D CREDITABLE COVERAGE NOTICE 27
GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS 29
HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE 32
OTHER NOTICES 34

Benefit Contacts

Resource	Phone in CST/Web Address
City of Amarillo Benefits Department City Hall, 601 S. Buchanan Street, Rm. 104	806-378-4235 (M-F, 8am to 5pm) **Benefits@amarillo.gov**
Medical – Aetna (Group #737475)	800-410-2386 (M-F, 7am to 7pm) – General Questions 855-TELADOC (24/7) or Teladoc App 800-556-1555 – Aetna 24-Hour Nurse Line **www.Aetna.com or Aetna App (Text "AETNA" to 90156 to receive a link to download the Aetna Health App)**
Prescription Plan – MaxorPlus Pharmacy	800-687-8629 – General Questions (24/7) 866-629-6779 – MaxorPlus Specialty (24/7) **www.maxorplus.com or MaxorPlus App**
Dental - MetLife (Group #126985)	800-942-0854 – General Questions 877-963-8932 – MyBenefits IT Support (M-F, 7am to 10pm/ Voice Response Unit, extended weekday hours and Saturdays) **www.metlife.com/mybenefits or MetLife App (search "MetLife")**
Vision – The Standard Insurance Company through EyeMed (Policy #160-646089-1)	866-289-0614 (M-Sat 7am to 10pm; Sun 10am to 7pm) **https://www.eyemedvisioncare.com/member/public/login.emvc**
Life Insurance and Voluntary Long-Term Disability - The Standard Insurance Company (Group #646089)	888-937-4783 – General Questions (M-F, 7am to 7pm) Life Claims: 800-628-8600 / LTD Claims: 800-368-1135 800-378-4668 – Portability/Conversion Questions **www.standard.com** **EOI link: https://myeoi.standard.com/646089** **(**Policy Number: 646089 required when logging in for EOI.)
Flexible Spending Accounts – ASI Flex (Plan Number 501)	800-659-3035 (M-F 7am to 7pm; Sat 9am to 1pm) **ASIFlex.com or ASIFlex App**
Pension Plan - TMRS (City of Amarillo Plan #00030)	800-924-8677 (M-F, 8am to 5pm) **www.tmrs.com or TMRS App**
457 Deferred Compensation – Nationwide (Plan #0038510001)	877-677-3678 – Customer Service (M-F, 7am to 10pm; Sat 8am to 5pm) **www.nrsforu.com or Nationwide App** **Enroll by Text to 877697and type in Ready.** Jim Hammock, Lubbock Nationwide Representative 806-441-6069 (M-F, 8am to 5pm) **Email: hammj25@nationwide.com**
Employee Assistance Plan (EAP) – Deer Oaks EAP Services	888-993-7650 (24/7) or iConnectYou App (Passcode is 131997) **www.deeroakseap.com** (Username & Password – Amarillo)
Voluntary Insurance Products - AFLAC	806-418-8881 (M-F, 8am to 5pm) **aflac.com/myaflac or MyAflac App**

Benefits Overview

When Coverage Begins:

On the first day of employment, regular, full-time employees working 40 hours per week are eligible to enroll themselves and their eligible dependents in the medical (includes prescription), dental, vision and life insurance plans.

Eligible dependents under the medical, dental, vision and life insurance plans include:

- Your legal spouse (legally married includes opposite and same sex)
- Texas Common Law Spouse (includes opposite and same sex)
- Child(ren) up to the age of 26, defined as your natural children, stepchildren, legally adopted children, foster children, children for whom you are the court-appointed guardian, physically or mentally disabled children of any age who are incapable of self-support where proof of disability is required or grandchildren in your court-ordered custody.

Benefit Changes – Qualifying Life Event (QLE)/ Open Enrollment:

Qualifying Life Event

To make changes to your benefit elections, you must make enrollment changes **within 31 calendar days from the effective date of the qualifying life event**. Some examples of qualifying life events include:

- Changes in Household – Having a baby or adopting a child, getting married or divorced, or a death in the family.
- Loss of Health Coverage – Losing existing health coverage, losing eligibility for Medicare, Medicaid or CHIP, or turning 26 and losing coverage through a parent's plan.

Any changes to your benefits because of a qualifying life event will need to be completed **within 31 calendar days from the qualifying life event** including providing the required documentation related to the change. If changes are not submitted on time, you must wait until the next Open Enrollment period to make your election changes.

Open Enrollment

Open Enrollment will be held each year in October/November with an effective date of January 1st of the following calendar year for any changes made during the Open Enrollment window.

2024 Healthcare Insurance
Employee Premiums (Per Pay Period)

MEDICAL PREMIUMS

Medical Plan 1*	Medical Plan 2*
Employee Only - $0	Employee Only - $0
Employee and Spouse - $0	Employee and Spouse - $0
Employee and Child(ren) - $0	Employee and Child(ren) - $0
Employee and Family - $0	Employee and Family - $0

*AEDC pays 100% of your medical premiums for you and your eligible dependents.

DENTAL PREMIUMS

Dental Plan 1	Dental Plan 2
Employee Only - $18.44	Employee Only - $20.29
Employee and Spouse - $34.77	Employee and Spouse - $38.26
Employee and Child(ren) - $32.46	Employee and Child(ren) - $35.71
Employee and Family - $48.68	Employee and Family - $53.55

VISION PREMIUMS

Vision Plan
Employee Only - $2.76
Employee and Spouse - $5.16
Employee and Child(ren) - $5.23
Employee and Family - $8.08

Medical Plans

The Medical Plans are an Exclusive Provider Organization (EPO) through Aetna and it offers you access to a broad network of in-network providers and facilities. The medical plan will only provide coverage for in-network services. Out-of-network services "will not" be covered under the medical plan. However, in emergency situations out-of-network services may be covered under the medical plan. Note: Outside the local Amarillo area there is a nationwide network through Aetna where you can seek care from other in-network providers and facilities.

