City of Amarillo 2025 Retiree 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.

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Benefit Contacts

	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**
City of Amarillo Accounting Department **City Hall, 601 S. Buchanan Street, Rm. 301**	806-378-6202 (M-F, 8am to 5pm) – Questions about retiree insurance premium payments.
Medical – Aetna **(Group #737475)**	800-410-2386 (M-F, 7am to 7pm) – General Questions 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)** **CVS Virtual Care - CVS.com/virtual-care** or click on "Get Quick Care" from the Aetna website or App
Prescription Drug Program – MaxorPlus Pharmacy	800-687-8629 – General Questions (24/7) 866-629-6779 – MaxorPlus Specialty (24/7) **www.maxorplus.com**
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")**
Life Insurance - The Standard Insurance Company (Group #646089)	888-937-4783 – General Questions (M-F, 7am to 7pm) 800-628-8600 – Life Claims 800-378-4668 – Portability/Conversion Questions **www.standard.com**
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
Pension Plan - TMRS **(City of Amarillo Plan #00030)**	800-924-8677 (M-F, 8am to 5pm) **www.tmrs.com or TMRS App**
Pension Plan - Amarillo Fireman's Relief and Retirement Fund (AFRRF)	806-378-3040 Finance Department (M-F, 8am to 5pm) City Hall, 3rd Floor, Rm. 301
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**
VIA Benefits through Towers Watson	844-596-0468 (M-F, 7am to 6pm) **https://my.viabenefits.com/cityofamarillo or VIA Benefits App**
Health Reimbursement Account (HRA) – HealthSecure	888-364-5027 – Customer Service **Email: customercare@healthsecurehra.com** **Website: www.healthsecurehra.com**
Sterling Administration - COBRA	800-617-4729 – Customer Service (M-F, 10am to 7pm) **Email: customer.service@sterlingadministration.com**

Benefits Overview

When Coverage Begins:
Pre-65 Retiree Medical and Dental Plans

To be eligible to receive these benefits you must be enrolled in the medical and/or dental plan on the day you retire and be at least 20 years of service at any age or 60 years of age or older with at least 10 years of service or received approved disability retirement approval through Texas Municipal Retirement System (TMRS) or Amarillo Fireman's Relief and Retirement Fund (AFRRF).

- ✓ You must be enrolled in the City's medical and/or dental plans at the time of retirement to be eligible for this benefit. Only dependents (legal spouse and eligible children) enrolled in the medical and/or dental plans prior to retirement are eligible to enroll in these plans.
- ✓ Retiree medical premiums are based on your years of service with the City of Amarillo (i.e., you have 12 years and 6 months of service at time of retirement, your premium will be based on 12 years of service).
- ✓ If you choose not to enroll in the pre-65 medical and/or dental plans at time of retirement, your election is irrevocable where you cannot elect coverage at a later date.
- ✓ Continuation of coverage for vision is only available through COBRA for 18 months. The COBRA administrator automatically mails out a COBRA packet to your home address on file.
- ✓ If an employee retires and elects the pre-65 retiree medical/dental plans there will be no lapse in coverage moving from the active to the pre-65 plans. Your first premium payment on the pre-65 retiree plan is determined by the last day of the pay period following your retirement date.
- ✓ Child(ren) enrolled in the pre-65 retiree medical and dental plans can remain on the plans up to the age of 26. Coverage will then automatically be dropped on the last day of the month they turn 26 years of age.
- ✓ When either the retiree and/or spouse turns 65 and children are covered under the pre-65 medical/dental plans, the children will automatically be dropped from coverage at the end of the month the retiree or retiree spouse turns 65 years of age.
- ✓ You may drop coverage anytime throughout the year. You do not need to experience a qualifying life event, nor do you need to wait until open enrollment to cancel coverage for your legal spouse and/or children covered under the pre-65 medical/dental plans, however you cannot add them back on the plans later. Your election to drop pre-65 retiree healthcare coverage on yourself and/or your covered dependent(s) is irrevocable.
- ✓ If your legal spouse is on the pre-65 medical/dental plans and you become divorced, the ex-spouse must be dropped from the coverage within 31 calendar days from the date of the divorce.
- ✓ Failure to drop an ineligible dependent within 31 calendar days from the event date will result in incurred claims not being paid and the member being responsible for all costs incurred.
- ✓ If you are divorced and later become married again, you cannot add a new legal spouse to these plans.
- ✓ The Accounting Department mails out invoices at the beginning of each month for that current month's premium and premiums are due by the 19th of each month.
- ✓ Failure to pay premiums by the established deadline will result in termination of coverage. If coverage is terminated due to non-payment, coverage cannot be reinstated for the retiree and/or dependents enrolled under the pre-65 plans.

