City of Amarillo 2026 Retiree Benefits Guide

CITY OF AMARILLO®
OPEN SPACES ★ ENDLESS OPPORTUNITIES

Updated October 15, 2026

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), this information is available on the City of Amarillo internet ***amarillo.gov/handbook****, then click on Retiree Benefits.*

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Benefit Contacts

Resource	Phone in CST/Web Address
City of Amarillo Human Resources Department **City Hall, 623 S. Johnson St., Rm. 1100**	806-378-4235 (M-F, 8am to 5pm); **Benefits@amarillo.gov** **Amarillo Internet: amarillo.gov/handbook, select Retiree Benefits**
City of Amarillo Finance Department **City Hall, 623 S. Johnson St. Rm. 2300**	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/amarillo** or click on "Get Quick Care" from the Aetna website or App 866-211-5678 (24/7) – CVS Virtual Care Call Center
Prescription Drug Program – RxBenefits using OptumRx	800-334-8134 – General Questions (M-F, 9am to 6pm) RxBenefits Member Portal: **Member.RxBenefits.com** **optumrx.com or OptumRx App** 855-427-4682 – Optum Specialty Pharmacy (24/7)
Dental – Delta Dental **(Group #23642)**	800-521-2651 – General Questions (M-F, 7am to 7pm) **deltadentalins.com or Delta Dental App** **Teledentistry – www1.deltadentalins.com/members/virtual-dentistry.html**
Life Insurance – **The Standard Insurance Company** **(Group #646089)**	888-937-4783 – General Questions (M-F, 7am to 7pm) 800-628-8600 or **email: lifebenefits@standard.com** – Life Claims 800-378-4668 or **email: CBT@standard.com** - Portability/Conversion **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 877697 and 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-Th, 8am to 5pm; Friday 8am to 12pm) **www.tmrs.com or TMRS App**
Pension Plan - Amarillo Fireman's Relief and Retirement Fund (AFRRF)	806-378-3040 (M-F, 8am to 5pm) Finance Department, City Hall, 3rd Floor, Rm. 301
Employee Assistance Plan (EAP) – AllOneHealth	800-451-1834 (24/7) or AllOneHealth.com/portal (for first time registrants Click "Sign Up" to create an account. Enter your work or personal email, the company code: **amarillo**, and a password), or **AllOneHealth App** (company code is **amarillo)** on the app store or google play.
Voluntary Insurance Products - AFLAC	Andria Keelin, 806-678-8441 (M-F, 8am to 5pm), **andria_keelin@us.aflac.com** Claims Assistance – Simone Johnson, SJohnson4@communicorp.com **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 (M-F, 8am to 7pm) **Email: customercare@healthsecurehra.com** **Website: www.healthsecurehra.com**
COBRA – Inspira Financial	888-678-7835 – Customer Service (M-F, 7am to 9pm; Sat 7am to 7pm) **Email: COBRAmail@inspirafinancial.com** **Website: mybenefits.inspirafinancial.com**

Benefits Overview

Pre-65 Retiree Medical and Dental Plans

When Coverage Begins and Eligibility

To qualify for pre-65 retiree medical and/or dental coverage, you must be enrolled in the corresponding City of Amarillo plan on your retirement date and meet at least one of the following retirement criteria:

- At least 20 years of City service, regardless of age;
- At least age 60 with at least 10 years of City service; or
- An approved disability retirement through the Texas Municipal Retirement System (TMRS) or Amarillo Firemen's Relief and Retirement Fund (AFRRF).

Enrollment and Eligible Dependents

- You must be enrolled in the City of Amarillo medical and/or dental plan at retirement to continue that coverage as a retiree. Only a legal spouse and eligible children enrolled in the corresponding plan before retirement may continue coverage. New dependents cannot be added after retirement.
- If you decline pre-65 retiree medical or dental coverage at retirement, you cannot enroll in that coverage later. The decision to terminate retiree or dependent coverage is also irrevocable.
- If you elect pre-65 retiree coverage, there is no gap between active employee coverage and retiree coverage. Your first retiree premium will be determined based on the last day of the pay period following your retirement date.
- Retiree medical premiums are based on completed years of City of Amarillo service. For example, 12 years and 6 months of service is treated as 12 years for premium purposes.

Dependent Coverage and Changes

- Eligible children may remain covered through the last day of the month in which they turn age 26, unless coverage ends earlier under another plan rule.
- Children can remain on the pre-65 retiree benefit plans until they turn 26 years of age or until the retiree and covered spouse turn 65 years of age. The children's pre-65 retiree coverage ends at the end of that month, even if they have not reached age 26.
- You may cancel coverage for yourself or covered dependents at any time without a qualifying life event or waiting for annual enrollment. Once canceled, coverage cannot be reinstated, your election is irrevocable.
- If you divorce, you must notify the Human Resources Department and remove your former spouse from retiree coverage within 31 calendar days of the divorce. A spouse acquired through marriage after retirement cannot be added to the pre-65 plans.
- You must notify Human Resources within 31 calendar days from the event date when a dependent becomes ineligible. 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.

Monthly Premiums and Payment

- The Finance Department mails invoices at the beginning of each month for that month's premium. Payment is due by the 19th of each month.
- Payment options are (1) automatic withdrawal from a checking or savings account on the 19th of each month, or (2) personal check or money order received by the Finance Department, by mail or in person, no later than the 19th.
- If an automatic withdrawal is returned for insufficient funds, a $30 nonsufficient-funds (NSF) fee applies.
- 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.
- Contact information for the Finance Department is listed on page 2 of this guide.

Firefighter Pension Premium Deductions

- Eligible firefighter retirees may authorize deductions of medical, dental, and life insurance premiums from their monthly pension payments by completing the Insurance Premium Payment Deduction form at retirement.
- If premiums change for the following calendar year, retirees using pension deductions must complete and return the updated authorization form by the stated deadline. These forms will be mailed to your home address on file at the end of the year for the following calendar year change.
- Retirees remain responsible for ensuring premiums are paid in full and on time. Failure to return an updated authorization or pay any premium shortfall may result in overdue premiums and termination of coverage.

Medicare Eligibility Before Age 65

- If a retiree or covered spouse becomes eligible for Medicare while enrolled in the pre-65 retiree medical plan, Medicare generally pays first and the City medical plan pays second, in accordance with applicable Medicare coordination rules and plan terms.
- If a Medicare-eligible retiree or spouse does not enroll in Medicare when eligible, the City plan may calculate benefits as though Medicare had paid first, potentially leaving the member responsible for additional costs. Contact the Human Resources Department before declining or delaying Medicare enrollment.
- If a retiree or covered spouse drops City pre-65 retiree medical coverage after becoming eligible for Medicare, that individual cannot re-enroll. Under the City's stated retiree benefit rules, dropping the retiree's pre-65 medical coverage also forfeits eligibility for the post-65 medical HRA benefit. This election is thus irrevocable.