In the local Amarillo area, the in-network hospital/facilities you can use is through Northwest Texas Hospital. Services performed at BSA hospital/facilities are out-of-network and will not be covered under the medical plan.

Locate in-network providers/facilities at **www.Aetna.com** or through the Aetna Health App (Text "AETNA" to 90156 to receive a link to download the Aetna Health App). First time users must set up and register an account through the Aetna site or App. Once registered, you can locate in-network providers/facilities locally or nationwide. You must log into your account every time to locate in-network facilities/providers. Aetna customer service representatives are also available to assist with in-network searches and their number is located on your Aetna card.

A medical card with prescription information on the back of the card is mailed to your home address on file for new hires and replacement cards can be requested by contacting Aetna customer service.

Summary of Medical Plan Coverage:

MEDICAL PLAN 1 **FEATURES**	**IN-NETWORK**
Deductible (per calendar year)	$1,500 Individual $3,000 Family
Out-of-Pocket Limit (per calendar year) Includes deductible, coinsurance, and prescription co-pays	$5,000 Individual $10,000 Family
Out-of-Network Coverage	**None**, except for emergencies
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/Immunizations	Covered 100% (deductible/co-pay waived)
Routine Well Visit Exams	Covered 100% (deductible/co-pay waived)
PHYSICIAN SERVICES	**IN-NETWORK**
Office and Specialty Visits	Covered 80%, AFTER Deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-Ray Diagnostic Laboratory using Quest Diagnostic Labs Diagnostic Laboratory (other than Quest)	Covered 80%, AFTER Deductible Covered 100% (deductible/co-pay waived) Note: Quest Diagnostic Labs has facilities across the U.S. Log into your account online at **www.Aetna.com** to find a Quest location. Covered 80%, AFTER Deductible IF done by any other laboratory/physician office.
Diagnostic Complex Imaging (MRI/CT/PET SCAN)	Covered 80%, AFTER Deductible

EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent Care	Covered 100% (deductible/co-pay waived)
Walk-In Clinics	Covered 100% (deductible/co-pay waived)
Emergency Room	Covered 80%, AFTER Deductible
Ambulance	Covered 80%, AFTER Deductible
HOSPITAL CARE (Northwest Texas Hospital - NWTH)	**IN-NETWORK**
Inpatient Coverage (In Amarillo, the only in network facility is NWTH)	Covered 80%, AFTER Deductible
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 80%, AFTER Deductible
Outpatient Hospital or Surgery	Covered 80%, AFTER Deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient and Outpatient Treatment	Covered 80%, AFTER Deductible
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**
Outpatient Treatment	Covered 80%, AFTER Deductible
OTHER SERVICES	**IN-NETWORK**
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy	Covered 80%, AFTER Deductible
Spinal Manipulation Therapy	Covered 80%, AFTER Deductible Limited to 20 visits per calendar year
Durable Medical Equipment	Covered 80%, AFTER deductible
Prosthetics	Covered 80%, AFTER deductible
Hearing Aids	$2,000 maximum every 3 years, AFTER Deductible

MEDICAL PLAN 2 FEATURES	IN-NETWORK
Deductible (per calendar year)	$1,500 Individual $3,000 Family
Out-of-Pocket Limit (per calendar year) Includes deductible, coinsurance, and medical/prescription co-pays	$5,000 Individual $10,000 Family
Out-of-Network Coverage	**None**, except for emergencies
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/Immunizations	Covered 100% (deductible/co-pay waived)
Routine Well Visit Exams	Covered 100% (deductible/co-pay waived)
PHYSICIAN SERVICES	**IN-NETWORK**
Office Visit	$25 Co-pay
Specialist Visit (includes mental health)	$50 Co-pay
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-Ray Diagnostic Laboratory using Quest Diagnostic Labs Diagnostic Laboratory (other than Quest)	Covered 80%, AFTER Deductible Covered 100%. Note: Quest Diagnostic Labs has facilities across the U.S. Log into your account online at **www.Aetna.com** to find a Quest location. Covered 80%, AFTER Deductible IF done by any other laboratory/physician office.
Diagnostic Complex Imaging (MRI/CT/PET SCAN)	Covered 80%, AFTER Deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care	Covered 100% (deductible/co-pay waived).
Walk-In Clinics	$25 Co-pay
Emergency Room	Covered 80%, AFTER Deductible
Ambulance	Covered 80%, AFTER Deductible
HOSPITAL CARE (Northwest Texas Hospital - NWTH)	IN-NETWORK
Inpatient Coverage (In Amarillo, the only in network facility is NWTH)	Covered 80%, AFTER Deductible
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 80%, AFTER Deductible
Outpatient Hospital or Surgery	Covered 80%, AFTER Deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient and Outpatient Treatment	Covered 80%, AFTER Deductible

ALCOHOL/DRUG ABUSE SERVICES	IN-NETWORK
Outpatient Treatment	Covered 80%, AFTER Deductible
OTHER SERVICES	**IN-NETWORK**
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy	Covered 80%, AFTER Deductible
Spinal Manipulation Therapy	$50 Co-Pay (Specialist Office Visit) Limited to 20 visits per calendar year
Durable Medical Equipment	Covered 80%, AFTER deductible
Prosthetics	Covered 80%, AFTER deductible
Hearing Aids	$2,000 maximum every 3 years, AFTER Deductible

100% Covered Medical Services - Both Medical Plans

Under both medical plans, some medical services are covered at 100%. This allows you and your enrolled family members to have quality care with little or no cost depending on the service(s) provided.

Preventative Care Screenings: If enrolled in a medical plan there are preventative care services for enrollees that are covered at 100%. Contact Aetna customer service for more information on other preventative care services available under the medical plan.

In-Network Urgent Care Clinic Visits: If enrolled in a medical plan, urgent care clinic visits using an in-network facility will be covered at 100% with no cost share to the member.