When Coverage Begins:
Pre-65 Retiree Medical and Dental Plans (Continued)

- ✓ Monthly premiums payment options are: 1) checking or savings account drafted out of the account on the 19th of each month or 2) by personal check or money order mailed in or dropped off in person and received in Accounting by the 19th of each month. Note: If funds are not available when drafted then failure to pay the premiums owed can result in coverage being terminated and there will be a $30.00 NSF fee. The Accounting Department's phone number is located on pg. 2 of this guide.
- ✓ Pre-65 Healthcare Premiums Deducted from Pension Checks
  - Firefighters – Medical, dental and life insurance premiums can be deducted from the monthly pension check by filling out an Insurance Premium Payment Deduction form at the time of retirement.
  - If there is an increase in premiums for the following calendar year and you have elected insurance premiums to be deducted from your pension check, you will be required to fill out and return the signed form by the established deadline. These forms will be mailed to your home address on file at the end of the year for the following calendar year change. Failure to return the signed form in a timely fashion will result in the change in premiums being overdue which could result in termination of coverage for failure to make up the difference in premium owed. It is the retiree's responsibility to make sure their insurance premiums are paid on time and the form is returned to the Finance Department.
- ✓ Eligibility for Medicare while on Pre-65 Medical Plan
  - If either the retiree and/or retiree spouse becomes eligible for Medicare while on the pre-65 retiree medical plan and medical coverage is continued, Medicare pays primary and the City's medical plan will be secondary.
  - If either the retiree or retiree spouse becomes eligible for Medicare and does not enroll during the Medicare enrollment window, the medical plan will apply a Medicare estimate first and then will pay according to the pre-65 medical plan benefits.
  - If the retiree and/or retiree spouse is eligible for Medicare and drops the pre-65 medical insurance with the City, they will not be eligible to re-enroll in the pre-65 medical plan and will forfeit their post-65 HRA medical benefit. This election is thus irrevocable.
- ✓ If the Retiree Dies:
  - Legal spouse enrolled under the pre-65 medical/dental plans will be allowed to stay on the plans up to the age of 65.
  - If the legal spouse remains on the pre-65 medical plan up to their 65th birthday, they are eligible for the post-65 benefit.
  - Child(ren) enrolled under the pre-65 medical/dental plans will be automatically dropped from coverage at the end of the month the retiree spouse turns 65 or when the child turns 26 years of age (whichever comes first).
  - If the retiree has elected retiree spouse life insurance coverage, this coverage remains in effect for 5 months after the retiree's death. After the 5 months ends, the retiree spouse would have the option to convert their policy (no portability) within 31 calendar days by contacting the life insurance provider.
- ✓ Annual Benefit Plan Changes:
  - The Benefits Department will provide the opportunity one time each year in the October/November timeframe where you can elect to change from either the medical and/or dental plan. However, you cannot add new dependents to the pre-65 retiree plans.
- ✓ COBRA continuation may be eligible for dependents losing coverage under the medical and/or dental plans. Questions about COBRA continuation can be answered by the COBRA administrator and their contact information is on pg. 2 of the guide.

When Coverage Ends:
Pre-65 Retiree Medical and Dental Plans

Your pre-65 medical (includes prescription) and dental benefits will end the last day of the month prior to the month you turn 65 years of age. The only exception is if your birthday falls on the 1st of the month, Medicare then begins the 1st of the previous month you turn 65 years of age (i.e., July 1st birthday, Medicare begins June 1st). You will then be eligible to enroll in the Medicare Exchange Service offered by VIA Benefits through Willis Towers Watson.