If the Retiree Dies

- A surviving legal spouse who was enrolled in the pre-65 retiree medical and/or dental plan may continue that coverage until age 65, subject to applicable plan rules and required premiums.
- A surviving spouse who remains enrolled in pre-65 retiree medical coverage through age 65 is eligible for the post-65 benefit under the City's stated eligibility rules.
- Covered children's pre-65 coverage ends when the surviving spouse turns 65 or at the end of the month in which the child turns 26, whichever comes first.
- If retiree spouse life insurance was elected, the spouse's coverage continues for five months following the retiree's death. After that period, the spouse may apply to convert (not port) coverage within 31 calendar days by contacting the life insurance carrier.

Annual Plan Changes and COBRA

- Human Resources provides an annual opportunity, generally in October or November, for eligible retirees to change their existing medical and/or dental plan options, subject to the available plans and enrollment rules. This does not permit enrollment of new dependents or reinstatement of previously canceled coverage.
- Dependents who lose medical or dental coverage may qualify for COBRA continuation coverage, depending on the qualifying event and applicable requirements. Contact the COBRA administrator listed on page 2 of this guide for eligibility, election deadlines, and premium information.

When Coverage Ends

Pre-65 retiree medical coverage (including prescription drug coverage) and pre-65 dental coverage end on the last day of the month before the retiree turns age 65. Medicare eligibility would then begin the 1st of the following month. If the retiree's 65th birthday falls on the first day of a month, Medicare eligibility generally begins on the first day of the preceding month, and pre-65 coverage ends on the last day of the month before that Medicare effective month. For example, for a July 1st birthday, Medicare generally begins June 1st and pre-65 coverage ends May 31st.

At the transition to Medicare, eligible retirees may access the Medicare exchange service administered by Via Benefits (Willis Towers Watson), subject to the City's post-65 retiree benefit requirements. Retirees should review Medicare enrollment deadlines and available coverage before pre-65 coverage ends.

2026 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 **whole 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).

2026 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 **whole 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).

2026 Monthly Retiree Premiums

DENTAL PLAN 1 (LOW PLAN)

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 (HIGH PLAN)

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 City's medical plans are **Exclusive Provider Organization (EPO) plans through Aetna.** The plans provide access to a broad network of in-network providers and facilities. **Except for certain emergency situations, services received from out-of-network providers and facilities are not covered by the medical plan.**

Local Amarillo Network:
In the Amarillo area, **Northwest Texas Hospital and its affiliated facilities** are in-network under the medical plan. Services provided at **BSA Hospital and its facilities are out-of-network and are not covered** under the medical plan, except where required for emergency care.

Nationwide Network:
Outside the local Amarillo area, you have access to Aetna's nationwide network of in-network providers and facilities. This allows you to seek care from participating providers and facilities when traveling or receiving care outside the Amarillo area.

Finding In-Network Providers and Facilities:
You can locate in-network providers and facilities at **www.Aetna.com** or through the Aetna Health App. To download the app, text **AETNA** to 90156.

First time users must create and register an account through the Aetna website or app. Once registered, you can search for in-network providers and facilities locally or nationwide. You must be logged into your Aetna account when searching for in-network providers and facilities.

Aetna Customer Service representatives are also available to assist with provider and facility searches. Aetna's customer service number is located on your Aetna member ID card.

Aetna Medical ID Card
New employees will receive an Aetna medical ID card at their home address on file. The medical card includes prescription information on the back of the card. Replacement cards can be requested by contacting Aetna customer service.

Overview of Medical Plans:

There are two medical plans that you can choose from. An overview of the two plans is provided below.

	Both Medical Plans	Medical Plan 1	Medical Plan 2
Deductible (per calendar yr.)	$1,500 Individual $3,000 Family		
Out-of-Pocket Limit (per calendar yr.)* *Includes deductible, coinsurance, and co-pays	$5,000 Individual $10,000 Family	Prescription co-pays applies	Medical and Prescription co-pays applies
Other Medical Services (In-Network) - Coinsurance	Covered at 80%, AFTER Deductible		
Physician Services Medical Co-Pays		Not applicable	Office Visit $25 Specialist (includes mental health, speech, physical and occupational therapy) $50
Urgent Care Clinics – IN-NETWORK	Covered under both Plans.		

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**
Primary Care Provider (PCP) and Specialty Office 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 80%, AFTER Deductible
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 WELLNESS SUPPORT SERVICES	**IN-NETWORK**
Inpatient and Outpatient Treatment	Covered 80%, AFTER Deductible
SUBSTANCE USE SUPPORT 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**
Primary Care Provider (PCP) Visit	$25 Co-pay
Specialty Office 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 WELLNESS SUPPORT SERVICES	**IN-NETWORK**
Inpatient and Outpatient Treatment	Covered 80%, AFTER Deductible

SUBSTANCE USE SUPPORT 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 you are enrolled in either medical plan, certain medical services are covered at 100% **when plan requirements are met**. This means you and your enrolled family members may receive these services with **no out-of-pocket cost** when using an in-network provider or facility, as applicable.

Preventative Care Screenings: Certain preventative care services and screenings are covered at 100%. Contact Aetna Customer Service for more information on preventative care services that are available under the medical plan.

In-Network Urgent Care Clinic Visits:
Urgent care clinic visits are covered 100% when using an in-network urgent care facility. Coverage is subject to the visit being for an urgent medical condition as defined by the medical plan. If the services are determined to be non-urgent or more appropriate for routine or primary care, the visit may be subject to applicable plan cost-sharing or may not be covered at 100%.

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):