Teladoc: Teladoc is a telehealth medical service offered to medical plan members. Members can call Teladoc at 1-855-Teladoc (1-855-835-2362) or access via Smartphone app (search for Teladoc) to request a visit. If you have a Smartphone, we encourage members to download the app and enter your demographic information. This will eliminate the need to register when you need the service. A medical doctor will assess you over the phone or by video conference call. In addition, the provider may also call-in necessary prescriptions at the member's requested pharmacy.

24-Hour Nurse Line: The 24-Hour Nurse Line can provide helpful information and possibly prevent an unneeded trip to the doctor's office. You can call the toll-free number listed in this guide on pg. 2 or go to **www.Aetna.com** and log into your account.

Quest Diagnostic Labs: Lab work is 100% paid. Log into your account at **www.Aetna.com** to locate local/nationwide providers. The Amarillo location is at 2207 S. Western Street, Space 50, Amarillo, TX 79109, and phone number is 1-806-358-0880. Hours of operation: M-Th 8am to 5pm (closed for lunch from 12:30 to 1:30pm) and Friday 8am to 2:00pm. To schedule an appointment, you can call 1-888-277-8772 or go online at **https://appointment.questdiagnostics.com**.

Prescription Drug Plan

If you enroll in the medical plan, you will automatically receive prescription drug coverage through **MaxorPlus Pharmacy.** Your prescription drug plan information will be located on the back side of your Aetna medical card. Note, copays do apply towards the out-of-pocket maximum under the medical plan. Using your Smartphone download the MaxorPlus App for quick access to your prescription information.

Category	Retail (30-Day Supply)	Mail Order (90-Day Supply)
Generic Drugs - Walmart/Sam's:	**$10**	**$20** (You can get a 90-day supply of your medication at Walmart/Sam's OR through MaxorPlus Mail Order)
Generic Drugs Filled Somewhere Other than Walmart/Sam's:	**$15**	**$20** (You can get a 90-day supply of your medication at Walmart/Sam's OR through MaxorPlus Mail Order)
Preferred Brand Drugs:	**$35**	**$70**
Non-Preferred Brand Drugs:	**$50**	**$100**
Specialty Drugs (limited to a 30-day supply only):	**$65**	Not Available – You may only get a 30-day supply

MaxorPlus Pharmacy offers certain preventive medications to you at no cost ($0 copay)

Preventive Medications: $0 copay

- Generic aspirin for cardiovascular & colorectal cancer prevention for patients 50 and older
- Generic aspirin for women at high risk of pre-eclampsia
- Bowel prep generics medications for patients ages 45-75
- Breast cancer prevention generic tamoxifen, raloxifene, or aromatase inhibitors for women who are at increased risk for breast cancer
- Generic, over-the-counter (OTC), and prescription folic acid medications for women up to the age of 55
- Generic fluoride oral supplements up to the age of 6
- Tobacco deterrents annual limit of 2 cycles of treatment (12 weeks/cycle) only on generics and brands with no generics

Contraceptives: $0 Copay

- Generics & brands with no generics

Statins: $0 Copay

- Generic lovastatin at $0 without Prior Authorization for ages 40-75*

**Prior Authorizations can be requested for other low-to-moderate dose statins*

MaxorPlus Pharmacy offers certain preventive medications to you at no cost ($0 copay) - Continued

HIV-pre-exposure prophylaxis (PrEP): $0 Copay

- Truvada for adolescents and adults who are at high risk of HIV acquisition*

**Prior Authorization is required*

Immunizations/Vaccines/Toxoids: $0 Copay

- Diphtheria Toxoid
- Haemophilus Influenza Type B Vaccine
- Hepatitis A vaccine - min 12 months
- Hepatitis B vaccine
- Human Papillomavirus Vaccine - max 26 years
- Influenza Vaccine - min 6 months
- Measles Vaccine - min 12 months to max 60 years old
- Mumps Vaccine - min 12 months to max 60 years old
- Rubella Vaccine - min 12 months to max 60 years old
- Meningococcal Vaccine
- Pertussis
- Pneumonia Vaccine
- Polio Vaccine - max 18 years
- Rotavirus Vaccine
- Shingles Vaccine - Zostavax (min 60 years old); Shingrix (min 50 years old)
- Tetanus Toxoid
- Varicella Vaccine - min 12 months
- COVID-19
- Respiratory Syncytial Virus (RSV) – up to age 2 and 60 plus
- Combinations of the above

Dental Plans

The Dental Plans will provide you and your family with coverage for typical dental expenses such as cleanings, x-rays, and fillings. The dental plan is provided through **MetLife**. The MetLife Provider Network used is **PDP Plus**.

DENTAL PLAN 1	
Annual Deductible* Individual Family *The deductible applies **only** when using Out-of-Network providers for Basic/Major Restorative and Children Orthodontia Services	 $50 $100
Annual Benefit Maximum (Per Member) Applies to preventative, basic and major services.	$1,000
Preventive Services - Cleanings (3 per year), exams, x-rays	100% (no deductible)
Basic Services – Fillings, extractions	80% (after deductible*)
Major Services – Bridges, dentures	50% (after deductible*)
Orthodontia for Children (up to 19 years of age) Note: Adult orthodontics is not covered by this plan.	$1,500 per Lifetime (50% of Negotiated Fee)

DENTAL PLAN 2	
Annual Deductible* Individual Family *No deductible applied when using either in- or out-of-network providers.	 $0 $0
Annual Benefit Maximum (Per Member) Applies to preventative, basic and major services.	$1,500
Preventive Services – Cleanings (3 allowed each calendar year), exams, x-rays	100%
Basic Services – Fillings, extractions	80%
Major Services – Bridges, dentures	50%
Orthodontia for Children (up to 19 years of age) and Orthodontia for Adults (Employee and Legal Spouse)	$1,500 per Lifetime (50% of Negotiated Fee)