2025 Monthly Retiree Premiums

MEDICAL PLAN 1

Years of Service*	Retiree Only	Retiree & Spouse	Retiree & Children	Retiree & Family
10 or Less	***$544.40***	***$1,088.77***	***$812.85***	***$1,245.38***
11	***$522.02***	***$1,044.02***	***$783.03***	***$1,200.63***
12	***$499.66***	***$999.28***	***$753.20***	***$1,156.36***
13	***$477.27***	***$954.54***	***$723.36***	***$1,111.16***
14	***$454.89***	***$909.80***	***$693.53***	***$1,066.40***
15	***$432.53***	***$865.05***	***$663.71***	***$1,021.67***
16	***$410.16***	***$820.31***	***$633.89***	***$976.93***
17	***$387.78***	***$775.57***	***$604.04***	***$932.16***
18	***$365.42***	***$730.81***	***$574.22***	***$887.43***
19	***$343.04***	***$686.07***	***$544.40***	***$842.68***
20	***$320.68***	***$641.33***	***$514.56***	***$797.95***
21	***$298.30***	***$596.59***	***$484.73***	***$753.20***
22	***$275.93***	***$551.84***	***$454.89***	***$708.46***
23	***$253.54***	***$507.10***	***$425.07***	***$663.71***
24	***$231.19***	***$462.33***	***$395.25***	***$618.98***
25-29	***$208.80***	***$417.61***	***$365.42***	***$574.22***
30+	***$201.35***	***$402.70***	***$357.96***	***$559.31***

*Retiree medical premiums are based on your years of service with the City of Amarillo (i.e., you have 12 years and 6 months of service with the City of Amarillo, your premium year of service used will be 12 years).

2025 Monthly Retiree Premiums

MEDICAL PLAN 2

Years of Service*	Retiree Only	Retiree & Spouse	Retiree & Children	Retiree & Family
10 or Less	***$598.84***	***$1,306.52***	***$975.42***	***$1,494.45***
11	***$574.22***	***$1,252.83***	***$939.64***	***$1,440.76***
12	***$549.63***	***$1,199.14***	***$903.84***	***$1,387.64***
13	***$524.99***	***$1,145.44***	***$868.04***	***$1,333.38***
14	***$500.38***	***$1,091.76***	***$832.24***	***$1,279.68***
15	***$475.79***	***$1,038.06***	***$796.46***	***$1,226.01***
16	***$451.18***	***$984.38***	***$760.67***	***$1,172.31***
17	***$426.56***	***$930.68***	***$724.85***	***$1,118.59***
18	***$401.96***	***$876.98***	***$689.06***	***$1,064.92***
19	***$377.34***	***$823.28***	***$653.29***	***$1,011.22***
20	***$352.75***	***$769.59***	***$617.47***	***$957.54***
21	***$328.13***	***$715.91***	***$581.69***	***$903.84***
22	***$303.52***	***$662.20***	***$545.86***	***$850.15***
23	***$278.90***	***$608.52***	***$510.09***	***$796.46***
24	***$254.32***	***$554.79***	***$474.30***	***$742.77***
25-29	***$229.68***	***$501.13***	***$438.50***	***$689.06***
30+	***$221.48***	***$483.24***	***$429.55***	***$671.17***

*Retiree medical premiums are based on your years of service with the City of Amarillo (i.e., you have 12 years and 6 months of service with the City of Amarillo, your premium year of service used will be 12 years).

2025 Monthly Retiree Premiums

DENTAL PLAN 1

Plan Option	Premium
Retiree Only	$41.96
Retiree and Spouse	$79.11
Retiree and Child(ren)	$73.85
Retiree and Family	$110.75

DENTAL PLAN 2

Plan Option	Premium
Retiree Only	$46.16
Retiree and Spouse	$87.03
Retiree and Child(ren)	$81.24
Retiree and Family	$121.83

Medical Plans

The Medical Plans are an Exclusive Provider Organization (EPO) medical plan 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
Specialist Visit (includes mental health)	$50
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.
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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
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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	$50 Co-pay
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

If enrolled in either medical plan the following medical services are covered at 100%. This allows you and your enrolled family members to have quality care with no cost.