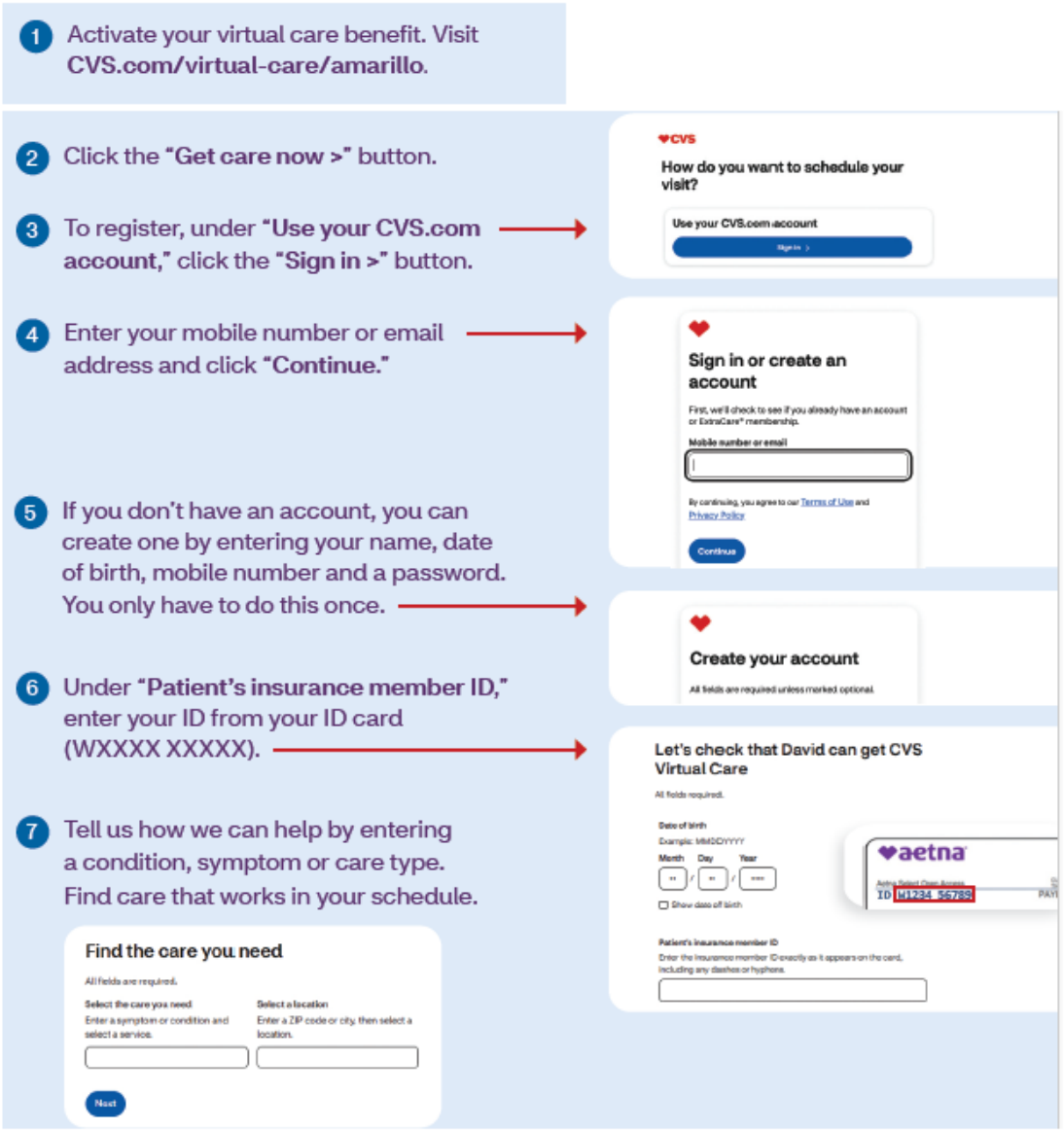
- Consult with a licensed therapist for mental health services and get help with medication management.

Additional Benefits:

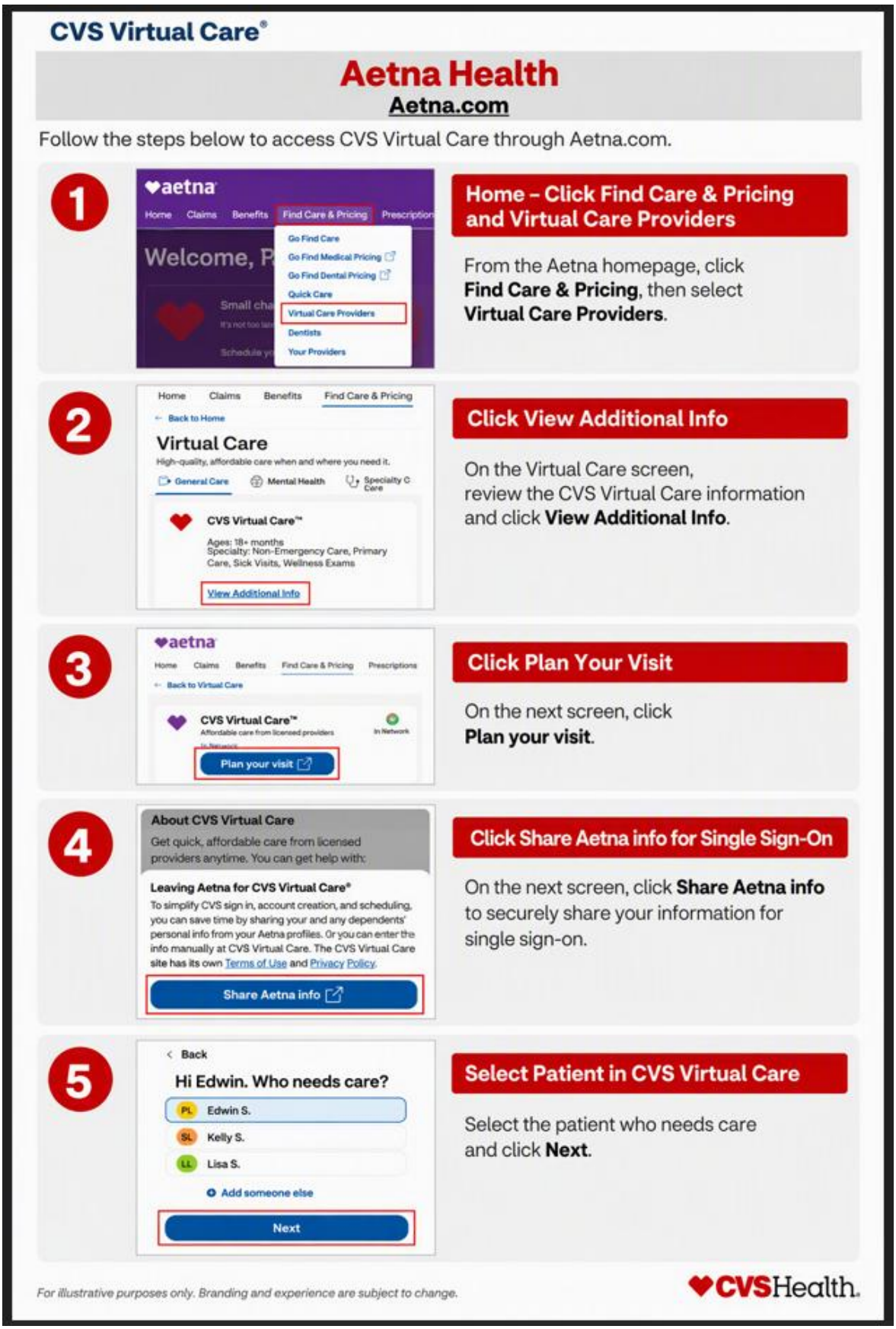
- When in person follow up care is needed, CVS will help coordinate those referrals with in-network providers.
- Access to your personal health information and lab results is available through the health dashboard.

What's next? Active your virtual care benefit by following the instructions below. 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.