Dental Information

- You will **not** receive an ID Card. When visiting a dentist, the member will simply provide employee's name and social security number. If you want to print a temporary dental ID card, go to **www.metlife.com/benefits** and "Register Your Account" for the first-time logging into this site.
- Use of an in-network provider under Dental Plan 1 for Basic, Major or Children Orthodontia will provide savings for certain services under this Plan. Search for participating dentists in MetLife's network – **www.metlife.com/dental**, click on "Find a Participating Dentist," select "PDP Plus" under your Network, and search by zip code and dentist/practice name is optional or through MetLife App (search "MetLife").
- Orthodontia benefits include traditional ortho braces, Invisalign, clear aligners (through Smile Direct Club). Contact MetLife customer service for more information about this benefit.
- Transition of Care benefits for existing orthodontia for qualifying children and/or adults may be available. Contact MetLife customer service for more information about this benefit.
- Provided above is a summary of your dental benefits, contact MetLife directly if you have additional questions about your dental benefits.

Vision Plan

The Vision Plan is administered by **The Standard Insurance Company through EyeMed**. You will save money by utilizing in-network providers. Under this plan, members must choose either contacts or glasses. A vision card will be mailed to the home address on file with the Benefits Department.

Vision Plan Summary (Plan 1: Balanced Care Vision II Plan H)

	EyeMed Insight Network	**Out of Network**
Deductibles		
	$10 Exam	No deductible
	$25 Eye Glass Lenses	
Annual Eye Exam	Covered in full	Up to $35
Lenses (per pair)		
Single Vision	Covered in full	Up to $25
Bifocal	Covered in full	Up to $40
Trifocal	Covered in full	Up to $55
Lenticular	20% discount	Not covered
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams		
Standard	Standard: Participant cost up to $40	Not covered
Premium (Allowance)	Premium: 10% off of retail	Not covered
Elective	Up to $150	Up to $150
Medically Necessary	Covered in full	Up to $200
Frame Allowance	$150	Up to $75
Frequencies (months)		
Exam/Lens/Frame	12/12/24	12/12/24
	Based on date of service	Based on date of service
Lens Options (Participant Cost)		
	EyeMed Insight Network	**Out of Network**
Progressive Lenses		
Standard	$65 + lens deductible	Not covered
Premium		
Tier 1	$85 + lens deductible	Not covered
Tier 2	$95 + lens deductible	Not covered
Tier 3	$110 + lens deductible	Not covered
Tier 4	$65 plus 80% of charge less $120 allowance	Not covered
Std. Polycarbonate	$40	Not covered
Tint (solid and gradient)	$15	Not covered
Scratch Resistant Coating	$15	Not covered
Anti-Reflective Coating		
Standard	$45	Not covered
Premium		
Tier 1	$57	Not covered
Tier 2	$68	Not covered
Tier 3	80% of the charge	Not covered
Ultraviolet Coating	$15	Not covered
Lasik or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers.	Not covered

Additional Balanced Care Vision II H Features	
EyeMed In-Network Discounts	15% discount off the remaining balance in excess of the conventional contact lens allowance. 20% discount off the remaining balance in excess of the frame allowance. 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers. This discount does not apply to EyeMed Provider's professional services or contact lenses.
EyeMed In-Network Secondary Purchase Plan	Participants receive a 40% discount on a complete pair of glasses once the funded benefit has been exhausted. Participants receive a 15% discount off the retail price on conventional contact lenses once the funded benefit has been exhausted. Discount applies to materials only.
Contact Lens Replacement by Mail Program	After exhausting the contact lens benefit, replacement lenses may be obtained at significant discounts on-line. Visit **www.eyemedvisioncare.com** for details.

Based on applicable laws, reduced costs may vary by doctor location.

Vision Plan Participant Service

Balanced Care Vision II from The Standard features the money-saving eye care network of EyeMed Vision Care. Customer service is available to plan participants through EyeMed's well-trained and helpful service representatives. Call or go online to locate the nearest EyeMed Access network provider, view plan benefit information and more.

EyeMed Customer Care Center: 1-866.289.0614

- Service Representative Hours: 7 a.m. to 10 p.m. CT Monday through Saturday, 10 a.m. to 7 p.m. CT Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at:

You can search specific zip codes or providers on the EyeMed website under the Insight Network:
https://eyedoclocator.eyemedvisioncare.com/member/en

Employees may create a Vision Member Account to access certificates, online ID Cards and EOB's by following these steps:

1. Begin at **https://www.eyemedvisioncare.com/member/public/login.emvc**. The address will direct you to The EyeMed's website.
2. Click on Create an Account. Please enter the primary member's social security number. If you encounter any problems with account setup or for help using online services, please contact our Web Support team at 1-866-939-3633.

Life Insurance

The Standard Insurance Company "The Standard" is the vendor for our life insurance plans. On date of hire or on the status change date from a part-time to full-time position, employees are automatically enrolled in the $50,000 Employee Basic Life Insurance & Accidental Death & Dismemberment (AD&D) benefit that is paid by the employer. Additional Life Insurance is available for yourself, your legal spouse and/or dependent children (through 25 years of age). These premiums are paid by the employee and deducted from your paycheck on a post-tax basis. Information is provided below regarding the insurance plans available to you.