Preventative Care Screenings: There are preventative care services that are covered at 100%. Contact Aetna customer service for more information on preventative care services that are available.

In-Network Urgent Care Clinic Visits:
Urgent care clinic visits will be covered 100% when using an in-network facility.

NEW IN 2025! CVS Virtual Care: CVS Virtual Care is a virtual medical benefit offered to employees and their dependents enrolled in the medical plan. Virtual visits are available for minors 18 months to 18 years old. When dependents become an adult (18 years of age or older and are enrolled in the medical plan), they can get adult care options by setting up their own account.

It's your care, your way

Enrolled members will have access to on-demand sick care, primary care, and mental health services at no cost to the member. This virtual care option is in addition to your traditional in-network providers. Access is included in your medical plan, made available through Aetna®, a CVS Health® company.

Here is what is included:

On-demand Sick Care – Available to adults and children over 18 months (24/7 including holidays):

- Obtain virtual care ASAP for non-emergency services with licensed providers for common illnesses (cough, colds, flu), common infections (ear, sinus, skin, urinary tract infections), and one-time medication refills.

Virtual Primary Care – Available to adults ages 18 and up (M-F, 7:00am to 7:00pm CST):

- Choose a dedicated provider and get a supporting Care Team.
- Schedule a primary care visit with your provider in days, not weeks.
- Ask your Care Team questions at any time, from anywhere through secure messaging.
- Schedule visits for routine care, sick care, and chronic illness management for things like diabetes, high blood pressure, allergies, etc.

Virtual Mental Health Services – Available to adults and children ages 13 and up (7 days a week, 8:00am to 7:30pm CST):

- Consult with a licensed therapist for mental health services and get help with medication management.

Additional Benefits:

- When in person follow up care is needed, CVS will help coordinate those referrals with in-network providers.
- Access to your personal health information and lab results is available through the health dashboard.

What's next? Go to CVS.com/virtual-care to register and set up your account for future virtual care or to learn more about these virtual care services. You can also click on "Get Quick Care" after logging into the Aetna website (**www.Aetna.com**) or App. A telephonic option is not available with this benefit.

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/Maxor Home Delivery:	**$10**	**$20** (You can get a 90-day supply of your medication at Walmart/Sam's OR through MaxorPlus Home Delivery)
Generic Drugs Filled Somewhere Other than Walmart/Sam's/Maxor Home Delivery:	**$15**	**N/A**
Preferred Brand Drugs – Walmart/Sam's/Maxor Home Delivery:	**$35**	**$70**
Preferred Brand Drugs Filled Somewhere Other than Walmart/Sam's/Maxor Home Delivery:	**$35**	**N/A**
Non-Preferred Brand Drugs – Walmart/Sam's/Maxor Home Delivery:	**$50**	**$100**
Non-Preferred Brand Drugs Filled Somewhere Other than Walmart/Sam's/Maxor Home Delivery:	**$50**	**N/A**
Specialty Drugs – only through MaxorPlus Specialty (limited to a 30-day supply only):	**$65***	**N/A**

*Some prescriptions may be automatically enrolled in a co-pay assistance program which could reduce the amount of your co-pay, but the maximum copay you would pay for a 30-day supply for specialty prescriptions is $65. Any co-pay assistance will not be applied towards a member's deductible or out-of-pocket maximum for the current calendar year.