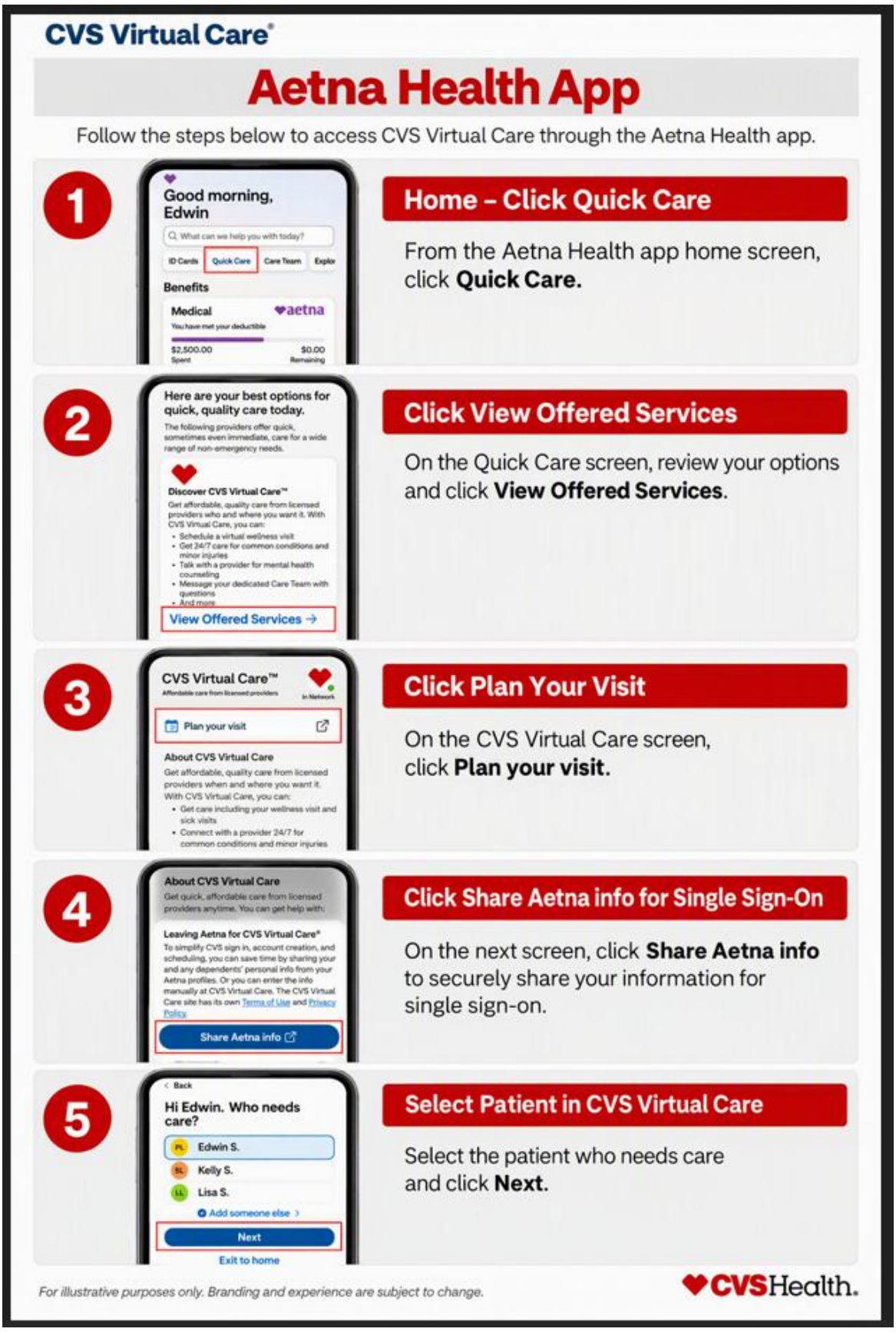
Provided below are the instructions on how to access the website through **CVS.com/virtual-care/amarillo**:



Provided below are the instructions on how to access the website through the Aetna website **www.aetna.com**:



Provided below are the instructions on how to access the website through the Aetna App:



24-Hour Nurse Line: The 24-Hour Nurse Line provides access to registered nurses who can answer health-related questions, provide guidance, and help you determine whether you may need to seek medical care. This service may help prevent an unnecessary visit to a doctor's office or urgent care facility. You can call the toll-free number listed in this guide on **pg. 2** or access the Nurse Line through your account at **www.Aetna.com**.

Quest Diagnostic Laboratory Services: Eligible laboratory services performed through **Quest Diagnostics** are covered at 100% when plan requirements are met. To locate a Quest Diagnostics facility, log into your account at **www.Aetna.com** to search for local and nationwide providers.

Local Quest Diagnostics Location:
2207 S. Western Street, Space 50, Amarillo, TX 79109
Phone: 1-806-358-0880.

Hours:
Monday through Thursday: 8:00am to 5:00pm
Closed for lunch: 12:30pm to 1:30pm
Friday: 8:00am to 2:00pm

Scheduling an Appointment:
Call **1-888-277-8772** or schedule online at **https://appointment.questdiagnostics.com**.

Prescription Drug Plan

If you enroll in the medical plan, you will automatically receive prescription drug coverage through **RxBenefits using OptumRx.** Your prescription drug plan information will be located on the back side of your Aetna medical card. Note, copays apply towards the out-of-pocket maximum under the medical plan (not towards the deductible). Using your Smartphone, download the OptumRx App for quick access to your prescription information.

Category	Retail (30-Day Supply)	Retail/Mail Order* (90-Day Supply)
Generic Drugs	**$10**	**$20**
Preferred Brand Drugs	**$35**	**$70**
Non-Preferred Brand Drugs	**$50**	**$100**
Specialty Drugs – only through OptumRx Specialty Pharmacy (limited to a 30-day supply only)	**$65**	Not Available – You may only get a 30-day supply

**A 90-day supply may result in greater cost savings.*

RxBenefits is the pharmacy provider for the City of Amarillo. RxBenefits administers the prescription drug program on behalf of the City of Amarillo and OptumRx serves as the pharmacy benefit manager that dispenses the prescriptions.

Key Points Regarding Your Pharmacy Benefits

- **RxBenefits Member Services and Portal**
  - **Member Services**: If you have questions about your pharmacy benefits, contact the RxBenefits Member Services Team using any of the following options:
    - **Chat with a live agent via the RxBenefits member portal:** Monday-Friday, 9:00am to 6:00pm Central
    - **Email: CustomerCare@RxBenefits.com**
    - **Call:** 1-800-334-8134, Monday-Friday, 7:00am to 8:00pm Central
  - **Member Portal – RxBenefits.com**: Access your pharmacy benefits information 24/7 from any device by registering on the My RxBenefits member portal at **Member.RxBenefits.com**. Once registered, you can set up your communication preferences, chat with a live agent, and so much more.

- **Options Available to Fill Your Prescriptions**
  - **In-Network Retail Pharmacies**
    - **OptumRx Website**: Go to **optumrx.com** and register by creating an account to get started. Once registered, you can locate a pharmacy.
    - **Optum App**: Once the App is downloaded (see enclosed flier) and you register for the first time you can locate a pharmacy.
  - **Mail Order**: Visit **optumrx.com** or use the OptumRx App where you can sign up for home delivery for a three-month supply of your medication (excludes specialty prescriptions).
  - **Optum Specialty Pharmacy**
    - Available 24/7 by phone 1-855-427-4682.
    - Sign in or register for the first time at **specialty.optumrx.com**.