Type of Coverage	Coverage
Employee	**Employee Basic & Additional Life Insurance** ○ $50,000 Basic Life Insurance with AD&D – **EMPLOYER PAID** ○ Additional Life Insurance with AD&D – **EMPLOYEE PAID (POST-TAX)** ○ $10,000 up to $500,000 (in $10,000 increments) ○ Additional Employee Life Insurance cannot exceed 8 times your Base Annual Earnings (rounded down to the next $10,000 of coverage). ○ No Evidence of Insurability (EOI) is required for amounts elected up to $250,000. If eligible, and electing coverage above $250,000, you will need to submit EOI online. You will then pay premiums on the $250,000 beginning with your date of hire or status change date. The Standard will notify both the employee and the Benefits Department of approval or denial of the EOI coverage. If approved, your premiums will increase based on the amount approved. ○ The deadline to submit EOI is 31 calendar days from your date of hire or status change date. ○ Link to EOI website can be accessed through your Smartphone or via your computer (see pg. 2 for link). You will need to provide your date of hire and base annual earnings when completing your EOI. ○ The Standard Insurance Company may request additional medical, testing, bloodwork, etc., during the EOI process. Each EOI is reviewed on an individual basis and the medical underwriters would request additional information if needed. The Standard will pay for additional testing if required. ○ Premiums elected will be based on your age as of January 1st of the current calendar year. ○ Age reductions at age 70 and 75 will reduce the amount of coverage available to you.
Legal Spouse	**Spouse Additional Life Insurance** • Additional Life Insurance with AD&D – **EMPLOYEE PAID (POST-TAX)** ○ $10,000 up to $50,000 (in $10,000 increments) ○ No EOI is required for any amounts elected. ○ The coverage amount for your spouse cannot exceed 100% of your combined Basic Life of $10,000 and Employee Additional Life coverage. For clarification purposes on this requirement, your "total" Employee Basic and Additional Life coverage must be equal to or greater than the Employee's coverage. ○ Age reductions are based on Spouse's age and coverage will be reduced to 50% at age 70 and to 25% at age 75.

Dependent Children	**Dependent Children Additional Life Insurance**
	• Additional Life Insurance – **EMPLOYEE PAID (POST-TAX)**
	  ○ $10,000 policy for each eligible child at a bi-weekly premium of .46 cents.
	  ○ No EOI is required.
	  ○ Dependent children are covered through 25 years of age.

Additional Life Insurance Employee Age Bracket and Employee/Spouse Age Reduction Changes

The Benefits Department will make any changes to your premiums and/or coverage levels at the beginning of each calendar year based on age bracket changes or age reductions at age 70 or 75 from the previous calendar year (January 1 through December 31st). These changes will be reflected on the first paycheck received in January. For example, your age as of January 1st of the current year (which is noted on your enrollment form) is 54 years of age. You turn 55 years of age in the current calendar year which caused you to go to the next age bracket of 55-59 years of age. Your insurance premium will then increase the following year based on your age bracket change. If you or your spouse turns 70 or 75 years of age in the previous calendar year, your coverage level and premiums will change in the following calendar year.

Evidence of Insurability (EOI)

If you are electing greater than $250,000 ($260,000 or more) of coverage under the Employee Additional Life Insurance Plan you will need to go online to Standard's website at **https://myeoi.standard.com/646089** and complete the EOI form within 31 calendar days from your eligibility date.

Updating Life Insurance Beneficiaries

You can update your life insurance beneficiaries anytime throughout the year through the online system.

Voluntary Long-Term Disability (LTD)

The Standard Insurance Company "The Standard" is the vendor for the voluntary LTD plan. This is an employee paid post-tax benefit and it offers income replacement if you are continuously disabled for 90 consecutive days or longer.

A summary of this benefit is provided below:

- For qualifying disabilities, you must be continuously disabled for 90 days before you become eligible to receive your monthly benefit.
- If approved, you will receive 60% of your eligible earnings, up to a maximum benefit of $12,500 per month.
- For a continuous disability, your benefits may last until your Social Security Normal Retirement Age depending on your age at time of disability. If you become disabled before age 62, LTD benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years, 6 months, which is longer. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins.
- Your benefits will be reduced if you have deductible income, which is income you receive or are eligible to receive while receiving LTD benefits. Some examples of deductible income include sick or annual leave pay and/or benefits being received under workers' compensation.
- If you enroll in the voluntary long-term disability benefit at time of hire or status change to full-time, your first premium deduction will be reflected on your first paycheck or the paycheck that covers your status change effective date.
- If you feel that you may have a qualifying disability where you will be out more than 90 consecutive calendar days, it is suggested that you begin the disability claim process after 30 days of your disability. The disability claim packet and filing a claim Frequently Asked Questions (FAQs) can be requested by contacting the Benefits Department.
- If you have further questions about this benefit, please contact MetLife's Life Claims customer service number located in the Benefits Contact list within this guide or call the Benefits Department.

Flexible Spending Accounts (FSAs)

ASI Flex is the vendor for Flexible Spending Accounts for Health Care and Dependent Day Care. FSA accounts allow you to set aside money from your paycheck pre-tax to pay for out-of-pocket health care expenses and child day care expenses and, in some cases, elder care expenses. You can enroll in one or both FSA plans. A list of eligible expenses including over-the counter (OTC) and reimbursement of orthodontia benefits can be found on the ASI Flex website.

What is a Health Care Flexible Spending Account (HCFSA)?
Eligible expenses include medical, prescriptions, dental, vision, hearing and over-the-counter health care products for yourself, your qualifying spouse, and children. A Debit Card will be automatically mailed to new enrollees in the HCFSA plan only and can be presented at point of sale in place of submitting a claim.

How much can I contribute to my HCFSA?
The minimum you can contribute is $100 and maximum is $3,050.

What is a Dependent Day Care Flexible Spending Account (DCFSA)?
Eligible expenses are those incurred while you and your spouse, if married, work or look for work. This can include daycare, general purpose day camps (overnight camp is not eligible), regular babysitting, before and after school care, nursery or preschool, and pre-kindergarten expenses.

How much can I contribute to my DCFSA?
Your contribution maximum limit is determined by your tax filing status. Married Filing Separately is $2,500 and Single, Head of Household, or if Married Filing Jointly is $5,000. The minimum you can contribute is $100.