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*

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

- Emtricitabine/tenofovir for pre-exposure prophylaxis (PrEP) 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
- Hepatitis A/Hepatitis B vaccine – min 18 years
- Human Papillomavirus Vaccine - max 26 years
- Influenza Vaccine -
- Measles Vaccine - min 12 months to max 65 years old
- Mumps Vaccine - min 12 months to max 65 years old
- Rubella Vaccine - min 12 months to max 65 years old
- MMRV – min 12 months to max 12 years
- Meningococcal Vaccine
- Pertussis
- Pneumonia Vaccine
- Polio Vaccine - max 18 years
- Rotavirus Vaccine
- RSV [Abrysvo (female or min 60 years); Arexvy (min 60 years); Byfortus (max 24 months)]
- Shingles Vaccine - min 50 years
- Tetanus Toxoid
- Varicella Vaccine - min 12 months
- COVID-19
- Respiratory Syncytial Virus (RSV) – up to age 2 and 60 plus

Vision Plan

- ✓ Vision coverage is not offered under the City's pre-65 retirement plan. Continuation of coverage for vision is only available through COBRA up to 18 months. The COBRA administrator automatically mails out a COBRA packet to your home address on file following termination and information about enrolling in COBRA will be provided.
- ✓ If you are electing to continue this benefit through COBRA for your enrolled dependents and they have a different address, then you will need to contact the COBRA Administrator.
- ✓ If you have questions about COBRA continuation, please contact the COBRA administrator and their contact information is on pg. 2 of this guide.

Dental Plans

The Dental Plans will continue to 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 to "only" Out-of-Network providers for Basic/Major Restorative and Children Orthodontic Services	 $50 $100
Annual Benefit Maximum (Per Member) Applies to preventative, basic and major services.	$1,000
Preventive Services - Cleanings (3 per calendar 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 per 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) 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.
- Provided above is a summary of your dental benefits, contact MetLife directly if you have additional questions about your dental benefits.

Life Insurance

The Standard Insurance Company "The Standard" is the vendor for our life insurance plans. Life insurance information regarding conversion/portability of life insurance at time of retirement and retiree life insurance is provided below.

Life Insurance Portability/Conversion at Time of Retirement

- ✓ Employees are eligible for portability (under the age of 65) or conversion of their current life insurance policies for themselves and or eligible dependents within 31 calendar days of the termination date.

Waiver of Premium – Approved for Disability Retirement

- ✓ If an employee becomes disabled because of permanent disability, they may be eligible for a waiver of premium for life insurance elected while an active employee. This Waiver of Premium benefit is available up to 60 years of age. The Waiver of Premium benefit includes the employer paid Basic Life and Additional Life Insurance elected for the employee, spouse and/or children. The Waiver of Premium packet must be completed and turned into the insurance provider within 31 calendar days from the date of termination. If approved for disability retirement you must convert the employer paid Basic Life and Additional Life Insurance elected for you and your dependents and pay the premiums to the life insurance provider until Waiver of Premium is approved. Once Waiver of Premium is approved, the life insurance provider will refund premiums paid during the waiting period. If applying for Waiver of Premium, you can elect retiree life and/or retiree spouse insurance, however if you are approved the City will refund premiums you paid on the retiree and/or retiree spouse life policies. If approved by the life insurance provider, there is a 180-day waiting period before the benefit begins from the date the attending physician certifies disability. If approved for Waiver of Premium this coverage ends when the retiree turns 65 years of age. When Waiver of Premium ends you have 31 calendar days from the retiree's 65th birthday to contact the Benefits Department to enroll in the retiree and/or retriee spouse life insurance.

Retiree/Spouse Basic Life Policies

- ✓ Retirees are eligible to elect a $5,000 or $10,000 life insurance policy on themselves at time of retirement. A retiree spouse life insurance policy is available in the amount of $5,000 only if the retiree elects the $10,000 policy for themselves. The monthly rates are provided below.
- ✓ If you enroll in the retiree life insurance, you can still convert your active life insurance into a whole life insurance policy. If the retiree chooses not to enroll in the retiree life insurance, the retiree can port their life insurance to a term life insurance policy. When converting or porting your active life insurance, you must contact the life insurance provider within 31 calendar days from the date of retirement.
- ✓ At time of retirement, you will be required to update your life insurance beneficiary elections. You can update your beneficiaries anytime throughout the year.

Type of Coverage	Monthly Premium
Retiree $5,000	$13.00
Retiree $10,000	$26.00
Spouse $5,000	$6.25 (if Retiree selects $10,000 policy only)

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 as your supplement 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. The first year you transition to Via Benefits the HRA amount received will be prorated.