If no medical card is available at time of dispensing your prescription, provide the following information to the retail pharmacy provider: RXBIN: 610011, RXPCN: IRX, and RXGRP: RXBENEFIT). Your medical card may be required, but this information is provided if needed.

Refer to the Prescription Benefit Coverage (PBC) document for a summary of information regarding your pharmacy benefits. This document is available on the internet site cityofamarillo/handbook, then click on Retiree Benefits and it is located under the Pharmacy section.

Vision Plan

- Vision coverage is not available under the City of Amarillo's pre-65 retiree benefit plans. However, retirees and their eligible covered dependents may elect to continue vision coverage through COBRA for up to 18 months, provided they meet COBRA eligibility requirements.
- Following retirement, the COBRA administrator will mail a COBRA election packet to your home address on file. The packet will include information about continuing vision coverage, enrollment instructions, applicable premiums, and election deadlines.
- If your covered dependents reside at a different address, please notify the COBRA administrator to ensure they receive the appropriate COBRA election information.
- For questions regarding COBRA continuation coverage, please contact the COBRA administrator using the contact information provided on page 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 **Delta Dental**. The Delta Dental Provider Network used is PPO or Premier.

DENTAL PLAN 1 (LOW PLAN)

Benefit Highlights: Delta Dental PPO™

Plan Benefit Highlights for: City of Amarillo
Group Number: 23642 - Low Plan
Effective Date: 1/1/2026

Benefits	Delta Dental PPO dentists**	Delta Dental Premier dentists**	Non-Delta Dental dentists**
Deductibles per member each calendar year	No Deductible	No Deductible	$50/ $100
Deductibles waived for Diagnostic & Preventive?	Waived for Non Delta Dental Dentists only		
Deductibles waived for Orthodontics?	Yes, for all Dentists		
Maximums Per member each calendar year	$1,000	$1,000	$1,000
D&P counts toward maximum?	Yes, for all Dentists		

Covered Services*	Delta Dental PPO dentists**	Delta Dental Premier dentists**	Non-Delta Dental dentists**
Diagnostic & Preventive Services (D&P) Exams, Cleanings, X-Rays, Sealants and Space Maintainers	100%	100%	100%
Basic Services Fillings and Simple Extractions	80%	80%	80%
Endodontics Root Canals	80%	80%	80%
Periodontics Surgical and Non-Surgical Periodontics	80%	80%	80%
Oral Surgery	80%	80%	80%
Major Services Crowns, Inlays, Onlays and Cast Restorations	50%	50%	50%
Prosthodontics Bridges, Dentures and Denture Repair/Reline/Rebase	50%	50%	50%
Implants Implant Services	50%	50%	50%
Orthodontic Services Dependent Children only up to age 19. Adults not covered	50%	50%	50%
Orthodontic Maximums	$1,500 Lifetime	$1,500 Lifetime	$1,500 Lifetime

For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).

* Limitations may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Benefit Highlights: Delta Dental PPO™

Plan Benefit Highlights for: City of Amarillo
Group Number: 23642 - High Plan
Effective Date: 1/1/2026

Benefits	Delta Dental PPO dentists**	Delta Dental Premier dentists**	Non-Delta Dental dentists**
Deductibles per member each calendar year	No Deductible	No Deductible	No Deductible
Maximums Per member each calendar year	$1,500	$1,500	$1,500
D&P counts toward maximum?	Yes, for all Dentists		

Covered Services*	Delta Dental PPO dentists**	Delta Dental Premier dentists**	Non-Delta Dental dentists**
Diagnostic & Preventive Services (D&P) Exams, Cleanings, X-Rays, Sealants and Space Maintainers	100%	100%	100%
Basic Services Fillings and Simple Extractions	80%	80%	80%
Endodontics Root Canals	80%	80%	80%
Periodontics Surgical and Non-Surgical Periodontics	80%	80%	80%
Oral Surgery	80%	80%	80%
Major Services Crowns, Inlays, Onlays and Cast Restorations	50%	50%	50%
Prosthodontics Bridges, Dentures and Denture Repair/Reline/Rebase	50%	50%	50%
Implants Implant Services	50%	50%	50%
Orthodontic Services Only for dependent children up to 19 years of age and for Adults (Employee and Legal Spouse only)	50%	50%	50%
Orthodontic Maximums	$1,500 Lifetime	$1,500 Lifetime	$1,500 Lifetime

For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).

* Limitations may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Overview of Dental Plans:

There are two dental plans that you can choose from. An overview of the two plans is provided below.

	Both Dental Plans	Dental Plan 1	Dental Plan 2
Annual Individual Benefit Maximum		$1,000	$1,500
Annual Deductible for Basic/Major Restorative and Children Orthodontia Services		Individual $50 Family $100 Deductible Applies Only if Using an Out-of-Network Provider	None
Preventive Services (Cleanings – 3 per year, exams x-rays, sealants, and space maintainers)	100% (no deductible)		
Basic Services (Fillings and simple extractions, root canals, surgical and non-surgical periodontics, and oral surgery)		80% (after deductible if using out-of-network provider)	80%
Major Services (Crowns, inlays and onlays, cast restorations, bridges, dentures and denture repair/reline/rebase and implant services)		50% (after deductible if using an out-of-network provider)	50%
Orthodontia for Children (up to 19 years of age)	$1,500 Lifetime Benefit		
Orthodontia for Adult (Employee & Legal Spouse)		Not covered under this Plan.	$1,500 Lifetime Benefit

Dental Information

- **Dental Cards** – A dental card will be mailed to your home address on file with the City. The employee's social security number can be presented to the dental provider for verification of benefits if no dental card is in your possession at time of service.
- **Delta Dental App** – Download the Delta Dental App and you can check plan details, browse claim history, get a cost estimate, find an in-network dentist and view your member ID card or save it to your digital wallet.
- **Delta Dental Networks** – You will receive the largest discount on dental services by using a Delta Dental PPO dentist. Enrollees also have access to Delta Dental Premier network dentists, but at a lesser discount. Provided below are the differences between using an in-network vs. out-of-network provider.
    - Delta Dental PPO Network - Find a dentist at **www.deltadentalins.com**, scroll down the page and locate **Find a Dentist**, and enter **Location** (required). You can search by just **Location** or by **Dentist or Office Name**. **Select a Network** and choose from the drop-down **Delta Dental PPO** then select **Find a Dentist**.
    - Delta Dental Premier Network - If your current dentist is not part of the PPO network or you want to expand your search further, consider a Delta Dental Premier dentist. Follow the same steps above but select **Delta Dental Premier** as the network.

  PPO and Premier providers are considered in-network, both network providers file the claim to Delta Dental, and there is no balance billing. In terms of coverage, benefits and co-insurance remain the same regardless of the provider the member decides to visit.
    - Out-of-Network (Non-Delta Dental Providers) – Delta Dental does not have negotiated fee agreements with out-of-network providers, so your out-of-pocket costs may be higher than when using a Delta Dental network provider.