Does a DCFSA impact the tax credit on my income tax return?
You cannot claim a tax credit for amounts contributed to your DCFSA. However, you may be able to claim a tax credit for amounts, up to IRS limits, not contributed to your DCFSA.

How do I submit claims and get reimbursed?

- HCFSA – As you incur expenses, you can submit a claim to be reimbursed. FSA monies elected under this Plan are available when you first become eligible for benefits or at the beginning of the calendar year following your Open Enrollment election.
- DCFSA – Your funds are available as you contribute throughout the year via payroll deduct into your account.

Under both FSA Plans there are several easy ways to submit claims. You do not have to choose only one option; you can use multiple options throughout the year:

- **ASIFlex Mobile App** – Download the app and log into your account. Then, just snap a picture of your itemized receipt and submit a claim via the app. You can also access your balance and account statement.
- **ASIFlex Online** – Sign into your online account to submit a claim. Go to **www.ASIFlex.com** to see your account statement and balance, submit claims, sign up for email, text alerts and direct deposit.
- **Toll-Free Fax or Mail** – Download and complete a claim form. Then, submit it with your itemized receipt. Keep a copy for your records.

Reimbursements will be made to you within three business days following receipt of a complete claim. Log into your ASIFlex account to sign up for direct deposit reimbursement to a bank account of your choice.

There is a grace period allowed under both FSA Plans that provides additional time to incur expenses. You have from January 1st through December 31st each calendar year and an additional grace period through March 15th of the following calendar year to incur expenses (15-1/2 months total). The deadline to submit reimbursements is June 15th of the following calendar year. If you have funds left in your account after March 15th of the following calendar year and no further expenses to submit you will then forfeit these funds into your FSA account(s) per IRS regulations.

Pension Benefits

Texas Municipal Retirement System (TMRS)

TMRS is a retirement pension program for employees. Eligible employees will automatically be enrolled in this program on date of hire for new employees or when they meet eligibility requirements for status changes. You contribute 7% of your gross compensation each pay period on a pre-tax basis and your employer will make a 14.9% matching contribution into your TMRS retirement account. When you have 5 years of service credit you are 100% vested. You earn a month of service credit toward retirement each month you make a deposit while employed in an eligible position. As a vested member, if you leave TMRS-covered employment, you may leave your deposits (includes employee/employer matching contributions) with TMRS, and your deposits will continue to earn yearly interest credits until you retire. If you are not vested and leave TMRS-covered employment, you may leave your deposits (includes only employee contributions) with TMRS up to 5 years and your deposits will continue to earn yearly interest credits. Download the TMRS App and register your account for easy access to your personal information.

Service credit with other statewide retirement systems or government entities may also count toward your eligibility for service retirement. With combined service, you may be able to retire earlier. Contact the Benefits Department for more information on Prior Service Credit.

To be eligible to retire and receive a pension annuity you must meet the following eligibility requirements. You must have at least 20 years of service at any age or be at least 60 years of age with 5 years of service or receive approval for disability retirement through TMRS.

You will be mailed a TMRS packet to your home address on file. You will need to set up your account online at **www.tmrs.com** or through the TMRS App and make your beneficiary elections. Any address or name changes will need to be updated through TMRS. After you meet your vesting requirement of 5 years, TMRS will require you to update your beneficiary information.

If you plan on retiring, it is recommended that you schedule an appointment with the Benefits Office within 30 days from your retirement date.

Other Retirement Plans

457b Deferred Compensation Plan through Nationwide

This plan provides an additional opportunity for employees to save money for retirement under the Deferred Compensation Plan through Nationwide by contributing pre-and post-tax dollars into a retirement account. You can enroll in this plan anytime throughout the year. Contribution changes will be effective at the beginning of the first available pay period after the contribution change from Nationwide is received by the Benefits Department.

You can increase, decrease, or stop your contributions anytime throughout the year. You can make this contribution change yourself by logging into your Nationwide account online or through the App, or by calling Nationwide customer service or by contacting our Nationwide representative by phone.

There is an Automatic Contribution Feature that allows you to increase your contribution automatically by a percentage of your choice each year. Go to "Manage Account," select "Automatic Contributions Increase," then "Manage Automatic Increase." Then scroll down and provide the necessary information to set up this feature.

The 2024 IRS Limits for the regular 457 is $23,000. If age 50 or older in 2024, an additional contribution of $7,500 is allowed for a total annual amount of $30,500. The minimum contribution you can elect is $10.00 each paycheck.

Active Employees – Special Catch-Up Option with 457(b) Deferred Compensation Plan

- ✓ You must be enrolled in the 457(b) Deferred Compensation Plan through Nationwide to be eligible to enroll in this benefit.
- ✓ An option is available for employees that have not maxed out their employee contributions up to the maximum IRS limits in the 3 calendar years prior to the year in which Normal Retirement Age occurs. Note: You cannot defer Special Catch-Up amounts in the year in which Normal Retirement Age occurs.
- ✓ Normal Retirement Age is 65 to 70-1/2 years of age.
- ✓ If enrolled in the Special Catch-Up Option, you are not allowed during this 3-year period to also contribute in the 50+ Catchup Contribution. After the 3-year Special Catch-Up period ends, the 50+ Catch-Up provision will resume to those eligible.
- ✓ If you are interested in finding out more about this benefit, contact Nationwide customer service at 1-877-677-3678, M-F: 7am to 10pm and Saturday 8am to 5pm CST.

Other Benefits/Information

AFLAC

Employees have the opportunity to enroll in AFLAC's supplemental insurance policies for Short-Term Disability, Cancer, Accident, Hospital and Critical Care. Contact the local AFLAC representative located in the Benefits Contact list anytime throughout the year to enroll in any of these policies. The insurance premiums are 100% paid by the employee post-tax through payroll deduction. Visit **aflac.com/myaflac** or download the MyAflac mobile app to register and log into your account. Once registered, you can enroll in claims direct deposit and file an AFLAC SmartClaim to get paid quickly and track the status of your claim.