If the retiree and/or spouse are 65 years of age or older at time of retirement, they will enroll in Medicare and be eligible for the post-65 retirement benefit. Your current active medical and dental coverage will continue through the end of the following month after retirement and you will self-pay these premiums directly to the Accounting Department.

- ✓ When the retiree and/or their spouse turns 65 years of age continuation of coverage through COBRA is not allowed.
- ✓ The retiree and/or spouse who is attaining age 65 will be transitioned off the retiree medical and dental plans. All other dependents who are eligible will remain on the plans until they no longer meet the eligibility requirements. This may result in a change in healthcare insurance premiums, so it is important that retirees check their ACH after there is a change in coverage.
- ✓ You and your legal spouse enrolled in the pre-65 medical plan are both eligible up to $1800 each year through VIA Benefits for your post-65 retirement HRA benefit.
- ✓ **Approximately 3 months from your 65th birthday** you should receive enrollment materials from VIA Benefits. If you have not received this information by this time, please contact VIA Benefits.
- ✓ **The retiree and/or retiree spouse are eligible to remain on this plan for their lifetime unless disenrollment from VIA Benefits occurs.**
- ✓ **You must stay enrolled in VIA Benefits to continue receiving this benefit. If you go outside VIA Benefits for your Medicare Supplement you cannot continue to receive these benefits and you cannot enroll at a later date.**
- ✓ If the retiree passes away, the retiree spouse is still eligible to continue the HRA benefit for their lifetime unless disenrollment from VIA Benefits occurs.
- ✓ VIA Benefits customer service number is 1-844-596-0468, M-F, 7am to 6pm CST and their employee website is **https://my.viabenefits.com/cityofamarillo**.

Pension Benefits

Texas Municipal Retirement System (TMRS)

- ✓ Your TMRS account will be retired on the last day of the month you are retiring.
- ✓ If electing to take your pension immediately following your retirement, your first pension check will be received the last business day of the following month after your retirement date (i.e., retiring in June, your first check will be received the last business day in July).
- ✓ Questions about your TMRS benefit, call TMRS customer service.

Amarillo Fireman Relief and Retirement Fund (AFRRF)

Firefighters will need to refer to the AFRRF for retirement eligibility requirements. Contact the Finance Department for any questions about this plan.

Other Retirement Plans

457b Deferred Compensation Plan through Nationwide

Any questions about taking a distribution or rolling over your monies into a retirement account, call Nationwide.

Other Benefits/Information

Accrued Sick Leave at Time of Retirement

- ✓ Up to 10 years of continuous service – Not eligible to cash out accrued sick leave (excludes Firefighters and Police Officers – see below).
- ✓ All City Employees (excluding Chapter 143 Firefighters and Police Officers) hired on or after October 1, 2007, with 10+ years of continuous service - 100% payment of accrued sick leave up to 60 days at time of retirement. Sick leave is capped at 480 hours. Can be cashed out and taxed accordingly if taking lump sum option or if enrolled in the 457b Deferred Compensation plan can elect to rollover the cash value of this sick leave at the employee's hourly rate pre-tax.
- ✓ Firefighters/Police Officers – Regardless of years of service, 100% payment of accrued sick leave up to 90 days at time of retirement. Can be cashed out and taxed accordingly if taking lump sum option or if enrolled in the 457b Deferred Compensation plan can elect to rollover the cash value of this sick leave at the employee's hourly rate pre-tax.
- ✓ All City employees hired on or before October 1, 2007, with 10+ years of continuous service and Firefighters/Police Officers, that are retiring from the City, will convert any accrued sick leave in excess of 90 days at time of retirement 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 Plan 1 coverage based on years of service with the City of Amarillo. The resulting dollar value will be deposited into the retiree's HRA account at time of retirement.
- ✓ The HRA account is set up and managed by HealthSecure and once enrolled information will be sent to the retiree's mailing address.