      Effective in 2026, Delta Dental may pay covered benefits directly to an out-of-network dental provider if the provider agrees to accept payment from Delta Dental. If the provider does not accept direct payment, you may be required to pay the full cost of services at time of treatment and submit a claim to Delta Dental for reimbursement. Claim forms are available when you log in to your account at **www.deltadentalins.com.**
- **Virtual Dentistry** – You can schedule live video visits with an in-network dentist or submit photos to receive a personalized treatment recommendation within 24 hours. Get started at **www1.deltadentalins.com/members/virtual-dentistry.html**.
- **Discounts on Hearing Aids** – Discounts on hearing aids and one year of free follow-up care is available through Amplifon. Call 888-779-1429 or visit their website at **amplifonusa.com/deltadentalins**.
- **Discounts on LASIK Eye Surgery** – Discount on LASIK eye surgery, including pre- and post-operative visits at over 900 LASIK locations nationwide. Call QualSight at 855-248-2020 or visit their website at **qualsight.com/-delta-dental**.

Life Insurance

The Standard Insurance Company (The Standard) administers the City of Amarillo's life insurance plans. The following information explains life insurance portability, conversion, Waiver of Premium and retiree life insurance options.

Life Insurance Portability/Conversion at Time of Retirement

- Upon retirement, employees may be eligible to continue their existing life insurance coverage through portability (if under age 75) or conversion to an individual policy. These options may also be available for eligible covered dependents.
- To apply, contact The Standard and complete the required portability or conversion application within 31 calendar days following termination of employment, subject to the applicable policy terms.

Waiver of Premium – Disability Retirement

- Employees retiring due to a permanent disability may qualify for Waiver of Premium through The Standard. If approved, eligible life insurance coverage may continue without premium payments.
- Eligible coverage may include employer-paid Basic Life Insurance and employee, spouse and dependent children Additional Life Insurance, subject to the insurance policy.
- Complete and submit the Waiver of Premium application to The Standard within 31 calendar days following termination of employment, in accordance with the City's procedures.
- While the application is under review, arrange for conversion of eligible active coverage and pay the required premiums directly to The Standard. If approved, premiums paid during the applicable waiting period may be refunded in accordance with the policy.
- Applicants may also elect retiree life insurance and/or retiree spouse life insurance. If Waiver of Premium is approved, the City will refund applicable life premiums paid, according to City procedures.
- If approved, an 180-day (6 months) waiting period applies before the benefit begins, measured from the disability date established under the policy.
- Under the City's stated provisions, Waiver of Premium coverage ends at age 65. Contact the Human Resources Department within 31 calendar days after the retiree's 65th birthday to request retiree and/or retiree spouse life insurance, subject to eligibility requirements.

Retiree/Spouse Basic Life Insurance

- At retirement, eligible retirees may elect a $5,000 or $10,000 retiree life insurance policy.
- A $5,000 retiree spouse life insurance policy is available only when the retiree elects the $10,000 retiree life policy.
- Retirees who elect City retiree life insurance may also be eligible to convert active employee life insurance to an individual whole life policy.
- Retirees who do not elect City retiree life insurance may be eligible to continue active employee life insurance through portability to an individual term life policy, subject to The Standard's requirements.
- Contact The Standard and submit any portability or conversion application within 31 calendar days following retirement, subject to the policy provisions.
  Review and update life insurance beneficiary designations at retirement. Beneficiary designations may be changed at any time during the year.

Retiree Life Insurance Coverage and Monthly Premiums

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

Post-65 Retiree Health Reimbursement Account (HRA)

The City of Amarillo offers an annual Health Reimbursement Account (HRA) benefit by Via Benefits through Towers Watson for eligible Medicare-eligible retirees and their legal spouse. The HRA may be used to reimburse eligible Medicare supplemental insurance premiums and other qualified healthcare expenses, subject to plan rules.

Eligibility and Retirement

- To qualify for the post-65 HRA benefit, the retiree and legal spouse must each be enrolled in the City's medical plan at the time of retirement. Eligibility for each person is determined separately.
- When an eligible retiree or spouse reaches age 65 and becomes eligible for Medicare, that person will transition to Via Benefits to select qualifying individual Medicare supplemental coverage.
- Eligible retirees or spouses must enroll in Medicare coverage before enrolling in their Medicare supplemental coverage through Via Benefits.
- Eligible retirees and spouses may each receive up to $1,800 annually in an HRA when enrolled through Via Benefits in qualifying Medicare coverage. The HRA amount is prorated during the first year of eligibility.
- Approximately three months before your 65th birthday, you should receive enrollment information from Via Benefits. If you have not received the materials, contact Via Benefits directly (refer to pg. 2 of this guide for contact information).
- The HRA allows you to pay for Medicare supplemental insurance premiums and other healthcare eligible expenses.
- To continue receiving the HRA benefit, you must remain enrolled in qualifying coverage through Via Benefits. If you disenroll or obtain Medicare supplemental coverage outside Via Benefits, the HRA benefit ends and cannot be reinstated at a later date.

Retirement at Age 65 or Older

If the retiree or legal spouse is age 65 or older at the time of retirement and otherwise meets eligibility requirements, that person may enroll in Medicare coverage through Via Benefits and qualify for the post-65 HRA benefit. The City's active medical coverage will only continue through the end of the month following retirement. The retiree is responsible for paying the applicable premiums directly to the Finance Department during this period

Changes in Coverage at Age 65

- When a retiree or covered spouse transitions to Medicare at age 65, their coverage under the City's pre-65 retiree medical and dental plans ends according to the applicable plan rules.
- Other eligible covered dependents may remain enrolled only while they continue to meet the pre-65 retiree plan's eligibility requirements. Review your premium deductions or ACH payments whenever coverage changes.
- COBRA continuation is not available solely to extend the City's retiree medical or dental coverage when an individual reaches age 65. Other COBRA rights, if applicable, are governed by the qualifying event and plan rules.

Continuing the HRA Benefit

- Eligible retirees and spouses may continue receiving the HRA benefit for their lifetime as long as they meet the program's ongoing eligibility and Via Benefits enrollment requirements.
- If the retiree dies, an eligible surviving spouse may continue receiving the HRA benefit for their lifetime, provided they remain enrolled through Via Benefits and meet the program requirements.
- For enrollment assistance or questions, contact Via Benefits using the information on page 2 of this guide.

Pension Benefits

Texas Municipal Retirement System (TMRS)

- Your TMRS account will be retired on the last day of the month you are retiring.
- If you elect to begin receiving your TMRS pension immediately upon retirement, your first monthly pension payment, including any elected Partial Lump Sum Distribution (PLSD), will be deposited into your designated bank account on the last business day of the following month. For example, if you retire in June, your first payment will be deposited on the last business day of July.
- Subsequent monthly pension payments will be made by direct deposit on the last business day of each month.