Employee Assistance Program (EAP)

The Deer Oaks Employee Assistance Program (EAP) is a free service provided for you, your dependents, and household members that begins on your first day of employment. This program offers a wide variety of counseling, referral, and consultation services, which are all designed to assist you and your family in resolving work and life issues in order to live happier, healthier, more balanced lives. From stress, addiction and change management, to locating childcare facilities, legal assistance, and financial challenges, their qualified professionals are here to help. These services are completely confidential and can be easily accessed 24/7, offering you around-the-clock assistance for all of life's challenges. Counseling services are available in person, over the phone, or via telehealth where you and anyone living in your household receive up to six free, confidential counseling sessions per issue.

- Program Access: You may access the EAP by calling the toll-free Helpline number, using our iConnectYou App, or instant messaging with a work-life consultant through our online instant messaging system.
- Telephonic Assessments & Support: In-the-moment telephonic support and crisis intervention are available 24/7 along with intake and clinical assessments.
- Short-term Counseling: Counseling sessions with a qualified counselor to assist with issues such as stress, anxiety, grief, marital/family challenges, relationship issues, addiction, etc. Counseling is available via structured telephonic sessions, video, and in-person at local provider offices.
- Referrals & Community Resources: Our team provides referrals to local community resources, member health plans, support groups, legal resources, and child/elder care/daily living resources.
- Advantage Legal Assist: Free 30 minute telephonic or in-person consultation with a plan attorney; 25% discount on hourly attorney fees if representation is required; unlimited online access to a wealth of educational legal resources, links, tools and forms; and interactive online Simple Will preparation.
- Advantage Financial Assist: Unlimited telephonic consultation with an Accredited Financial Counselor qualified to advise on a range of financial issues such as bankruptcy prevention, debt reduction, financial planning, and identity theft; supporting educational materials available; unlimited online access to a wealth of educational financial resources, links, tools and forms (i.e. tax guides, financial calculators, etc.).
- Alternate Modes of Support: Your EAP offers support alternatives in addition to traditional short-term counseling including telephonic life coaching, AWARE stress reduction sessions, and virtual group counseling. During your call with one of our counselors, ask if these programs would be right for you.
- Work-life Services: Our work-life consultants are available to assist you with a wide range of daily living resources such as locating pet sitters, event planners, home repair, tutors, travel planning, and moving services. Simply call the Helpline for resource and referral information.
- Child & Elder Care Referrals: Our child and elder care specialists can help you with your search for licensed child and elder care facilities in your area. They will discuss your needs, provide guidance, resources, and qualified referral packets. Searchable databases and other resources are also available on the Deer Oaks member website.
- Take the High Road Ride Reimbursement Program: Deer Oaks reimburses members for their cab, Lyft and Uber fares in the event that they are incapacitated due to impairment by a substance or extreme emotional condition. This service is available once per year per participant, with a maximum reimbursement of $45.00 (excludes tips).

CONTACT US:
Toll-Free: (888) 993-7650
Website: www.deeroakseap.com
Username/Password: amarillo
Email: eap@deeroaks.com

Access your EAP 24/7 by downloading the iConnectYou app that instantly connects you with professionals for instant support and help finding resources for you and your family. To access iConnectYou, download the app from the App Store (iPhone) or Google Play (Android) and register using the iConnectYou Passcode: 131997.

Name, Address and/or Beneficiary Changes

Provided below is the information you will need to change your address, name and/or beneficiaries.

- **Address Change**
  - These changes can be updated in Workday either through your computer or on the App. These changes are transferred electronically to the benefit vendors except for employees enrolled in the TMRS retirement plan and AFLAC. See additional information on how to make these changes by benefit plan as shown below.

- **Name Change**
  - These changes can be updated in Workday either through your computer or on the App. Documentation for the name change will be required at time of request. **A name change on your dependents can only be performed through your computer, not on the App.** These changes are transferred electronically to the benefit vendors except for employees enrolled in the TMRS retirement plan and AFLAC. See additional information on how to make these changes by benefit plan as shown below.

- **Beneficiary Changes**
  - Basic Life Insurance provided by the Employer and Optional Employee Life Insurance – Updated in Workday**.**
  - Nationwide 457 Deferred Compensation
    - Log into your account at **www.nrsforu.com**.
    - Beneficiary Change – Select "View Account" and Click on Beneficiaries. Click on "Manage Beneficiaries." Select Primary and Secondary Beneficiaries where they both add up to 100%.
  - TMRS Retirement Plan – See information below on how to make a beneficiary change.

- **TMRS – Log into your account at www.tmrs.com or call TMRS Customer Service at 1-800-924-8677**
  - Address Change – Under Quick Links under Update, Click on "Contact Information" and Select "Edit".
  - Name Change – Under Quick Links under TMRS Forms, Click on "Download Forms", Click on "Commonly Used TMRS Forms", Click on "Address or Name Change Form." Fillable form pops up and fill out required fields. Print out and sign form. Fax or mail form per instructions at the top of the page.
  - Beneficiary Change – Under Quick Links under Update, Click on "Beneficiaries", Click on "Update Retirement Beneficiaries." Fill out the requested information.

- **AFLAC**
  - If you have an address or name change, contact AFLAC M-F, 8am to 5pm by phone 1-806-418-8881.

Active Employees – Considering Future Retirement

This is a free service provided to employees through Via Benefits that is a resource providing guidance to help assist you in planning and questions you have regarding health insurance during retirement including Medicare. Visit the New Discover VIA Benefits Website at **https://my.viabenefits.com/discover/** or call customer service at 1-855-803-2540, M-F, 7am to 8pm CST.

Future Retiree Benefits

To be eligible to receive these benefits you must be enrolled in the medical plan on the day you retire and be 60 years of age or older with at least 10 years of service or received approved disability retirement approval through TMRS or 20 years of service at any age.