Accrued Annual Leave (AL) at Time of Retirement

- ✓ All City employees (excluding Chapter 143 Firefighters and Police Officers) hired on or after October 1, 2007, are eligible to cash out their annual leave at their current hourly rate up to 30 days at time of termination. Can be cashed out and taxed accordingly if taking lump sum option or if enrolled in the 457b Deferred Compensation plan can elect to rollover the cash value of this leave at the employee's hourly rate pre-tax up to IRS annual limits.
- ✓ All City employees hired prior to October 1, 2007, shall be eligible to cash out their accrued annual leave at their current hourly rate at time of retirement not to exceed 65 days. Can be cashed out and taxed accordingly if taking lump sum option or if enrolled in the 457b Deferred Compensation plan can elect to rollover the cash value of this leave at the employee's hourly rate pre-tax.
- ✓ All City employees hired prior to October 1, 2007 "electing to retire", will be allowed to convert any accrued annual leave above 65 days into a Health Reimbursement Account (HRA). Each 30 hours of accrued annual leave above 65 days will be converted to the equivalent of one of month of retiree-only Medical Plan 1 coverage based on years of service with the City of Amarillo. The resulting dollar value will be deposited into the retiree's HRA account at time of retirement.
- ✓ The HRA account is set up and managed by HealthSecure and once enrolled information will be sent to the retiree's mailing address.

Retiree Assistance Program through Deer Oaks

The City realizes that planning for and adjusting to retirement can be difficult. That is why we allow retirees and their household members to continue to access the Employee Assistance Program (EAP) services for life!
Services include:

- 24/7 Assistance via the Helpline
- Short-Term Individual & Marital Counseling
- Referrals to Community Resources & Support Groups
- Access to Online Articles, Tools, Tips & Resources
- Interactive Online Will Preparation
- Consultation with Attorneys & Financial Counselors to Discuss Legal/Financial Aspects of Retirement
- Assistance in Obtaining Medical, Financial, Legal or Aging Services.

Contact Deer Oaks EAP Services tollfree at 1-888-993-7650, by email: **eap@deeroaks.com**, or visit their website at **www.deeroakseap.com** (username/password: amarillo).

AFLAC

If you have an AFLAC policy through the City and have questions about your benefits, please contact AFLAC.

Name, Address and/or Beneficiary Changes

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

- **Address/Name Change**
  - Contact the Benefits Department using one of the following methods:
    - Email: **Benefits@amarillo.gov**, phone: 1-806-378-4235, or in person M-F 8am to 5pm.
    - This will update medical, dental, retiree life insurance and the City's internal HRIS system (Workday).

- **Beneficiary Changes**
  - Retiree Life Insurance
    - Request a beneficiary form from the Benefits Department using one of the following methods: Email:**Benefits@amarillo.gov**, phone: 1-806-378-4235, or in person M-F 8am to 5pm.
    - Primary and secondary beneficiary elections must both add up to 100%.
  - Nationwide 457b 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.
  - Amarillo Fireman Relief and Retirement Fund (AFRRF) – 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.

- **Firefighters Only – Amarillo Fireman Relief and Retirement Fund (AFRRF)**
  - Name/Beneficiary Changes – Contact the Finance Department M-F, 8am to 5pm by either of the following methods:
    - Phone: 1-806-378-3040.
    - In Person at City Hall.

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 City's 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 City of Amarillo's 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 City's 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, 2025.***

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 - OMB 0938-0990

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. **Notification and required documentation must be provided to the COBRA Administrator for this extension request.**

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings on your premium that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income[12]

How Can I Get More Information?

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

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

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 City of Amarillo	4. Employer Identification Number (EIN) 75-6000444
5. Employer Address, 7. City, 8. State, 9. Zip Code 601 S. Buchanan Street, Amarillo, TX 79105-1971	6. Employer Phone Number (806) 378-4235
10. Who can we contact about employee health care coverage at this job? Benefits Department	
11. Phone Number (if different from above) Same	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.

If you are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Form Approved OMB No. 1210-0149 (expires 12/31/2026)

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 1-806-378-4235 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 City of Amarillo's 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 January 31, 2021, 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)

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