Amarillo Fireman Relief and Retirement Fund (AFRRF)

Firefighters will need to refer to the AFRRF for retirement eligibility requirements. Contact the Finance Department regarding 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 up to IRS annual limits.
- ✓ 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 up to IRS annual limits.
- ✓ 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. 12-hour Firefighters who retire will be allowed to convert any available sick leave, above the 90 days (1080 hours) paid at retirement into an HRA. Each 42 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.
- ✓ 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 annual 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 retirement not to exceed 65 days. Canbe 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 annual leave at the employee's hourly rate pre-tax up to IRS annual limits.
- ✓ 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 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. 12-hour Firefighters who retire will be allowed to convert any available annual leave, above the 65 days (780 hours) paid at retirement into an HRA. Each 42 hours of accrued annual leave above 65 days will be converted to the equivalent of one month of retiree only Medical Plan 1 based on years of service with the City of Amarillo. The resulting dollar value will be deposited into the retiree's HRA.
- ✓ 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

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! Your mental health and well-being matters. The EAP provides mental health counseling and a wide range of whole health support services for all employees and anyone living in your household.

Your well-being is our priority. The EAP Member Portal will provide:

- Enhanced Features: Access mental health support, self-guided therapy (iCBT), financial wellness tools, work-life resources, and new medical advocacy referrals.
- Convenient Support: Easier navigation and seamless connection to services like live chat, phone support, and online request forms.
- Member Portal App or Via Your Computer: You'll be able to access the member portal from your mobile device or computer and request support anytime.
- Self-Scheduling Counseling Appointments: Members can book appointments on their own schedule – quickly and conveniently
- Webinar Registration: Easy access to register for upcoming live and on-demand educational webinars

How to Get Started:

1. Visit **AllOneHealth.com/portal** and click "Sign Up" to create an account using your email and company code: **amarillo**.
2. For help creating an account, click "Email Support".
3. You will receive an email confirmation to complete the registration process.

Download the AllOneHealth App

1. Download the **AllOneHealth App** on the app store or google play.
2. Company code to register is **amarillo**.

Free EAP Services Offered!

- **Request a Mental Health Session**
  Request counseling by submitting an online form or live chat. Choose from in-person or virtual counseling options to meet your needs. You and anyone living in your household receive up to six free, confidential counseling sessions per issue.
- **Request Referrals & Resources**
  Submit a request for family care and lifestyle support including childcare and eldercare referrals, legal referrals and financial consultation, personal assistant referrals and medical advocacy consultation.
- **Explore Thousands of Self-Care Articles & Resources**
  Health and lifestyle assessments, interactive checklists, soft skills courses, podcasts, resource locators, exclusive discounts, and expansive articles on whole health and well-being.
- **Visit Your Online Financial Center**
  Featuring worksheets, calculators, and a wide range of financial resources and tools to help reach personal goals and build financial wellness.

We provide these EAP benefits to help you thrive in all areas of life with holistic support for mental health, well-being, and more. These benefits are completely confidential to use. We encourage you to reach out to EAP for personalized support!

AFLAC

If you have an AFLAC policy through the City and have questions about these policies, please refer to pg. 2 of the guide and contact the AFLAC representative.

Name, Address and/or Beneficiary Changes

Keeping your personal information and beneficiaries up to date is important. The following information explains how to make changes based on your benefit plans.

- **Address/Name Change**
  - Contact the Human Resources 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 Human Resources 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**.
    - Select "View Account" and Click on Beneficiaries. Click on "Manage Beneficiaries." Designate Primary and Secondary Beneficiaries so the allocations total 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/Phone Number Change – Click on **My Profile**, under Contact Information Click on **Change Home Address or Change Phone.**
  - Name Change – Click on **Contact TMRS**, then click on **For Retirees**, fill out Name Change form and submit to TMRS.
  - Beneficiary Change – 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, Finance Department, Rm. 2300.

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

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** 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, 2027.***

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: Human Resources Department
Address: 623 S. Johnson Street, Amarillo, TX 79101
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: Human Resources Department
Address: 623 S. Johnson Street, Amarillo, TX 79101
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 are receiving this notice because you have recently become covered under a City of Amarillo group health plan (the Plan). This notice explains your rights to COBRA continuation coverage, a temporary continuation of group health coverage that may be available when coverage would otherwise end. It also explains actions you and your family must take to protect those rights. Other coverage options, including Health Insurance Marketplace coverage, may cost less than COBRA.

The City of Amarillo is a governmental employer. Its group health plans are subject to the public-sector COBRA continuation coverage provisions of the federal Public Health Service Act. For additional information about your rights and responsibilities, consult the applicable City plan documents or contact the City Human Resources Department.

What Is COBRA Continuation Coverage?

COBRA continuation coverage allows qualified beneficiaries to continue Plan coverage after a qualifying event causes a loss of coverage. Each covered employee, covered spouse, and covered dependent child who meets the applicable requirements may have an independent right to elect COBRA. Qualified beneficiaries generally must pay the applicable COBRA premiums.

For a covered employee, qualifying events include termination of employment (including retirement) for reasons other than gross misconduct, or a reduction in hours of employment, if the event causes a loss of Plan coverage.

For a covered spouse, qualifying events that cause loss of coverage include:

- Death of the covered employee;
- Termination of the covered employee's employment (other than for gross misconduct) or reduction in hours;
- The covered employee becoming entitled to Medicare (Part A, Part B, or both);
- Divorce or legal separation from the covered employee.

For a covered dependent child, qualifying events that cause loss of coverage include:

- Death of the covered employee;
- Termination of the covered employee's employment (other than for gross misconduct) or reduction in hours;
- The covered employee becoming entitled to Medicare (Part A, Part B, or both);
- Divorce or legal separation of the covered employee and spouse;
- Loss of eligibility as a dependent child under the Plan.

Who Must Report a Qualifying Event?

The City is responsible for notifying its COBRA administrator, COBRA administrator, of employment termination, reduction in hours, death of the employee, or the employee's Medicare entitlement, as applicable.

For divorce, legal separation, or a dependent child's loss of eligibility, the covered employee or qualified beneficiary must notify the City of Amarillo Human Resources Department in writing within 60 days after the later of the qualifying event or the date Plan coverage would otherwise be lost because of that event. Include the employee's name, affected individual's name, the event and date, current contact information, and supporting documentation (such as a divorce decree or other eligibility documentation). Submit notice to benefits@amarillo.gov or contact the Human Resources Department at 806-378-4235 for an approved submission method. Do not assume that a change reported only through Workday constitutes COBRA qualifying-event notice.

Timely notice is important. Failure to provide required notice may result in loss of COBRA rights. Keep copies of all notices and documentation submitted.

How Is COBRA Offered and Elected?

After a qualifying event has been reported, COBRA administrator will provide the applicable COBRA election information to qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA. A covered employee may elect on behalf of a spouse, and a parent or legal guardian may elect on behalf of a dependent child.

Qualified beneficiaries will have at least 60 days to elect COBRA, measured from the later of the date coverage would otherwise be lost or the date the COBRA election notice is provided. If COBRA is elected on time and required premiums are paid, coverage generally is retroactive to the date coverage otherwise ended. Follow the election notice from COBRA administrator for election instructions, deadlines, premium amounts, and payment procedures.

How Long Does COBRA Last?