Pre-65 Retiree Medical/Dental

You must be enrolled in the medical and/or dental plan at the time of retirement to be eligible for this benefit. Only dependents (legal spouse and eligible children) enrolled in these plan(s) prior to retirement are eligible to enroll in the pre-65 medical/dental plan. If an employee retires and elects the pre-65 medical/dental plan there will be no lapse in coverage moving from the active to the pre-65 medical/dental plans. When either the retiree and/or spouse turns 65 and children are covered under the pre-65 plans, the children will automatically be dropped from coverage at the end of the month the retiree or spouse turns 65 or when the child turns 26 years of age (whichever comes first).

Health Reimbursement Account (HRA) Sick Leave Benefit

Employees with 5 years or more of continuous employment will receive payout of sick leave up to 720 hours. At time of retirement, employees can convert hours above 720 hours into a Health Reimbursement Account (HRA). Each 30 hours of accrued sick leave above 90 days will be converted to the equivalent of one month of retiree only medical coverage at the current rate for Medical Plan 1. The resulting dollar value will be deposited into the retiree's HRA.

Retiree Life Insurance

Employees are eligible to elect a $5,000 or $10,000 Retiree Life Insurance policy on themselves. A Retiree Spouse Life Insurance policy is available in the amount of $5,000 if the Retiree $10,000 policy is elected. Retirees can select either of these Retiree Life Insurance policies and still convert their current life insurance policies.

Post-65 Retiree Benefits

Retirees and their legal spouse must be enrolled in the medical plan at time of retirement to be eligible for the post-65 Health Reimbursement Account (HRA) benefit offered by VIA Benefits through Towers Watson. The retiree and/or spouse will be transitioned to this service when they reach the age of 65 and are Medicare eligible. Enrollment in Medicare using VIA Benefits at time of eligibility allows the retiree and/or spouse up to $1800 each year into an HRA. The HRA allows you to pay for Medicare supplemental insurance premiums and other healthcare eligible expenses.

Health Coverage Notices

This brochure contains several legal notices that are required to be distributed to participants in group health plans sponsored by the City of Amarillo.

The notices included in this brochure are:

- **HIPPA Notice of Privacy Practices** explains how the group health plans protect your personal medical information.
- **Medicare Part D Creditable Coverage Notice** provides information about how your current prescription drug coverage under the health care plans is affected—and your options for coverage—when you become eligible for Medicare.
- **General Notice of COBRA Continuation Coverage Rights** explains when you and your family may be able to temporarily continue coverage under the health plans if coverage would otherwise end for you.
- **Health Insurance Marketplace Coverage Options and Your Health Coverage** describes the Health Insurance Marketplace, eligibility and tax credit information.
- **Newborns' Act Disclosure** that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.
- **Women's Health and Cancer Rights Act** that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.
- **Notice of Special Enrollment Rights** that explains when you can enroll in the plan due to special circumstances.
- **Children's Health Insurance Program (CHIP)** provides health coverage to eligible children, through both Medicaid and separate CHIP programs.

HIPPA 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.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the ***City of Amarillo*** (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on ***January 1, 2024.***

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

Protected Health Information

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

How We May Use Your Protected Health Information

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

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

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

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

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

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

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

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

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

Your Rights

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

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

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

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

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

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

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

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

Our Legal Responsibilities

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

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

If you have any questions or complaints, please contact:
Name of Entity/Sender: City of Amarillo
Contact/Office: Benefits Department
Address: P.O. Box 1971, Amarillo, Texas 79105-1971
Phone Number: 1-806-378-4235

Complaints

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

Medicare Part D Creditable Coverage Notice

Important Notice from the City of Amarillo About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Amarillo (the "Plan Sponsor") and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

Name of Entity/Sender: City of Amarillo
Contact/Office: Benefits Department
Address: P.O. Box 1971, Amarillo, Texas 79105-1971
Phone Number: 1-806-378-4235

Updated: April 1, 2011

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

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights under COBRA

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

If you're dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

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

When is COBRA 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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator at 806-378-4235 within 60 days after the qualifying event occurs. You must provide this notice to the Benefits Department with required documentation.

How is COBRA Continuation Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of Continuation Coverage

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

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

· The month after your employment ends; or

· The month after group health plan coverage based on current employment ends.

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information: If you have any questions about COBRA continuation coverage, call the City of Amarillo Benefits Department at 1-806-378-4235.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period with coverage starting the 1st of January of the following calendar year or if you experience a qualifying life event.

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

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

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

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

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.[1]

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your Summary Plan Description or contact the City of Amarillo Benefits Department at 601 S. Buchanan Street, Amarillo, TX 79105-1971 or by phone 1-806-378-9379.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name AEDC	4. Employer Identification Number (EIN) 75-2351745
5. Employer Address, 7. City, 8. State, 9. Zip Code 600 S. Tyler Suite 1600, Amarillo, TX 79101	6. Employer Phone Number (806) 379-6411
10. Who can we contact about employee health care coverage at this job? Benefits Department	
11. Phone Number (if different from above) (806) 378-4235	12. email address Benefits@amarillo.gov

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

- With respect to dependents:
  - ☒ We do offer coverage.

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

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

OMB Control Number 1210-0149 (expires 11/30/2023)

Other Notices

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).

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema? Call your Plan Administrator at (806) 378-4235 for more information.

Notice of Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment no later than 31 calendar days after the marriage, birth, adoption, or placement for adoption.

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

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

To take advantage of special enrollment rights, you must experience a qualifying event and provide the City of Amarillo's Benefits Department with timely notice of the event and your enrollment request.

To request special enrollment or obtain more information, contact the Benefits Department at 1-806-378-4235.

CHIP NOTICE

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

CITY OF
AMARILLO
OPEN SPACES • ENDLESS POSSIBILITIES