COBRA generally lasts up to 18 months after termination of employment or reduction in hours. Certain other qualifying events—including death, divorce or legal separation, Medicare entitlement, or a dependent child's loss of eligibility—may provide a spouse or dependent child up to 36 months of continuation coverage. Special rules may apply if the employee became entitled to Medicare before a later termination or reduction in hours.

Disability Extension

If a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage, the 18-month period may be extended by up to 11 months, to a maximum of 29 months, for eligible qualified beneficiaries. The disability determination must be reported to the COBRA administrator within 60 days after the determination is issued and before the end of the original 18-month COBRA period. Contact COBRA administrator promptly for the required notice procedure and documentation. If Social Security later determines that the individual is no longer disabled, the COBRA administrator must generally be notified within 30 days of that determination. Additional premiums may apply during the extension.

Second Qualifying Event Extension

If a second qualifying event occurs during an initial 18-month COBRA period, a spouse or dependent child may be eligible for up to 36 months total coverage measured from the first qualifying event. The second event must be one that would have caused a loss of coverage if the first event had not occurred. Examples include the employee's death, divorce or legal separation, Medicare entitlement, or a dependent child's loss of eligibility. Notify the City Human Resources Department in writing within 60 days after the later of the second event or the date coverage would otherwise have been lost because of that event; provide supporting documentation. Contact the Human Resources Department or COBRA administrator promptly to confirm applicable notice procedures.

Premiums and Early Termination

Qualified beneficiaries generally pay the full applicable cost of COBRA coverage, plus an administrative charge of up to 2% (102% total). During an eligible 11-month disability extension, premiums may be up to 150% of the applicable cost. The initial premium generally cannot be required earlier than 45 days after COBRA is elected; subsequent payments are subject to applicable due dates and grace periods described in the election materials.

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). This notice provides basic information to help you evaluate options for yourself and your family.

What is the Health Insurance Marketplace?

The Marketplace helps you find and compare private health insurance plans available in your area. Visit HealthCare.gov for information about available coverage and enrollment.

Can I save money on health insurance through the Marketplace?

You may qualify for a premium tax credit or other assistance depending on your household income, the cost and availability of employer-sponsored coverage, and other eligibility requirements. Assistance is generally unavailable if you are eligible for employer coverage that is affordable and provides minimum value.

Does employment-based health coverage affect eligibility for Marketplace savings?

Yes. For the 2027 plan year, employer-sponsored coverage is generally considered affordable for an employee if the employee's required contribution for the lowest-cost self-only plan providing minimum value does not exceed 10.22% of household income. For family members, affordability generally depends on the cost of the lowest-cost employer plan that covers the employee and the applicable family members. If the employer's offer is affordable and provides minimum value, the person generally cannot receive a Marketplace premium tax credit for the same period. Eligibility is determined separately for the employee and family members.

Minimum value generally means the plan covers at least 60% of expected allowed costs and provides substantial coverage for inpatient hospital and physician services. If you purchase Marketplace coverage, you may lose the employer contribution toward your employer-sponsored coverage, and that contribution may have favorable federal tax treatment.

How can I get more information?

Visit HealthCare.gov for coverage options, enrollment information, and Marketplace assistance. For questions about coverage offered by the City of Amarillo, review the City's applicable plan materials or contact the Human Resources Department at 806-378-4235 or **benefits@amarillo.gov**.

PART B: Information About Health Coverage Offered by Your Employer

You may need the following information if you apply for Marketplace coverage. The item numbers 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 623 S. Johnson Street, Amarillo, TX 79101	6. Employer Phone Number (806) 378-4235
10. Who can we contact about employee health care coverage at this job? Human Resources Department	
11. Phone Number (if different from above) Same	12. email address Benefits@amarillo.gov

Coverage offered by the City of Amarillo

☐ **All employees** ☒ **Some employees**

Eligible employees: Regular full-time employees who meet the eligibility requirements of the City of Amarillo's group health plan.

Dependents: ☒ Coverage is offered to eligible dependents under the terms of the Plan.

☒ The City's coverage is intended to meet the Affordable Care Act minimum value standard, and the employee cost of coverage is intended to be affordable based on employee wages.

If you are not eligible for the City's health plan, or if an offer of coverage does not meet applicable affordability or minimum value requirements, you and your family may qualify for Marketplace coverage and financial assistance, subject to Marketplace eligibility rules.

Source: U.S. Department of Labor Marketplace Coverage Options model notice (adapted for the City of Amarillo); IRS Revenue Procedure 2026-26 (2027 affordability percentage).

Other Notices

Newborns' and Mother's Health Protection Disclosure

Under federal law, group health plans and health insurance issuers generally may not restrict benefits for a hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or 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 newborn earlier than the applicable 48-hour or 96-hour period. Plans and issuers may not require the attending provider to obtain authorization for a hospital stay that does not exceed these periods.

Women's Health and Cancer Rights Act (WHCRA) Notice

The City of Amarillo group health plan provides benefits for mastectomy-related services as required by the Women's Health and Cancer Rights Act of 1998. For individuals receiving benefits in connection with a mastectomy, covered services include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of all stages of the mastectomy, including lymphedema.

These services are provided in a manner determined in consultation with the attending physician and the patient. Applicable deductibles, copayments, and coinsurance are consistent with those that apply to other medical and surgical benefits under the Plan. For more information about coverage and cost sharing, contact the City of Amarillo Human Resources Department at (806) 378-4235.

Notice of Special Enrollment Rights

If you decline enrollment in the City of Amarillo group health plan for yourself or your eligible dependents (including your spouse) because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents if you or they later lose eligibility for that other coverage, including exhaustion of COBRA continuation coverage, or if the other employer stops contributing toward that coverage. You must request special enrollment within 31 calendar days after the other coverage ends or the employer contributions stop, as applicable.

If you acquire a new dependent through marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible dependents. You must request special enrollment within 31 calendar days after the marriage, birth, adoption, or placement for adoption. Coverage following birth, adoption, or placement for adoption will be effective as of the date of the event when a timely and complete enrollment request is submitted. Coverage following marriage will be effective in accordance with applicable federal requirements and Plan provisions.

You and your eligible dependents may also qualify for a special enrollment period of 60 days in either of these circumstances:

- You or an eligible dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because of a loss of eligibility.
- You or an eligible dependent becomes eligible for premium assistance under Medicaid or CHIP toward the cost of the City's group health plan coverage.

For loss of Medicaid or CHIP eligibility, request enrollment within 60 days after coverage ends. For newly available premium assistance, request enrollment within 60 days after the determination of eligibility for that assistance.

To exercise special enrollment rights, you must submit a timely enrollment request and any required supporting documentation to the City of Amarillo Human Resources Department. Contact Human Resources at (806) 378-4235 or benefits@amarillo.gov for instructions. Eligibility, effective dates, and coverage are subject to applicable federal law and the terms of the Plan.

This notice describes special enrollment rights under the City's group health plan; it does not replace the Plan's governing documents.

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 July 31, 2026. 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: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ 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	**ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	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
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
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, 2026, 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. Sec 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 5/31/2029)

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